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Session 4PD
Health Care Cost Trends Post-September 11, 2001

Track: Health

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Summary: On September 10 the economy was slowing, health care costs were rising, managed care was experiencing consumer backlash, and employers were receiving large health insurance rate increases. The tragedy of September 11 exacerbated these conditions. At the conclusion of this session, participants have keener insights into the post-September 11 factors underlying health care cost trends and how others in the industry view the future of health care costs.

MR. KARL MADRECKI: For this session, we have a very distinguished panel. I'm Karl Madrecki. I'm your moderator, and my distinguished panelists are Jeff Allen from Ernst & Young, Dean Taylor from BlueCross and BlueShield of Tennessee, and Lisa Tourville from Ingenix United Health Care.

Terrorism—that's what September 11 represented. I had the unfortunate circumstance of being in Washington, D.C., on September 11, as did some other people in this room, and it was rather startling. We didn't know quite what to expect. A lot of things happened to the country after that. From a health insurance point of view, terrorism represents a risk consideration without precedent. It certainly is not like an epidemic, and it's certainly not like anything that went into risk-based capital (RBC). RBC, or how much capital you should require as a company, was based on misses and probabilities of ruin but certainly didn't incorporate a concept of something as ill defined as terrorism from that standpoint.

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

From another perspective, if an act of terrorism occurs, we suspect that the rules are going to change dramatically. We don't know what the event is. We don't know how you can describe that particular event, but that's what we're here to talk about. It tends to vary where it happens, this very localized kind of thing from that standpoint. The other aspect that came out of September 11 sort of destroyed the concept of covariance in your RBC formula. If you're not familiar with that, your asset risks are supposed to be independent of your claim risk, but then again maybe not from that standpoint. If you think about it, if you want to hold a little extra money, you can't because it's not tax deductible, and there's really no place to put it. In fact, as we get into valuation throughout this meeting, we're going to find out you can't hold much margin at all anymore. So, it presents a lot of challenges from that standpoint.

The fact of the matter is, terrorism was just unneeded fuel. We were already in something or dealing with something where the price was doubling in five to seven years or five to six years. We're seeing levels of health care inflation that we haven't seen since the '80s, and if anybody was around in the '80s, we were delivering rate increases every six months. All this does is compromise the ability to pay, and ability to pay is one of the biggest challenges we're going to face as a health insurance industry going forward. It doesn't matter whether it's federal or state government, the employer, or the individual. We'll get to talk about a lot of these things. We certainly know what it did to the economy on top of that. It definitely increased the uninsureds. Certainly it brought out the politicians and encouraged lots of regulation, maybe with a lot of misunderstanding on top of it. Certainly it heightened our individual feelings of rights to health care from that standpoint, and providers are stronger than ever from that standpoint.

In the General Session, 1GS, Dr. Shavers talked about a lot of things. I will personally say I disagree with Dr. Shavers. Everything you do in health care increases the cost of health care, and we're good at it. We're very good at it. Not only are we aging as a society, but also we want the best treatment. We want it now, and if we don't have to pay for it, that's even better. Somebody else will. There's no economic involvement. These are all things you're familiar with. You add these all up, and there's only one place for health care costs to go, and that's up. So we have two things coming together—very high trends and terrorism.

To illustrate, Chart 1 is perhaps somewhat representative, but we all see those surveys that are out there about health care costs measured by price. If you compound them, which is a good actuarial thing—you don't add them, you compound them—you find that health care costs on a median basis—what we cover, not per capita, but what we cover—have been up around 50 to 80 percent in the last five years. It's no secret we're looking at 15 percent rate increases and up from that standpoint. But the pie has changed, which is what we've paid for. Inpatient hospital used to be a very dominant thing, and maybe five years ago it used to be about 30 percent of the cost of the health care claim dollar. It's down to about 25 percent. Don't feel bad for the hospitals. Remember the pie has grown by

70 percent. So all that means, if the average rate of increase for the last five years was about 11 or 12 percent, is that the poor hospitals have only gotten about 7 percent a year, and then that's what happens, just a little slower than others.

We know what's happening in outpatient hospital care. It manages to keep up with everything, meaning that it's still about 20 percent. There's a big blurring. What's the difference between inpatient and outpatient hospital care? Since everything has shifted to the ambulatory setting, it's also an area we're ill equipped to understand. There is no such concept as an admission there, a very hard thing to count.

Professional earnings and other, the bulk of which is physician fees, have also managed to be about the same. So that means they've been tracking along at the average of about 11 to 12 percent a year. And the rest of the donut, what we see most visibly as pharmaceutical, is the card program. That does not pick up the pharmaceuticals that are in everything else. It's in the other three pieces of the pie. That, as we well know, even with the changes in the co-pay structure and everything else, has managed to increase itself to almost one out of every five cents on the dollar. Since it's grown as a piece of the pie, we're looking at something that's grown at about 20 percent a year, give or take, and all the changes in the co-pays are temporary steps in terms of cost shifting from that standpoint.

When we put it all together, we end up with a number of challenges. We've got something that's increasing very rapidly in price. We have the new challenge of terrorism, and we're left with a lot of political questions. Has anybody noticed that no one seems to understand that price is claims divided by members? You see it all the time in Washington, D.C. There is no concept of the fact that the price of health care is really the claims. Another challenge in terms of explaining health coverage and health prices is the concept of guarantee issue. Why can't I have health coverage now that I know I need it? In a system of voluntary health insurance, this presents dramatic challenges. As we all know, insurance companies, especially health insurance companies, have all the money in the world, and they could never possibly lose money from that standpoint.

Along the line, though, for managing companies that are in health insurance, when you have very high trends you have a lot of trouble getting enough underwriting income, and if your investment income is exacerbated, your RBC ratios are going to slide. In theory, even if we've been making money as an industry, and I mean that on the average, we find that our RBC ratios are sliding, which means we have less coverage than we did before. It's very difficult. In addition to that, we have to worry about the loss of competition. There aren't as many people competing in health insurance as there once were, and that will have certain ramifications.

So, with that as a backdrop I'd like to introduce Jeffrey Allen, who will introduce us to terrorism and trend management, followed by Dean Taylor and Lisa Tourville.

MR. JEFFREY ALLEN: I have three main topics I'm going to talk about this morning. I'm going to talk a little bit about the anthrax event from last fall. Then I'm going to talk a little bit about other potential terrorism events. Finally, I'd like to talk a little bit about developing a proactive approach, thinking ahead toward managing biological terrorism treatments and events.

First a little bit on the anthrax event from last fall: We had five fatalities from that event, and those were tragic. I think that on the same page, we are also fortunate that it was limited to that. Many others contracted anthrax, but were successfully diagnosed and treated. We saw a nationwide increase in the demand for health care services due to a higher demand for diagnostic and preventive services. So we saw not only higher costs due to the direct effect of anthrax, but we also saw some indirect costs. We saw increased demand for health services due to mental stress, unemployment and local emergencies. As costs were evaluated initially, additional costs might have varied from one to three percent on top of the current 12 to 15 percent trend that we were seeing at that time. Again, we are fortunate that the event was not sustained longer than it was. But it also led to increased public funding, $4.3 billion proposed for fiscal year 2003, and I know that that legislation just recently passed. I believe the final number was close to that $4.3 billion figure.

We step back a second and take a look at the categories of impact from the anthrax event. Where did we see costs increase from this event? First we saw increased treatment for routine illnesses. They were previously untreated, but someone who had symptoms similar to anthrax symptoms would now get treatment where maybe in the past that person wouldn't have. We also saw an increase in general stress and anxiety, an increase in antianxiety medications and sleeping aids, an increase in chronic illness symptoms due to higher anxiety that would make those symptoms worse, an increase in mental health services and antidepressants, and increased substance abuse. We also saw an increase in defensive treatments, in lab tests and anthrax antibiotics. Also, we saw a change in the recommended treatment for anthrax from ciprofloxacin (Cipro) to doxycycline. So you can see that, in addition to the direct costs of the anthrax event, there were also a number of indirect costs, where health costs went up in relation to this event.

There were also geographic variations. Those closer to the events had higher utilization. But I would also say, coming on the heels of the September 11 attacks and the high media coverage of this event, in some of those geographic variations, the drop-off wasn't as great. This was because there was so much awareness of this event, and also with the anthrax delivered through the mail, anyone anywhere in the country felt in some way connected to the event.

I'd like to spend a few minutes to talk about other potential terrorism events similar or along the same lines as the anthrax. These are the other types of events that could occur. We can categorize them into biological events, like smallpox. There's been a lot of talk about smallpox in the news recently, and what's the proper way to treat and prevent outbreaks of smallpox. Botulism is also a possible biological

weapon. Tularemia and Ebola are both African-based viruses that can be packaged and delivered as biological weapons as well.

There are also chemical agents, mustard gas, serrin that was used about 10 years ago in Japan, radiation, dirty nuclear bombs, and possible reactor leakage or bombings to reactors that would cause a radiation leakage. There are also conventional attacks, bombings and suicide bombings. The Centers for Disease Control and Prevention (CDC) Web site is a wealth of information on any of these types of weapons.

Other catastrophic events that companies should also be prepared for and thinking about include how to deal with emergency situations of a more conventional sense, i.e., earthquakes, hurricanes and fire. Companies are also dealing with acute conditions such as congestive heart failure, asthma and diabetes in similar ways in terms of isolating these events and treating them with the best medical care.

I put together a summary of the potential terrorism events. I struggled over how to title these, not being real comfortable with putting down advantages and disadvantages. I hope you understand my perspective in how I titled those, not to condone this, but I couldn't come up with a better title for these columns. In the case of biological weapons, they kill with smaller doses, but they're harder to deliver effectively. I think we saw that with the anthrax event. While they can be powerful, it can be difficult to get the agent to the target.

In terms of chemical weapons, some may be made simply with pesticides and fertilizers, but more deadly nerve gases really require more expertise and are a little more difficult to develop. With radiation or dirty bombs, the real weapon is in contaminating an area, so decontamination is the greatest challenge. Some have called it really a weapon of dislocation. It makes a certain area unusable for a long period of time without real heavy decontamination. So it's not as devastating in terms of lives as nuclear weapons, and the materials are easier to obtain and get to the target. You're familiar with the other two categories. Nuclear devices can be just devastating and require technical skills that might be difficult but not impossible for a terrorist to obtain. Conventional bombs are easier to construct and deliver to target sites, and damage is more limited.

I have a brief diversion if I can ask your permission. It's a James Bond story. I was watching the end of "Goldfinger" last week, and I was under the misimpression that Goldfinger was trying to blow up Ft. Knox with a nuclear bomb. I realized, watching just the end of this, that he was really trying blow up a dirty bomb to make the gold radioactive for the next 80 years so that he'd have a corner on the market. I thought this was interesting, the distinction between those two types of weapons.

I borrowed this information from Dan Wolak from General and Cologne Life Re. He laid out a scenario. We haven't done much in terms of laying out scenarios, but I think this is a helpful next step in terms of assessing our readiness for terrorism

events. Dan had a scenario laid out for a concentrated attack. A metropolitan area is hit by a terrorist attack. Health claims rise from 500,000 people in the metropolitan statistical area, with two million total people in that area. Claims for impacted people will be 12 times the normal annual claims, and most of the excess claims incurred will be during a 60-day event.

The question to ask yourself, as you look at how you would handle an event like this, is how will the costs of each health insurer change after this event? How will that affect their costs? What percent of those costs will be covered by worker's compensation? I guess the location of the people and the timing will have an impact. Also, what percentage of the costs are self-insured or uninsured or reinsured? I think a next step is to spend some time laying out scenarios like this and seeing what the implications would be.

I'd like to spend a little bit of time now talking about developing a proactive approach for dealing with these types of situations. How does a company think ahead and set up a framework for addressing these types of potential situations?

The first step is assessment of the treatments and increased cost prior to the event and then also in an unprepared population. It's used for benchmarking, planning and forecasting. What you'll find out is that you'll definitely have a benchmark level before the event, but then in an unprepared population, treatment's going to shoot up to another level. Your long-term hope is that the best medical care will be delivered to those people, and those claims will be reduced, maybe not as low as before the event but somewhat. Your goal really is to bring your claims down from the claims that you'd have in an unprepared population. The Office of Public Health and Preparedness, which was established last November, and the CDC are taking leadership roles in coordinating surveillance information and responses, so it's important to stay tied into those organizations to monitor new events and activities.

Step two is to identify the at-risk groups once an event has occurred. Who is most at risk for this? Measure their baseline utilization services, those directly related to the agent and those that are indirectly related, like we talked about earlier with mental health conditions. Those types of things, those types of treatments, will need to be benchmarked. It's also important early on to establish targeted communication based on risk level. There are a number of ways to communicate, and you'll probably want to communicate differently with those most at risk than those not as closely at risk. Therefore, establish phone intervention, direct mailings probably to those closest, but also mass mailings to entire memberships, 800 numbers and the Internet. Used as education, this is a very up-and-coming vehicle for communications.

Step three is to develop baseline treatment protocols and best practices for these types of events. You want to deliver early cost-effective care, and your goal is to improve outcomes and cost reductions. You want to establish tracking mechanisms to measure cost and utilization. So, you'll want to identify what is really the best

treatment for these populations. I think the example of the treatment change from ciprofloxacin to doxycycline is a good example. In a situation like this, sometimes it will take some time before the actual best practice will emerge. So you'll have some unprepared time, early in the event, when people are going to be trying all different types of treatments. You want them to zero in on the best treatment. So, the more you're tied into the CDC and other organizations to figure out what the best treatment is, those treatments will get out to the populations the quickest.

Finally, step 4, and this really is throughout the process, is performance measurement. This is continuing to measure utilization and cost, comparing it to benchmarks, and measuring the huge impact on plan pricing of reserves, valuation, and solvency. As they start thinking ahead, as they start setting up structures for these types of events, organizations need to assess their exposure to the risk. What's the regional concentration? What's the presence of reinsurance? They should have a formal response plan for emergency occurrences, policies and procedures in place, responsibility assignments. In a situation like this, there's a lot of information flowing in different directions. The clearer you can be on the assignments and the responsibilities up front, the better you'll be in a chaotic situation.

To summarize: Step one, identify the event. Step two, identify at-risk groups and open lines of communication. Step three, understand treatments and patient behavior. Step four, identify the best practices. Step five, measure performance. The goal then is to improve outcomes for your membership.

MR. DEAN TAYLOR: As Karl mentioned in his introduction of the panel's presentation today, I'll be focusing on the short-term implications of health care cost trends in the aftermath of September 11 of last year. By way of introduction, I'm a pricing and product development actuary with Tennessee's BlueCross and BlueShield plan, and I manage our individual and small-group product lines. Trend projection is an important aspect of what I do on a day-to-day basis, and I had a particular interest in researching the immediate and short-term effects of September 11 on the health care trends in my company's products. Short term I define as being within the first 12 months after this traumatic event. Of course the events of September 11 have altered the course of many industries, including the insurance industry, in far-reaching and profound ways.

The outline of my presentation today will first cover the trend environment prior to September 11, 2001, and next I'll talk about the immediate impact of the terrorist attacks. Following that, I'll discuss the impact on health care claims at BlueCross and BlueShield of Tennessee (BCBST). I'll end my presentation with a summary and conclusions.

First of all, to see the impact of September 11 on health care cost trends, let's establish a benchmark for trends prior to this date. From Watson Wyatt's 2002 annual survey of 200 companies, we can see that there has been a steady increase

in employers' health plan cost trends over the past three years. As can be seen in Chart 2, the costs for retired employees are approximately one to one-and-a-half points higher than those for the active employees. Also, the rate of increase has been steadily rising over the same three-year period. Incidentally, this survey was conducted prior to the events of September 11 and the deepening recessionary environment.

Chart 3 zeroes in on the 2002 active employees' expected cost increase of 13.6 percent (the top row) and splits it in two ways, first among four main types of insurance plans—indemnity, PPO, point-of-service (POS), and HMO—and second, at the bottom two rows of the graph, by medical only and prescription drug. As expected, the indemnity plans exhibit the largest cost increases here, whereas PPO and POS have lower increases from the overall 13.6 percent. Interesting is the fact that the HMO trend is 13.9 percent, which is higher than the aggregate trend of 13.6 percent and the second highest just below the indemnity trend. When we slice the data between medical and prescription drug, we see the significantly higher drug cost trend of 17 percent versus the lower medical trend of 13 percent. In Chart 4, the retirees' expected cost increase from 2001 to 2002 was broken down. For the post-age-65 retirees, the overall trend of 15.1 percent is split between a drug trend of 18 percent and its corresponding medical trend of 11.7 percent. For the pre-age-65 retirees, the overall trend is slightly lower at 15 percent compared against the post-age-65 retirees' 15.1 percent, whereas the drug trend is slightly higher at 18.4 percent versus 18.0 percent, and the medical trend is significantly higher at 14.4 percent versus 11.7 percent.

In Chart 5, the results of several years of double-digit cost increases have resulted in employers trying several actions to try to stem the tide, one of which is the amount of the employee or retiree premium contribution level. For active employees, employers in the survey plan to increase the employee contribution, with underlying cost increases being equal to trend 41 percent of the time and more than trend 15 percent of the time. The remaining 44 percent at less than trend are more than likely to have no increases in the dollar amount of contributions beyond the current levels. For retirees, it's interesting to see that employers plan to have the status quo. This means either no increase or only moderate increases in the retiree contribution at less than trend only 30 percent of the time, with a 57 percent increase in contributions with trend and with 13 percent of employers increasing contributions at a rate greater than trend.

Chart 6 shows actions in the next 12 months, which employers plan to incorporate into their plans to moderate health care cost trends. The blue bar represents the percentage of employers likely to take that particular action; the red bar, those employers somewhat likely; and the yellow bar, those employers who are not likely to take that action. Of particular note on row 1, along with the typical action of reducing benefits and/or increasing co-pays, turn your attention to row 4, targeted interventions. Sixty percent of employers are interested in using targeted interventions such as health management to control their health insurance cost.

And in the second row from the bottom, an amazing 75 percent are planning on using the Web for employee education. Also, as you'll notice in the last row, for the defined contribution approach to health insurance, even though it is still relatively new, a full 20 percent of employers are considering it for 2002.

I'll now shift to the second phase of my presentation in presenting the immediate impact of the terrorist attacks on the insurance industry. First of all, in Chart 7 on the property and casualty side, we see that the attacks on September 11 far eclipse any other catastrophic event to date, resulting in losses that will total an estimated $50 billion. The next largest catastrophic event, in contrast, was Hurricane Andrew in 1992, with $15.5 billion in losses. This event is followed in order of severity by the Northridge earthquake, then four other hurricanes, and lastly the winter storms of 1993. The magnitude of the $50 billion loss from the events of September 11 spawned new directions in how to reinsure such an event between private industry and the government and has resulted in a major reorganization of the federal government.

In the immediate aftermath of September 11, a national survey conducted within a week showed that 71 percent of respondents were depressed, 49 percent had difficulty concentrating at work, and 33 percent had trouble sleeping. Again, this was a national survey. In New York City, the rate of agoraphobia or a terror of public or open spaces among school children was 15 percent, or three times the national average. Eight percent of the students were found to be suffering severe depression, and 11 percent were determined to have the symptoms of post-traumatic stress disorder.

According to the Institute for Health and Productivity Management, since September 11, the use selective serotonin reuptake inhibitors and antidepressants has increased 16 percent nationwide. In addition, there has been a greater rate of absenteeism and a yet unknown impact of what is labeled "presenteeism," an effect of employees being on the job but not fully productive. In particular, a PCS American productivity audit found that self-reported presenteeism doubled in the two-week period following September 11, which did not include the impact of the anthrax scare.

Chart 8 shows the amount of emergency federal grants to states deemed most affected by the terrorist attacks. The total amount to these eight states and the District of Columbia is $20 million, which is part of the $5.1 billion in disaster-related funds released by President Bush on September 21. The awards were given to state governments for substance abuse prevention, addiction treatment and mental health services, particularly with a focus on meeting the special needs of children and adolescents.

Now I turn to the highlights of the impact on health claims at BCBST. After several months of run out, the medical claims for the last four months of 2001 companywide appear to exhibit the normal variation in seasonality with no

significant variations that we had expected, particularly delayed office visits to practitioners followed by a surge of visits afterwards. Prescription drug claims were affected slightly, but less than expected, whereas the behavioral health claims utilization had a significantly low per-member/per-month amount in September 2001, with an offsetting spike in October and the following months tapering off. We had particularly felt that claims for antianxiety and antidepressant drugs would rise dramatically, and the behavioral health claims would spike and then plateau to a new level. However, the next two charts show that this was not the case.

For antidepressant drug utilization in our plan, there has been a steady rise in the prescriptions per thousand per year throughout 2001. For purposes of antitrust requirements, I've left out the y-axis values in Chart 9, as well as on the next graph. However, suffice it to say, the values are plotted on a scale that represents the entire value, with the y-axis scale beginning at zero. In September of 2001, there was a noticeable drop in utilization, as there were delayed visits to practitioners and pharmacists. This was followed by an upsurge in October, but the last two months of the year have remained relatively steady. Accordingly, we have not experienced the increase in utilization that we had expected and, hence, have not increased our trends in the short term because of this.

The 2001 behavioral health experience is depicted in Chart 10. Here we have the last six months of 2001 inpatient days per thousand and outpatient visits per thousand. As can be seen, there was a decline in utilization for both inpatient days per thousand and outpatient visits per thousand in September, although the decline was more pronounced for the outpatient. A surge in utilization occurred the following month, which was expected, but the last two months of the year it tapered off. We had expected these two months to continue at a new higher plateau like October, but apparently utilization has quickly returned to normal levels.

To summarize, at BCBST, we have found that the short-term impact on health claims was minimal and less than what we were expecting. The largest impact appears to be in the area of behavioral health and in the use antidepressants and antianxiety drugs. However, even though there's been a discernible decline and then a surge in utilization for these services and drugs in September and October 2001, respectively, it appears that such swings were short-lived and have not resulted in significantly higher thresholds as we had expected. Beyond the short term, health claim trends could be more affected by a new normal level of stress or a heightened awareness as society at large stays vigilant in the war against terrorism. This impact could be dramatic and pronounced should there be another major attack or widespread biological or chemical warfare. This concludes my presentation.

MS. LISA TOURVILLE: I'm going to try to talk about the future of the medical health care trends and what we're expecting over the next year and a half. Some of the bullets I'm going to touch on are price, the aging population, demand,

consumer demand (both marketing and the media), medical technology, pharmacy pipelines (some of the impacts we're expecting those items to have), legislation, and then a summary of what the overall outlook is.

For price, Chart 11 shows what the medical care combined premium increases (CPIs) have done for physician, hospital and pharmacy. I know a lot of people will take a look at the CPI information and not really give it a lot of credibility. I don't agree with that, because there's a great deal that you can learn from not only the slope of the graphs but also the levels. We watch these very closely. In contracting with the provider groups, we're not always going to match CPI. Oftentimes we don't want to. Ideally, we'd like to come in below. But depending on what's happened in the previous years, we could come above. I'm sure you've seen a lot of the announcements of some of the things we're seeing that have come out. The hospital systems are pretty proud of themselves at what kind of negotiations they've come through, and you can definitely see that in the change in the slope on the hospital CPI.

Pharmacy is a little bit different. It's starting to come down a little bit, and hopefully that's going to continue. Physician seems to have tapered off, again, something we're keeping a very close eye on. As for aging and changing of demographics, I've also had a lot of people question whether or not that really has a serious impact today on health care costs, and there's a lot of talk about the baby boomers and what's going to happen 10 years from now. There's no question there's an impact today due to changes in demographics, and part of it is just the natural aging of the population. Some of it is what's happened over the last 12 to 18 months, partially due to the recession, partially due to September 11, some of the changes that occurred. There have been layoffs in companies, many of them targeting low seniority, which tends to be a lower age group, leaving the higher age, higher demographic population. There have also been some companies that have targeted their layoffs via early retirement packages, things like that, which would of course lower the overall demographic impact, so this is something to watch for on a specific customer-by-customer basis.

For the impact on trend of changing demographics, what we've been seeing and what we really expect to continue is right around one to two percent on aggregate blocks of business, as seen in Chart 12. We did an analysis on 33 different customer groups to see what kind of a demographic impact they had had on their trend over the past year. We were pretty shocked to find where everyone fell out. Three of them had a less-than-zero percent impact on trend due to demographics. Thirteen were between zero and one percent. Twelve were between one and two percent. Two were between two and three percent. Three of them had a greater – than three percent impact on trends due to demographics.

There was one that we really dug into in trying to get to the bottom and figure out what was going on. It turned out they actually had an impact of trend of 5.4 percent due purely to changes in demographics, and when we really dug into it, we

found a couple of major changes that had occurred. It was an area that had a lot of high-technology companies and, during the recession over the past year, some had gone out of business. Many had done some pretty serious layoffs. So they lost a great deal of their younger population and at the same time added two very large school districts. Being able to try to help explain that and also try to figure out whether the actual trend will continue into the future is pretty critical to what we do.

Whether or not advertising media impacts trends…I did find a Web site that had some historical advertisements related to health. I had a lot of fun with that. One – ad says, and it's due to toothpaste,--can a woman work and keep her health?

This one I found very interesting. It was 1942, and Parke Davis & Company put it out. They were pretty much saying that a lot of the doctors have gone off to war. So, there's not very many left over. If you're not sick, please don't call the doctor.

Well, we don't have claims to go back historically and test whether or not these advertisements had a real impact. We do for this one. You wake up one morning, and you see on NBC that Katie Couric is going to have a colonoscopy on national television. So we started tracking colonoscopies per thousand to see what kind of an impact we are going to see. In Chart 13, you can see they were running just above nine per thousand in 1999. She had hers done in the first quarter of 2000. Two articles came out in the *New England Journal of Medicine* the following third and fourth quarters, I believe, and we've seen the rate double. Now, she just had another one done in the first quarter of 2002. Of course we haven't seen the impact of that, but I certainly do not expect these rates to decrease.

One of the articles in the *New England Journal of Medicine* talked about another procedure, which is similar called a sigmoidoscopy, and that it's nowhere near as effective as a colonoscopy, so providers should convert and start using colonoscopy instead of the sigmoidoscopy. So, the medical professionals in our company came up and said, oh, well, there's going to be relief, because we're actually replacing something rather than just adding something. The problem is the sigmoidoscopy costs $95, and the colonoscopy costs $400. As you can see in Chart 14, at the time when the article came out you can actually see the sigmoidoscopy, the bottom line, start to slope downward, but the utilization for the colonoscopy jumped a lot higher than what that decrease was. It definitely was not a win-win situation.

When it comes to things like this, you have to look also at overall expenditures, both short term and long term. If more people are having colonoscopies done, hopefully we're catching colon cancer at a much earlier stage, and the cost of care will be less in the long term. The problem when you're looking at your books, your financial statements, for the upcoming six to 18 months is that the cost is going to have a big impact up front.

Some of the other things that impact pretty significantly are medical technology and the pharmacy pipeline, illustrated in Table 1 and Table 2. Some of the things we look at on the medical side are changes in guidelines, new diagnostic tests, and new treatments. Pneumococcal vaccine was one where they actually changed the guideline. Previously, I think children under the age of two did not receive the pneumococcal vaccine. The guidelines were changed so that, not only should children under the age of two receive them, but also they should receive three by the time they're at the age of two. There are many providers who implemented this change immediately. There were some who went back to their three-year-olds and said we need to bring you in and have you get three vaccines over the next six months to catch up. We were able to track that. This was something that was implemented, or the guideline changed, I think, a year and a half or two years ago. We were actually able to go in and track that after the fact and see what kind of an impact it had. It had a pretty significant impact for something that small. Newborn hearing tests were the same type of thing. They changed the guideline to impact a much larger population.

Table 1

Medical Technology

- ♦ Changes in Guidelines
  - Pneumococcal Vaccine, Newborn Hearing Tests, Implantable Defibrillator
- ♦ New Diagnostic Tests
  - Intracoronary Brachytherapy, Lysophosphatidic acid (LPA) assay, EXACT™ stool DNA assay panel
- ♦ New Treatments
  - LDP-02 (anti-b7 mAb), HapatAssist™, AbioCor™ , Hattler Respiratory Catheter

Table 2

Pharmacy Pipeline

- Brand Name Patent Expirations
  - Prozac, Glucophage, Prilosec, Prinivil, Claritin
- Move from Prescription to Over-the-Counter
  - Claritin, Allegra, Zyrtec
- Changes in Guidelines
  - Cholesterol
- Changes in FDA Status
  - Synthroid
- New Medications
  - Exubera, Aranesep, Clarinex, Uniprost, Crestor

6/24/2002 Society of Actuaries - Health Trends Post 9/11 - Lisa Tourville 8

The implantable defibrillator is one that we are quite concerned about and are watching quite closely. The impact has not hit yet. We're looking at it as a 2003 event for the most part. This is something that they implant inside you generally if you have an abnormal rhythm in your heart. They've decided that anyone who has had a serious heart attack should have this implanted, not just those with abnormal rhythms, and the reason is because they feel that sooner or later everyone who has had a serious heart attack will have abnormal rhythms. We took a look into it to figure the impact if everybody adopted this new guideline and actually implemented it. First of all, the cost to implant the defibrillator is approximately $30,000.

Currently about 80,000 people out there have them, with irregular heartbeats. For people that have serious heart attacks, we're looking at about 400,000 per year, with three million sitting out there who at some point in their lives have had a serious heart attack. The question is, with the provider group, will they only start implanting these for people who have serious heart attacks from here on? Will they go back to the pot of three million that are sitting out there that they could actually draw out of? It's something that we are watching very closely. It's got our medical professionals up in arms.

For new diagnostic tests, the LPA assay is the new ovarian cancer test. Again, nothing else out there today does this. There's not going to be much of a reason for a physician not to use this type of a test for ovarian cancer. It's going to be a cost

up front just to implement, to actually give the test itself, but then we're also going to capture cases of ovarian cancer that will need to be treated. Again we're catching them earlier, but in the short term, in the end of 2002 into 2003, there will definitely be a cost associated with this one. For the new treatments, HepatAssist is the kidney, artificial kidney; AbioCor is the heart; and the Hattler respiratory catheter is the lung.

There is the pharmacy pipeline. I actually have quite a bit of fun following a lot of this stuff because you can learn so much just from watching television. I watch these Clarinex commercials, and I just want to get that feeling. I want to get to the top of that mountain, and I know that I'll feel so much better, and life will be better. The problem is that Clarinex is virtually identical to Claritin, and the reason they're trying to promote Clarinex is because Claritin is about to lose its patent. So if they can shift their membership over to Clarinex, then they won't have to worry about the generic substitute coming in and taking over their covered people. The other thing involving Claritin is the possibility of it becoming to an over-the-counter product, which is also going to have a big impact on the income from the pharmaceutical company for Claritin. Allegra and Zyrtec are running up against the same thing concerning over-the-counter. I heard several months ago that it looked like that was going to get postponed a couple of years, but I'm now hearing that it could be as early as December that these become over-the-counter products.

One of the other interesting ones was Prilosec, and that's also going to be losing its patent, I believe in fourth quarter of 2002. Well, they came out with a new one called Nexium. I'm not sure if you've seen commercials for that one, but it's the exact same thing. I read somewhere that they got the patent on Nexium because they defined the chemical composition once it was digested rather than when you take it in pill form. So it's the exact same thing. They just defined it a little bit differently, got the new patent on it, and again are out there trying to switch everybody over to Nexium. One of the other games they play which I found very intriguing, is if you look back at the Claritin versus Clarinex issue, Claritin sells for approximately $70 for a prescription, and Clarinex came out at $52. Again, why would a provider not switch somebody over to Clarinex? It's supposed to be better, as far as they're hearing, and it's cheaper. With Nexium and Prilosec, they did the same thing. Prilosec was $140, and Nexium was $120. The interesting thing with that one is there is a generic sitting out there that is $25.

One of the other things with changes in the guidelines is—cholesterol. There was an article that came out that said currently only 30 percent of those that should be treated for high cholesterol are treated for high cholesterol. If everyone adopted these guidelines, took your cholesterol drugs, divide it by 0.3, that's your new projection. Whether or not everything gets implemented in one day or it actually grades in is where you have to talk about that, but that is kind of a scary one, too, quite a big impact. I had a little fun with changes in the Food and Drug Administration (FDA) status. I don't know if you're familiar with Synthroid, but it targets hypothyroidism, which generally tends to affect women, and Synthroid is

over 40 years old. It's been around for so long that when the FDA implemented their approval process, they were grandfathered in. They didn't even have to go through the process that you have to go through for approval. Well, some recent issues have popped up, and the FDA has decided to force Synthroid to go back through the official approval process. Now it's unlikely that they will lose their approval, but there's always the possibility. So we decided to go in and take a look at Synthroid and find out what the impact would be if all of the Synthroid users switched over to the generic that exists. A lot of people are using the generic, but a lot of people are using Synthroid. We found out that both the generic and Synthroid cost around $15, but the co-pay for Synthroid, being brand name, was $20, and the co-pay for the generic was around $10. So, for the generic, the health plan is paying $5. For Synthroid they're paying nothing, which is great for the consumer. If they switch to the generic, they'll actually have a decrease in cost of $5, but for the health plan, it's something to watch out for.

Among some of the other new medications that are coming out—I already talked about Clarinex—Exubera is really the only other one that we're watching very closely. We're watching all of these, but watching this one very closely. This is inhaled insulin for diabetics. First of all, it's rather expensive. The other thing is, it's going to target a big population that up until now has refused to receive treatment. There are a lot of people that should be giving themselves the shot of insulin every day, and they just can't quite bring themselves to do it. So, there would be some pretty significant costs, plus there are others who don't have quite as severe a form that would probably switch to the inhaled form. These are definite impacts.

Let's talk a little bit about legislation, such as the Patient's Bill of Rights (PBOR). Just to give some history, this started way back in 1996 with President Clinton, and several things occurred over the past couple of years. Last year in June the Senate passed a version of the PBOR. The House passed what they called the Patient Protection Act in August 2002. Now, of course, we've been trying to track this all through time and are trying to figure out how we price for it. What do we tack onto trend? Is it an administrative expense? Is it a medical expense? How are we going to handle this? The Congressional Budget Office kept coming out with new projections every time a new version of the bill was passed or was presented, and you can see from these estimates that it was a little difficult to follow because the values, the projections, changed pretty drastically from time to time. Now, the only good thing was the most recent version of the Senate bill, which is 1052, and the most recent version of the House bill, HR 2563 (Table 3), were both at four percent. The problem is they weren't for the same reason. If you actually went in and looked at the bills, it's for different reasons.

Table 3

Legislation - PBoR Estimates

- Congressional Budget Office Estimated Ultimate Effect on Premiums for Employer-Sponsored Health Insurance:
  - S. 283 (4.2%)
  - S. 872 (4.2%)
  - S. 889 (2.9%)
  - S. 1052 (4.0%)
  - H.R. 2315 (2.6%)
  - H.R. 2563 (4.0%)

6/24/2002 Society of Actuaries - Health Trends Post 9/11 - Lisa Tourville 10

Table 4 gives an example of the Congressional Budget Office estimation as they went through it. This was the most recent House bill, HR 2563, and, we'll go through and pick out the things that we believe impact us, because some of it wouldn't. Then we determine whether it's an administrative expense or a medical expense. Finally, we try to determine if we have any way to do a calculation on our own. The Congressional Budget Office is generally pretty good at that kind of thing, but we've seen examples such as the Balanced Budget Act where their estimations came out just a little bit off, and relief acts followed, and all kinds of wonderful things.

Table 4

Legislation - PBoR H.R. 2563

Table 2.
Estimated Ultimate Effect of H.R. 2563, The Bipartisan Patient Protection Act, on Premiums for Employer-Sponsored Health Insurance (In Percent)

Provision	Increase in Premiums
Subtitle A--Utilization Review, Claims, and Appeals	
Utilization review activities	0.2
Procedures for initial claims and prior authorization	a
Internal and external appeals	0.9
Subtitle B--Access to Care	
Consumer choice	0.1
Choice of health care professional	a
Access to emergency care	0.4
Access to specialty care	0.3
Access to obstetric and gynecological care	0.1
Access to pediatric care	a
Continuity of care	0.2
Access to needed drugs	a
Clinical trials	0.8
Treatment of breast cancer and second opinions	0.2
Subtitle C--Access to Information	0.1
Subtitle D--Protecting the Doctor-Patient Relationship	a
Subtitle E--Definitions	
Coverage of limited scope plans	a
Title IV--Availability of Civil Remedies	0.7
Total	4.0 **4.0%**

SOURCE: Congressional Budget Office
a. Less than 0.05 percent.

Source: http://www.cbo.gov/showdoc.cfm?index=2953&sequence=0&from=6

6/24/2002 Society of Actuaries - Health Trends Post 9/11 - Lisa Tourville 11

As for the outlook on the legislative piece, the bill was scheduled to move to a House-Senate conference committee in September of 2001, and, of course, September 11 occurred, and suddenly the priority dropped pretty significantly. We've been following it, and it's not back on the active docket. It's not scheduled for a conference committee, but I don't think it's a dead issue. It's definitely something that we're watching closely. The other thing that we're a little bit nervous about and are keeping an eye on is, with a lot of the layoffs that occurred through the year 2001, whether or not any possibility of some kind of increasing coverage for nationally uninsured, something like that, is going to pop up again. So, we're watching it pretty closely.

To summarize, overall prices and—again I mean the core price, not mixing intensity with it—the provider negotiation, we are expecting higher negotiated provider reimbursements through 2003. Aging of the population will continue to increase health care trends. Advertising and exposure will continue to increase consumer-led demand for services and prescription drugs. The trend from medical technology has a lot of things coming up in 2003 that are going to impact us, and I think it's one of the biggest years we've had in quite a long time. However, on the pharmacy side, I think it's actually the opposite, which is kind of a relief right now. There are several drugs that are losing their patents. The generics will be coming out. I think we're going to see a little bit of relief there. As for the new blockbusters, there are not as many on the docket right now as we've seen in the past. That's one place I really do see a little bit of relief. The PBOR and other legislation could have significant

impact on trends. Unfortunately, it's not quantifiable right now because we don't know what the bills are going to look like when they're finalized.

MR. MADRECKI: There are a number of things going on. Let me try to put it in perspective and then open it up for questions. It's very clear we're in a business of managing high trends and high rate increases with all its potential for backlash and everything that means. A number of actuaries that I have talked to have been visited by their executive management and been asked to be placed in the business of being the risk manager in their plan post-September 11. I don't know if you would like that job, but you're certainly welcome to visit Jan Carstens after this meeting and join the Terrorism Task Force of the Academy of Actuaries, because that is a seriously difficult job to be handed by your management from that standpoint. I ask you to consider the use of war exclusions in our business, in the health business, and what they mean, if they mean anything when the event actually occurs. I've heard that in a number of states the use of war exclusions or terrorism exclusions is against public policy, and I suspect that those provisions are bouncing all over the place from that standpoint.

We're also not an industry that's known for its catastrophe coverage. If anybody grew up in disability or life, you know about things like three or more deaths, 10 or more deaths, common events, common causes and per cause. Should the industry rush out and buy cat coverage with big deductibles that's covered on a per-cause event, and what in the world is a per-cause event from that standpoint? So, there's a lot of work that needs to be done on this subject. Now we'll open it up for questions.

MR. ROBERT WARREN: At Kaiser Foundation Health Plan of the Mid-Atlantic States, we're in the Washington, D.C., area. We have about 150,000 federal employee plan members, and we had some pretty interesting spikes in utilization that mirrored a little bit what Tennessee had. There's one thing that hadn't been mentioned, and it might be a regional thing, but there is some evidence and some more anecdotal evidence that there will be about 10 to 15 percent more maternity cases come June than normal. It might be a little late for pricing or for trending, but incurred but not reported claims better consider that.

MR. MADRECKI: I have heard that. Watch out for the birth rate.

MS. TOURVILLE: That's something that we've actually been watching very closely, mostly with the obstetric-gynecological visits regionally. We've definitely seen some spikes. The thing that's going to be interesting is, right now we're pricing and projecting into 2003. More than likely with the areas in which we are seeing spikes, there's actually going to be a relief on the trends into 2003.

FROM THE FLOOR: I believe the first presenter on terrorism mentioned that the risk of that hadn't been modeled in the RBC work in the past, and I was wondering

if that is being considered now and what the likely impact of it would be. Obviously it would increase the RBC.

MR. MADRECKI: There are a lot of people in the room that worked on RBC. RBC is modeled on a probability of deviation from expected and an error and then a correction cycle, and since we tend to know a lot about things like epidemics, you can build in the probability of that. I've not seen a move; if somebody knows differently, please correct me. I think we have to work through the issues with the Academy on that because you can't just put enormous amounts of money in the bank. There's another theory behind putting enormous sums of money in the bank, and I've been chastised for worrying about it. Somebody said, didn't I know that the obvious thing that would occur is the very first thing we would ask as an industry, for the government to step in? The second one is if you have the money, they're going to take it first, anywhere there's a deep pocket. So it presents an interesting challenge beyond the probability. The other thing that's come up is that, when you deal with an epidemic, it's sort of a probability that might occur, so you can deal with .001 or .0001 or something like that. The question with terrorism is not the probability that it would occur, but where it will occur and when it will occur, which presents an interesting challenge.

MR. JOHN DAWSON: I perform actuarial services for self-insured employers, and I understand your comment that maybe we should back off on providing coverage for terrorism. That's not an option for self-insured employers. We saw very little impact for the employers we do business with, and September 11 didn't affect us in the Midwest. It didn't affect us in many other parts of the country. But for those employers it did affect, it affected them in a big way. So I guess I've got a challenge for our profession. Let's find a way to not run away from that risk. Let's find a way to provide coverage for self-insured employers and small insurers that really need to have that.

MR. MADRECKI: I don't know if we're running away from the risk. I think it's a matter of defining what the risk is and providing an economically viable coverage in a reinsurance market that's been pretty strict.

MR. DAVID MAMUSCIA: Are there any estimates on the second phase of mental health parity and what that might do to trends? I read something, and I don't remember where it was. It was a source on the Internet of a one percent estimate, but I don't know what it was based on.

MR. MADRECKI: Are you talking about another trend driver?

MR. MAMUSCIA: Yes.

MR. MADRECKI: The issue of parity…

MR. MAMUSCIA: Would it have a leveraging effect on the trend otherwise?

MR. MADRECKI: To my understanding, there are several different versions of what mental health parity means, and I actually don't have an estimate on that. This is beyond what it means to be treating something as equal and with the same limits. So, I really don't know.

MS. TOURVILLE: I know we've been doing a lot of analyses on a state-by-state basis where there have been some mental health parity legislative things passed, and there are definitely impacts on those. I'm not familiar with whether there's national parity law, if that's what you're getting at.

MR. THOMAS WILDSMITH: The Congressional Budget Office has scored the leading mental health parity proposals in Congress at nine tenths of a percent. Now that's a national average, and it averages in all those employers who are already at parity and all those states that already have parity laws in place. If you peel back and look behind the estimates that are done, they consistently show that the cost of parity varies dramatically based on the kind of program you have, with network-based HMO coverage generally being scored somewhere below one percent. When you get to POS and PPO, it's usually double to triple that. For indemnity plans, the scores are coming up five or six percent or higher. So, the national debate in Congress is based on it costing one percent or less. Depending on where you sit, it can cost a lot more for a particular employer.

MR. MADRECKI: Thank you, Tom.

MR. SCOTT GUILLEMETTE: I noticed in all of the presentations, which were excellent in my opinion, none of them really talked about the hardening of the other markets. I mean they briefly touched on the property and casualty market. But as a result of the hardening of those markets and the collapse of the number of carriers in the professional liability marketplace, have any of the companies out there taken into consideration how that piece of the pie is growing? That means the professional liability that'll be charged to the physicians and to the hospitals and the double and triple premium increases that they're experiencing that will ultimately be passed through to this industry.

MR. TAYLOR: That's something that we will look into at BlueCross of Tennessee. As of yet it's still sort of on the horizon for us, but that's a good point.

MR. MADRECKI: From the standpoint of malpractice, there is the absence, or was it St. Paul Companies that went out of the business? My understanding is that physician malpractice is approaching a crisis stage in several states, which will ultimately be passed on with physician fees, because every time we have a malpractice problem we end up having to increase the professional payment substantially. For the remainder of the reinsurance market, I understand that's in quite a bit of disarray, without defining new coverages.

MR. CHRISTOPHER HEPPNER: I have a question on the trend rates in the future. You talked about one demographic, which was aging, which is an obvious one, but the other one is health status, and I mean basically deterioration of health. There's been an awful lot in the press about the obesity problem in America, and have you done anything to really measure how we can account for that aspect of the trend?

MS. TOURVILLE: Effectually, there are several different components of demographics that we study. I don't have the figures with me, but we are definitely looking at obesity and some of the diseases that are related to obesity and the increased utilization we're expecting there. I don't have the figures at my fingertips, though.

MR. DANIEL WOLAK: Thanks for using a couple of my numbers earlier, Jeff. It's interesting. On the panel that Jeff and I were on, we also had someone who was from a New York-based hospital, and one of my expectations was met by one of the comments that she made. I guess in preparation for the aftermath of September 11, on September 11, from a hospital side, of course, the providers are focused on the care part. Okay? One little advantage that we may have in a health care situation is that the providers are not thinking about the billing services in the case of a flood of patients from a catastrophe. So we may be able to save a few dollars on the health insurance side because simply there would not be a billing mechanism in place if there is a flood of patients due to an event. But I guess if we talk about the health care here, what are the thoughts of the panel from the pricing side? We have a new risk. What is the risk? On the group life side, there's some talk about concentrations. You've got a large group in a large city or you've got a number of groups in a small area. There is a different potential pricing issue. I don't know if the life side has fully come to grips on how to handle that when you have a concentration, but on the health side we have a responsibility for the financial solvency of our organizations or to provide consulting services for financial solvency. What are your thoughts as far as what people may be thinking about or, what should the pricing actuaries be thinking about in this type of environment that we now live in?

MR. ALLEN: I think that's a real challenge. In the case of terrorism events, bioterrorism events, we don't have much data to work with. As actuaries, we work with data to develop pricing, and there's just not data to work with to set up expectations. I have seen some work by a researcher using game theory techniques. I'm sorry I don't recall the name right now. I could look it up if anyone wants to look into that, but he was using game theory techniques to track the activities of terrorism groups and looking to see if events would relate to the types of activities that these groups were undertaking. He was looking at things like Internet activity, the amount of Internet traffic related to a certain terrorism group, and coming up with estimates of whether or not attacks would take place, both conventional and unconventional. But other than that, that's my answer, it's very difficult with the lack of data that we have right now.

MR. MADRECKI: I think one of the things that you hit on is one of the concerns, whether you have a self-insured group or, since companies tend to be regional or have certain concentrations in areas, that we're susceptible to a regional risk. I agree with that wholeheartedly. I would have to say from a pricing standpoint, I'd have to consider the pricing on aggregate stop loss to be an interesting challenge at this particular point in time. That would get at the heart of the self-insured problem. From that standpoint, I would certainly want to have that. The flip side of that is if we can't set up tax-deductible contingency reserves, are you going to have a hard time hiding that money or putting it away for a rainy day? And I guess there'll be some valuation sessions later that'll get into margin and things like that as well.

MR. CHRISTIAN ULMER: I work for Deseret Mutual, which is in essence a large ERISA trust of one employer and had to deal with that very question. So I thought I'd at least volunteer what Deseret Mutual did in this case. We are based in Salt Lake City, and over the years we have purchased catastrophic medical reinsurance, which, of course, collapsed after September 11. So we were sitting in Salt Lake City two months before the Olympics and felt like we had to deal with that and we dealt with it on the benefit side. There really was no other way. We, in essence, put in a terrorism limit. Admittedly, in an ERISA trust benefit, that's a little easier to do than in a regulated insured plan. We put in a maximum per life, if there were a terrorism event, and even reduced that by a fun little formula. If there were more than 200 lives, say, there are 400 lives, the maximum will reduce by half, by however many lives there are divided by the 200. Anyway, that's what we did.

MR. MADRECKI: You said it was an ERISA group, not an insured group.

MR. ULMER: That's correct.

MR. MADRECKI: The challenge might be that for anything that's insured, that might not fly.

MR. ULMER: Exactly.

MR. MADRECKI: Through the state insurance departments.

MS. CYNTHIA MILLER: There are a couple initiatives underway that the American Association of Health Plans is working on. They are looking into forming some kind of pool for terrorism or catastrophe reinsurance. It's not really even reinsurance; it would be a pooling mechanism that health plans could participate in, because I don't think we can count on the government to bail us out if we haven't tried to help ourselves. In fact, the property and casualty industry got that exact same comment after September 11 when they went to the government and said, okay, help us. The government said, well, what have you done to help yourselves first? So, we feel like we have an obligation to try to find at least a solution to a certain level. And then to Dan's comment in which he said if there's a flood of people that

come in, the providers' billing systems might not work. There are health plans that are going to need to think about that, because if you have a staff model HMO or you actually own facilities—and this was actually pointed out by a woman from Kaiser on one of the American Association of Health Plans' calls—they are a provider. Not only are they an insurer, but they're a provider also. We're probably going to have a situation in which providers can't turn people away. Those of us that do have those kinds of facilities are going to encounter a cost spike, whether there are insureds or not. Fortunately, Anthem's not in that situation, but not everybody in the room can say that.

MR. HOBSON CARROLL: I'm just wondering in all this discussion about trends going forward, are you watching the other slice that I think we might need to worry about? I guess I'll call it legal trends. I know it gets into some of those pieces, but I think there's a separate identifiable piece now. I keep reading all these stories about the cigarette lawyers turning their eyes on the insurance industry, particularly the benefit insurance industry, around the country.

MS. TOURVILLE: Is it something that we're looking at? Absolutely. In the area that I'm in, that's not part of the focus. The gentleman talked before about medical malpractice and what that would do; that would come through as far as the provider negotiations with us, and it's something that we're definitely discussing. On the other side that you're referring to—did you want to add something? I'm sorry.

MR. CARROLL: No, you're getting into it. I wasn't talking about the malpractice side, but the side where they're going to come after us.

MS. TOURVILLE: Sue the carrier, absolutely. It's tough to quantify something right now, but we definitely have some people in our corporate area that are focusing on that.

Chart 1

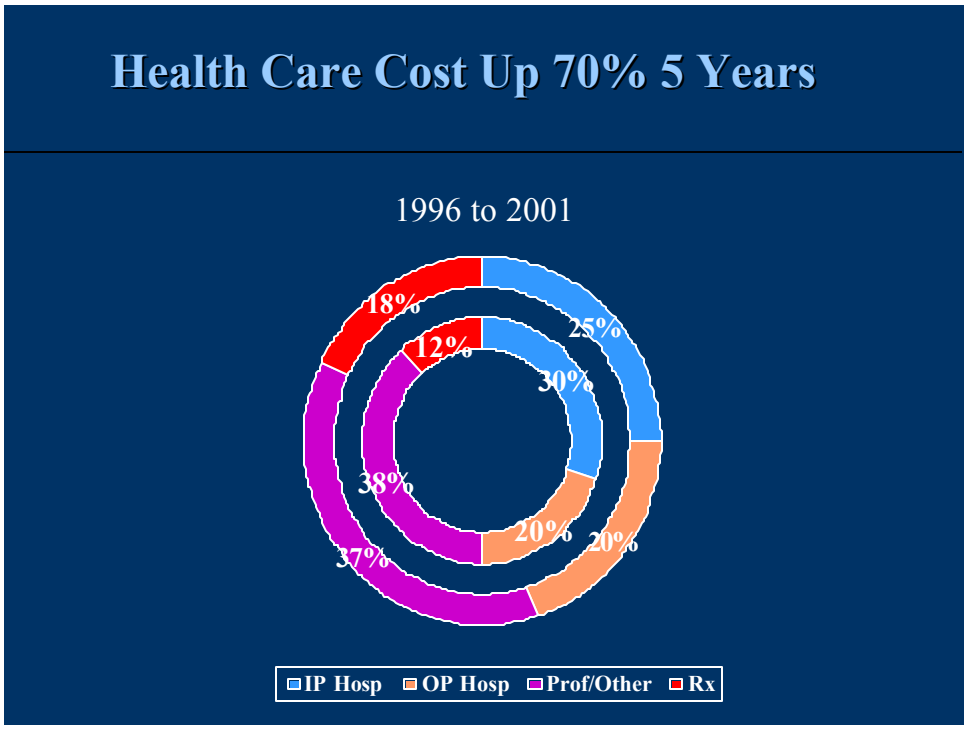

Chart 2

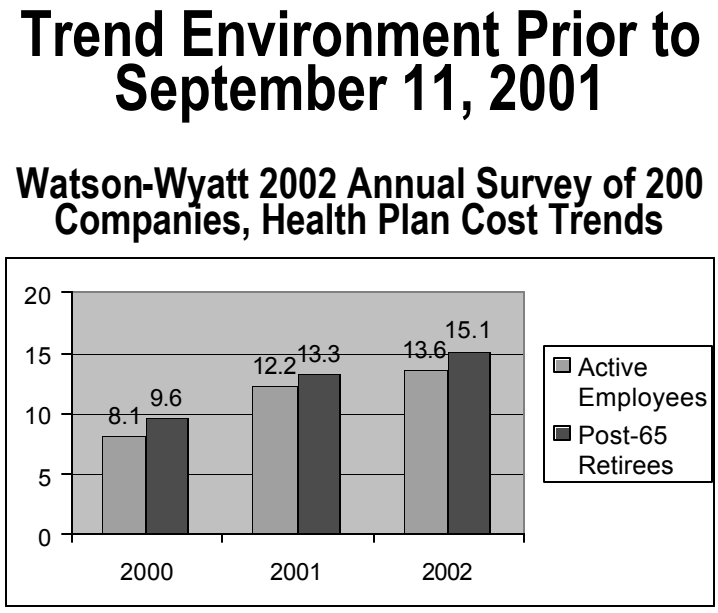

Chart 3

Trend Environment Prior to September 11, 2001 (cont'd)

Watson-Wyatt 2002 Annual Survey of 200 Companies, Active Employees' Expected Cost Increases from 2001 to 2002

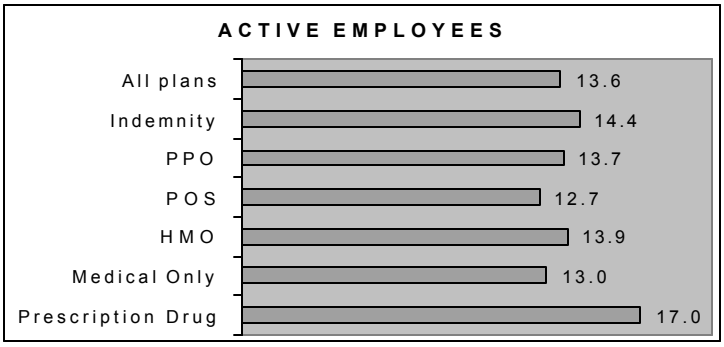

Chart 4

Trend Environment Prior to September 11, 2001 (cont'd)

Watson-Wyatt 2002 Annual Survey of 200 Companies, Retirees' Expected Cost Increases from 2001 to 2002

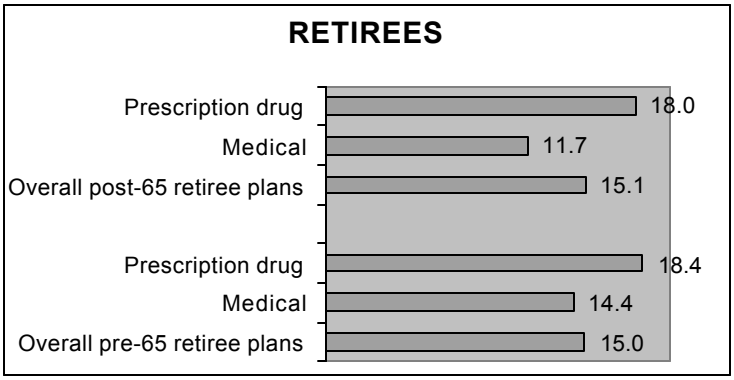

Chart 5

Trend Environment Prior to September 11, 2001 (cont'd)

Watson-Wyatt 2002 Annual Survey of 200 Companies, Employee/Retiree Expected Contributions for 2002

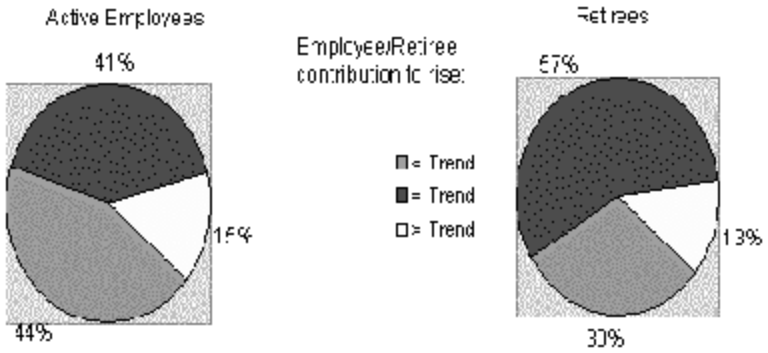

Chart 6

Trend Environment Prior to September 11, 2001 (cont'd)

Watson-Wyatt 2002 Annual Survey of 200 Companies

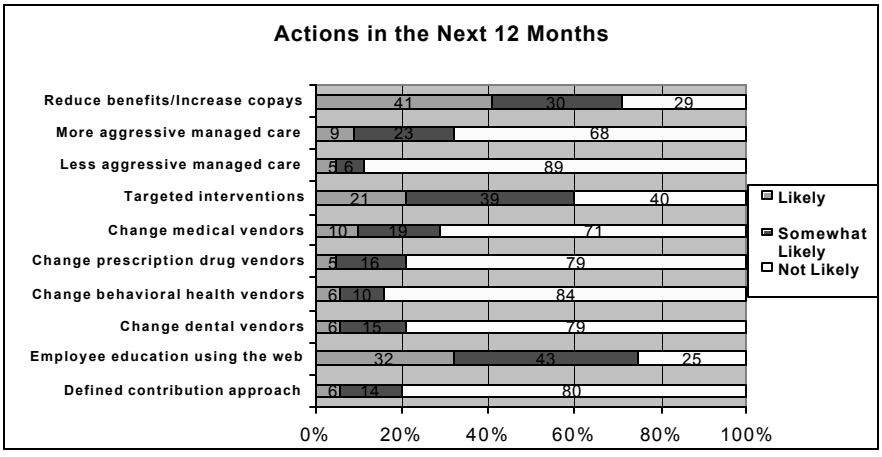

Chart 7

Immediate Impact of Terrorist Attacks

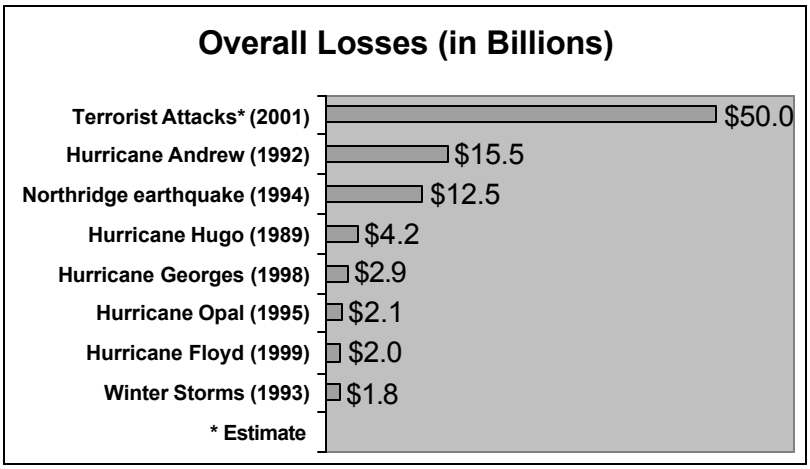

Chart 8

Immediate Impact of Terrorist Attacks (cont'd)

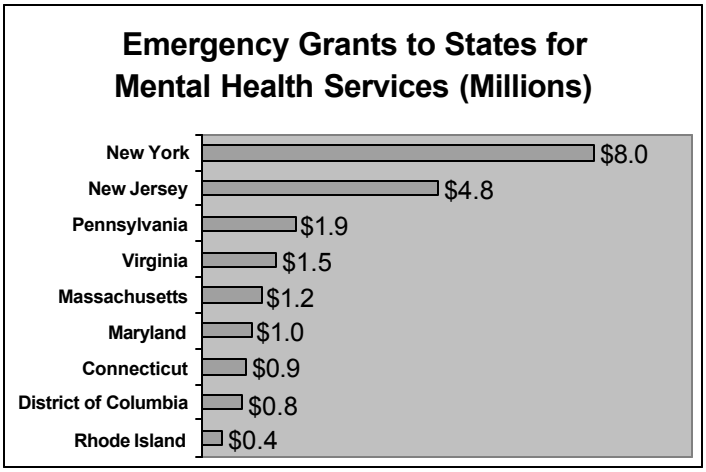

Chart 9

Impact on Health Claims at BCBST (cont'd)

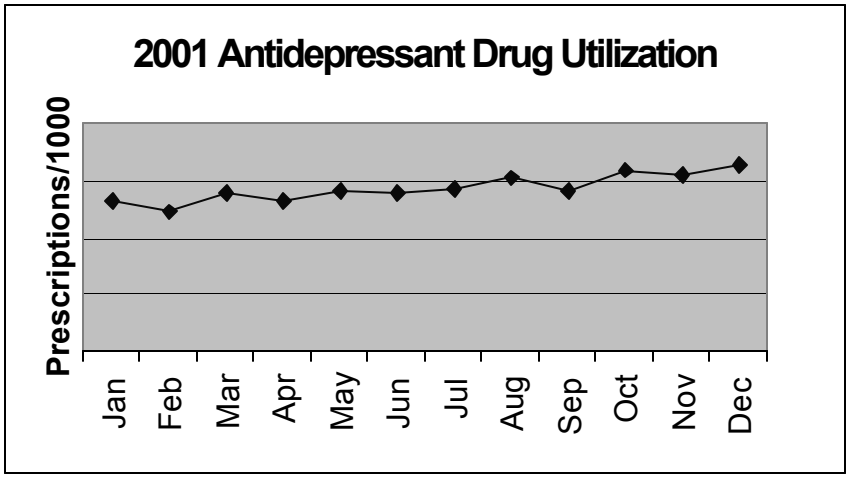

Chart 10

Impact on Health Claims at BCBST (cont'd)

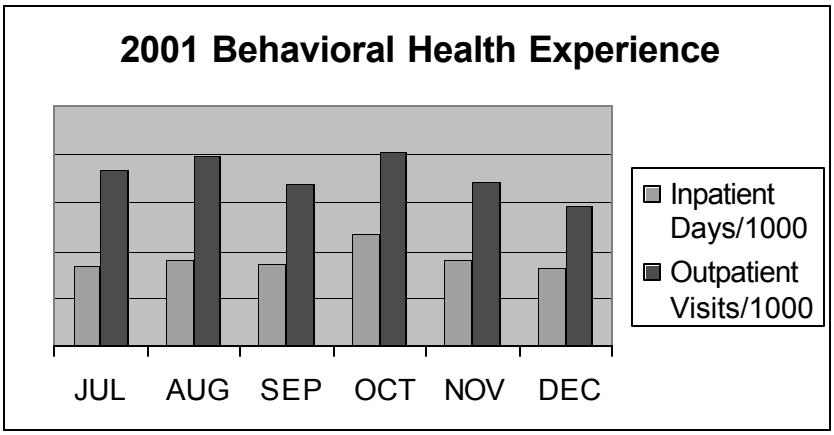

Chart 11

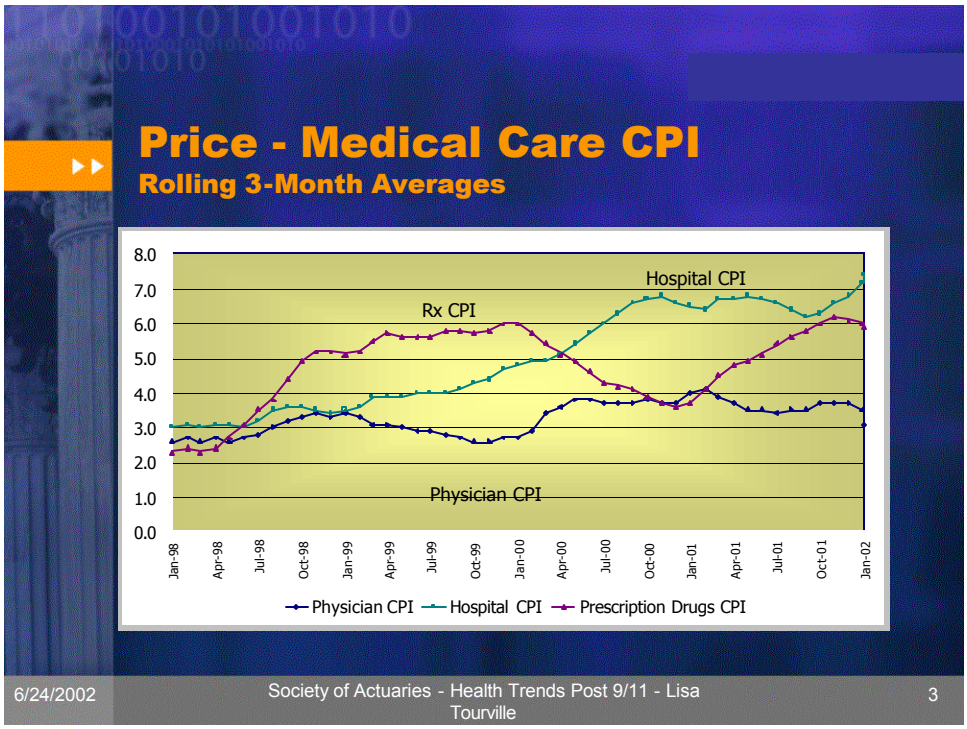

Chart 12

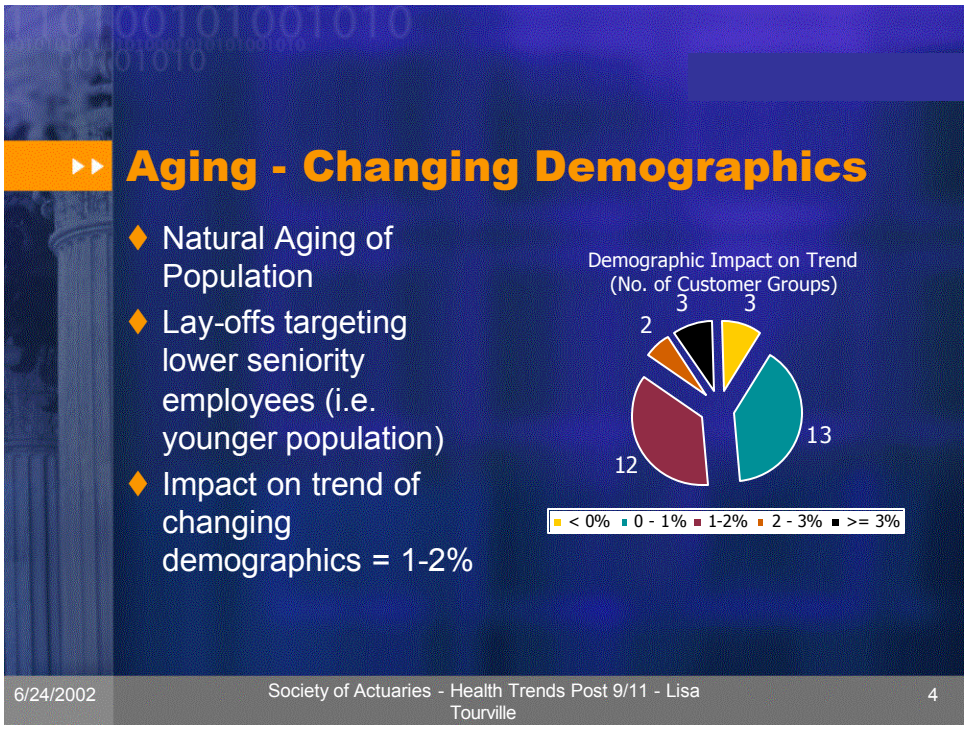

Chart 13

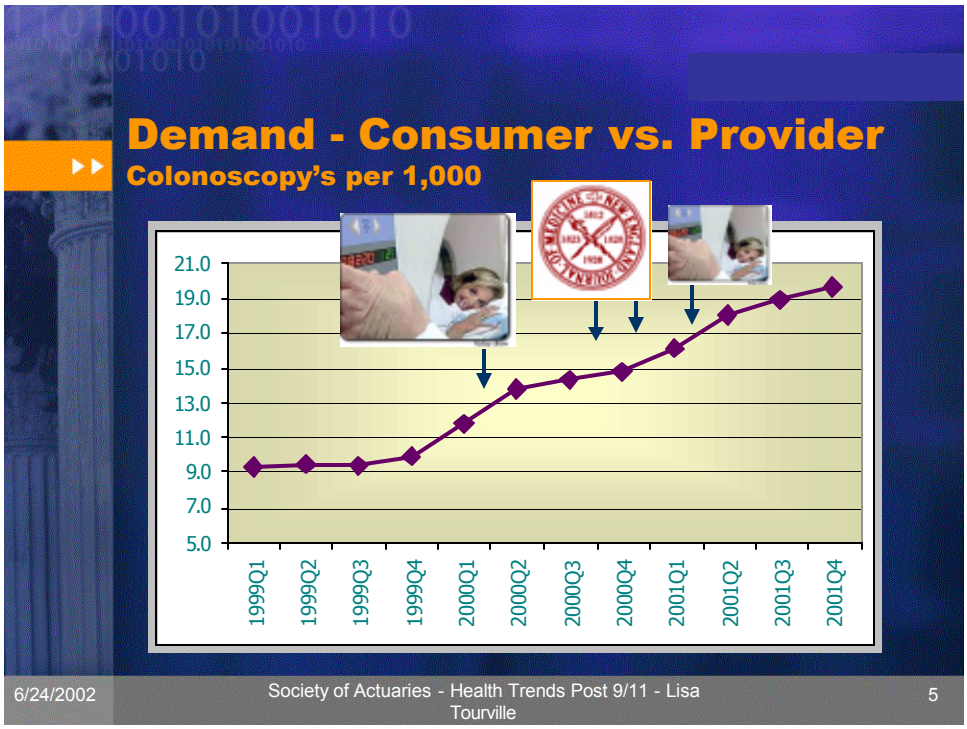

Chart 14