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Session 116PD
The Future of Managed Care

Track: Health

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Panelists: JOHN M. BERTKO
JAMES P. TURNER

Summary: Managed care has been under scrutiny, especially since Congress opened the debate on the Patient's Bill of Rights. Panelists discuss this topic and also present their views on whether we are experiencing a temporary swing in the pendulum. Attendees learn about the pressures on managed care programs and the strategies being used to address the changing dynamics of the managed care environments.

MR. DAVID V. AXENE: We're going to have three speakers today. Jim Turner will begin the session. Jim is a partner with Deloitte & Touche, and he will be speaking on the contracting perspective, getting into some of the tiered networking issues. John Bertko, a chief actuary with Humana, will be talking a little bit about what Humana has been working on and will look at what a typical plan is doing to anticipate the future of managed care. I'll close, talking more about the medical management side and what to expect in the future as it turns to the medical management side.

MR. JAMES P. TURNER: Over the past couple of days, there have been a lot of good presentations. What I want to cover here this morning is an environmental assessment, a recap of what we've been hearing and what we've been living. One alternative future is focused on the provider contracting angle and something that looks like tiered networks. There's a case study at the end. I don't know if I'll have time to go into that, but it has some specifics around the particular client that we applied this to at Deloitte.

In terms of the picture today, before we look out into the future, what's driving a lot of the activity is the double-digit cost increases that we're seeing and less tolerance to accept those from the purchaser community.

I think I've heard, at least a dozen times, that managed care is dead or that we're not going to see any future in managed care. I've also heard, probably a dozen times, that its demise is premature. What's interesting now in the marketplace is that, while three to five years ago there was a consensus view in the market about what the future was going to look like and a bevy of consultants trying to do work around that consensus view, today, there is little consensus about what the future product designs look like or what the role of the health plan is. In fact, three to five years ago, a lot of people in the industry were even questioning whether the health plan had a role. There was little consensus and a lot of confusion about what to do for provider strategies, at both the health plan and hospital levels.

Providers, we're finding, were reluctant and continue to be more reluctant to manage risk, and we're ill-prepared after the late 1990s.

The consolidation in the hospital industry and the lack of incentives for efficiency are also influencing these cost increases. When we're looking at what the marketplace is looking for, there is an appetite for something different. I am using some information that was put together by Watson Wyatt. When it was looking at some of the consumer-driven health-care models, there was no consensus from the employees about what they wanted to do.

Forty percent were interested in defined contributions, but 23 percent were objecting to that. Probably the balance and some portions of these percentages didn't really understand what that meant.

The employees still want their employer to facilitate the process of purchasing health care on their behalf. Employees want open access and more choices. They say they're willing to pay more for fewer restrictions, although the preference of those that are willing to pay more are more around paying more at point-of-service (POS), rather than higher contributions or higher premiums.

We're seeing more plan designs emerging, but, as of the time we were putting the presentation together, not a lot of plans were being sold that had incentives to move patients to cost-efficient providers.

From the employers' perspective, they are also interested in implementing new delivery systems and purchasing models. Some are looking at that, but the minority of employers really want to change health plans. Most of them want to have more choice and control by the consumers, their employees, and a majority are looking at multitiered networks but institute them only if there are going to be significant cost savings.

One of the reasons I decided to speak on this end is that there really is a lot of interest from employers about going back to a more selective provider selection model.

I'm going to talk about one project that we did for a large, self-insured state employee group. Basically, it's a tiered network model, with a broad choice of providers. The way that it was organized is an employee has to choose a primary care physician or a clinic. Along with that choice comes a panel of other providers, specialty providers and hospital systems.

Each clinic or provider group has its own historical referral and hospital admission characteristics. Ultimately, we put them into three tiers of providers. The design also allowed employees and dependents to choose their own network, so each family member can have a different benefit design. The cost sharing is going to be greater for people who choose to go into provider groups that have more expensive tiers.

It was also designed so that the premium cost for the employees was independent of whom they chose. The way it is structured, since it is a self-insured employer, is there is more than one health plan, but they're really acting as administrators. Their role is to keep the members healthy, introduce programs around disease management, get more favorable provider contracting, more on the fee-for-service basis, the core function of claims adjudication, and agree to some performance standards.

Table 1 shows how many provider groups were available. They are basically clinics, and this was the risk-adjusted experience. We used ambulatory cost groupings, and this was before any benefit adjustments. This is the raw claims cost, and you can see that there was a wide variation.

Table 1

An Alternative Future

Illustrative Provider Group Risk Adjusted Experience

Provider Group	PMPM Cost	Provider Group	PMPM Cost	Provider Group	PMPM Cost	Provider Group	PMPM Cost
A	$200	N	$241	BB	$261	OO	$286
B	$215	O	$242	CC	$262	PP	$287
C	$216	P	$243	DD	$269	QQ	$290
D	$218	Q	$244	EE	$270	RR	$296
E	$219	R	$245	FF	$271	SS	$302
F	$225	S	$246	GG	$272	TT	$303
G	$226	T	$247	HH	$276	UU	$304
H	$227	U	$248	II	$278	VV	$305
I	$228	V	$249	JJ	$279	WW	$306
J	$231	X	$252	KK	$280	XX	$315
K	$232	Y	$253	LL	$281	YY	$328
L	$233	Z	$254	MM	$282	ZZ	$333
M	$234	AA	$258	NN	$283	AAA	$340

PMPM = Per Member Per Month

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This includes all primary care, all specialty care and all hospital services, independently or included in whatever the particular group provided. Even the low-cost provider may have been using a high-cost hospital for certain procedures.

In looking at Table 2, this is after benefit cost. The total average benefit cost was $225, with level one being $198, about 12 percent below the average, and the highest was at $250. This is per member per month (PMPM) claims cost risk-adjusted.

Table 2

An Alternative Future

Illustrative Impact of Employee Incentives

- Members select more cost efficient providers
- Cost savings can be predicted through modeling of member movement

Before	Level 1	Level 2	Level 3	Total
Cost PMPM	$198	$227	$250	**$225**
% of members in Level	31%	36%	33%	100%
% of members with access to level	60%	70%	50%	100%

After	Level 1	Level 2	Level 3	Total
Cost PMPM	$198	$227	$250	**$219**
% of members in Level	45%	35%	20%	100%
% of members with access to level	60%	70%	50%	100%

- Additional employer savings occur because of employee cost sharing in lower tiers
- Targeting Level 1 cost PMPM would result in an overall reduction in employer spending of 12%

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The distribution of membership within each of the initial tiers was basically evenly split between the low-cost and the high-cost providers. The employer, in this case, was looking at cost savings from two areas. It was introducing cost sharing at levels two and three that were much higher than it had previously had. At the level one, the low-cost providers were introducing some cost sharing that was a little higher than it'd had before.

Just increasing the amount of cost sharing was going to save dollars.

The other thing is, because of the way that it structured that cost sharing, the hope was that it would steer more members to choose the low-cost providers. We ran a number of scenarios about what would be the likely selection, but we did design the benefits so that the expected claims cost of each one of the tiers would be similar—so there wouldn't be a big differential if they chose tier three versus tier one. There was a lot of modeling done around that.

Table 3 is what the benefit design looked like for each of the tiers. Going from level one to level three, there was an office co-pay differential of about $10 to $25. The emergency room co-pay was the same for all three. Looking at inpatient admissions, there was a five times differential—a nominal $100 per admission co-pay to a $500 co-pay.

Table 3

An Alternative Future

Sample Plan Design

Level 1	
Office Copay	$10
ER	$50
Copay per Inpatient Admission	$100
OP Surgery Copay	$50
Coinsurance	100%
Deductible (S/F)	$100/$200
Rx Copay	$10/$25
Out-of-Pocket Limit (S/F)	$3000/$6000

Level 2	
Office Copay	$15
ER	$50
Copay per Inpatient Admission	$250
OP Surgery Copay	$100
Coinsurance	90%
Deductible (S/F)	$200/$400
Rx Copay	$10/$25
Out-of-Pocket Limit (S/F)	$3000/$6000

Level 3	
Office Copay	$25
ER	$50
Copay per Inpatient Admission	$500
OP Surgery Copay	$150
Coinsurance	80%
Deductible (S/F)	$300/$600
Rx Copay	$10/$25
Out-of-Pocket Limit (S/F)	$3000/$6000

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Coinsurance was also introduced at some of the higher tiers. All of the tiers had a deductible, and the prescription drug was carved out, I believe, so that was the same for all three tiers.

In terms of the design and where the employer wanted to get with the pricing, there were two factors that they were trying to weigh. One, when it initially did the tiering, there were a lot of areas, particularly rural areas, where there were no tier-one providers, so the employer, which also had the union involved, wanted to make sure that there was at least one tier one provider in any given geographical area. It could move more providers into tier one and improve the access, but that definitely had a benefit cost associated with it.

The other design feature that it played with was cost sharing. How large did it want the cost sharing on the tier one to tier three, and what was the differential? Those were the factors that were played with.

Let me summarize some of the features in terms of each of these attributes. The providers group by cost was what was initially done. The provider groups would be split into three tiers by membership, but the employer can change the access provisions to make sure that numbers in certain areas have a low cost-sharing option.

The cost determination for providers, when we did the study, was based on their actual historical claims experience. When we were selling this to the provider

groups, we left open the option that if there were too high a cost, they could come back in and readjust their fee for service or their fee-for-service equivalent so that they could have an influence on where their tiering was, but they could adjust only that. We wouldn't accept, "We are going to reduce our hospital utilization by 20 percent." That wasn't acceptable.

In terms of provider information, I don't know where they finally got on this one, but some of the information would be available to consumers in terms of the cost differentials, and why that particular provider maybe moved to a tier two or a tier three.

A great attribute of this system is that the efficiency benefits of moving to a tier one impacts the employer and also goes to the patient. It wasn't instituted in the first year, but this year, they're working to include some quality indicator rewards for each of the provider groups. The initial design was based solely on the cost efficiency.

Members can change their providers once they select them. There are certain limitations, like they can't jump tiers, but they can stay within a tier, and they have to go through some of the same provisions that we have now to change a provider.

Clearly the cost differential is reinforced to the members every time they have to have a higher cost sharing if they are in tier two or tier three. In this particular case, we relied on the health plans as the administrator for all of the administrative functions and for all the contracting with the individual providers.

Although it stayed self-funded, the employer avoided the direct contracting traps. Again, risk adjustment was key to this. Some of the tiered networks we're seeing coming out now don't really address that. It's more on the provider that you choose at the POS. Theoretically a provider can choose a cost-efficient hospital to do an appendectomy and can choose a different hospital to do a coronary artery bypass graft (CABG). That choice is coming back toward the provider.

The providers can take risk under this system. The other part of the risk that they're facing is whether they're going to be staying in the same tier or move the next year. They can have great influence about where they end up in the following year.

Did the provider community accept it? This was in a fairly highly penetrated managed care market, so there was mixed acceptance. This was in Minnesota, for the state of Minnesota. You can imagine it would sell differently in South Carolina than it would in California. I do a lot of work in California, and I think the capitated medical groups would be interested in something like this because it does give them a little bit more control over how they deal with the hospital networks that they're associated with. There was mixed acceptance, but this did get through.

Do the care systems have to be fixed once you choose? Can you go outside the system with your provider? With your primary care physician, you can choose any hospital. That's clearly going to impact that provider group as to where they're going to end up in tiers next year.

What's the value of a model like this going forward? It reinforces the use of the most cost-efficient provider each time services are received. You do have that feature. If you're in tier three, every time you go, there is a higher cost to you. It allows additional cost sharing with provider choice, so the provider choice is there. You do have to lock in, but it does give you opportunity to have minimal cost sharing if you choose to. It does have the risk adjustment feature, which is going to be a big selling point to the providers.

It encourages the use of the most cost-efficient provider groups. Again, the consumers choose, but they're accountable for their choice. If in the system there are more efficient providers being used, it reduces the total plan cost.

This can be sold as a consumer-driven health-care model without significant adverse selection issues. It permits the employer to say it has a defined contribution plan, but the terms are a little bit different from a voucher approach. It enables the employer's or the purchaser's cost to remain neutral regardless of where they select their provider. So, designing the benefit so that it has little impact on who the employer chooses, again, based on risk-adjusted claims experience, avoids the direct contracting pitfalls that you may have from a large employer by using the health plans in which they have expertise.

Having done a lot of work with providers in the past, this is, in my view, something that will reengage the provider community in refocusing on cost efficiency and quality care and also gets the hospitals and medical groups talking to each other, particularly in areas where consolidation of hospitals has caused a lot of consternation by the capitated medical groups. The employer gets to retain the control of the benefit design and the network composition.

While this was done as a self-funded plan, you could envision this, and it could be designed to be worked for a single health plan, where the variables are the provider groups and what their cost levels are, but the employer can choose which of those provider groups or systems are going into which tier. It gives additional benefit design opportunities to the employer.

In this particular case, there was some value in that there was no premium differential depending on which health plan the members chose to administer their benefits. It provided broad access to providers. I think only a small percentage of providers weren't contracted at all.

The employee and dependents have the flexibility within their own unit to choose their benefit level and their provider within the same health plan.

It's a flexible tool that, from the employer's perspective, is going to save money in three areas: cost sharing, moving members to more efficient providers, and getting the provider community reengaged in cost efficiency.

There is a case study that talks about what some of the benefits were. The employer had targeted 5 percent savings into the year. It turned out that it got 8 percent savings, where the total potential savings, based on the model if everyone had moved to tier one, was 12 percent. It was a significant first-year cost savings for the client.

At this point, we're going to go on to our next speaker.

MR. JOHN M. BERTKO: Good morning. I'm John Bertko from Humana. I'm going to spend a few minutes talking about our plans. I'm also going to present a revisionist history of what Jim just said. He's a calm speaker. I'll just say 18 percent trend for the next four or five years.

Think about it. It means four years from now, we're going to have $400 PMPMs. We're going to have per-employee costs of $1,000 a month that employers are going to have to pay. Not as many people are going to be covered. More important, half of you are going to be out of work.

Now that I've got your attention, I think all of us are trying to address this. Jim talked about a pretty interesting case study of one of the many approaches here. Let me paraphrase a little bit of what came out of an article by James C. Robinson, who is a professor at University of California, Berkley. He talks to a lot of groups. He put an article together in *JAMA* last May, I believe, called "The End of Managed Care."

He said that we've tried government controls. They didn't work. Everybody knows about the hospital Certificate of Need and everything. We've tried health plan controls. Nobody likes them, or at least the media don't like them. We've tried provider groups, and provider-sponsored organizations (PSOs) have gone down in flames. What's left? Well, consumers might be what's left. We have tried everything else.

Here's where we are. What I'm intending to present today is one company's approach to this. There are probably as many approaches as there are companies in this marketplace today, so take this just as one. I'm going to try to present our thinking behind this and potentially the reason why this is at least one approach that might work.

We call our product SmartSuite. The point I'd like to make here is that what we're offering to consumers is choice and consumer direction at the same time. Rather than just having a consumer-directed plan, our philosophy is a range of choices from traditional plans—think today's HMOs and PPOs—with stops along the way all

the way over to the consumer-directed plans with the greatest possible cost sharing. That's what we're aiming for.

With a plan mix, more choice really means more choice. During the 1980s and 1990s, we had a lot of cafeteria plans and flexible benefit plans. Typically they would offer an HMO, a self-insured PPO and some catastrophic plan, and nobody chose the catastrophic plans. Effectively there were two choices, as usual.

There would be a lot of benefits and dollars circulating around in long-term disability or shooting off into 401(k) plans, but in terms of cost-effective strategies, it really wasn't important.

In our product mix, we've got 14 separate plans in this iteration. We've got another one that we're piloting as of July 1 that's got 42 iterations. The range of choices on this is gigantic. That's one of the reasons we're doing this to ourselves—that is, we're offering it to our own associates out the door, is to see what works and what doesn't.

I'm going to talk about year one. July 1 of last year, we enrolled our associates in a six-plan mix. We arranged those 14 plans, and these are on the market today, into a choice of four bundles. Bundle 1 happened to be the richest one. It was close to our current traditional HMO and PPO features.

Bundle two, out of order, happened to be the cheapest one. There were big co-pays and deductibles, so it was a steep step down if an employer chose that one. Again, think of bundle one as being at the richest end, bundle four being at the cheapest end, and there's overlap in the middle areas. Three and four are other choices for the employer to make.

What is the change from now, compared to 1985, when the first big cafeteria plans or flexible benefit plans end? It would be too simple to say it's the Internet, but it's more information provided on an easier basis. In our case, we've developed what we call the Wizard, internally. It's an electronic questionnaire with multiple paths. I will claim credit for my actuarial colleagues who helped drive the logic tree and helped not so much by writing the way the questions are formatted, but by looking through what some of the main choices had to be.

Our employees liked it quite a bit. More than 80 percent of our associates use it. Not everybody agreed with the choice that was suggested. We make the Wizard neutral on choices, that is, no weights that said to go one way or another. That means if you elected no gatekeeper, we're not going to recommend an HMO. If you said you can't afford to have any out-of-pocket expense, it's going to send you back toward the traditional plan.

This wasn't possible back in the 1980s, or if it was possible, it was a $1-2 million paper-based consulting windfall for consulting firms. I used to be a consultant, so I

can say those things.

Our associates enrolled electronically. It doesn't have to be electronic, but most of our employer customers have the ability to enroll most of their employees electronically. In some cases, kiosks can be used, people can do it from home and can even do it from a library, I think. It doesn't always work, but it will capture a lot of people.

We had some special plan features. Jim did a good job of describing what I would say is fairly aggressive tiering or complex tiering. We did simple tiering in terms of the physicians here. I won't talk more about that because he covered it more than adequately.

We get to those plans at the highest cost-sharing end of it, consumer-directed things, and we made some practical choices here. Some of our competitors are putting together plans that have health savings accounts, personal care accounts, whatever you want to call them. A year-and-a-half ago, we weren't ready for this.

What we cooked up was something that provided a $500 allowance as opposed to a true savings account up front, a gap—in the words of the Democrats, a doughnut hole, which is what they used when they described the new prescription drug proposal— and then more or less full coverage after that.

We couldn't decide among ourselves ahead of time which one would work better. The first one was $500, then a $1,000 deductible and then 80-20 and then 100 percent. The alternative was $500, followed by a $2,000 deductible, followed by 100 percent. We put it to a vote. People voted with their feet, and they couldn't tell. We got about an equal amount of enrollment in each of the two.

In our newer iterations, we're going to have health savings accounts. As almost everybody knows, all of us are waiting for the Treasury to rule on this. I don't know that I've heard anything in the past day or so, but I was at a meeting in May in Washington, and the Treasury guys there said, "Hold your breath. It's coming." Well, I'd have been long dead had I done that.

Here's an example. I won't go too much into this other than to say, if you have small costs, are a normally healthy person and have got to have a preventive visit for a mammogram and an office visit, most of that is paid for under the first $500, the "Coverage First" part of it.

Here is the part I think that we always knew was important. Our company for our associates and for our first couple of clients said it was important. We underestimated the explanation for new kinds of products. Now, keep in mind we're rolling this out to our own company. We've got employees who deal with health insurance issues every day of their lives. When we got done with our open enrollment and did a post-enrollment survey, one of the common responses to

Coverage First was, "What was that? How did it work?"

We thought we had done a tremendous job of explaining it, and we didn't. I should say it differently. Compared to everything else, we did a good job, but it wasn't enough. These are new kinds of products, and you can't underestimate not so much the consumer resistance, but the lack of consumer knowledge on these kinds of things.

FROM THE FLOOR: How many people were covered?

MR. BERTKO: We had a total of 15,000 roughly in year one because we wanted to concentrate. We have 5,000 employees in our Louisville location, and so we rolled it out only in Louisville. We have 5,000 employees and about 10,000 members. I'll show you some stats in a minute.

We had a bunch of online tools, the pre-enrollment stuff, the enrollment Wizard and enrollment tools. You could click on links and get to the plan comparisons. This was, "Help yourself, please." We had our CEO send out a letter every month for the three months up to the open-enrollment period.

Where will savings come from? This is the critical issue. Does this work? So far, at nearly at the end of year one, the answer is that it seems to work. Our trend on a do-nothing basis would have been in the high teens. That's what we're showing to other customers in our Louisville location.

Today our trend, as measured nearly to the end of the year, and you know all the incurred but not reported (IBNR) stuff, seems to be in the high single digits. In my mind, that 10 percent gap is worthwhile for a single year and has the potential to go on for several years.

Where does the savings come from? Employee choice. The range of benefits, as I said, came from about this wide, to opening it up to that wide. The contribution strategy here is incredibly important. Most of you have heard the phrase "managed competition." That went by the wayside. It just wasn't that popular to say, "Let's line up plan A, plan B, plan C, and pay the same and see what happens."

It turns out that, over the years, nearly every provider was in every network so choosing from A, B and C made absolutely no difference. However, this way, which is similar to the way the Federal Employees Health Benefits Program (FEHBP) works, you pick a reference plan, and the employer picks it and says, "I'm going to fund this much."

We picked as our reference plan our PPO from the year before. We tweaked it a little bit for benefits, but we said, "We're contributing this much," which was about 79 percent of the reference plan premium for that PPO. If you wanted to buy up a to something, you'd have to pay a little more. Mostly people got to buy down.

In our case, where we have a range of payroll, from the CEO down to people who work paying claims or in the mail rooms, it turns out that on a single-employee basis, if you bought down to Coverage First levels, you'd save on single employee, $15 per pay period, roughly $30 per month, or on a family basis, about $120 a month. That $1,000-plus per year was significant to somebody making $20,000 or $25,000 a year.

What else did they do? It appears that employees and their spouses looked over and said, "It looks like we're covered twice." We had 220 dependents disappear from coverage, so we went from about 9,900 covered members down to 9,700. As best we can tell from out post-enrollment survey, only one person went bare. At least that's how they answered the survey question.

We did explicitly keep in cross-subsidies. Keep in mind here, what we've done is we've taken a risk pool, which is concentrated in two traditional plans, HMO and PPO, and fractured it. We did it purposely. We're trying to tell people that it might be good for them to move into these consumer-directed models that are much cheaper, but we've kept up cross-subsidies.

We consciously overcharged the expense of those Coverage First products, and there is huge positive selection for people choosing that. We measured it on what the claims were beforehand. They were roughly 50 percent of the average claims of the associates in Louisville. We measured their claims, and to date, they're down to about 35 percent of the average.

They are healthy people, and it appears that the consumer-directed part of this is causing them to think about how they spend money. It's likely, as we move into the last month of the year and the Coverage First $500 gets ready to expire, there's no rollover provision. We'll probably get a pickup in that. I'm going to be back to our customers and prospects and probably some of you eventually in three or four months when we actually know what's happened.

Here are a couple of statistics. Again, payroll deduction didn't change on the traditional PPO offering. We had 6 percent of people move to those two Coverage First options, about equally divided. We put in a step along the way. We put in a midlevel $250 deductible PPO plan. We thought it would be a nice idea to have a step down. We didn't expect much enrollment in it, but the rethinking that people did by the buy down made some of them choose it— another 5 percent. We were double what we thought our first-year migration would be.

In Louisville we have changed our plan again to this more complicated one for the second year, but we instead rolled out a close version to this first plan to our non-Louisville associates, about 10,000 employees. There's been lots of word of mouth about how this works and better education. In fact, some of the people in our Green Bay location held seminars—I would almost call them budgeting seminars—on this.

We appear to have gotten 20 percent, I'll call it second-year enrollment, in the Coverage First plans among our non-Louisville associates.

One of the things that I'd like to point out with this approach is it offers a clear choice to our associates. It says that you can have traditional plans, you can have co-pays and you can be secure in what your health-care budget is going to be for next year. You get sick and go to the doctor, and it's going to be a $20 co-pay and $100-per-day admission. You don't have an out-of-pocket worry.

In our first year, we looked at who enrolled in the Coverage First plans, and our main building with finance and actuaries was the place where it was chosen. We know people in the finance department who ran spreadsheets to see which way they'd be better off.

How many of you have at least a $500 deductible on your Volvo? Why wouldn't you have a $1,000 deductible on your health plan? You, as a class, all make a lot of money. You can afford a $1,000 deductible. I'm exaggerating a little bit for effect.

People who can afford that are better off to some extent because their payroll deductions have gone down. But they've got to put that money that's no longer being deducted from their paycheck into their savings. I'm certain our $20,000-a-year people are living paycheck to paycheck and don't have room for a $1,000 deductible, and you've got to accept that.

Consumers have got to assess this tradeoff in budgets: higher payroll deductions but more predictable health-care expenses or much lower payroll deductions but possibly much higher deductibles.

The point that's connected with this is that employers, our customers in this case or Humana's customers, have to start rethinking this. We've quoted this maybe 100 times now, and at least half the times, we go out and ask, in better terms, "What's your reference plan?" The employer and frequently the broker or consultant says, "Huh?" We say, "Well you've got to pick something that you're going to fund and then go up or down from there."

Of that group, most of them say, "What would you recommend?" We're not consultants. We're in the business of saying, "This is how plans work. We're trying to give you a solution." We run lots of iterations on this thing.

Where else will this save money? We continue to need to distribute more information on alternative treatment options. I've talked only about the Wizard, but most of you who pay any attention to this know that there are all kinds of what are sometimes called "shared decision-making tools" that are electronically available. All of that will help and will give alternative treatment options.

At some point, do we get to actual costs? Back in the 1950s, you went to a doctor,

got a bill from the doctor and submitted it to your plan, whether it was a BlueCross plan at the time, the Metropolitan where I used to work years ago or something like that. People don't see the bills today. They see a $10 or $20 co-pay. Again, it's well-known that they are not aware of what the actual costs of things are.

What's part of our responsibility here? I'm assuming that many of you are in here because you either work on products or you work with people who do product design. More options doesn't mean 15 flavors of vanilla. It means not only are we selling ice cream, but also we're selling cookies, cake and candy, as well. Those options have got to be more diverse in the future.

We need to retain efficient traditional options. I think Jim's presentation was essentially saying, "Take traditional options and make them more efficient for state employees." I think that was probably the whole direction of what the state of Minnesota was doing.

Second, we've got to offer new, lower-cost options that are understandable and that have big potential out-of-pocket savings, at least as the reference plan is set up. In total, it's more choice for employees and consumers.

There are a number of huge questions here. Are consumers going to be ready to evaluate efficiency before choosing providers? I've used efficiency essentially as a code word, cost. Will they be willing to look at it? Today's newspaper, at least on the news clips I saw on my computer this morning, said one of the California plans is now going to add quality to how it pays hospitals because all of the hospitals are complaining that just because they're high cost, they shouldn't be cut out of networks.

Many of us are going to be struggling with the combination of cost and quality measures over the next couple of years. Will individual consumers be willing to carefully assess the need for services before buying affordable health insurance? My two daughters are now college age, but I'll tell you that when they were younger and something was needed for them, the question wasn't, "Do I have a $30 emergency room co-pay or a $20 co-pay for the doctor?" It was, "Let's haul Kate to the hospital because she is burning up."

Will consumers take this time? We don't know that yet. There's an awful lot we don't know about consumer behavior.

MR. AXENE: I'm going to talk about what we can do as far as medical management. We've all tried to give a little bit of history, and so I'm going to try to do that.

There are some skeptics in the room, I'm sure. There are some proponents of managed care, I'm sure. Similar to these reality-TV things, I'm going to try to talk a

little bit about reality-based managed care and my impression of what our likely future is. We'll then go into questions and answers.

I will have to include a caveat to what I'm about to say, which is that I probably come from a role of still being an advocate of managed care, probably from a perspective whereby I was frustrated to hear my actuarial peers say that managed care is dead. You'll probably figure out my bias halfway through here.

Here's a little bit of history. If you go back to the beginning of managed care, and not quite as far back as when the Kaisers and the Group Health Cooperatives got started, but probably around the time that the federal government started throwing money out to the HMO act, managed care was offered as a cost-effective alternative, predominantly offering some type of medical management.

Some of the cost advantages were unfortunately disguised as richer benefits. They could offer more for less. Some health plans were more effective than others at delivering the cost savings. In some markets, managed care was always more expensive than traditional coverages. In other markets, managed care became less expensive.

As time went on, plans transferred risk to providers, unfortunately with most providers accepting this risk without having any idea of what was going on, and they had no idea or tools available to manage the risk themselves.

There were some isolated patient complaints about access to care, which I'm sure caught our lawyer friends' interest. Some provider complaints emerged about unreasonable payment levels. We saw newspaper articles about how plans were negotiating with hospitals. There was a lack of patient access in some situations and what was called obtrusive plan oversight. In other words, the plans were stopping patients from getting care.

The word "gatekeeper" was used frequently. A few years ago, we ended up with the patient-friendly Patient's Bill of Rights proposals. Some plans have responded with a provider-friendly, coordinated-care model. We've heard about John's model here and the one that Jim was working on. Often times these are a euphemism for no or little medical management.

The market has eased off on medical management in response to the fear of the Patient's Bill of Rights and whatever else has been passed and the strong public opinion saying, "We don't want you pushing us around any more." But ironically, employers are again concerned about the cost of their benefit programs.

We're back to where we started. We started with a cost concern. We went through a lifecycle, and we're back to a cost concern. I think John's 18 percent might be low. It's frightening where things might be headed in the near term.

Let's talk about the skeptic's view. I'll try my best to present your point of view in an unbiased fashion.

Some of you say managed care, as we knew it, failed. It was a disaster, it didn't work, it didn't accomplish anything. Others say the plans weren't able to deliver their cost savings promises. In other words, they promised the world and couldn't deliver it.

Others say that managed care is poor-quality care, and patients don't want it. They think that managed care, or whatever it should be called, is just a horrible situation. Others say it's an interesting idea, but it passed its time and is not going to work anymore. I could quote a few of you in an earlier meeting that I attended on Monday, I believe, saying that it is clearly dead; it never was intended to work.

I'll switch over to the proponent's view. Many say it was a good idea, it did work and it is still working in many places, although some have failed at implementing it. I think there are several examples where you can see that, in certain communities and certain plans, the concept of managed care is alive and well.

However, most say that the managed care industry did a poor job demonstrating its value to its publics, since there is so much misperception. I think that most agree that certain segments of the managed care market went too far in the wrong direction, giving the industry a black eye. Some point out that reasonable hurdles or barriers to unnecessary and potentially avoidable care have been misinterpreted as poor access to care.

If you could just bear with me for a second, if people are consuming too much health care—if we could define too much—why is restricting that excess consumption called poor access? At some point in time, you're probably doing some good by restricting the access. However, if you go too far, perhaps you then can talk about poor access.

So, who is right? What is the real situation? Was managed care good? Was managed care bad? Is it good now? Is there a future or is there not? The only way that I can answer that question, whenever I have a disagreement with someone, is to go through the givens, the things that we can all agree on. Hopefully we can mostly agree on this list of givens.

First of all, delivery patterns still vary significantly across the United States. The average lengths of stay for identical conditions and identical patients in two different communities are significantly different. I think we can all agree that discounts have gotten too big in many environments, hurting the financial viability of providers, both physicians and heath systems, and their ability to deliver high-quality care.

When a hospital's compensation or reimbursement reaches a level that they can no longer adequately staff the number of rooms that it takes to meet the population coming to that hospital and patients are turned away from hospitals to go to another hospital because they don't have enough nurses, there is a serious problem with the quality of care. I think some of that has been caused by lack of reimbursement—some from the government and some from health plans.

I think we can all agree that patients need to be involved in their health-care decisions, but at the right point and with the right information at their disposal. Both of the approaches described by Jim and John earlier were ones in which patients were involved in making the decisions.

I believe we could all agree that the direct-to-patient consumer drug advertising has had a major impact on the utilization of new drugs and will for the short term. We cannot pick up a magazine and not see an ad. I'm sure everyone in this room has a story about someone consuming a designer drug due to advertising.

I think we can also agree that bad news usually travels faster than good news and that bad news is often interpreted as the norm. When we see newspaper articles, we're often seeing an exception. After all, that's why the newspaper sells. Having recently joined an accounting firm and seeing all of the articles about accounting firms, hopefully there is only one of us having a serious problem, or else several of us will be needing new jobs soon. Just because there's one bad apple, it doesn't mean that they're all that way.

Whenever good news is presented in the managed care world, it is usually openly questioned. More often than not, the good news is questioned and challenged as coming from biased sources.

I think we can all agree that physicians truly control the system and have the greatest chance of controlling the outcome. I think that we have to realize that the physicians do have this control, and we have to facilitate what they do. I'm an advocate of physicians controlling the system.

It turns out that the least-qualified evidence questions even the best clinical evidence of improved efficiencies. Somebody will have an anecdotal experience and will challenge the best evidence that's out there. I think that we will find that quality is poorly defined within the health-care system, but it's always important to each of us. Because we have poorly defined quality, we continue to argue about it, when, in fact most of us are not even using the same definition.

As long as there are venture capitalists and large corporations, I'm sure technological and biotech advances will continue at light speed. There are going to be increasing numbers of options as we go down the path. As the previous speakers identified, and as all of us know, few users have the information they need when they enter the health-care system.

Through the Internet, we all have more information. Through newspaper articles and medical journal articles, we all have more information today than we have ever had. However, very few of us have enough information to truly know whether or not our providers are doing what is correct.

In moving into reality-based managed care, I've tried to identify some keys for future success. If there is going to be a future for managed care, I think that these keys need to be considered.

The first one, and probably one of the most important ones, is improving and maintaining the cost affordability and the price stability of health-care benefits. Employers don't like these 18 percents John was talking about. I believe it was Dr. Brian Klepper at session 86SM, the Health Section luncheon yesterday, who commented that the cost was greater than the post-tax profits of the *Fortune* 10 or something like that in his meeting. If you go back to 1985 to 1989, another study showed that the average health-care cost of the *Fortune* 100 was greater than 50 percent of the pretax profit.

Basically, Dr. Klepper told that the same thing that was true in the 1980s is true today. It's unacceptable to have a health-care system that we can't afford. Some of the ways of improving that are to minimize unnecessary practice, get rid of variation in the system implement realistic provider discounts (realistic on both sides, not just on the health plan side), try to get patients to consume only the care that they really need and develop a cost-affordable solution for pharmacy.

I have a client that I have been talking about. It's sensational, sort of like those exceptions, but it's fun to mention it. The client had a 62 percent trend rate last year on its pharmacy costs. Yes, it was high, but it is a real anecdotal case, and it's a significant employer.

The second key for success is to make sure that we have high-quality care. Let's define it. Let's find out what it really means. We need to proactively determine the efficacy of emerging technologies and their impact on the health-care system to make sure that we really want to pay for these new technologies.

I think we also have to make sure that all stakeholders are getting the information that they need to make good decisions. The patients need to know whom they can trust and where they should go. The provider needs to ask the question, "Am I doing the best possible job of delivering high-quality care? The regulators need to know who's performing and who's not. The payers need to know whether they're getting value for their expenditures. I'm sure the plan sponsors also want to know the answer to the same question.

I think that we should proactively share the costs and the purchasing decisions to those most able to make the correct decisions. This involves the patients. The

patients need a benefit design that incentivizes them to make good choices. Both of the examples that were presented before were attempting to do that.

However for those of us who cannot afford catastrophic situations, we have to have catastrophic protection or else there's no safety net to take care of us. I believe that there will be a return of medical management, whether it's a wolf in sheep's clothing or a sheep in wolf's clothing. I don't know what it's going to be called. As long as there's potentially avoidable care out there, there is an opportunity for medical management of some type to come back.

The cost concerns will enforce the reintroduction in a relabeled, repackaged and improved version. Active medical management focuses on provider-driven problem areas and elective events where it will benefit the most. That's where I believe it is going to go.

Inpatient acute care, disease management, predictive modeling and focused review are the issues that will probably dominate medical management of the future. Passive medical management through broad dissemination of information to focus on patient-driven utilization areas or problem areas is going to be key to this.

I predict that most plans are going to have some type of quality measurement that will be believable across their entire network to encourage patients to choose the quality providers. Helping them understand their outpatient care choices, making sure they're picking the right drugs, and combining that with a consumer-driven plan design are definite components.

The consumer's choice whether or not to participate in the managed care system will continue to include a cost-value decision. At some point in time, the provider is going to have to make those hard choices, and I think John's example was excellent. Does somebody want predictable costs with an out-of-pocket per month, out of their paycheck, or are they willing too take the low-cost option and deal with the $1,000 or $2,000 deductibles?

I hope and believe that the consumer will not only choose the plan, but will begin to choose the provider in light of the cost-effectiveness and performance. The tiered co-pay approaches have a strong likelihood of succeeding if we can figure out a way that the providers can collect those co-pays.

A few weeks ago, I was speaking at a meeting in Boston with a bunch of hospitals, and the biggest complaint that the hospitals in Boston had was "We have no idea how to collect co-pays and deductibles. We've never done it before." I remember when Group Health Cooperative in Seattle introduced co-pays in the mid-1980s. It took significant reorganization to be able to physically collect co-pays. They had to put cash registers in different clinics, and they'd never done it before.

The issue of the ability to collect those co-pays and deductibles will require the health plans to partner with the providers in a new way, or at least help them to administer it so that they will collect the appropriate dollars. The consumer influence on outpatient care choice is going to increase, and we need to educate them.

The new managed care will have to have a quality focus, or it will not succeed. I still am a fan that quality is a proxy for cost, since I find that the highest-quality system generally is the most cost-effective and the most affordable. For common conditions, I still find that to be the case.

Delivery systems demonstrating the highest quality will gain the most enrollment. If we have an appropriate definition of quality and communicate that to our employees and our dependents within these health plan options, people will choose the highest quality given a choice. If they have to give up something, they will not give up quality.

The idea that consumer acceptance of controlled access enhances quality is a tough one. I go back to raising children. We have three kids, and fortunately they're almost all grown. But, as parents, my wife and I established boundaries and found that kids liked boundaries. They said they didn't, but in the long run, the kids preferred boundaries. They knew there was a safety net within those boundaries.

I believe that consumers of health-care services similarly like boundaries. They like to know where they should go. Much like raising children, I think health plans and the industry need to help consumers to understand where they should go, and that becomes somewhat of a boundary.

The broad dissemination of materials on quality and about the plans, as John and Jim both indicated, is going to be critical to make this thing work. Plans are going to have to partner with providers more intensely than ever. It's not going to be easy. There's a lot of bad blood between plans and providers. The data coordination between plans and providers is going to have to become even more intense than it ever has been.

In summary, as long as there are cost concerns, some form of medical management will survive since it works. The biggest change will be packaging it so it will become more acceptable to more publics. Much like the Life cereal ad where it says, "Mikey likes it," once its true benefit is done in a healthy way, the public will like it once it sees what the alternatives are.

The plans that understand the consumer the best and most effectively present the value proposition will win. I think that medical management will be at the key of that. This is the end of our remarks. We will open it up for questions.

FROM THE FLOOR: I'd like to add to John's comment about the Volvo and the

deductible. If you take a person who's making $20,000 a year, as you mentioned, working in Green Bay, I bet that person is driving to work, probably driving an old car and already faces the risk of the transmission going, which is going to cost $1,500 or $2,000. When he takes it in, the mechanic says, "Oh, you need new brakes and new tires." That's going to be $3,000 before he's done. He's either got to come up with $3,000 or junk the car and then come up with a down payment on a new car.

This is just a message for the actuaries in this room to think about. The employees are already taking a risk bigger than a $1,000 deductible with their car. The only difference is that when their car goes, they have to come up with the money. When their health goes, and let's say they break their leg or something and have a $5,000 hospital bill, when they have to pay the $1,000 deductible, they blame you, the employer, for the lousy health plan.

When their car goes, they rearrange their financial structure of their lives to get the new car or repair the old one, but they don't have any animosity toward their employer. I guess the psychological problem to work out is to make it so that the employee doesn't get mad at the employer based on the deductible that they decide to purchase.

MR. JOSEPH ROMANO: I have some comments and questions for Jim and John separately. Jim, first of all, if I remember the quotes exactly, you said, "No premium differential to members," and you correct me if I'm wrong, "and next year we'll do the tier changes." We'll regroup the hospitals in the next year's cycle, so it's an annual cycle.

The question is, the challenge I see in tiering hospitals and tiering networks is once you move to multiple-employer sales, you then have different renewal periods of your employer groups that are out of sync with your tiering changes. Although you wouldn't expect significant movement, you would have some, and some of that movement might be into the higher-cost tiers. Therefore, your premium, if it's set level, would be inadequate for some employer groups.

You'd have a situation where you effectively have to overprice for the presumed movement over time to keep yourself equivalent or level. I'm curious what your comments are on that.

MR. TURNER: First of all, you did get my quotes right. I'm always nervous because I've seen quotes in the newspaper before, and they're not always right. With respect to the example that I showed, it was a much-simplified approach because you have a closed system with all of the timing and dates aligned. The design features that you'd need to put into a multipurchaser model would be significant because you would want to have all of your health plans aligned with the same medical groups.

You'd be looking mostly at a total replacement. In terms of the timing of the provider contracting and the premium rate development and how that ties together, that would be a design feature you'd have to work in with your employer. Can you repeat the part about the overpricing?

MR. ROMANO: My point would be that if your tiering is on an annual basis, you're going to retier your hospital and your network every calendar year. You have employer groups renewing throughout the year, so they're in a cycle of premium that's out of sync with your tiered passage.

So if you're pricing level premium, in theory you should be overpricing for that movement for a period of time, for an employer group's renewal period passes your tiered calendar period.

MR. TURNER: In terms of the example you showed –

MR. ROMANO: Yes, in the example you had, it was in sync.

MR. TURNER: The premium was the same depending on which health plan was chosen, so that wouldn't necessarily apply in the situation you're in.

MR. ROMANO: Right, but what I'm saying is, if you start rolling out the multiple groups, I think you've got to be concerned about the movement of any providers, especially up, because then you'll be basically underpriced for those employers that have a period of choice that extends past your calendar year period.

MR. TURNER: It would be a major consideration.

MR. ROMANO: I have a comment for John. I thought that SmartSuite was a small-group product?

MR. BERTKO: No, it's not. The target market for us is between 500 and 5,000 employees.

MR. ROMANO: Full replacement or not?

MR. BERTKO: Yes, total replacement, at least that's how we're rolling it out, and I can see in limited circumstances that we would perhaps allow a local highly efficient plan into the traditional plan spectrum.

MR. ROMANO: But relative to your plan experience, you didn't have any concern about selection because you had the whole pot. As you roll it out, if you get less than the full pot, do you have any concerns for any building in of risk for selection in terms of the piece you have?

MR. BERTKO: Just to repeat, you got us right. We are trying to roll this out

primarily as a total replacement product, and we're selling it as keeping the risk pool intact. But, yes, if we were to make exceptions, you'd have that worry about whatever happened to the traditional.

MR. ROBERT G. LYNCH: you have to remember that 1 percent of $400 PMPM is twice as much as 1 percent of $200 PMPM. That can be taken as good, as well, from a business perspective. You have more premium volume to get paid out of.

As a little aside to that, there are two kinds of rules in business that I think I heard at my first SOA meeting. Number one is the first step to making money is don't lose money. Number two is it's always better to compete on low price rather than rich benefits. Where these two comments are coming together is, if I can whine and moan a bit, I have a problem, and I think it's an institutional problem within the health insurance and managed care industries dealing with sales and marketing departments. They're paid largely on percentage of premium, so I'm always fighting with my sales and marketing people who want to compete on the richest benefits so they have more in their pocket, whereas I'm trying to follow the maxim of competing on price by keeping things leaner.

I'm also troubled by the fact that with not only internal sales, but also external sales brokers, commissions are percent of premium. Those percentages are not dropping so that the salespeople are getting paid increasingly more. Maybe it's jealousy, but I see that when they've got a 4 percent commission, 4 percent of $400 PMPM adds up fast. But also when we're working on a 2 percent profit margin, that is a lot money compared to our profit margin.

I'm feeling frustrated that part of trying to keep costs down is not being shared by sales and marketing. I'm finding myself continually at odds with sales and marketing over that, and I don't really know what to do about it. I think it's something that needs to be dealt with on an industry wide basis If we try to cut broker commissions, all the brokers send their business to the other guy, and then we're out of luck. I don't know if you'd like to comment on that or not or just let my complaints go.

MR. BERTKO: I'm the health plan guy up here today, so I can say two things. First of all, join the club. All of us probably have similar complaints. The second is that, in some aspects of the market, particularly in small groups, there is a move on turning commissions from percentages to flat. At least I've observed that.

I'd point to the commission schedules in the airline industry as one indication of an inevitable trend that all of us are going to fall into. I perhaps have more compassion because you and I have are going to have jobs and incomes, and the commissions for brokers and agents are probably going to be dropping in real terms— maybe not nominal terms, but real terms—over the next few years. That would be my guess.

MR. TURNER: I tend to agree. I think all of our Internet friends who are trying to do direct-to-consumer marketing might like those brokers and agents to have less to do also.

FROM THE FLOOR : I'll just mention what we're hoping to do as far as quality measures go over the next several years—the wheels move pretty slowly. We want to produce results-oriented quality, which is answering the question. I don't care how you relate that you got this person healthy or you kept this person healthy. It's a simple concept in the way we're going to look at it. It would be based on some sort of risk adjusters to assign health stat numbers to the health status of people and then compare the movement of those individuals over time between health plans, providers or hospitals.

The primary road block is poor availability, but hopefully over the next few years we're going to make some inroads in that. Even if they don't affect the payment to providers, we believe that if we can develop this kind of information and publish it, it will be a powerful incentive for people to start looking at each other and say, "Why are they doing better than us?"

FROM THE FLOOR: As I see it, we're reacting to the high trends of HMO. Jim and John have advocated some benefit changes that could help us out. But I agree with Dave. I believe that this is a provider-driven product. I believe that when HMOs came out, there was some aggressive contracting, and I see now that providers are trying to search for a new level of contracting or receipt of payment such that we're seeing a push or even a blip in the trends.

I'm just wondering if you believe that, once we achieve this new level, will the trends flatten out, even without benefit design changes.

MR. TURNER: I don't have an answer to the specific question, but I think what we've all talked about in terms of medical management, changing the provider tier and changing the benefit design is not going to impact the force of trend in health care. We know we're going to see replacements in therapies. If the long history has provided any rear window for us to look out to where the future is going, something more expensive will replace something cheaper.

That's just the way health care has been, and our demand is insatiable when it comes to health care. My big question, because I just want to add on to this, is what's the sustainable change that's going to impact trends? Once you eliminate the potentially avoidable days and unnecessary procedures, there's a limit to that. There's a limit to what you can do on benefit design. There's a limit to what you can do on provider selections, so I just wanted to add to that.

MR. BERTKO: I actually think the trend scenario for the near term, four or five years, is very bleak. I used some terms that Wall Street analysts use sometimes. Hospitals have incredible pricing power at this point. They've consolidated. I think

Dave mentioned a couple of examples where they're filled to capacity. They have no reason to give us discounts, and that's pretty gloomy.

The second part of it, and there is a BlueCross BlueShield Association (BCBSA)-sponsored study of trend. There are trend up-ticks and down-ticks in terms of new technology. We are in an up-tick of new technology, and everybody knows the drug stuff. There are a bunch of new diagnostic procedures, tests and all kinds of other stuff, including outpatient types of things, in the works. The last one, which we've been silent on, is what's going to happen partly as a result, and it's going to be a terrible feedback loop.

Prices get higher, small groups drop coverage. Small groups drop coverage, hospitals have less revenue. Hospitals raise prices, prices get higher. I don't see any end to that in the political scenario of the next four to five years. I thought my 18 percent was realistic, but maybe not.

MR. AXENE: I'm a perpetual optimist, so for me to be an optimist and to say what I'm about to say, you can imagine how I would feel if I wasn't an optimist. There are a couple of things going on that we haven't talked much about in this session. First of all, whether it was blamed on September 11 or Enron or whatever it's been blamed on, there's a tremendous lack of confidence in the economy right now. I think Wall Street hit an all-time pre-September 11 low just yesterday.

There's a lack of confidence in business right now, which means profits are down and health-care costs are going up. The statistics about who's going to pay for it, the result of people going bare, the increased and the uninsureds, all of this is tied into an environment of Patient's Bill of Rights.

I mentioned it in my session yesterday, and I'll mention it here. It turns out if you go through each of the developed countries with socialized health care systems, it took eight to 10 years after health care was legislated as a right. Before, nobody could afford the system, so they had to establish a socialized system. What's happening right now, in my opinion, is that we're going through a bad time. Yes, it's a trend blip, a lot is due to provider costs, whether it's hospitals or physicians. There's the getting rid of capitation. We're going through a lot of chaos right now.

The economy has been able to withstand this in the past, but we're in a fragile part of our economy, and there's an election coming up in a few years. I believe that we might not miss the national single-payer bullet this time because it's a serious economic situation.

I quoted some statistics yesterday at another session, but if I've got the numbers right, 84 percent of the patients are very happy with their recent care. Yet 60 percent of the employers believe that health-care costs are totally out of control, and less than 40 percent of employers believe that health plans are doing a good

job. That just calls upon us. We have essentially a national crisis that too many people are not paying attention to.

FROM THE FLOOR: One last comment. I believe that consumer education is key. I point to the fact that when the Clintons started to look at health care, I saw hospital and medical trends every day in the newspaper. What I saw on the job were flattening trends for health insurance. If you inform the people of what's going on, nobody wants to increase the utilization, nobody wants to increase the costs and no one wants to be the bad guy, so I think consumer education is the key.

MR. MARTIN STAEHLIN: I know this session is called "The Future of Managed Care," but for a minute I want to change it to "The Future of Health Care Financing." I haven't really heard any discussion of tiering of employees. I wonder if you guys would talk about that. I'm a tier one, and I'm sick of paying for the tier threes, and I'm not going to stand for it anymore.

Given what Dave just said, I don't know why employers haven't said—John you talked about contribution rates as being really important, and I think the surveys are pretty easy—"How many years have you been smoking? Are you still smoking? How many times a day do you eat at McDonald's? How much have you spent on health care in the past couple of years?"

There's a real way to say, in a total compensation package, how people are consuming health care, and possibly they ought to pay for these patterns.

MR. BERTKO: You've got a key item here. I think that the only practical way to do it is some way that's akin to ours in which people make self-selections on which tier they're in. Frankly, the healthy folks choose high-deductible plans.

Let me now go more directly to your question about tier one and tier two. I come from a family, growing up in Ohio, whose genes lead to big guys, lots of fat. I spend 30 minutes on the exercise bike to wear off my eating habits. Now is that genetic, or is it something else? I don't think I'm ready either as an individual or as a health plan executive to say somebody is in tier one, versus tier two, versus tier three. The confounding incidence of that, even in heart disease, which you might say is a little bit more clear cut, would make it a very difficult public policy issue.

I would say I can't see the direction for having that happen. Smoking is probably the one thing that has been successful over the past, but even with weight control programs, who is to say who is overweight versus obese, and do you charge them more? Again, I don't think I'm ready for that one.

MR. AXENE: An airline offended me last week. They created an awareness of, I'll call it high-capacity people, who are now going to have to pay more to fly. I think that this is probably a good thing for society because it places the issues on what you're talking about, Marty.

I think that, ironically, it's going to raise attention. I don't like it. I think that there's a lot of controversy and a lot of issues. But I thought it was interesting to see them take an open stance being that probably the highest-occupancy, highest-profitability airline in the country is now choosing to focus on another issue.

I think that there will be health plans. Yes, there will be lawyers chasing them, but I think there's an opportunity there to do something about health-care consumption.

MR. TURNER: I would just add that, as long as we're on a year-to-year financing scheme where you have an opportunity to choose a new health plan every year, you get your employees tiered into a tier one, tier two, tier three, that part of their health-care coverage choice is a need for catastrophic protection. For others, it's a low co-pay to take kids to the doctor. We haven't bifurcated that.

Australia recently introduced a lifetime community rating, where you elect to get into long-term health-care coverage. There are premium adjustments through the years, but until we're on a longer-term financing scheme, people will be penalized for moving from tier one to tier three because of certain actions. It's a huge public policy discussion, which I think a lot of people will be afraid of.

The election is coming up, and what drove it in 1992 was the issue of security. You had brought up, John, that if half of us are going to be out of a job or half of us are going to be out of health insurance coverage, we may be more likely to move to a tiering for employees as long as there is a government backup to it.

MR. FRANK L. PARTRIDGE: I've got a couple of comments and anecdotes I'd like to get your thoughts on, from the high-frequency, low-cost and low-frequency, high-cost ends of the spectrum. This happened to somebody who is near and dear to me. This is more on dental, but I think it could apply to medical. You go to a new dentist that you haven't been to before, and all of a sudden you get a huge bill for having four cavities filled.

My friend talked to her friends, talked to different dentists and found out that they charge a lot less. Applying this to insurance, they need to be more engaged even in terms of finding lower-cost emergency room or urgent care. I think that would go a long way.

On the other end of the spectrum, somebody who's into biotech things asked me what the limit is in terms of what society will pay if we're coming up with some new cancer treatments, new drugs, new therapies, injections. I didn't want to tell him that as long as employers are paying for it and the member's not engaged, who knows if the sky is the limit? Perhaps that's a spectrum in which we need to do more. Medical management has to keep in managing and controlling those types of costs.

MR TURNER: When you talked about the sky being the limit, I'd have to agree

with that, and what we've seen in long-term care is that the sky is the limit because people continue to get their long-term care until they spend down their assets and move to a government program.

I haven't heard the debate about someone's being too expensive and so we're going to stop the health care or the options that are available. But there will be that tiering between those who are able to afford and those who are not and have the harder choice.

FROM THE FLOOR: I have a comment on John's comment on diagnostic cost and technology. This is anecdotal, and keep in mind I'm working for DP&C Health Plan, which is owned by the University of Pittsburgh Medical Center Health System, but looking back at our trends over the past few years, our trends for the diagnostic cost category have been around 60 percent. It has now moved from what I considered a moderate-to-low cost category to being one of our major cost categories.

MR. AXENE: Thank you for attending the session.