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Session 118PD
The Future of Managed Care

Track: Health

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Summary: Traditional notions of managed care have not fared well in recent years. Individuals are clamoring for more choices and fewer obstacles to receiving care; insurers are rethinking the wisdom of techniques such as preadmission review; and providers are increasingly averse to taking risk and are also increasingly aggressive about seeking the same reimbursement rates under HMO contracts as under PPO contracts. Yet, at the same time, one of the key drivers behind the original managed care revolution—the need to control the spiraling cost of health insurance—is as important a consideration now as ever before. In this session, panelists present their views on the future of managed care in light of the current environment.

MR. DALE H. YAMAMOTO: Both of our panelists today don't need a lot of introduction because in my mind they're managed-care icons. They're going to be talking about the future of managed care.

When I was asked to come up with a panel to address the issue of the future of managed care, these are the two people that came to my mind immediately. I purposely asked them to put together their presentations independent of each other because I wanted to have a discussion that set out what their thoughts were for the future. If there were some common points, I thought that was a good thing because at least you can understand from two different viewpoints what they think the future is. I think that just solidifies some of the thoughts of what's going to happen into the future. Dave is going to talk first and then Harry.

MR. DAVID V. AXENE: I often look at the future and try to figure out where it's headed. My first question, when somebody asks you to talk about the future of managed care, is, "Why?" Why do you want to talk about it? Is the future being questioned? That's one of the things I want to talk about. Perhaps another question is: "Why does there have to be a future?" There are people in this world who wish that the future of health care would go away. "What is likely without a managed care future?" is another question I'd like to talk about. I was trying to address current events. When I was making this speech last spring, I decided to talk about the Iraq war. As we all know, it's sort of still going on, but we aren't seeing it as often on television. So, maybe it's not as much of a current event as I thought it would be.

Why is the future of managed care or health care questioned? The consumer demands and reactions, perhaps the Patient Bill of Rights, the health plan reaction to managed-care reform legislation—there's a lot going on in today's current events that are questioning or raising questions. They are raising questions such as: "Can we do these things anymore? Is it appropriate?" Health plans have moved to a kinder, gentler utilization and case-management approach.

Earlier at this meeting, an actuary from Aetna shared something about their kinder, gentler approach, and how it related to health-care costs. You heard in this meeting how that approach might increase health costs, but there has been significant movement away from managing the care to perhaps not managing the care. There has been a shift away from provider-risk transfer. In other words, the doctors don't want the risk anymore, and that's creating more challenging provider contracting. If providers don't want the risk anymore, and they don't want to give you the low prices anymore, what do they want to give you? It's usually the high price and lots of services. When that happens, the ability to maintain competitive premiums becomes even a greater issue. So, all of these issues seemingly are raising questions about the future of health care. What is the future of managed care and the like?

There are serious concerns about health-care affordability. With a group of others, I wrote a paper on affordability. I presented results from it at Society meetings a couple of times, and there are issues about the affordability of care that are causing increasing concerns. I don't think anybody here would disagree that the economy is pretty bad right now. It's maybe getting a little bit better in your sector; maybe it’s not. Employers don't seem to have enough money to pay for health care. The government sure doesn't have any money, and it really won't after it gets the proposed drug program going. Employees don't have any more money to give to health care. So who's going to pay for the health-care system? If you look into the future, there's a serious question of where this is all taking us.

There's a distrust of big-business promises that have not consistently provided savings. First of all, it was the HMOs. Somebody at a reception the other night was saying that the high-cost problem to worry about with HMOs today is still the

executive-pay packages. Those alone are causing distrust today. As organizations convert from not-for-profit to for-profit, there are concerns about what that's going to do to trend rates. There's a professor at Wake Forest University who likes to send out articles to explain to people what is bad about Blue plans converting to for-profit status.

But basically there's the "Enronitis," the fallout, the Sarbanes-Oxley—all of the things today that have created an environment where people don't have a sense of trust for business, how well it's doing and how they treat their customers. You throw in a few disease-management companies that have promised the world, and then which suddenly haven't been able to deliver on their promises. Then you throw in some savings of case management or care management, and people haven't been able to see the savings they'd like to see. What's happening is that on and on we have distrust, and people are wondering where this thing is going.

I'd like to ask the question: "Why does there have to be a future?" I'm referring predominantly to what we have called "managed care." Why does there have to be a future? I happen to be a managed-care advocate. I apologize for that if you're not, but I happen to be one because I've seen managed care work effectively when implemented appropriately, and I probably will continue that perspective for some time. I may have to change the label, but I'll continue that probably near-term. Underlying managed care principles are not flawed. They remain sound today. For example, medically unnecessary services regularly do happen. Since they happen today, and they're not necessary, one way of controlling the cost is to make sure fewer of them happen and, if possible, that none of them happen. One way of looking at that is, if unnecessary things continue to happen, we're wasting our resources, unnecessarily driving up the prices.

We're at a point of time in the health care life cycle similar to the early ecology movement. We need to have some conservation of our health-care dollars, and maybe we should start a health-care Greenpeace Society so that we can preserve the dollars that we have to spend. Frankly, studies today show as much waste as a percentage of the total as there was 10 years ago. In fact, if anything, there's more waste today than there ever has been because we have now eased up on the health-care management and the care-management principles. So today there are more and more things happening that are subject to question.

Practice-pattern variation hurts patients. Dr. Wennberg of Dartmouth University has studied that for years. But the practice-pattern variation hurts patients because things happen to patients that didn't need to happen. It decreases the quality of care. There's no clinical justification for what's going on in the variation. As a result, some of the managed-care principles were trying to control that and minimize that. So they were actually trying to do good things. Now maybe they were done poorly. Maybe they were implemented incorrectly. Maybe people didn't want it to be true. But as long as that variation exists, some people are having things done to them that there is no need to have done.

More importantly, providers are often unaware of their contribution to today's problems. When you talk to providers, they understand their patients. They say they're the worst patients with the highest risk status, and each is the most efficient provider around. Yet when you compare their practice patterns to somebody else, you will find that may be true; it may not be true. But most often it's not true.

Underlying managed-care principles are not flawed, as I've said. The economics of the health-care system can and should be considered an integral part of the system. Generally, in today's health care discussions, economics is the bad word. You don't want to get into cost. You don't want to get into dollars. People want to focus on quality, not money. But the economics of the system, as once was said by a former colleague of mine, is the introduction of common-sense business practice into medicine. Why don't we have common-sense business practices applied to medicine? We, as actuaries, bring a great set of skills set to the table. By partnering with doctors, we can help people understand that the economics of it can be improved.

One of the things that we've said for years is that the quality of care and the cost or efficiency of that care are convergent items. It turns out that the most efficient, high-quality doctors tend to be the lowest-costing doctors. The ones that don't seem to know what they're doing and are inefficient tend to be the high-costing ones. So, if we can encourage providers to be more cost-effective, if we can encourage them to be more efficient and more effective, then they will have higher quality of care almost by default.

Metrics can be developed to measure, monitor and improve today's health-care system, and we, as actuaries, are probably the best to do that. Unfortunately, some of our professional counterparts have been taking away some of our space, and so we aren't at the center of that. But we need to be closer to the center of that. These underlying principles were often forgotten, sometimes disguised, very poorly implemented and usually misunderstood or ignored. The best-laid plans blew up in our faces. When people think about the bad side of managed care, what do they think about? Just throw out a couple of ideas. What do you think of when you think of the bad side of managed care?

FROM THE FLOOR: I'd say denied care.

MR. AXENE: Give me another one.

FROM THE FLOOR: I'd say short hospital stays.

MR. AXENE: What's another one?

FROM THE FLOOR: I think of drive-through deliveries.

MR. AXENE: What's another one?

FROM THE FLOOR: Bureaucrats making medical decisions is another bad side of managed care.

MR. AXENE: Those are wonderful answers. Let's talk about drive-through maternity. Where did that come from? That came from people finding out that there is no medical reason for a woman to be in the hospital longer than 12 hours if she has a normal, uncomplicated vaginal delivery. It doesn't mean that they don't need care anymore, but they found out in the best practice that there was no clinical reason for that. Now the mother may need some rest care. Maybe she will need some babysitting. Maybe she will need some other things. So, some aggressive organizations decided to mandate that, and now we have drive-through maternity.

I'll next address denied care. If providers are doing things that shouldn't be done, is that denied care or is that appropriate gatekeeping? People generally assume that if anything was denied, the denial was inappropriate. Therefore, they said, "Oops, denied care, we shouldn't be doing that." But if it shouldn't be done in the first place, or it's wise not to do it in the first place, is it denial or is it just encouraging appropriate care?

Another downside of managed care that was mentioned is too short of a hospital stay. I remember getting a hate letter from somebody when I was working in Seattle. It was a gory picture, but I'll give you an example of it. It was a cartoon of a woman leaving the hospital dragging the umbilical cord behind her. The sender was mad at our consulting group for what we were doing in shortening the length of maternity stays. It was a hate mail because they felt we were doing something bad. We weren't trying to do something bad. What we were doing was trying to explain that maybe seven-day stays for normal vaginal deliveries are a little long. But a few years ago that was appropriate. Most of the principles of managed care were poorly communicated. Frankly, most of you in the audience, if you had your choice, would probably choose a PPO far more than an HMO for those same reasons.

The health-plan market's ability to effectively implement and communicate is dismal. If you want to see some of the worst ads bragging about what they do best, take a look at the HMO-industry ads. There are some exceptions, but it's been dismal how effective they are in communicating the good that they do. Bottom-line pressures have often jaded the underlying philosophical, more altruistic principles of managed care. You know, we have to make some money. Sometimes the pressure to make money becomes the pressure to make too much money. Then it becomes the pressure to pay your executive too much because you made too much money. When you carry that all through, the market doesn't care for that very much. However, if we would go back and focus on the basics of what we were really trying to do in what we used to call "managed care," help our publics better

understand and appreciate the key underlying goals, the future is bright. On the other hand, forget about that. I mean, there's just no hope.

What is a likely health-care future without a managed-care future? All health-care-system stakeholders have serious financial concerns. I've already talked about the employer community. The past two years are the first time since the late 1980s where the cost of health-care benefits on a per-employee basis has exceeded the pre-tax profit per employee. Most employers can't afford it anymore. In fact, most employers are talking about transferring more cost to the employees because they can't afford it anymore. Some of them are saying if they don't cut back their health-care costs, they're not going to rebound in this recession. There's significant movement in many of the large employers to find ways to transfer cost to the employee or eliminate those services.

Employees have been faced with low pay raises, increased deductibles and co-pays and high unemployment. We're at a point right now where most employees are grateful for a job rather than wanting to complain about paying too much for their health-care benefits. The employees are not in a strong negotiating position. The providers, on the other hand, have historically aggressive responses to health plans to increase negotiated payment amounts to meet today's needs. The providers are demanding more and more, which is raising the price of health care. You bring up the idea of inefficiency or medically unnecessary services, and they'll walk out, saying, "We don't have to contract with you."

Fortunately, they have some malpractice pressures that are forcing them to understand that there are fiscal realities. When I say "fortunately" they're having pressure, I mean that it's good for them to have some pain somewhere because they understand that there is an economic world. On the other hand, they're making it up with higher inflation, and so right now we're facing a provider sector that's even worse than most of us had predicted. Several people in sessions during this week have talked about how their trends are going down. I'll believe it when I see it. There are so many pressures here I don't see how they can possibly take a significant downturn when you look at this on a global, holistic basis.

Continued cost increases, severe selection bias, consumerist pressures, provider-contracting challenges and reduced profits all restrict health plans' ability to provide cost-effective solutions. Right when they need lots of money to invest to make it better, they're short of dollars. Obviously, the government has no challenge. They have more than enough money. You heard they're repealing the IRS, and they're going to give us all of our money back on taxes. No, we're opening up a new can of worms with a pharmacy program when the current regular program is under-funded. It's going to add all kinds of challenges. The near-term affordability outlook is bleak. Everybody is stretched. We have to have some kind of change.

What about the war? That caused an apparent positive effect on confidence in the economy. When the war first started, there was a good, positive blip. Now it lasted

a little bit longer than everybody wanted, supposedly. It's hard to say where that ended up. I do know that the financial cost of the war will raise taxes, or at least it will raise expenditures so that eventually we may have to raise taxes. It decreases available funds that we can spend for health care. There are other issues that the economy needs to jump-start it. I believe terrorism fears will increase indirectly from the war, indirectly increasing health-care costs. Everything is pushing up right now. What is needed?

Employers, I believe, will continue to shift health-care costs to employees. They can't afford it. Some employers will go out of business. Employees will increasingly opt out of coverages, increasing the uninsured counts. Those of you who have looked at the uninsured will find out that about half of the uninsured are the healthy working well, where a significant amount of them are already working. A lot of them could get coverage, but they chose intentionally not to have coverage. What we have is an uninsured problem brewing. I recently did a project in the state of Kansas where they're really worried about the uninsured population in Kansas. I never worried about the uninsured population in Kansas until I did that project. But I never worried about health care until I looked at that state, and that mediocre, average, run-of-the-mill state has a serious uninsured problem. Now, if Kansas has a problem with the uninsured, you can imagine what the major metropolitan areas are dealing with.

Unfortunately, it speeds up a national health-care solution, or the need for one. I just don't know what the solution will be, but it tends to speed. My prediction is that managed care will return. Maybe you want to call that the second coming of managed care, but perhaps under a different name. I don't think they'll ever use the name "managed care" again because it has too much baggage. It will have a different appearance. We'll disguise it in sheep's clothing this time instead of wolves' clothing, and with a different sense of urgency, but it will return. I, frankly, don't think we have a solution unless we all want a nationalized, socialized system. It is a viable solution to provide high-quality, patient-centered, cost-effective and affordable care to the masses. Perhaps it's not everybody's ideal choice, but I think it's better than most of the alternatives that I see.

As long as there are affordability concerns, some form of managed care will survive, since it works. Everywhere that it's been appropriately applied that I've seen over the past 32 years that I've been doing this, it works. Unfortunately, people have poorly implemented it, and it didn't work in certain locations. The biggest change will be repackaging it so that it will be more acceptable to more publics, like the Mikey Life cereal ad, where they feed the kid cereal, and he says "Mikey likes it." We have to package it in such a way that "Mikey likes it," and I think that that will be the creative touch of our major players in the industry. But the plan that understands the consumer the best and that most effectively presents the value proposition will win. Implementing what will be a winning solution is where I think it's at.

MR. HARRY L. SUTTON, JR.: My outlook going back in history may be different from Dave's in that I think of managed care as the HMO business. I don't happen to consider most PPOs effective managed care. It's partially discounted, uncontrolled care. If somebody can negotiate a discount, costs might be lower than some other uncontrolled plan without a discount. I want to look at trends in the HMO industry. I want to relate to how it's changing. I've retired four or five times so far. In my new job, I work for a consulting firm related to a very large health plan company.

In fact, I don't know what my parent company's objective is in the world. As far as providing health care for the population of the United States the way Canada feels, everybody should have access to basic health care, whatever that might be. I'm not sure where the U.S. health-plan companies are in this. As I'll show you, the majority of them are now for-profit. A lot of people question whether health plans should be for-profit or whether health care should be for-profit, but obviously anyone who runs a business has to make money to survive.

I'm going to talk about four things—trends in managed care, particularly in the HMO industry and the way the big players operate today; public concerns; other health-care systems; and finding leadership. When we get to the end, I'm worried about the same stuff that Dave is, but I may be approaching it from a different angle. We had a similar SOA program on trends in managed care two years ago, and as I go through, I will tell you what I predicted two years ago and whether it came out right or not. Much of it, including the most important part, didn't.

Sixty-five percent of Aetna's business, even though it owns a bunch of HMOs, is ASO. In Minneapolis, the biggest plan (formerly related to UnitedHealth Group), Medica, which is by definition not-for-profit in the state of Minnesota, has 50-60 percent of its business as ASO. HealthPartners, which was a staff model and then expanded outside of that, has 40 percent of its business as ASO. The former head of HealthPartners is now the chief executive of Kaiser Foundation Health Plan. Now whether he converts Kaiser to something different, I don't know.

How could these big players make so much money if they're all ASO carriers? You certainly can't normally make that money just by contracting to pay claims for somebody. Several other things have happened. Because of the question of selection and managed competition, à la Alain Enthoven, all three major carriers in the Twin Cities area will quote on any group but only if they get 100 percent of the group. WellPoint and the others have said the same thing. They will not "slice" products. In other words, multiple HMOs will not enroll one employer and live with the luck of the draw of the people they might get with enrollment. Now, I doubt whether they could get health-risk adjusters from employer data ahead of time and agree to adjust the rates based on the risk adjusters. I don't think they trust the system, so they essentially aren't doing it. The other way to get around risk selection is to go ASO where you're not taking any risk, and the employer can perhaps measure how efficient you are in managing health care.

In my opinion, the employers caused part of the problem by not sticking with the HMOs where they had the providers and the health plans on risk. There's no reason not to make a doctor, at least to some extent, watch his expenses, what he orders and what he does if he's on risk, being paid a capitation, has withhold incentives, etc.

The number of HMOs has shrunk by about one-third in the last seven or eight years. The number is still shrinking, but it remains high considering industry conglomeration because, unlike health insurance carriers who can get a license in any state without changing their state of domicile, each HMO has to be licensed separately in each state. I don't know if that will ever change.
There are probably about 10 or 15 HMOs that go bankrupt every year. A lot of small HMOs are bought up by other ones, or some just shut down because they can't get big enough to make money. The number of HMOs will probably continue to drop somewhat.

Right now PPOs seem to be the major enroller. HMOs have dropped to approximately 22 percent of the employer enrollment. Now this may not be exactly correct. How do you count your enrollment if 65 percent of your business is ASO? If you use InterStudy publications that survey all the HMOs, they don't count anyone who is not on a risk premium as an HMO member. Part of the data that shows the HMO members dropping sharply can be attributed to the dropout of Medicare. The Medicare-enrolled population has dropped from around 15 percent or 16 percent down to 12 percent, from 7 million down to 5 million since 1997.

It's not clear to me whether the employees on ASO have managed health care or not; they often use the HMO network. To write ASO business, health plans have to convert to fee-for-service for most services. Mental health may be capitated; case management or disease management may be capitated. I'm not even sure that the total HMO membership has really been declining, but the way carriers operate with ASO, the risk premiums are declining.

Sixty-three percent of the HMO enrollment is with for-profit companies now. As we go back to the beginning of the HMO movement with Kaiser, GHA, Group Health of Puget Sound, and so on, the original integrated HMO-type models (mostly not-for-profit) had the majority of the enrollment. Even CIGNA, which used to own hospitals and clinics, got rid of them and finds it easier to pay claims or pay capitations than to have bricks and mortar and manage health care itself. I think the ASO business is indicative of the fact that the big insurance carriers that weren't HMOs have put their methodology of writing and managing health insurance business into the HMO industry, which was once a risk-taking business.

If you read Aetna's and similar reports, after they've grown the business, if they have large group clients that they lose money consistently on, for example California Public Employees' Retirement System (Calpers) or Federal Employees, they get rid of them. They cancel out. This means they keep the more profitable

parts of their business so their profits go up, but then some other carrier or ASO arrangement has to take over the employer that they dropped from a risk basis.

It was interesting going back to the 1970s, when we started the HMOs under the federal statutes. After 1973, when somebody would apply to get a license as an HMO, if enrollment was projected at more than 5,000, the government questioned it as being way too high. Now they enroll 5,000 people in a week. A lot of people figured that the viable size of an independent HMO used to be relatively small. When I talk to health plans once in a while, it seems you have to be as large as 50,000 to 100,000 members to be viable financially. I've talked to a couple of small plans that want to be bought out by somebody, and nobody will take them because they're too small. It's not worth even investigating for them. They just shut down and dropped their HMO business.

I find the Federal Employee Health Benefit Plan (FEHBP) interesting because it's cited as a model for the uninsured or for Medicare-like options, and yet approximately 100 HMOs have dropped out of FEHBP in the last five years. My sense, without really knowing, is that a lot of them had a hard time making money with the federal employees as enrollees because of the mandated community-rate system required. A lot of HMOs were audited and sued for large sums of money because the rate the plan charged was higher than what the government determined their community rate should have been. These conflicts did not go over very well in the long run.

One of the things that I had projected two years ago was that the enrollment of Medicaid would drop, but that was very wrong. Right now HMOs administer 58 percent of the total Medicaid population in the United States, and, by and large, the HMOs doing it are quite profitable at it. Some companies have almost solely Medicaid members and learn how to deal with the states. Considering the general budget deficits, states are changing eligibility for Medicaid, disenrolling some of the current eligibles. We may lose 30,000 to 40,000 in Minnesota. Minnesota government has sharply raised the premiums payable by the individuals who enroll under Minnesota Care so that many can no longer afford the Medicaid-type coverage anymore.

In the past, states have often cut Medicaid premium rates to HMOs. I see Gordon Trapnell trying to figure out how to come up with actuarial soundness in Medicaid rates. The question is whether the state will cut the reimbursement rate, the eligibility, or a little of both. If some plans have this as their only line of business, what's going to happen after that?

The large plans in the United States, the big players with revenues of $10-$30 billion, are profitable and have had three very profitable years. The stocks are way up, 100-150 percent in the last three years. As David mentioned, the public looks at the salaries and stock options, and somebody is getting $25 million. The people

wonder why health care is so expensive and ask, "Why don't they spend that money providing health care to the uninsured?"

Then there's the administrative cost, and Aetna is an interesting example. I think *The Wall Street Journal* and the other newspapers don't understand the financial statements. If much of your business is ASO, and you have all your claim processing expenses and employer fees included in your revenue and costs, the administrative costs would look high. I remember in the first quarter, the administrative cost for Aetna, as they reported it, was around 20 or 21 percent. I'm sure that's because they were counting all the administrative costs for the 65 percent ASO business and dividing that into the risk premiums to come up with an administrative expense. But most large health plans have administrative costs under 10 percent when you look at risk premiums and the administrative cost underlying the risk premiums. One of the reasons the small plans can't survive is that they can't get their administrative costs much under 20 percent if they're very small, including marketing cost.

There are still a few integrated health plans like Kaiser or Group Health of Puget Sound. It's not clear whether they can survive in an area without massive penetration. Medical center plans is one area that has not grown dramatically, but could be a possible model. The reason I mention these is that they are close to being integrated plans. They are owned by a very high-class, usually expensive, tertiary care hospital or group of hospitals that have common ownership. Most of these plans have over 200,000 members, and most of them make money unless they put somebody in who keeps trying to fill the hospital up because he's a former hospital employee.

We used to see this happen when I was in the reinsurance business. We insured a number of these plans, and they'd put in a young hospital administrator. He viewed his job as filling the hospital beds. His bonuses were based on how much money the hospital made, and he didn't really care that the HMO lost money. We reinsured one in California, for example, that contracted with some of the big players in California and had enrolled 100,000-200,000 population. The hospital lost $10 or $12 million year after year. They kept their hospital reasonably busy, and the question was whether they would ever run out of money. We were worried about insolvency.

These are just my current impressions about public concerns. As David said, I think the health-care delivery of the health plans is much less controlled than it was. From what I've read, I'd say that because the hospital utilization of the plans has gone up, patient protection does not seem to be a number-one issue in Washington. Of course now they're dealing with prescription drugs for Medicare and Association Health Plans (AHPs are similar to self-insured multiple employer welfare association plans). AHPs are a great thing to be interested in because they can't cost the government anything until the plans go bankrupt. The government doesn't

have to invest any money, and the Labor Department could administer the whole thing for $5,000 per plan per year.

The numbers of the uninsured are vague, and there are some estimates as low as 20 million. The typical 2001 estimate was 41 million. With increasing levels of unemployment, that level should be up around 45 million. The uninsured is a major political problem, and the major political candidates for president are starting to come forward with plans for universal coverage.

I think 1.5 million employees have the option for consumer-directed health plans (CDHPs). I think maybe there are 50,000-100,000 enrollees. Most of the defined contribution (DC) or CDHPs, with the exception of Definity, have very little, if any, enrollment. Voluntary enrollment for employees, because of a high deductible ($1,500-$2,500), is not very attractive. We have a lot of employers enrolled in Minneapolis, and while there are outliers in both directions, 10 percent enrollment would be a very good enrollment. There are a lot of research projects trying to look at who opts into the CDHP. Are they the low utilizers, high utilizers, or what?

My own personal opinion is that they're working with the wrong end of the market. They're working trying to control the cost by giving the employee $500 to $1,000 for first-dollar coverage under a healthcare reimbursement account (HRA), which is a self-insured-employer medical-benefit plan that has to be offered to all employees. I'm not sure saving money at that level of cost is worth spending a lot of money on, and I don't know what they do to save money on the high-cost cases. The high-cost cases are a very small percentage of the population and, therefore, really aren't affected by $500 to $1,000 worth of primary care. They are little affected by the deductible, but the deductible still scares people, as it did with medical savings accounts. My feeling is that the approach they're taking with the low-cost part of the market, unless they also do something to control the cost of high-cost cases, is never going to have any long-term effect in the marketplace.

One of the things that I guessed right two years ago is that we now have various levels of management of care. Some of it's just pricing, but carriers will offer an HMO with a small, narrow, tight, closed panel. In addition, the carrier may offer different PPOs, point-of-service (POS), even straight indemnity, at varying prices. Carriers may vary combinations to different types of companies, but they require a single carrier. High-income-employee companies may get a more expensive plan, and low-income Medicaid may get a very tight network of doctors who are used to dealing with Medicaid and are used to getting low fees.

Hospital costs are increasing rapidly, now the largest factor in trend increase. Also, most hospital contracts have outlier provisions, tending to increase high-cost cases. If you follow the Tenet story in California, 40 percent of their revenue for the managed-care industry is from outliers.

While hospitals may lower contract rates for routine cases, when charges exceed $30,000 to $50,000, the contract rates revert to a small discount from billed charges. When they buy an existing hospital, they automatically raise the billed charges by 20-25 percent, so that they've shifted the profit of the hospital to the very high-cost types of cases. The low-cost type of case has relatively low rates.

Specialty hospitals are being built, and some have physician ownership—heart hospitals, orthopedic hospitals, cancer hospitals. What does this do to the hospital revenue for a general hospital that does some of everything? The consensus is that they're taking the high-profit cases away from the general hospitals. There is a movement to ban all these hospitals or to ban physician ownership. Some are owned as much as 20 percent by physicians, and this does theoretically cause a problem about self-referral from a physician to something he owns. I think the term they use is "high-profit" specialties—hip replacements, heart surgery and so on. These are very expensive, but produce, I believe, most of the hospital's profits. I think we need a major change in how we pay the provider system.

As Dave mentioned (he doesn't believe it, and I'm not sure I do either), there seems to be a slight downtrend in some costs. The inflation rate in drugs has leveled off a little bit, but the hospital costs are still going up 6 or 7 percent a year. Medicare reimbursement has only gone up 3 percent. I think the shift away from Medicare reimbursement to hospitals by freezing the rates for three years after 1997 has perhaps, but we don't know yet, put the hospital reimbursement below cost for Medicare. Even if it hasn't yet, ultimately low Medicare increases would impose a cost shift onto private business.

Disease management is small yet. As David indicated, it's not clear that it saves a lot of money, but I am convinced it's going to be a way to go. Actuaries will have to learn more about the delivery of medical care, learn how to analyze data and how to predict costs for populations where you have enough data to measure the likely cost. I was going to try to get some commentary on the tiered-benefit plans from our parent company, Ingenix, which gets a lot of data. I can give you one illustration of what I think our company is looking to do, a form of disease management. We want to control the cases that spend the high percentage of dollars.

Some data that we have from Medstat and other places shows that the 3 percent of the highest claimants add up to between 40 and 45 percent of the total medical expenditures. This is before deductibles, coinsurance and so on. So, we have a very high percentage of the cost and a very small number of cases.

Now, if you can intervene before that happens, that's one thing. For example, in Medicaid, if you intervene with pregnant women before they have a problem and be sure they get prenatal care and get it consistently, you can reduce the high level of premature births. You can lower the cost dramatically because you're intervening with the patient before the incident that's going to incur the high cost could happen

and you're making sure it doesn't happen. How you do that with some of these other illnesses—auto accidents, quadriplegia—is that you're going to have to measure who does the best job in getting these people to recover.

One of the examples involves looking at kidney transplants. There are many thousands of kidney transplants in a year, maybe over 25,000. There are some 200 hospitals that are equipped to do kidney transplants. More than half of them do six or fewer in a year. We do not want our patients to go to one of those hundred centers where the doctors do a couple in a year. We can measure the cost and the accidents that happen during the recovery period and the re-surgery and so on. But how do you get involved with that patient?

The people that I've talked to feel that unless the patient has a cost incentive, you can't even get his attention. So, we tell the patient that he's going to pay 30 percent of the bill on the kidney transplant (total cost $60,000 to $75,000) if he goes outside contracted facilities. He's going to have to pay $20,000 out of his own pocket if he wants to go where his doctor is telling him to go. We need an ombudsman, a nurse or a doctor to explain to him the quality of the facility where his doctor has been telling him to go. The plan will pay his travel expenses and his family's expenses to go to a facility that has low mortality outcomes, low incidence of surgical problems afterwards and gets the best possible result.

Now you can't guarantee that the outcome will be perfect because there's always some risk with that kind of surgery. But we want to attack the problems of the high-cost cases and see if we can't sharply reduce them. If we can get rid of a couple of $100,000 or $200,000 cases, we don't care which doctor the person sees for a routine physical. If we have the data, we know how to use it to analyze the results that we're going to get from each hospital. Our parent has a big transplant network. They want every bit of data defining the cases, the symptoms, the complexity of the cases, the outcomes and the cost. As Dave has said, the cost or charges for these services have nothing to do with the quality of care or the outcome.

I would like to talk about quality, and this is very similar to Dave's comments. I want to reference this article from Becher and Chassin that was published in *Health Affairs* last year. They categorized unnecessary services, services that are necessary but done in error with mistakes, and omission of needed service. So, the question is: What part of the health-care system is going to be responsible for managing the quality of care and getting all these things changed? The article is interesting. It says that the change instrument could be consumers.

Employees or patients almost universally ignore any data about the quality of the hospitals in their community. They assume the doctor is putting them in the best or nearest hospital because that's where he practices. Data was published in Pennsylvania and Cleveland about quality, even adjusted for severity of heart disease, heart surgery. The best hospital never got a single additional patient. This

was a hospital outside of Philadelphia that had the lowest cost and the best outcomes. The state stopped reporting the data. First of all, everybody said, "We always get sicker patients, and they don't measure the sickness level right."

I don't think that consumers are going to be able to get their act together to do anything. So far, at least, they get a lot of information, but most of it involves wanting to learn about the illness their doctor told them they have, and they look up a whole history. They look up the Mayo Clinic newsletter. They look up the Harvard newsletter. But it doesn't make them change doctors or anything like that.

Then we have purchasers—employers. Historically employers have almost been more worried about the cost than the quality. Control Data was one of my big clients a long time ago, and we were talking about quality. The manager took the podium and said, "You know, we're having a hard time." (They were going bankrupt.) "We're more worried about the cost. I mean, we want to get a pretty good health plan. We don't want it to be too bad, but we're going to buy the lowest-cost one we can get." Right now I think many employers are more worried about cost than quality, although they talk about quality. If you assume that they could get better quality, and the cost would go down, that would be one thing, but I'm not sure employers really believe that yet.

The government tries to attack the HMO industry, regulate it and prevent it from denying necessary health care and so on. Academic medicine, research and education are interested in doing a lot of research, but they're not interested in trying to figure out how to lower health-care costs.

Organized medicine is where I made my worst mistake two years ago. I thought the doctors would come around and take control of the HMO industry. Now maybe it's because the HMOs all merged with the big carriers, but that didn't happen. I thought medicine would, but the American Medical Association (AMA), which has fewer than 50 percent of the doctors as members today, I think, is fighting for the economic rights of physicians to make more money. The AMA joins with the trial lawyers in pushing lawsuits against HMOs for putting physicians at risk and not telling the patients, or denying care, and trying to come up with class actions and RICO actions against the HMO industry.

Finally, health-care providers, the doctors who work with the patients and the hospitals that deliver care seem too busy to address the quality problem comprehensively.

I think the only ones that can afford to do this, because it is expensive to try to change physician practice patterns and collect the data to prove to them that they should be doing something better, are the mega plans—the Aetnas, the CIGNAs, the UnitedHealth Groups, WellPoint and so on. I don't know all of them, but many have revenue from $10-$30 billion a year. They can get the databases from large populations and learn how to measure the efficiency of the various doctors,

hospitals and the quality of care. They get all this data, and they are probably going to be the ones to do it. If they can do it and manage the care more cheaply, they will be very competitive in the marketplace. It's very hard to get doctors to even look at their practice, let alone to change it, even though they and the doctor next to them don't do the same thing on the same type of case.

One thing that bothers me about the whole health-care system we have was based on the opening speech by Roy Romanow, who discussed the report on the Canadian health-care system. George Halvorson, who's now the executive at Kaiser, says we have a system where every element of the system, and there are tens of thousands of little pieces of health-care delivery, is trying to maximize its profit, whether they're not-for-profit or for-profit. Therefore, how do we ever put it together and keep a reasonable level of profit over the whole thing? It's almost impossible to do it.

I'm disturbed by the fact that the integrated plans with investment in bricks and mortar have such capital requirements that the big carriers who were going into business that way are getting out of the capital business. Prudential had some staff models. CIGNA has a great model based at a major hospital in Phoenix, for example. They no longer want to invest capital in it. They want to make it more like insurance. They just want to pay either capitations or fee-for-service. Now they have the data capability to manage it better, but I don't know if it would be better if they actually had the bricks and mortar of the clinics and hospitals or not. It will be interesting to see how the medical center hospital-based systems work.

For the United States, a political problem is the individual's expectation of unlimited service at no cost. How do we get our society, the health-care system, to provide basic care but with a view on what the country can afford to pay? If you read Howard Bolnick's essay about an international health-care system—there's at least a summary of it in the last issue of the *North American Actuarial Journal*—he likes the British system in the sense that they have a basic level of care that everybody gets. If you want other care, you have to buy private insurance or pay out of your own pocket for the excess. Now, our society probably won't accept that. But in almost every other society, either the doctors or government agree to ration care, and I'm not sure our system can survive if we don't do that.

We look at 30,000 gastric staplings a year; we look at Centers of Medicare and Medicaid Services (CMS) permitting another 10,000 people to have a defibrillator planted that costs $40,000. That's another $400 million gone out the door there, like that's a peanut. We don't have any way of restraining demand. The drug companies want to sell drugs that can make billions of dollars, and they may keep people alive another three months. We're insatiable with the demand and an assumption that we have an earned right to get all the health care we could ever possibly imagine.

MR. YAMAMOTO: I work almost 100 percent with employers, and the mantra right now is CDHPs. Harry, you alluded to that a little bit in your presentation, but I think one of the key reasons why it's being talked about at virtually every strategy discussion that I have with our clients is to try to get more consumer initiative or consumerism into the whole marketplace. An HMO is probably a typical place where you go in for an office visit, it costs you $10 and you're taken care of. That is a gap between the typical CDHP thinking and today's managed-care programs. How do you see today's managed care programs, primarily HMOs, approaching that kind of mind-set that their clients are going to be asking for soon?

MR. SUTTON: I think I've discussed DC plans. DC is all right, but now they're consumer-driven plans because they, by no means, can be a DC unless they enroll the whole employer. As I mentioned here, what they're doing compared to typical indemnity plans is fattening up the bottom. You know, if the average indemnity plan has a $300 deductible, smaller employers probably have $500 deductibles or higher. Now with the consumer–driven health plan, the employer pays 100 percent for the very first time you go see the doctor. Now, admittedly, you can accumulate money in theory through an HRA if you don't spend it all, assuming you stay employed there, or you could continue it to use for COBRA or after retirement. After the HRA there is a high deductible, so the employee is at risk for out-of-pocket. So maybe the employee won't use as much care in there someplace. But they don't address, that I've seen, what they do to control the costs of the high-cost cases. When you get over the deductible, the plans typically pay 100 percent of everything. A $2500 deductible is almost first-dollar coverage today. I understand why people are enthused about it. First of all, if you give everybody $500 at the bottom, and they can do anything they want with it, and now they have a $2500 deductible, you've probably lowered the benefit plan substantially if nothing happens. But the money comes out at the bottom, and I don't know how they intend to control where the high costs are—the top 70 percent of the cost with 20 percent of the people or whatever number you want. I just think they're starting at the wrong end of it.

MR. AXENE: We may have a slight disagreement here, and that's good. Several years ago, a group of friends and I went away and tried to figure out where the health-care system was going to go down the road. I think it was in 1997 or 1998, and what we concluded was that something like DC had to emerge because it was going to get into uncontrollable cost. Consumer-driven or DC, whatever is the politically correct way of describing it today, I think that the biggest fantasy for the employer community is that there's hope that something might help. In other words, they're all frustrated because they can't control the cost, and now there's something new. In the insurance industry, we have an insatiable ability to create something new that's really old. How many of you were working in the mid-1970s as actuaries? How many remember the Mendocino Plan? The Mendocino School District in California at that time had either a $500 or $1,000 deductible that each person got to spend as they wished, and they superimposed on top of it a $1,000 deductible. Blue Shield was the carrier. Somehow they priced the actuarial value of

a $1,000 deductible at $1,000, and so perhaps it worked well that time because they were able to give away more than they should have. But the general consensus of that school district that tried it for a while was that it didn't work. What I'm seeing today in a lot of the CDHPs that Harry was talking about is repackaged Mendocino County School District programs that 20 or 30 years ago we decided didn't work well. However, employers need hope, and hope is a good thing.

Getting the patient involved in the process is important. You can take a consumer-driven approach and combine it with tiered networking. Some people call these transparent networks, a topic I love because it makes it transparent to the employee something about how much his providers are costing. By packaging tiered networks with CDHPs, I personally think we have a better chance of making it work.

Now, frankly, I think the hope and zeal of our employee-benefit consulting-firm brothers are going to make DC/CDHPs have increasing enrollment. In fact, there are a couple of actuaries here, one from Destiny and one from Healthmark, who spoke the other day about their enrollment. They're getting some fantastic success. The big barrier to that was the tax issue. Well, it's amazing how the IRS changed the tax issue almost overnight, and it's a lot easier now. In the past week there was another change that makes it even better. I personally think that those programs are going to emerge. Employers are going to start looking at DC, at what the most they will have to pay from now on will be because they can't afford any more. Health plans, I think, are going to experiment with the HRA or the personal care account, whatever it's going to be called, on an option basis. I'm not sure very many of the employers are going to want to give that money to the employee, but there may be tax-advantage status that may brew with that. I think it's there. I think it's going to continue. I think that it's a solution that's causing a lot of chaos in the marketplace, and chaos is usually associated with hope.

MR. DAVID M. TUOMALA: I disagree with almost everything that was said at this panel, so I guess disagreement is good. I happen to believe that managed care is a flawed concept, and always has been a flawed concept, primarily because it doesn't address the demand side of the equation. I think the fundamental economic principle that we have in the American system of health care is that we have a provider who has certain economic incentives. We have a patient who is insulated from the cost of the services that he receives. It shouldn't surprise us that that leads to an increased demand or an over-demand for services. I think an external system, like managed care, tries to influence that process of care but is never going to be able to do that because the transaction is occurring between the individual provider and the patient. The patient has to be involved in that. Patients have to have some economic incentives. They have to make those kinds of decisions. I think that's the fundamental problem that we have today. I can buy a $100 service for $10. Well, I would do that all day long if I could do that in other areas of the economy.

MR. SUTTON: I don't disagree with you.

MR. YAMAMOTO: Thank you. If there are no other questions, please thank our presenters.