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Designing a Defined-Contribution Health Plan

Track: Health

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Summary: Defined-contribution (DC) health plans are a hot topic. Recent surveys indicate a strong interest in this model by employers, and most health carriers are at least thinking about if and how to respond to the potential demand.

MS. LEIGH M. WACHENHEIM: Our first speaker will be Michael Kleinman. Michael is the director of health finance at Golden Rule Insurance Company, where he's been responsible for developing the company's group health business and for pricing and positioning a new line of insurance products, including Medical Savings Accounts (MSAs). Michael is going to answer several questions for us today, including what is a DC health plan, why move to a DC health plan, what are the advantages and disadvantages of a DC health plan, how do these health plans compare to DC retirement plans, and what plan designs are currently in the marketplace.

Then we'll hear from Bob Cosway. Bob is a principal and consulting actuary with Milliman U.S.A. He works with a broad array of risk takers in both the private and public sectors. He assists with strategic planning, risk assessment management, provider reimbursement, incentive development, and experience analysis. Bob is going to talk about pricing and risk considerations in developing a DC health plan. Some of the key issues that he will address include defining a DC health plan from

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

a risk perspective, reflecting age, gender, family, size, and other differences in rating structures, risk selection, and risk adjustment.

Finally, we'll hear from Bob Kelly who is an assistant vice president and pricing actuary at Horizon Blue Cross/Blue Shield in New Jersey. Bob has a strong and enduring interest in the application of free-market economics to the development of health care. During the late 1990s, he was very active in the MSA movement in New Jersey. He's presented continuing education seminars to brokers and accountants and has helped make possible an MSA-compatible insurance product in his heavily regulated state. Bob is going to be discussing the regulatory and tax environment around tax-preferred savings accounts and how DC plans might be treated for this purpose.

MR. MICHAEL KLEINMAN: Golden Rule currently does not offer a DC plan per se, but we are one of the national leaders in medical savings accounts plans, and they do share some of the same attributes with the DC plans we're going to talk about.

What is a DC plan? Why should you move to one? What are some advantages and disadvantages of them? I want to compare DC plans with the 401(k) and 403(b) retirement plans that many of us are familiar with. And then I want to take a few minutes to go through some of the plan designs that are actually being offered in the marketplace today.

DEFINED-CONTRIBUTION HEALTH PLAN

A DC health plan means different things to different people. There's not one definition that fits all. As I was preparing for this presentation, I spoke with and corresponded with a number of people in the industry who said that the kind of plan that's being developed can be called a DC plan, but it can also work under the existing defined benefit (DB) methodology.

Here's the general definition that I'm using for DC. One, the employer makes a contribution, a fixed contribution, generally, into some kind of a fund. The employee then chooses how that contribution is going to be utilized. The employee could purchase an insurance policy of his or her choosing in the marketplace, or the employee could choose to utilize the employer fund or first-dollar benefit without any kind of deductible, copayment requirement, and buy a high-deductible plan, or the employee could take the same dollars and use them for noncovered benefits such as dental services, eyeglasses, hearing aids, and the like. Under a pure DC plan, the employee would be able to go out into the insurance market where he or she lives and purchase a plan from whatever carrier he or she chooses. There are not many pure DC plans on the market today due in part to regulatory and underwriting issues that will be discussed in a few minutes by the panel.

CONSUMER-DRIVEN HEALTH PLANS

Increasingly, similar types of plans that are not pure DC plans are becoming known as consumer-driven plans. The two plans are distinguished in this way: An

employer is going to make a contribution into a fund. The employee is going to choose how that fund is utilized. In a pure DC plan, the employee can go anywhere in the individual insurance market and buy his or her insurance. Under a consumer-driven plan, the employee will actually choose from an array of plans that have been prescreened and are offered by the employer. This is the model that, currently, is most prevalent in the marketplace and it's being called the consumer-driven plan as opposed to a DC plan. The employee can choose to go out and buy a low-cost insurance plan, and any money that remains in the employer fund can be used to cover deductibles, copayments, or noncovered services. If the employee chooses a high-cost plan, the employee might actually have to use all of the employer's contribution and dip into his or her own pocket or his or her own funds just to cover the additional amount.

As I've talked about this with different audiences, people say, well, wait a minute, that's not new. I work for a big employer, and my employer has got a traditional plan and a couple of HMOs. My employer pays X for a single plan and Y for a family plan and I pay the difference between what the employer pays and whatever the plan that I choose costs. Is that a DC plan as well? I say, well, sort of. In my estimation, that wouldn't be a pure DC plan. That would be a type of consumer-driven plan.

In a DC plan, the employee can go out into the individual insurance market and buy his or her own plan. Under a consumer-driven plan, the employee will actually choose from an array of plans that have been prescreened and selected by the employer. Here's a question for you. Why do employers offer health insurance?

FROM THE FLOOR: To attract and retain good employees.

MR. KLEINMAN: To attract and retain good employees—bingo. That's why employers offer health insurance in the first place. And, as we're very well aware, employers are not obligated in most places to do that. What does an employer want out of this arrangement? They want a hassle-free arrangement where the employees are satisfied. There's no reason to give a benefit to an employee just to have that employee come back and complain about it. So what the employers really want is for their employees to be satisfied with their health plans.

One of the problems that we're having with our existing managed care plans is that there are restrictions placed on employees. These can be restrictions in terms of the providers that they can go to or restrictions in terms of coverage that they have. So one reason employers are looking to move to a DC plan is to improve employee satisfaction.

Another reason is medical inflation. Claims costs are increasing to a double-digit rate for the first time in almost a decade. These double-digit increases, coupled with an economic downturn, mean that employers need to spend more money on medical coverage at a time when they have less money because their base of

business is depressed. This isn't a good situation. Employers will either need to increase the cost sharing with employees through lower benefits or increase employee contribution in order to moderate these increases, or the employers are going to have to spend more for health coverage.

There's another interesting phenomenon in the marketplace. Employers are becoming more afraid of potential liability and this liability comes on two fronts. First, there's a fear that if an employer has a self-insured plan and in any way, shape, or form takes part in the medical decision and there's an untoward medical outcome, that employer could be held responsible. This fear was recently exacerbated when Congress began debating the Patient's Bill of Rights (PBOR) that is currently in a conference committee. Incidentally, with the events of September 11th and with the pending military action, Congress probably has more important things to deal with than PBOR. So I'm not optimistic about it passing, but the potential liability concern is still there.

There's also a potential liability concern on the part of employers as it relates to privacy. If an employer were to find out that an employee had AIDS, or some other contagious disease, or maybe a very expensive disease, and would then terminate that employee, there's a potential liability there. Some of you will laugh and say, that's not going to happen. Not more than a month ago, I read a story about a supermarket checker that had AIDS and was terminated and that case is now pending before a court.

Let me ask you another question. What is the most expensive fringe benefit you provide your employees?

FROM THE FLOOR: Insurance.

MR. KLEINMAN: Insurance—health insurance, that's right. Now, when you talk to your employees about health insurance and you ask them what it costs, what will they tell you?

FROM THE FLOOR: They don't know.

MR. KLEINMAN: They don't know is one. Or?

FROM THE FLOOR: Payroll deduction.

MR. KLEINMAN: Their payroll deduction, exactly. Payroll deduction is a very small part of the total cost of what your employees think of as being their health insurance cost. This very large benefit you're giving is an invisible benefit. The employees not only don't appreciate it, they don't even know about it. But if you move into a DC plan, your employees will know about it, because they're going to help you spend it. They're going to see how much money is there. And by helping

you spend it, , they're going to know how these dollars are spent going down the road.

Why should employees want a DC health plan? First and foremost, you have more choice in your insurance coverage under a DC plan. If I'm a young healthy person, I don't need that first-dollar HMO plan. What I'll do is use my fund to buy a high-deductible plan and use the balance to get some orthodontia work completed that I couldn't have afforded previously. Or, if I'm an older employee, I don't want the first-dollar health plan. Maybe I need a hearing aid that's not covered under most plans. So here the employees will have more choice in the type of benefits, the type of medical coverage that they can buy.

Employees will also have a greater choice in medical providers. Although many HMOs have very large panels available, some have fairly small panels. Thus, employees may not be able to see some of the particular doctors that they've seen in the past or might not be able to access some of the facilities that they believe and perceive are of high quality. Employees would also have an incentive to spend their employer contribution wisely. With most health plans, at the end of the year if you haven't had any medical expenses, you don't get anything back, and there's no incentive to wisely use your medical coverage. Under a DC plan, if the employer is putting money into a fund from which you can buy insurance and you buy a high-deductible plan, at the end of the year if there's money left in that fund, you can roll it over. So under a DC or a consumer-driven plan, the employee would have a proper incentive to spend the employer's contribution wisely.

Currently, most of the plans on the market offer extensive information on providers online, so you need to have some computer savvy in order to access them. This information is difficult to get elsewhere, information such as the providers' credentials, their education, whether they're board certified or not. You get information online on providers' fees, office hours, and even languages that the doctors may speak.

How many people know whether their personal doctor is board certified or not? These are things that people just don't ask, or don't know to ask.

Another reason an employee might like to have a DC plan is that if the employee has a true DC plan and then changes employers, he or she doesn't necessarily have to change his or her insurance coverage. That employee wouldn't have to select a new primary care doctor or obtain new specialty referrals just because he or she switched employment. So portability under a true DC plan is much enhanced.

DEFINED-CONTRIBUTION VS. DEFINED-BENEFIT PLANS

I'd like to do a little comparing and contrasting between DC and DB health plans that will highlight some of the disadvantages of moving to a DC plan. Currently, most employers' contribution is a percentage of premium in some way, shape, or form. It can vary from anywhere from 50 percent of the single cost probably on the

low end to a 100 percent of the single cost where the employee pays the difference between single and family if he or she chooses family coverage. There are probably still a few employers out there that pay 100 percent of their coverage, but not too many. So here you've got an employer paying a percentage of the cost of insurance.

Let's say that we've got a true DC plan, and the employer has turned loose its employees into the individual insurance market to buy coverage. How much does that equate to in a percentage? How is the employer going to know what to pay? The employer can figure this out. We're going to give everybody a voucher. We'll give them a flat dollar amount. They can take this dollar amount and go out and buy their own individual coverage. That would be great, wouldn't it?

Now, let's see, I'm a 25-year-old triathlete, and I'm going out to buy my own individual insurance policy, and I've got this one-size-fits-all voucher from my employer. I'm going to be pleased as pie. I'm going to be able to buy a high-deductible plan. I'm going to have a huge amount of that voucher in a fund that I'm going to rollover from year to year and it's going to be great. Now, I'm a 64-year-old employee. I've got that same one–size-fits-all voucher. Where am I going to go buy coverage for this amount of money? I'm older and these plans are age-rated. So it doesn't work and it could get worse. Let's say I'm a 64-year-old employee with that one-size-fits-all voucher and I've got cardiovascular disease. Or I'm a diabetic with high blood pressure. Who's going to even want to take me in some market that's not guaranteed issue for individual coverage? So we've got a real problem here. I don't have the answers to these questions, but these are issues that, if we're going to see more and more DC plans, we're going to need find answers to.

We said earlier that one of the advantages to an employer moving to a DC plan is to lower the cost or at least ensure that the cost won't increase as much as inflation does. It's an advantage to the employer. It's a disadvantage to the employee. So the employee would end up picking up more costs. So much for the employer contribution side.

Let's look at how those contributions are going to be utilized. Under a DB plan, an employee purchases benefits from options an employer selected. Under a pure DC plan, the benefits are going to be selected by the employee. The employee could go out and buy an insurance plan, either a low-deductible or a high-deductible plan, but what if the employee decides to go naked and self-insure coverage, just not buy anything at all? I wonder how the employer would feel about that. Would there likely be paternalistic or maternalistic employers out there that would disagree with an employee doing that? If so, under a DC plan, how could the employer deal with it?

Another issue, particularly for large employers, is availability of individual health plans. What's available in Seattle, Washington in the individual health insurance

market may or may not be available in Miami, Florida or in New York City. And most large employers right now who are self-funded have at least one plan that's available pretty much throughout the country. Those are some issues that could create problems.

DC HEALTH PLANS VS. DC RETIREMENT PLANS

As I peruse various documents, Web sites, marketing materials, and hear people speak on this topic, I hear statements like, "you love your 401(k) plans. You know how they work. Come on and buy a DC or a consumer-driven plan that works just like it." Well, let me tell you, if I'm looking at 401(k) plans around the country and consumer-driven health plans-0, I see a whole lot more differences than I see similarities. Yes, the employer does make a contribution to both, but in a DC retirement plan, the employer will, generally, make a contribution equal to a percentage of salary. Under a DC health plan, does that work? Would your employees be happy if their health contribution was based upon their salary?

Let's take two 63-yearold individuals. One is an executive and one works in the mailroom. Both of them would probably have to pay the same for their underlying health coverage. Would it be equitable to make a contribution to that as a percentage of salary? I don't think so. You have the same issues. Do you fix the dollar amount of the contribution to all employees? If so, how do you do it? Do you adjust it by age, gender, health of the employee, health of the family? We don't have good answers to these questions. There are also differences in the use of employer contributions. Under a DC retirement plan, the employee in Seattle would be able to buy and pay the same amount for a mutual fund as the employee in Miami and the employee in New York City. Under a DC health plan, you're probably not going to have that same availability.

DEFINED-CONTRBUTION PLANS IN THE MARKETPLACE

I'd like to discuss some of the DC or consumer-driven plan designs that are currently in the marketplace. First and foremost, this is a selected list. I didn't attempt to include everybody in the marketplace who has a plan like this. I couldn't do that because the list is fluctuating and changing so rapidly. These are companies that I've become aware of through various avenues. The information that I have on these companies is primarily obtained from public sources. I attempted to contact each of these plans. I wrote to them. Many of them got back to me, either with a phone call or a letter. Some of them provided extensive marketing materials to me. I'm not an expert on these companies' plans. As we go through them, you're going to see some similarities between and among many of the companies, and you're going to see some differences as well.

The first company is Blue Cross of California. Its parent company is Wellpoint. Inside California, the company is known as Blue Cross of California and outside it operates under the name Unicare. It calls its DC or, more appropriately, its consumer-driven plan, FlexScape. It's targeting the small-employer market in the 2 to 50 range, and these plans would be subject to small-group reform in most

states. Blue Cross of California has set a very low minimum contribution for employees. It can be as low as $80 to a $100 per employee, per month. Mark Weinberg, who is president of the Individual and Small Group Business division for Wellpoint, was quoted as saying, "With the upsurge of medical information and price inflation some companies were looking to move down in premium price." Rather than simply dropping their health benefits, the opportunity to offer a portfolio of products with a fixed contribution is a nice way for the companies to transition down their costs. With the Blue Cross of California plan, employees do choose from a selection of employer-approved plans. The program was initiated a few months ago in California, and Blue Cross of California recently announced expansion to Illinois, Indiana, and Virginia. Again, according to Mark Weinberg, Blue Cross of California is getting good sales, with about 5 to 10 percent of its new sales coming from FlexScape.

With Definity Health Plan, the employer makes deposits into an account that it calls the Personal Care Account. The employee will then choose a high-deductible insurance plan and use the Personal Care Account for first-dollar coverage or for uncovered services such as dental, vision, and other alternative care. Definity also provides some extensive health tools and resources that includes information on the providers and on their fees. Currently, it's offering this to self-funded employers only.

The next is Destiny Health. I spoke with Ryan Levin, who’s an actuary from Destiny Health. Ryan was one of those who said that his plan could work equally well under a DC or a DB plan. Destiny Health set up what it calls a Personal Medical Fund. In addition, it separates insured benefits for hospital and surgery care from chronic medication. It also has a Personal Medical Fund safety net that is insured if expenses exceed a particular annual threshold. If your total out-of-pocket maximum has been exceeded, the insurance will kick in. Destiny has a very large provider network: 300,000 physicians and 2,800 hospitals. Currently, its enrollment is relatively small. It has approximately 2,000 members, mostly in Illinois. The parent company of Destiny is Discovery Holdings, which is a large South African insurance company that has hundreds of thousands of people covered in South Africa under medical savings accounts.

HealthAllies is a plan that is consumer driven as opposed to being a DC plan. This is an interesting plan in that there’s not an insurance component within the HealthAllies’ plan. In fact, its target market is both insurance carriers as well as employers. It offers discounts on items that are typically not covered such as dental care, vision wear, and alternative types of coverage such as laser eye surgery or acupuncture. It has two products: BenefitsPlus, which allows access to the networks, and FlexPlus, which takes a Section 125 Flexible Spending Accounting and wraps that around the BenefitsPlus package. Its provider information and provider selection tools are extensive and show the medical school the provider attended, whether the provider is board certified, and what languages the provider speaks.

HealthMarket is targeting employers with more than two employees. It offers the HealthMarket Savings Account. It's insured by Legion Insurance Company and is available in the District of Columbia and four states, Texas, Georgia, Pennsylvania, and Wisconsin. Under this plan, you're given the freedom to see any physician that you choose, and you're given tools that allow you to actually compare physician qualifications and fees in making your choice of doctors.

Highmark Blue Cross and Blue Shield of Pennsylvania offers a plan called BlueChoice. It's targeting employers with 50 to 1,000 employees. With BlueChoice, an employer makes monthly contributions into a fund, and the employees choose from up to 16 different insurance options, having to pay the difference between what the employer contributes and the total cost.

Lumenos has a DC/consumer-driven health plan. It's targeting large employers across the country. With Lumenos, a health savings account is funded by the employer. Employees have access to very large numbers of providers and a vast majority of the pharmacies nationwide. Its employers will generally self-insure health coverage. Lumenos has got some nationally recognizable names, such as Novartis, Pitney Bowes, Pharmacia, and Gerber, either as clients or scheduled to become clients January 1.

My health bank has a DC plan called 123 Defined-Contributions Benefits Administration. Myhealthbank's strategy is to partner with insurers and it recently began a DC relationship with Regence Blue Shield in Washington state. It's targeting employers outside of small group reform, which is the 50-plus market. With Myhealthbank, as with many of the other plans, the employers make a defined contribution to what they call a Health Freedom Account. The employees will choose a health plan and any part of the employer contribution not spent on health insurance can be used for deductibles, copays, dental, vision, and other services that may or may not be covered under traditional plans.

Sageo is different from the other companies that I've presented in that it's more of a facilitator to employers as opposed to a provider of the DC plans. It wants to be the e-solution providing access to company-sponsored benefits, including enrollment as well as a directory of participating providers. It also wants to be able to send information on the products and services available to the employees via the Internet, e-mail, or telephone. Sageo is part of Hewitt Associates. It's interesting to note here that each of these companies has got extensive information available on the Internet, but that actually is one of the weaknesses, because despite the electronic age that we live in, not everybody is comfortable going on the Internet to obtain information on their health plans.

Vivius is a very interesting model. It's trying to set up partnerships with sponsoring carriers in particular target markets. It plans to have two or three target markets open by the end of next year. And I believe the first two it's working on are Minneapolis, where Vivius is based, and then Kansas City. Vivius has a Healthcare

Purchasing Account that holds the employer's contribution, but here's what differentiates the plan from the other plans: The employees will actually choose doctors, providers, and facilities from 22 different categories and put together a personalized provider panel for themselves and a different personalized provider panel for each member in their family. Vivius provides an immense amount of information online concerning providers' costs, their education, and their area of specialty. For out-of-area care or for care that's not available within the employee's personalized provider panel, Vivius offers what it calls a Wrap Insurance benefit.

In summary, DC plans or consumer-driven plans mean different things to different people. Right now in the marketplace there's relatively low participation in these kinds of plans, but there's a lot of activity from the 10 plans that we just saw and from other plans that we didn't talk about that either are in operation or are planning operation in the near future. There are some incentives for employers to move to DC and consumer-driven plans. Medical cost inflation is one, the economic downturn is another, and liability concerns are a third. So we have some significant outstanding issues in terms of how to underwrite the DC plans. Also, in the regulatory environment some changes are needed in order to make these plans more commonplace. And that's a wonderful segway to our next speaker, Bob Cosway.

PRICING/RISK CONSIDERATIONS IN DEFINED-CONTRIBUTION HEALTH PLANS

MR. ROBERT GORDON COSWAY: I'm going to talk about the risk characteristics of DC health plans. "Defined-contribution" is not a well-defined term. When I think of it, I think of three different characteristics. One is a new way for the employer to define its contributions. Second is a way for the employer to try to step back from the selection of the options offered to employees. And, third, all this seems to be wrapped up in the Internet as a mechanism to allow more variability and more choice. So a pure DC could be that the employer defines a fixed-dollar amount for each employee. The employee then purchases health insurance on the open market with that fixed amount and the Internet is the facilitator for all of these decisions. But I don't think anyone is doing this, and no one is really envisioning this as the ultimate, but there have been steps toward these kinds of things.

DEFINED-CONTRIBUTION PLANS – TWO KEY ISSUES

The two key issues are how are we going to define the DC for each employee and by what mechanism is the money, the employer contribution, plus the employee contribution, going to be used to finance health care. How is it going to get to the carriers and/or the providers? In terms of the first issue, the DC health costs vary by age, gender, family status, all of which are measurable, and health status, which is less easy to measure. Currently, employee premiums in flex-type plans do not vary by age, gender, or health status and only sometimes vary by family status. Since we have employees paying for fixed amounts and we know that the underlying costs are not fixed, we can calculate that the employer contributions are

varying by these sorts of variables. Employers are, effectively, paying more for older employees with families than they are for younger employees without families.

How might we define a defined contribution? It could be the same for all employees. It could vary for single versus family. It might vary by age and gender, or by location, or some combination of all of those. And just to illustrate the obvious, if we had a population that on average costs $350 per employee to insure, but if we were to look underneath that and say, what's our best consistent estimate of what the costs are by age and gender? Or, get rid of gender and estimate the costs by age and family size. Most of your singles are costing less than the $350. Most of your families are costing more. If you were to go to the extreme case and give everybody a fixed credit of $350, you'd find the singles would all be very happy. They could buy their insurance for less than $350 and have a credit left over. Most of your families would need to come up with additional money just to keep the same level of coverage, so this doesn't really work. Many methods handle this by still defining the employee contribution as a fixed level amount, but when you've set the price tags for the various options you maintain the smoothing over of age, gender, and family size that has historically been there in terms of the price tags. But the differences between the variables that you reflect in your DC amount and the variables that drive your premiums or your price tags could create major problems.

The second key issue is by what mechanism are the employer and employee dollars going to be used to finance health care? There are at least four ways that this has been envisioned to happen: individual market, employer-based market, single-carrier market, or an aggregator market. The individual market is what we described as a pure DC. The employee gets a fixed credit, then goes to the insurance market and buys a policy. If the premium is more than the DC, they have to come up with more money. If it's less, they pocket the money or maybe use it for dental or other benefits.

There are problems with that in all states or at least most states. The current individual insurance market is not efficient. It's a fringe market. It's not ready for a million people to come with vouchers in hand to buy insurance. I think it probably could be ready, but currently it's not. Selection is a big concern. There could be a big mismatch between the premium that the market would charge for coverage that might vary by age, sex, and family size, and the amount of voucher that the employer credits each employee.

The second approach, which is happening, you could think of as the employer-based market, which is just an extension of the current flex-plan structure. Flex plans look an awful lot like DC. The employer provides an amount or a credit. Employees have to pay the difference and they have a choice. DC, typically, would mean more choices, one of which would probably be one of the spending account options that Michael referred to earlier. One of the common options to think about

in DC is to allow the spending account with a high-deductible catastrophic coverage. But the employer is still acting as the intermediary. To an extent that employers are trying to get out of the business of providing health care, this method is not getting them there. It's simply adding more choices.

The third method would be the single-carrier market, where a single large carrier would go to an employer and say: I understand you want to offer more choice and you want to have online enrollment and we can do that for you. We can provide all the options that your employees are looking for—probably a wider selection than what you are currently offering your employees. Maybe we'll offer our own MSA, but you don't need to go elsewhere. We can provide all the options. It will be seamless. All the selection problems you've heard about will still be there, but we'll have all your employees, and we can deal with those problems better than if you're expecting to insure your population up among multiple carriers.

And, finally, there is what I call the aggregator market, where they'll be entities evolving to act as intermediaries between the employers, employees, and carriers. They would go to various carriers and try to define a single way for those carriers to work together to offer coverages to employers. They might collect all the premiums from the employer and the employee and then allocate those premiums to each carrier, depending on which employee signed up for which carrier, possibly including some diagnosis-based risk adjustment to reflect the risk of adverse selection. The only ones that I'm aware of talk about risk adjustment, but they're just doing age and gender, which is fairly common. The next step might be some sort of diagnostic-based risk adjustment.

RISK ISSUES

What are the risk issues of DC? The employer group is the risk aggregator and a carrier is willing to take the whole group, realizing that there will be some expensive people in that group, but also some healthier people. And as long as you get a fairly broad cross section of the group, you can deal with that from a traditional underwriting perspective. But if you go to a DC approach where you get a much smaller portion of the population, there's a bigger risk that you'll get selected against and get just sick people. Roughly 15 percent of commercial members incur 80 percent of the billed charges. Twenty-six percent of the members might have zero claims in a year. Traditional rating factors, such as age and gender, don't work very well if employees have a wide variety of plans to choose from.

In Chart 1, to illustrate this, these are bill charges, so they're a little higher than the traditional paid cost you might think of. If you've got a group that's got an average annual per member, per year of bill charges of $2,600, you've got the highest quintile averaging almost $11,000. The other 80 percent are all averaging lower than your overall average. The conclusion is if you only enrolled the healthiest 20 percent, there's a big windfall. If you only enroll the least healthy, there's a big loss. The more you segment the population, the more people choose

what they think is in their own best interest, the more risk there is that a given plan will be hurt by that selection.

Are carriers going to be willing to take only a few individuals out of a employer group? I think one of the biggest risks is being the first-dollar HMO, or indemnity plan, or it might be a self-insured plan by an employer, that's offered against a lower-cost catastrophic savings account plan, where a lot of the younger, healthier people will be very intrigued by the idea of paying a $1,000 cash premium in a year, thinking that they'll never use it and will be able to roll that over from year – to year. The fear is that all the healthy people will gravitate to the MSA-type plans and the first-dollar indemnity plans will be left with all the sick people. There was an escalated workshop at the SOA Dallas Spring Meeting last May, where people talked this around the table, and there were no answers given, and the people were concerned about what the next steps were in this area.

POSSIBLE ALTERNATIVES

There are alternatives. One would be to try to limit the amount of choice. In other words, just don't offer the high-deductible plan. But that defeats the purpose of DC if employers are going to try to maintain the current relatively narrow choice people have. Or, if you go the individual market, you're probably going to need some sort of high-risk pool. If you're going to require people to take all comers, even the sick people, you're probably going to need some structure to share that risk among the various carriers. Another alternative that's widely discussed is the use of health status risk adjusters. Some of the aggregator models that have been discussed would use this approach, where the aggregator would reallocate the premium dollars based on who signed up for which plan and what their measure of health status is.

Plans have been relatively slow to adopt risk adjusters. There really hasn't been a strong need. There may well be soon with DC. There's really no universally accepted method of risk adjusting. When the Health Care Financing Administration (HCFA) decides on a final one for the Medicare+Choice Program, that may lead other carriers to use that same approach, because HCFA is the leader in a lot of these issues. At this point, there are a lot of plans that are still in the running for that. There has also been a mixed reaction to prior limitations of risk adjusters. There was a California purchasing cooperative where the results didn't work too well. Then there's a perception that this is a zero-sum game. It's just moving money around between carriers. Or, in the case of Medicare, it was a negative-sum game, because HCFA was intended to pull out seven or eight percent of overall revenue as part of the introduction of risk adjusters.

GROUPER OPTIONS

There are several good options out there. The Society of Actuaries is now doing a study of these and focusing, in particular, on new ones that use prescription drug utilization as an indicator of health status. But the ones that are out there that you might want to look into are the Adjusted Clinical Groups (ACGs) that are created by

John Hopkins University, and CSC Healthcare Group is the commercial vendor for that. The DCG, or Diagnostic Cost Group, is HCFA's current working model for the Medicare+Choice Program and is produced by Boston University and HCFA. The Chronic Illness and Disability Payment System (CDPS) is mainly a Medicaid tool produced by the University of California at San Diego. The CRG, or Clinical Risk Group, is a fairly recent creation of 3M that we've looked at and think is a good tool. And there are several large carriers who've created their own home grown diagnostic-based risk adjusters.

SELECTING RISK ADJUSTER METHOD

If you are going to use risk adjusters to try to deal with the selection issues in DC, there are a lot of key issues to consider. You need consistent data across all the plans. What we've found in looking at risk adjusters, is if you don't have complete diagnostic data on all the records, the noise involved in the calculations often is bigger than what you're trying to measure, so you really need to have good, complete data. And then the question that will come is how good are these models at predicting differences? I think age/sex is measured at about four percent R squared in terms of predicting the proportion of the variances predictable. Most statistics on these risk adjusters are in the teens, so they're better than age/sex, but they're not the entire answer.

IMPLEMENTATION ISSUES

If we do get to an approach where someone is using risk adjusters to smooth out these selection issues, there are some big issues to think about. One is the data issue. Do you have enough data? Second would be do you do it prospectively or retrospectively? You could envision going into the year using prior years' claims history to allocate money based on risk adjustment or you could wait until the end of the year and look at what the actual diagnoses were during that year, which would, in theory, be a much better predictor of what actually happened during the year. But are carriers willing to wait until the end of the year and have a big reallocation of revenue? Then there's the question of whether you're calculating individual risk adjustment premiums or maybe you're doing it more on an aggregate on a carrier-by-carrier basis. Maybe you think that carrier X for some reason attracts sicker people, so you measure that on a plan basis and use that from year to year.

RISK ADJUSTERS AND DEFINED-CONTRIBUTION PLANS

If we go to more of a DC approach, the market will probably adopt some sort of risk adjustment structure to help deal with the selection issues. The unknowns are which version, will the data be good enough, will you do it prospectively or retrospectively, and who is going to create this? Is it going to be the carriers coming together to create some sort of structure, large employers, the governments, or maybe these aggregators that are evolving?

In conclusion, a pure DC plan will present challenges to the current underwriting process. The approaches that are out there now can be dealt with under the current

underwriting approaches, but as things continue to evolve, some form of risk adjusters will probably be an important part of the process.

REGULATORY AND TAX ISSUES

MR. ROBERT A. KELLY: The reason that I'm here is, simply put, to encourage you to go back to your offices and do product development, bring out a DC plan, have your company think about it at a minimum, and reach out to your sales force. Choice and responsibility are the keys to the DC movement, if I could call it that. And choice and responsibility are, in my view, the keys to wealth and the hallmarks of freedom, so these are definitely things that we need to pursue. I find this stuff to be almost unbelievably complicated, but I would implore you to stay after it. I think that it has some legs and it has some future.

HEALTH SAVINGS ACCOUNTS

Health savings accounts (HSAs) are a common element of a DC plan. The HSA is usually paired with a high-deductible plan and sometimes parental services are covered. This is the heart and soul of DC plans, as you currently see them out on the street now, which is to say, they're employer driven.

This is the economic rationale for why insurance causes over-consumption. Let me give you a quick example to drive the point home. If we all went out to dinner tonight and shared the check and then tomorrow night we all went out to dinner and paid our checks separately, which night would have the higher cost? I think that's pretty clear and that attaches the spirit of the criticism of the employer exclusion. So we have HSAs that are designed to level the playing field between employer-sponsored insurance and out-of-pocket health care spending. Ideally, they'd have four characteristics in order to perform their function properly.

One is they would be funded with pre-tax dollars, and withdrawals from them for health care expenses would be tax-free. This allows them to enjoy a level tax playing field with employer-sponsored insurance. Second, they would be transferable from year to year. You could roll them over, so that if you did not spend money in an account in one year, it would continue to accrue to your benefit in the following year. Third, the account would be portable. When you change jobs, the account comes with you. Fourth, the account would be cashable. If you wanted to use the funds in the account for nonhealth care purposes, you should have the option. You'd be subject to ordinary income tax and, perhaps, a penalty.

I'm going to reiterate those. I think they're the four key elements of savings accounts. One, it has to be tax free in and out in order to compete with insurance-provided spending. The second group, items two, three, and four, if you will, are to enhance the sense of ownership that the employee has and that the accounts have to be rolloverable. They have to be portable, a tough job, and they have to be cashable. Those are the four things that you're looking for.

Currently, these are your basic options in delivering savings accounts that have tax-preferred features. I'm going to go through each one of them relative to those four criteria, do a quick analysis of how they stack up, and look to Washington for possible changes.

MEDICAL SAVINGS ACCOUNTS

MSAs score high marks upon all four of those criteria. They meet all of them. They're tax free in and out. They're portable. They're cashable. They roll over. However, they have three problems. First off, they're only available for small group participants and self-employed people. If the market is not there, you're out of luck with MSAs. Secondly, there are benefit design limitations. MSAs have minimum and maximum deductibles and maximum out-of-pocket limits in order for the high-deductible insurance to qualify the account for the tax-preferential treatment. My experience has been that the plan designs are too rich for the individual marketplace and too poor for the small group marketplace, so you get trapped by them when you do plan design.

I don't know that in New Jersey the small group marketplace is ready for a $1,600 deductible plan. On the other hand, the individual marketplace in New Jersey is a higher deductible than that. Furthermore, in my own practice, I really love 50 percent coinsurance. I've lost the thrill of deductibles. I like coinsurance straight down the line. In our product development, we're considering some things like 50 percent coinsurance from here until forever up to fairly high limits, so that the health plan and the member can partner effectively in managing the health care costs.

The other major problem that I have with MSAs is they require changes to the employee's tax return. I know I hate doing my tax return. I have fairly straightforward taxes, but I use an accountant because I can't stand the sight of the Internal Revenue Code. It's a problem for me. I may be overstating it, but I have a feeling it's a problem for your normal employee, also. You have to attach different forms to your tax return. You can't use the short forms anymore. You have to use the long forms.

One solution to the MSA is the Lipinski-Dooley-Thomas-Fletcher Access Amendment to the so-called Patient's Bill of Rights. This is the House version. On September 11, PBOR went down in flames, so to speak, but it would help on a number of fronts It would open up MSAs to everybody, not just small groups and individuals. Further, would reducing the deductibles make the MSA more palatable for small groups? In my market, small groups are not ready for a $1,600 deductible. Maybe they'd be more ready for a $1,000 deductible. So, basically, of those three problems, eligibility classes will not be a concern if this amendment to PBOR passes, because MSAs will be eligible everywhere. They will, however, still have the problem of plan design, where you don't have unlimited flexibility in designing the catastrophic insurance plan, and they will still have the irritation with regard to the tax law.

FLEIXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) as a savings account vehicle in a DC plan are considerably suboptimal. They are tax free in and out, so they meet criteria one, but they do not meet criteria two, three, or four. They don't roll over. You use them or lose them in the FSA. They're not portable or cashable, so they're less than ideal. However, some of the solutions are very powerful. There is a bill currently in the House of Representatives, H.R. 167, that would amend the Internal Revenue Code of 1986 to allow carryover of unused benefits from cafeteria plans and flexible spending arrangements (up to $3,000). You can check out the status of these bills and get copies off of the House Web site at thomas.loc.gov. It's quite user-friendly, actually. The thing that surprises me about the House Web site is that there must be a dozen bills for FSA rollovers in the House. And how they ever decide which ones to actually proceed with and how that should properly get integrated with the other parts of the law is truly a mystery to me. It's quite remarkable.

I bring H.R. 167 to your attention because it's a powerful solution. It gives almost unlimited freedom to the FSAs. Not only does the FSA, if this solution passes, meet all the four key criteria, but it doesn't have the limitations that the MSA has. It doesn't have the negative consequences on your income taxes, and there's no plan design limitation associated with an FSA, so there' s real promise there. Unfortunately, I don't think anything is going to pass this year. My own personal take is that MSA expansion will pass next year. I think that the Democrats are sufficiently unafraid of MSAs, but they will let it go, and I think Bush is married to them. I think that although PBOR legislation creeps along, MSA expansion will happen.

I used to be optimistic on FSA enhancement, but when Senator James Jeffords (I-VT) hopped ship from the Republican party, the balance of power shifted toward the Democrats and enthusiasm for changing the FSA laws started to wane. I think it's a close call for next year. Nothing's going to happen this year, but next year I don't know. I think it probably is not going to happen.

SECTION 105 PLANS

The so-called Section 105 Plans are the third option. These are self-insured medical reimbursement plans that are used as a vehicle to be a tax savings account for DC purposes. I believe it's the form that Aetna is using on its recently unveiled plan, and Definity uses it, and Lumenos uses it. It's fairly common. It has several problems associated with it. First, there is some uncertainty as to the tax treatment, that there are a few details here causing concern. I don't know whether I really want to get into it, but Aetna and the other companies are taking the position that a 100 percent employer-paid plan that's not part of a cafeteria plan is rolloverable. You can roll over unused balances from the first year to the second year. That's the issue on a 105 plan. It appears to be okay on a straight reading of Section 105. However, the Section 125 Regs have this disturbing element in them that says the lose-it-or-use-it rules apply with respect to a health plan without regard to whether the plan is provided through a cafeteria plan. The medical

reimbursement plan is a health plan, so one could read this to mean that use-it-or-lose-it rules apply to 105 plans. The IRS has indicated it will not rule on tax consequences of a health plan or HMO health carryovers. I don't know exactly what that means. I think it means that they won't bust you if you do it, but I'm not absolutely sure of that. However, regardless of that, my take on that is that Aetna wouldn't really take a wild chance like that. I think that it's probably fairly solid that a 100 percent employer-paid 105 medical reimbursement plan has carryover features. You can roll it over. However, it's definitely not cashable, and it's not portable in a tax-efficient fashion, so 105 is less than ideal, too.

PROBLEMS WITH THE SOLUTIONS

So you've got three options right now to deliver a tax-preferred savings account and none of them is perfect. The MSA is a very strong one. It was designed to meet the four criteria, so that's not really a surprise, but it carries with it a little baggage. I, personally, find small group only to give you handcuffs. And I think that will go away, but even if we get expansion legislation next year, I find the plan design limitations to be irritating, frankly speaking.

On MSAs, scores for those of you who may not be aware of this, in order to actually administer the savings account, you have to either be a banker or an insurance company as defined in the Internal Revenue Code. So if you aren't either a bank or an insurance company, you have to get special approval to be a trustee.

But in all these solutions there's still a problem. All of these solutions still preserve the tax code preference for health care spending relative to spending on other consumer goods, and from an economic perspective this is inefficient. Put another way, at the end of the day with a pre-tax dollar, the employee's choice is a $1of Prozac or 50 percent of Jack Daniels and that may not be ideal from an economic perspective. Surprisingly, there's a possible solution out there and it's a form of government DC, also known as refundable tax credits. I think we should be aware of this, because if refundable tax credits happen, then the efficacy of MSAs, and FSAs, and Section 105 plans is undermined.

REFUNDABLE TAX CREDITS

Refundable tax credits are a form of DC from a government's perspective. Instead of subsidizing health insurance with the exclusion mechanism as it currently exists, a refundable tax credit system would eliminate the exclusion mechanism in its pure form and replace it with a government contribution or voucher, to be usable for health care purchases with a set dollar denomination. In its pure form, they're talking about a $1,000 per adult and $500 per child refundable tax credit voucher for the purchase of health insurance. No more employer exclusion. In this case, this is a level playing field everywhere then, because any additional purchases are done with after-tax dollars, be they for health care or nonhealth care. It's a very forward-looking plan. It also paves the way for Medicare DC.

I have often wondered in these savings vehicles what we are saving for. Medicare is pretty comprehensive. Where I come from, I don't know what Medigap costs. It's maybe a $1,000 a year, maybe a little more. So what's the present value of your Medigap premiums? I don't know. Not much. $10,000, $15,000, I guess. Now when you hit age 65, I don't know that you need a tax-preferred account in order to do that. However, if this refundable tax credit idea flies, it opens the door for Medicare to be a DC plan. Where instead of a fixed set of benefits, the federal government turns around and gives the estimated cost for a beneficiary directly to that beneficiary and allows that beneficiary to do as he or she sees fit. Now, how the regulation climate would play out there is anybody's guess, but this is a self-contained plan, the refundable tax credit.

If the refundable tax credit comes in its pure form, you don't need MSAs anymore, because everything after the government contribution in the form of a voucher is done with post-tax dollars. Everything by definition is portable and cashable and the first criteria no longer applies, so this has really changed the landscape. Fortunately, or unfortunately, as the case may be, I don't think we have to worry about that, because I don't think it's going to happen. These issues here are some of the few that come up. It would probably increase the uninsured. I think that's probably true. It may well invite mandatory catastrophic coverage. I think you're going to see a lot of people recommending mandatory catastrophic insurance either at a state or federal level, probably federal. Who will regulate it and how is anybody's guess.

Let me give you a couple of references here. The Patient Access Choice and Equity Act (H.R. 4925) is a rather complicated version of refundable credits. It taxes you for general spirit and you might want to check it out on the House Web site. More interesting in my mind is an analysis called Reforming the U.S. Health Care System, National Center for Policy Analysis (NCPA), Policy Background Number 149. Check out the NCPA Web site at www.ncpa.org. For those of you who don't know NCPA, it's headed up by a man named John Goodman. Goodman is the co-author of *Patient Power*, the bible of MSA. NCPA is headquartered in Dallas, Texas. And it's no great surprise that Goodman sits at Bush's elbow as a health care adviser. I do believe that the refundable tax credits, which I am surprised to see pop up in such a pure form down in Washington, are via Goodman. From Goodman to Bush and from Bush to his political compatriots.

It's a well thought out, real forward-thinking plan that I think will probably never happen. It will never happen because we hear the Americans are ambivalent on a couple of core questions. And here's core question number one: Should insurance be for catastrophic (unpredictable and material) events or for catastrophic events and income redistribution? This needs discussion before the selection issues can really be dealt with.

This is a paraphrase from an American Medical Association (AMA) study on adverse selection. The AMA comes down, not surprisingly, on the side that insurance should

be for catastrophic events and not for income transfer. But let me quote to you something that I think is interesting. This is from the AMA document. "Plans that cannot survive in the face of consumer choice should not remain in the marketplace." That's pretty simple. If the comprehensive plans can't survive in the face of consumer choice, goodbye. That makes a lot of sense. I don't see anything particularly wrong with that position. People do have a problem with that position, though, and I may be one of them. I, too, am ambivalent on this score. It does seem to have a certain heartless character to it. The way I like to rephrase this particular core question is to say: Is health care a right or is it just another economic good? I think that's the core issue that we're dealing with.

As my compatriots here said, no one has the solutions. I sure don't have the solution, but I'd like to show you this little proposition. From one perspective, that conclusion looks preposterous and I tend to agree, but think about the argument. That argument seems plausible to me. If the government is responsible for health care, then they're responsible for funding it and so unhealthy behavior is tantamount to robbing your neighbor. So here we have a preposterous conclusion, a plausible argument, and a somewhat disturbing conclusion.

If you've got a conclusion you don't like, the logic seems strange. The premise is questionable. The premise here is, should government be responsible for health care? I'd like to close by hoping that you will agree with me that maybe not, and maybe we should try to keep the health care transactions to the extent possible in the free market. The opposite of free market is the unfree market, and freedom in and of itself is a good thing.

MR. DAVID M. TUOMALA: I'm with Definity Health. I have one observation and I don't know if it will result in a question or not, but I think one of the biggest issues that we see is the lack of a real consistent definition of what DC is and what it is not. Because, frequently, Definity Health and other what I would call consumer-driven benefit designs are sort of lumped in with the DC genre of plans, and I don't think that we view ourselves that way or market ourselves that way. But philosophically our belief is that DC in and of itself is not a solution to anything, that we need to have more consumer-driven economics within the health care system and that's at least a partial solution. I don't know that we believe that the government should be involved either, but that's just an observation.

MR. KELLY: Let me just take a piece of that if I could. I forgot to do it, but I was thinking of calling it consumer-driven health care as opposed to DC health care. I, too, think consumer-driven health care is more accurate. It catches the essence of what the players in this race are trying to do more accurately than DC does. As a matter of fact, you can almost split people who are pro and con by asking them what they call it. Those who call it DC, generally, are going to have a negative attitude, in my opinion. Those who call it consumer driven are going to be positive.

MR. HOWARD CONWELL MAYBERRY: I've read a little bit about this before, where there wasn't much of an interest on the part of employers because the economy was so strong. But recently, there seems to be a downturn. Do you know if there has been any more attention given to this on the part of employers than there was in the past?

MR. KLEINMAN: I don't have any statistics on that. There was a survey or a report by Booz Allen several months ago that said an economic downturn would really change the employers' viewpoints on DC plans from consumer-driven plans. In an economic downturn, you take a look at everything. I open the newspaper every day and I see companies are laying off people. Companies have to look at their costs. This is one way that companies may choose to latch onto where they can reduce their health care costs and actually give the employee some choice of how that happens as opposed to simply increasing deductibles or increasing employee contributions into the plan. Other thoughts?

MR. MARK LITTLE: I'm from Milliman U.S.A. Managed care came into vogue. Health care costs have still been almost double the rate of CPI for the last 30 or 35 years. Unless that slows down, DCis not going to be successful either. Do you think that DC, the way it's headed, has the potential to reduce the trend on health care to the point that we as a country will be able to afford health care?

MR. KELLY: In its pure form, we can't afford it if we won't buy it, so I'm not quite sure I know how to react to that. Is the consumer self-interest, theoretically, that whatever is unaffordable is unattainable? And, heaven forbid, some health care procedures are not economically viable. Nobody wants to make those decisions. I don't think the government wants to make that decision, I don't think the companies want to make that decision, and I don't think that the consumers want to make that decision. From my perspective, I really can't answer that question. My enthusiasm for consumer-driven health care is not because I am enthused about its potential for controlling costs, but rather because choice and responsibility are good in and of themselves, so I don't know if I can elaborate any further on the long-term cost implication.

MR. WILLIAM J. RUSCH: I'm with of Aetna. Where do you think other employee benefits fit into this DC spectrum, such as long-term care, disability, life insurance, pure retirement, and health benefits?

MR. KELLY: I'm not sure how to answer that. My knee-jerk reaction was a spectrum of choice for people is possible, why not? But my secondary choice is I have this vision of our whole life being under a cafeteria plan arrangement, where instead of getting paid in cash we get credits for various type of activities, and I'm not sure I want to go there. I don't know whether that's responsive to what you were feeling, but I don't see any particular reason why we can't expand the choice to other lines.

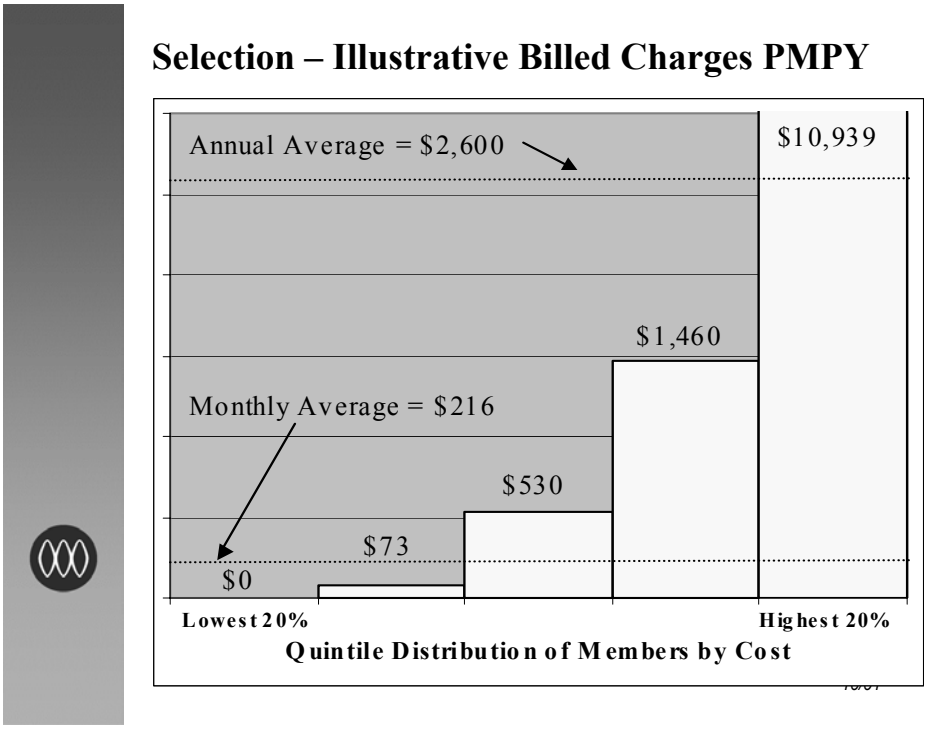
MR. COSWAY: One possible result of this would be if people do have these accounts that roll over year after year, that might mitigate or make it more possible for people to retire early. Given that companies are scaling back their retiree medical plans, maybe part of this will result in individuals being required to save for their own early retiree medical benefits before Medicare kicks in.

FROM THE FLOOR: This strikes me less as group insurance and more as a funding mechanism for individual insurance at its extreme. You talked about some of the advantages of group insurance that are going away such as individual underwriting versus the group underwriting. What about expenses? If I remember correctly, one of the advantages is that it's cheaper to administer a large group of individuals than each individual separately. Do you see a big increase in expenses for administration under these plans?

MR. KLEINMAN: If I could take a shot at that, the potential is really there. Under individual insurance today, the commission, for instance, that is paid to a producer is generally quite a bit higher than it is under a group plan. So, yes, the underlying expenses could increase. If you have individuals out there buying their coverage, the individuals are going to opt many times for a higher-deductible plan. So the actual dollar amount going into the insurance component may be smaller than it is today. But an individual plan has higher administrative expenses than a group plan does, generally.

MR. COSWAY: The Booz Allen report that Michael referred to tried to quantify that and I think they said $18 billion a year is spent between benefit consultants, employers, human resource staffs, and plan marketing expenses. And their argument — I think they were biased — in favor of DC was that those expenses would go away if it becomes more of an individually marketed benefit. Of course, it would be replaced by marketing done by health plans more directly to individuals. It also seems like premium collection is going to get much more complicated if it's not all done through the group, so I don't think it's clear. I would guess expenses might collectively go down if it goes all the way one way, but we're not going to go all the way. We're going to have a hybrid approach, and I would guess in that environment the expenses have to go up if you still keep both structures.

Chart 1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