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Staying On Course: Factors Driving The Pricing And Design of Today's Health Products

Track: Health

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Summary: Participants discuss what steps can be taken to anticipate and mitigate the effect of the recession on health insurance costs. Those attending this session gain an understanding of the factors, including current economic conditions driving the pricing and design of health insurance products.

MR. DARIN DALTON: Staying on Course: Factors Driving the Pricing and Design of Today's Health Products. My name is Darin Dalton, from Tillinghast-Towers Perrin in the Atlanta office. This is a very broad topic as you might imagine. We try to approach it by breaking it into three sections with three different presenters.

The first section will be on the current factors driving current change, which will be presented by Chris Girod from Milliman USA, in the San Diego office. The next section is on benefit issues from the employer perspective, which will be presented by Mike Taylor from Towers Perrin's Boston office. And the third section is an overview of the pricing of the evolving product designs, which will be presented by Brent Greenwood from the Reden and Anders office in Atlanta. First up is Chris Girod.

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

MR. CHRISTOPHER GIROD: I'm going to talk about some of the economic and other factors that are driving the design and pricing of health care products right now. The two big drivers that I want to talk about on a bigger picture level are the fact that health care inflation is increasing and healthcare consumers are demanding more choice. There are a lot of variables underlying both of these, but these are going to be two of the overriding themes of what I'm going to talk about.

For most of us, health costs are going up. Chart 1 shows you a little bit of proof. This is one trend index that has been developed by Milliman USA, but you probably all have your own favorite trend indices as well. This one shows trends for all benefits for a typical commercial population. It's a 12-month moving average from January 1998 over a three and a half year period. If I were to extend this another 18 months, which I could have, the top of the trend line would continue to wiggle around between nine and 10 percent. Actual trends maybe higher or lower, but in any case, the theme here is that trends are going up.

In a recent survey done by UCLA, they surveyed 460 employers, and fully 25 percent of those expected their premium rates to go up by 20 percent or more in 2003. That's a big jump, and it's a big segment of the groups. The interesting part of that survey is they all said that they plan to revise their benefit plans in order to help offset some of the costs.

So who's responsible for these trend increases? I always like to point the finger at somebody. Unfortunately, I think it's a lot of people. A lot of us are all to blame—health care providers, members, employers, the economy (business, if you will), government, lawyers and health plans are all to blame.

So health care providers are to blame. Why? Well, one of the trends we've seen over the last few years is that providers are withdrawing from risk. They don't want to be capitated anymore. It used to seem like a good idea in the early '90s, but it's not such a good idea anymore. Capitation rates have been held flat or given lower increases than cost increases. So, providers are losing money on it. They're not getting the increases they need and they're also finding out they're not quite as good as they thought they would be at managing the risk. They're not insurance companies.

We've seen a lot of physician organizations go bankrupt over the last five to 10 years. In fact, in California there are currently about 250 to 280 medical groups right now. In 2000, 34 of them went away, and in 2001 26 went away. The pool is shrinking. One of the other things we're seeing within the capitated population that you don't hear quite so much about is that physicians are closing their practices to capitated patients. So when you move to a new town and sign up for the HMO benefit plan, they give you the directory and you pick a couple of primary care physicians (PCPs) that look good and maybe you start calling them. That's when you find out that their practices are closed to patients who under a capitated plan. They don't want any more of those.

Why are providers also to blame? We're seeing hospital consolidation. The number of hospitals in many cities has gone down over the last 15 to 20 years. Obviously we did have too many beds in a lot of cities, but especially over the last couple of years, hospitals are closing their ranks in order to increase their negotiating clout with health plans. New technology is also a reason. Obviously, providers want to give the best care they can. We see a lot of great exciting growth in technology in the United States, and providers want to use it. But it all has a cost.

And the fourth thing I'm going to stick them with is cost shifting. I can't blame them for it. I think they're probably smart to do it. But, for example, as payments from government plans, such as Medicare and Medicaid, go down, they may only be getting $.50 on the dollar, or maybe less. They're increasing their bill charges, so they can recover those costs from commercial plans on insured patients and others. Think for a moment about the types of discounts you're seeing in your commercial contracts. It used to be inpatient hospital, discounts of 30 percent seemed like a rule of thumb. Now maybe it's more like 50 percent. Who pays retail charges anymore? Somebody is paying them.

Who else is to blame? Well, members are, of course. They have an insatiable demand for choice recently. Shifts from HMO plans to open-access plans have been going for the last five to six years. I found a recent Kaiser Foundation study that said HMO enrollees among Californians dropped from 55 percent in 2000 to 48 percent in 2001. That's about a 12 to 13 percent increase in one year. And there are a lot of HMO members in California, and a lot of people involved.

Direct consumer marketing. I could blame the marketers for this, but I'm going to blame the consumers, because they're the ones that eat it up. We've all seen the ads for Viagra, Claritin and Allegra, but it's not just the drugs. In Northern California there was a medical group that was advertising on the radio and in newspaper ads for CAT scans. Come to us and get a CAT scan. If you're a big group that suddenly switches to open access, and providers start direct marketing for CAT scans, what happens to your out-of-network costs? It's not a good thing.

Lastly, I think members are to blame a little bit, because we all want the Cadillac of healthcare, but nobody wants to pay for it. If you have cancer, or your child has cancer, you don't want them to get the Yugo of healthcare. We all want the best, myself included.

So who else is to blame? Employers and the economy. The economy has been weak lately. More costs are shifting to employees. There are higher employee contribution rates, higher top levels of cost sharing, and cutbacks in benefits. We've seen quite a few layoffs. What does that do? Well, one of the things it does is it drives up your COBRA rates. A lot of the healthy people go away when there's a layoff, and the sick people stay. You end up with more COBRA people. They represent a higher proportion of your costs.

Who else can we blame? Well, we have to blame government and we've got to blame the lawyers a little bit. Mandated benefits are part of the problem. We've all heard about mental health parity and 48-hour maternity stays. A new one I just heard about is removing the active war exclusion in policies. If it's in there it must have been worth something, so if we take it out, we've got to increase premiums a little bit don't we? These all add up. There is cost shifting resulting from small Medicare and Medicaid payments. Medicare pays $.50 on the dollar in a lot of places for hospital care, and it might pay $.60 per physician dollar or less. Medicaid is even lower, such as 30 or 40 percent payments.

And lawsuits are another factor. Members and providers are suing plans. Now lawyers have figured out that they can sue actuaries. We hear about this a lot in the consulting world. Our professional liability insurance goes way up. That makes our costs go up and we have to pass it on to the people to which we consult. So if you're on the health plan side you may start to hear this from your consultants, if you use them. They want limits on liability and binding arbitration, and it's not a reflection of a change in the quality of our work, or the fact that we will stand behind it. It's because of the fact that we're getting attacked by lawyers for very big lawsuits. And you try to explain to a jury that we missed our reserve estimate by $5 million on a $1 billion reserve, and all they know is you were off by $5 million. And we lose.

Health plans are also to blame. Leveraging effects are something you hear about from time to time in hospital contracts. If you have a per diem hospital contract that pays a $1,000 a day up until bill charges hit $50,000, and after that it pays 80 percent of billed charges, as trends go up, if that threshold doesn't go up also, there's a leveraging effect, and trends go up. It's up to all of us to work with our provider people to stay on top of things like that.

Interest rates are low, and investment income is down a little bit. Well, it's typically not a big deal for health insurance plans, but in the mid-'90s investment income was a good source of income for health plans. It's going away now.

I also want to mention consolidation. For example, in California five years ago there were 30 HMOs and there are 20 now. Just read your newspapers and see what WellPoint and Anthem are doing. There are fewer and fewer health plans. That doesn't necessarily mean more cost, but it does mean less consumer choice.

Chart 2 has to do with the failure of managed care. Your hear about this all the time. What people are talking about is the failure of managed care to control long-term costs increased over time. That may be true, and it may be that they can't control trends over time, but Chart 2 suggests that managed care has reduced the denominator. It has squeezed a lot of excess out of the system, and that's a savings that we will continue to reap over time.

Chart 2 shows hospital inpatient acute care bed days per 1,000 members for a typical commercial loosely managed population. As you can see over the last six years, bed days have gone down from 318 per 1,000 to 280. Again, this is for a loosely managed plan. A well-managed plan might have bed days below 130 per 1,000. If I extrapolate this graph back in time into the '80s, there may be 400 days per 1,000. Well-managed care has helped ratchet this down. Now there are offsetting savings in other areas, such as outpatient costs and whatnot. But this is a savings that we continue to reap over time. So I don't think managed care has failed.

So, costs are increasing and demand for choice is up. What are the implications? Clearly we're seeing increases in premium rates, employee contributions, and cost-sharing levels. We're also seeing reductions in coverage. One of the examples you hear a lot about in the media is reductions in Medicare + Choice prescription drug benefits. We're seeing what are called tiered copays now. This isn't a new thing. We've seen them with the drugs. We've seen three- and four-tier copays. We've also seen them in physician costs. You have a higher copay for your specialist than for your PCP . We've seen it among physician groups, and even in- and out-of-network. You have a $5 copay in-network, and higher cost sharing out-of-network. The only new thing is now they're doing it with hospitals. The costs are a lot bigger, so it's a lot more sensitive.

There is increasing popularity of open-access plans and emergence of defined-contribution (DC) plans, medical savings accounts (MSAs), consumer-directed plans, and high-deductible plans. They are all sort of from the same genre. And the concept is basically to push first-dollar responsibility back on to the consumers, so they can decide whether they want to control the utilization or if they want to shop around for the Hyundai or the Yugo of health care.

There are a few other implications also. We've seen a lot of growth in resources for members to evaluate plans and physicians. One of the ones you hear about is the Leapfrog Group that ranks hospital safety performance. There are also plans like Definity and HealthMarket that are allowing consumers to do cost comparisons among providers. Even state regulatory agencies fall in this category. In California they're asking physician groups to report financials and are making some of that information available to the public.

One of the implications that I read about a few times recently is a patient negotiating discounts directly with providers. They may go to the dentist and get a $5,000 bill and ask directly for a discount. In one case, I actually read about a business that will negotiate for you. This probably won't be a big thing over time, but it is an interesting phenomenon.

The last thing I want to mention is a concept that to me, as an actuary, is very interesting, but as a consumer and a person with kids and a family, is a little bit frightening. I call it increasingly focused cost accountability. It basically is assessing

cost accountability at lower and lower levels into smaller and smaller risk pools. We've seen increasing use of self-funding, risk adjusters and underwriting among smaller and smaller employer groups. An interesting phenomenon that's come up recently is the emergence of re-underwriting for individual coverage. That basically means that every time your anniversary comes up they look at your claims experience and your diagnosis, and then charge you a rate accordingly. So, if you have a whole bunch of claims, they may stick you in a higher risk pool and jack your premiums way up. The NAIC, or at least one committee, has recently come out against this, so we'll see how long it lasts. But, it's kind of a scary trend.

MR. MIKE TAYLOR: I'm going to spend some time here talking a bit about the employer's point of view. My perspective is that the employers are purchasers. They're the people that are purchasing these products for their employees. One of the things that I feel very strongly about as we talk about consumerism is that very often there's not enough direct conversation between the various stakeholders.

Chart 3 is from a classic survey that we did. Towers Perrin's clients are mostly large employers. So, I apologize for giving you a little bit of a biased picture of the world. These are mostly employers that have 5,000 lives or more. When we surveyed these large-employer benefit managers in the fall of 2001 about the pressing health benefit issues for them, the top three things were quality, cost and administration. I would argue that if we did that now, cost would clearly be the number one. I mean you don't have to be a soothsayer to pick up a newspaper and find out that the increases that are coming in are much greater than we anticipated. And I would also argue that this was a survey done of benefit managers, but actually now the chief financial officer (CFO) is in the picture, because it's a cost issue here.

If you ask them how they are addressing the issues, you'll get the results shown in Chart 4. It's not a big surprise that there has been a lot of increased cost sharing. But there also was a lot of encouraging consumerism. I think we can argue as much as we like about the different consumer health plans and whether they cut costs or not, but I don't think there's any argument with the fact that we want to have consumers involved in the game. They've got to get some skin in the game. They've got to understand what the costs are, so some of the alternatives that large employers are talking about are involving consumerism, but not necessarily with the spending account. There are things that we can do that basically support consumers without having a spending account attached to them. So I think that's one of the spins that we're talking about.

And then a lot of them are doing the classics. They are doing vendor switching and the measures shown here. The interesting one, though, is implementing the DC plans. When we did this survey two years ago that wasn't even on the radar screen. So you can see there that in the fall of 2001 it was one of the issues that was very hard on employers minds, and even more was the idea of exiting as a health plan sponsor. I think we've seen that soften a little bit in the last months. I'm sure my colleagues would agree with me that there has been a tremendous amount of

activity in consumer-driven health plans in the last quarter and the first quarter of this year. I've been doing two or three presentations a week to clients about this issue. It's dropped off now, as we get into the heavy lifting of the rate renewals and the price negotiations, but my sense is that it will pop up again.

When employers are faced with all the situations that Chris talked about, where are they focused? Well, they focus into the big areas. The big areas are the traditional ones in which you spend a lot of your time, or in financial management and design. They're clearly spending a lot of time doing plan design changes, encouraging more cost sharing, taking a look at where some of their expenses are coming from, and handling the whole idea of introducing hospital co-pays and co-insurance. They also are doing vendor management, which is very traditional. If they don't get a good deal from Health Plan X, they are going to go to Health Plan Y and see if I can get a better deal. The reality, as Chris mentioned, is that it's much harder now because of the consolidation of health plans. There are far fewer health plans, and they are less concerned about the fact that you're an employer and whether you have 5,000 lives or 50,000 lives. If they've got a million lives it doesn't matter that much to them anymore. That's something that employers find very hard to take, in terms of the fact that they've lost leverage. So, there's still a lot of switching.

Then there is the carving out to the specialty vendors. We've clearly seen that in the pharmacy benefit management (PBM) arena, and we've seen that in behavioral health. With a lot of the press these days with our PBMs, one might argue that you will see some coming back to having it more integrated with the health plans. So, a whole discussion of whether or not you should carve out various services is becoming a very big discussion. It's going to make it very difficult for you from the pricing perspective if we stop pulling pieces out of what you traditionally considered the world of pricing around your medical costs.

I'm going to talk to you at the very end about some employers that are actually splitting up health plans into many more component parts. And that gets us to the population health and clinical outcomes.

One of the issues that comes up with consumer-driven health plans is that if you look at the claims distribution of your population it's the 80/20 rule or the 5/50 rule. Five percent of your population is incurring 50 percent of your claims dollars, and you have a whole bunch of people that actually don't get anywhere near the $1,000 that you might be giving them in the spending account. So as we discuss the pricing and the cost impact of putting these programs in with employers, we also get into the discussion of how their employees are using health care. How much does a chronic diabetic cost you year over year? What does the risk profile of your members do to your health care cost? If I know the risk profile of my population, what is my health plan doing to help me with that? Do I have the right disease management programs in place? Am I focusing on demand? Do I need to do something else in order to impact it? There's a whole series of outcomes and a series of dominos that start expanding when you get into these discussions around

some of these new products. And that's the bucket that I'm calling population health.

And then, arguably, you could talk about the consumer focus. What you're really doing, if we were in a business other than healthcare, is segmenting the market. Employers are segmenting their employee population into various market segments and trying to design health plans that will work for them. Not only will they work for them in terms of dealing with their health profile, but also that are attractive from the point of view of marketing, providing rewards and retention, and all those kinds of things. So there's a lot going on there in terms of the employer strategy.

Defined contribution is really not new. There was a lot of confusion in the early days. Is this a DC plan, a consumer-driven health plan or a self-directed health plan? It's such a curse. We as consultants are really guilty of it. We're the ones that come up with these catchy phrases. But the reality is that really it's not a new strategy. The common element is a shift in the responsibility for the payment and selection of health care services from employers to employees. And the point on the continuum to some extent is what distinguishes these DC strategies. Only within the past several years have progressive DC strategies become viable health care solutions because of the emergence of several new DC vendors benefiting from advances in technology and increased interest in consumerism.

Under the traditional role, the employer was pretty much responsible for it all. They picked the plans, paid for the plans, offered the plans and administered the plans. In many cases, employers have single carriers or in some cases multiple carriers. And the employee had very little role in that whole thing.

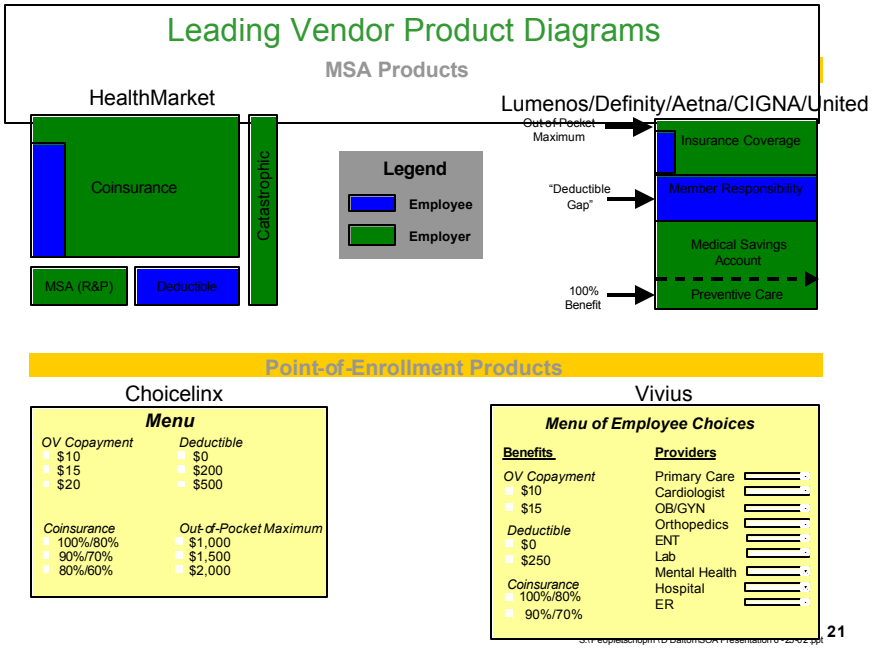
Then we got into the cafeteria plan model where employees were given the some credits and they could purchase various health plans. We had to offer more choices and more intermediaries. Now, we're moving over to the more progressive plans, in which we're trying to give the employee more responsibility. You can see that the ultimate employer responsibility would be to give employees cash or vouchers and let them go out onto the open market and purchase health care. As we know, that's a real challenge right now. The individual insurance market is still pretty broken and not affordable. So that's not necessarily an option.

There are several components of a consumer-driven health plan (CDHP). You've got an employee-directed medical savings account that is funded by the employer. There is a lot of flexibility around some of these things. Most employers are treating this as an unfunded liability for the tax advantages. There also is the insurance coverage. Typically it's a PPO with fairly high deductibles. How you present it, in some cases, may impact the enrollment. So if you describe it as a catastrophic plan, certain employees may decide they don't want that. You could say it's actually a high-deductible plan. So again, it's all in how you wrap this baby up and package it.

Finally, there's no question that the explosion of Web technology and information over the Internet is a way that you can package information. Provider information, general health information, disease management tools and account information can all be provided via online services.

Figure 1 shows some product diagrams. There are quite a few models in the marketplace that are being offered around consumer-driven health plans, and we've divided them into a couple of models. The one on the left is the health market model. To some extent, it's targeting the small employer. You can see that in this model there is first dollar coverage for catastrophic care. The employee spending money and the spending account is really more routine and preventative.

Figure 1



On the right side is a very common model that's emerging. In this model you've got an MSA, and a deductible gap, which is really the employee's responsibility. Then you get into the PPO coverage. The medical spending account is typically between the $1,000 to $2,000 for a single and a family. And then that's usually 75 percent of the deductible amount, so the deductible on top of that employee responsibility could be another $1,000, or something like that. And then you kick in on the PPO coverage on the top. So we call those the medical spending account products. Those are the top two.

On the bottom are some variations of what we call point of enrollment. These are really some self-designed health plans. Basically, with the ability, and most of it is based on your skill and experience about pricing this, the employees build the

health plan to meet their needs. So if they decide they want to have a health plan with a $15 co-pay, a 90/70 co-insurance, a deductible level, and out-of-pocket maximum, the handy Web wizard comes up and says that's going to cost you $5,000. The employer has set its contribution at $4,000; therefore, your contribution is going to be $1,000 and that translates into a bi-weekly payment. If they change that around, they'll get another formula and another contribution. It really does that. The advantage of that is that it get the employees much more involved in the idea of designing a health plan to meet their needs and meet their budget. Of course, you've got to rely on some pretty sophisticated Web stuff and some actuarial models to build it so it makes sense.

The Vivius model on the right is the same idea, but with an additional wrinkle that says, to some extent, a lot of the costs are driven around the condition of the employee and the physicians that the employee uses. So, not only do you pick your benefit plan design, but you also pick your providers. And that relies on the fact that there are variations in the cost of various providers, which we know there is in a market place, and they've been negotiated. For example, in the Vivius model, if you were a chronic diabetic you'd need a health plan with a certain design, but you would also need certain providers that you go to on a regular basis. You know you're going to need a PCP, you know you're going to need an internist, and you're probably going to need an endocrinologist or something, so you will pick those providers. You will plug them into the matrix, and those providers' negotiated costs will then be factored into the plan design. It's a pretty complicated model. It requires a lot of network. We're not seeing a lot of traction yet with Vivius, although it is an alternative.

Why are we focusing on this? The big one is employee accountability. We definitely want employee's to have skin in the game. We have got to get people to understand this. You've heard this quote ad nauseam: people think that a doctor's office visit costs less than a haircut. That is frightening. People just don't understand what health care costs. Although they're getting more and more knowledge about it as they read the newspaper and watch the TV programs. There's a very popular show now, which is the "Houston ER" program. If we could run that show and explain to them the episode that they just watched in which Joe Smith was into the emergency room and got the full boat of heroic measures cost $100,000, wouldn't that be nice? We could do a lot for health care costs if we did that. But of course, we don't do that. We just say everybody is entitled to having the full boat of those glamorous nurses and doctors running around banging on our chest. I've been a hospital administrator and it isn't romantic at all. It's ugly and nasty.

You need to examine the idea of new empowering employee tools, such as Web-based health information and health risk assessments, nurse coaches and health intervention, and provider pricing and quality information. You are also definitely going to have to pay attention to the whole idea of encouragement of provider competition in terms of price and quality in your practice. Those network

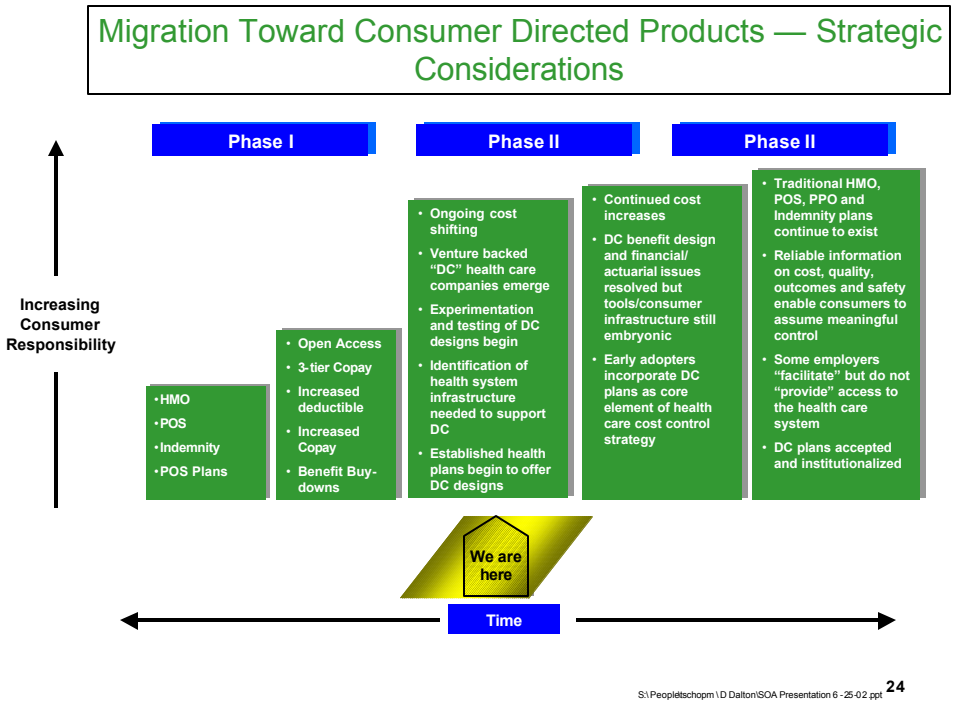
contracting people have a lot of impact on the things that you do. And, we definitely are going to see some provider pushback. I've been in managed health care for 30 years, and I've got to tell you there is no way that providers are really going to want to have their prices on the Web. I hate to be cynical, but they're going to fight that tooth and nail. They're happy to be in there in a range, and they're happy to be in there with some other indication that says they're the best quality.

So who's signing up? The good news is that there are employers that are willing to take a shot at this. And to their credit, I would argue that we need to do this. The old way is not working. We need to consider these alternatives, but we need to think them through. Right now the enrollment nationwide is probably 100,000 people covered by consumer-driven health plans with medical spending accounts. It's probably evenly split between large and small market. There are a lot of small employers signed up with vendors like Destiny, HealthMarket and some of the Blue Shield plans, usually total replacement, and usually fully insured.

Large employers are mostly self-insured and are in an option environment. There are only a couple of large employers that are offering total replacements. Definity has Countrywide, Charter, Raytheon, Textron, Medtronic, the University of Minnesota, Scientific Atlanta and the University of Louisiana. Lumenos has Novartis, Pharmacia-Upjohn, Pitney Bowes, Abbot Labs, Intel and TRW. Aetna has Aetna, Toys R Us and Levi Strauss. Some of these are pretty impressive names. I have to give Definity and Lumenos credit. They figured out how to get to this market. They figured out the way to get to this market is go to the CFO or the CEO, to be in the *Wall Street Journal* and *Business Week,* and on the TV, not the way that we normally do it, which is to go through the normal distribution channel. They bypassed all that and they got a lot of traction. And you can clearly expect there would be an upswing in it as United and Cigna start to get traction. The entrance of the traditional players into consumer-driven health plans is really going to expand this market. And, it's already for some changes in the way that Definity and Lumenos are going to the market, so I expect this year to be a very big year of change.

Figure 2 shows the classic consulting continuum that nobody really understands. We really have to think of this as a continuum. We have to think that we're transitioning from where we were, at rigidly defined HMO and point of service, to the right, at a much more broader series of choice. I would say that we're in the middle of phase two. We've got ongoing cost shifting, we've got these venture capital backed DC companies, and we've got the identification of the infrastructure. Whether we like it or not Definity and Lumenos are creating a new model of health care delivery. They basically said they're not going to build this stuff, but rather go out and partner. They're going to partner with the network, a claims administrator, a data warehouse and consumer service, and they put these things together in about a fraction of the time that we've taken to move these things over the last 30 years.

Figure 2

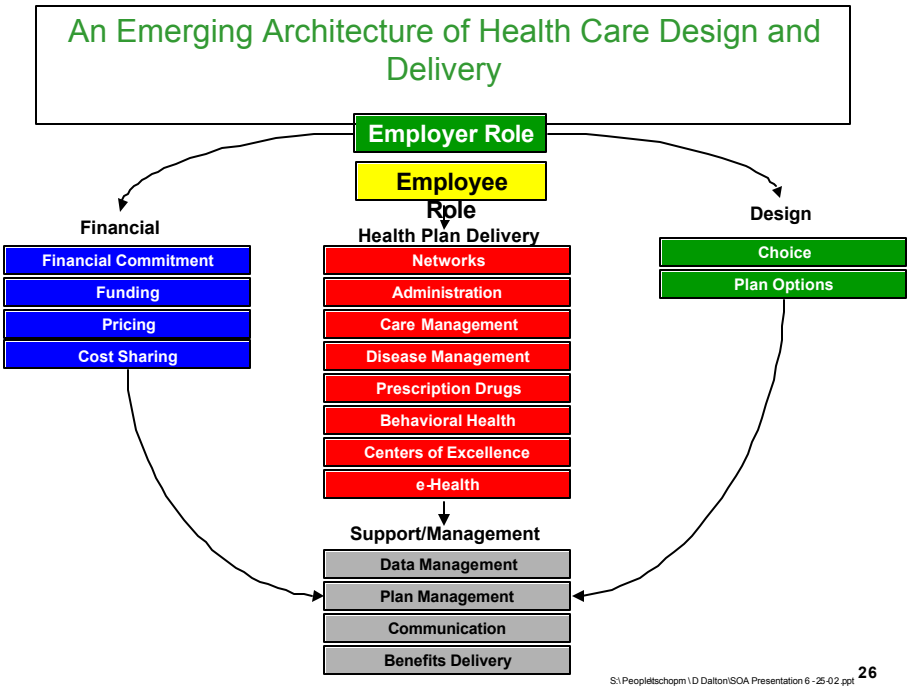


Now the question is, will they work or not? We're not sure yet, but clearly they're showing us the different model, and a different infrastructure to which we need to pay attention. So, I think we're sort of there. Then, the whole idea is that as we go to the right here we all know that there are cost increases. The reality is that utilization trend is going up. And it's driven by a million things, but unless we do something it's going to continue to go up. So we need to look at that. And we're all starting to get more experience as the information comes back from these large employers. Again, it's kind of a transition here.

There are numerous plan design examples that you could use without a spending account, to some extent, to support consumerism. You know the idea of introducing, the old fee schedules. The idea of in- and out-of-network benefit levels are flexing the variation and provider cost. We've all seen three-tiered pharmacy programs, we're now seeing four tiers. We're seeing co-insurance. We're seeing different PCP and specialists' co-pays. Not that any of these are new, by the way, we're just seeing increased attention around them. Greater employee cost sharing is another area in which we're seeing activity. Benefit budgeting, such as MSAs, flexible spending account match, and benefit differential between core and other providers are also plan design examples. Brent's going to talk about some tiered networks that we're seeing. The whole idea of risk-adjusted contributions is another area of interest. So there's a variety of planned design things that you can do in your traditional plans that we think can support consumerism.

Figure 3 is a classic consulting slide, which shows that for the first time we've got this employee role squarely in the middle of this architecture that we didn't have before. So employees are suddenly going to have a role in talking about network, in talking about care management and disease management. And then the employer will continue to be involved with the design and the financial commitment here. The whole idea is that employers are looking at every moving part in this particular continuum.

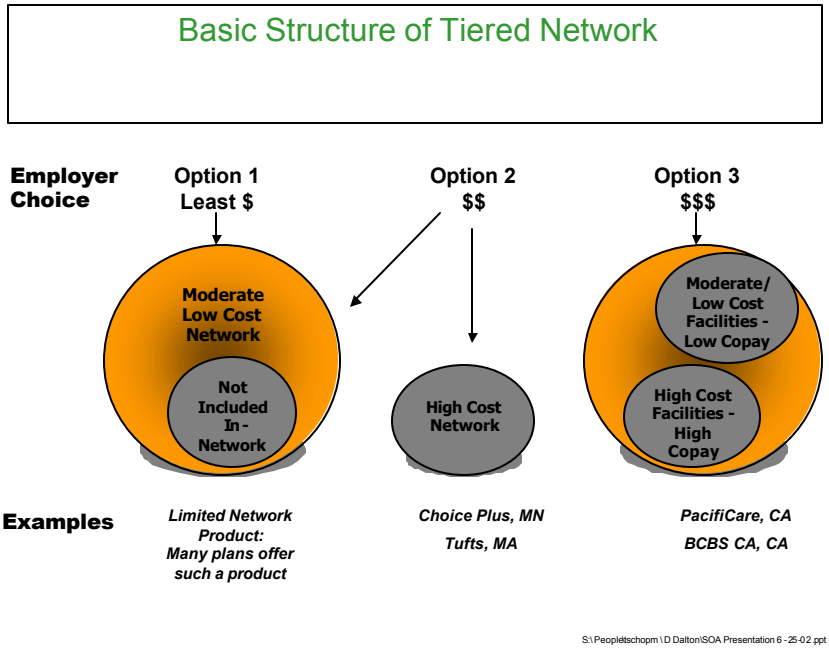
Figure 3



MR. BRENT GREENWOOD: I'd like to talk to you, probably a little bit more specifically, about two particular products that are emerging in the marketplace. I'm also going to discuss the actuarial issues associated with pricing these two particular products based on our experience of going through and pricing these products for clients. In addition, I'll discuss a new pricing model that we've developed for the personal care account and give you some examples of early observations that we're finding as they relate to these different products.

Figure 4 shows the basic structure of tiered network products. Outlined here are three kinds of options. First is the bigger circle under option one. It's pretty much your limited network. As plans have explored, they've evaluated their networks. They know which ones that are high-cost and low-cost providers, and they wanted to develop a limited network more associated with their low-cost providers. Many plans have that limited network product.

Figure 4



The second option is one that you see within Choice Plus Minnesota, where you have your high-cost and low-cost networks, and there are different employee contributions. Essentially, the employee chooses one of those networks based on employee contributions, benefits and things of that sort.

Then the third option, which I'm going to follow through a little bit further, is where you have all of your network within this same bubble, but depending on whether they're high-cost or low-cost you're going to change the co-pay. You have to figure out what kind of impact that's going to have. So you're burying your co-pay based on the network.

There are many common business objectives and reasons why plans are looking at these tiered network products. One is obviously in response to some of the significant increases in the hospital contracts that have materialized over the last couple of years. They are trying to figure out some way they can take back some of the cost that they have really negotiated in these contracts. Many of the clients that I'm looking at are looking at a new product. They want to make sure that it's distinguishable in the marketplace, not just the same level as what they have at low option product, but much more distinguishable. So, we might be looking at anywhere from a 10 to 15 percent price advantage over their current standard product.

We also want to empower the members, trying to give them a choice pretty much based on economic incentives. There are methods that you can use to incorporate quality here, but most of the things that we're seeing right now are primarily driven by economic incentives.

Also, we want to encourage providers to negotiate rates that best reflect their level of efficiency. You might have some providers that think they're very high quality, so they're very high cost, and over time they might find that that's not really what the consumer is looking for. Finally, plans are looking at this product as something new to help broaden their market share.

Now let's look at some of the product design issues that you have to consider as an actuary when you're pricing these things. First off, how many tiers do you want to develop? Do we want to develop two, three or five tiers? It depends on how much you want to complicate your own life as it relates to pricing these things out. Also, we need to decide if we want to tier just the facilities, or if we want to incorporate the physicians within this. It is much more difficult to try to evaluate the cost efficiency of your different providers or different physicians. And you have to look at PCP, specialist or hospital-based physicians.

Also, the geographic access within tiers is quite important. As I'm developing my tiers, I need to know if all of my three tiers, or all of my lowest cost hospitals, are in the rural areas, such that my urban type members would have a difficult time getting there. So you want to make sure that you have broad geographic access within each tier.

Also, what do we do with tertiary facilities? Based on our measuring, are they all going to end up in our highest cost tier with the highest co-pays? Or are we somehow going to try to distinguish them and distribute them between the different tiers manually? And then how do we handle the non-par providers? Are they included in this program or not?

Usually what I find is that the pricing objectives tend to drive the parameters. If a plan wants to price this product by 10 percent below their standard, that tends to drive the parameters. Also, how do we classify those tiers? If it's dealing with facility, are we just going to deal with the inpatient side? Or, are we also going to include the outpatient services associated with that facility? And, are we going to include positions?

The measuring for tiering becomes very important, obviously, as far as how we're going to measure those facilities. Those facilities or physicians are going to be very interested in how you rated them, so then, they can do their own evaluation to see whether they're fairly treated or not.

Are we going to look at raw cost, or are we going to use some sort of case mix/health status adjustments so we can look at, hopefully, everybody on the same

level of playing field as best as we can. Or, do we possibly just want to look at it on a per contract basis? For example, on the physician side we dealt with clients, and they didn't really want to get into the per patient cost, but they had maybe 15 to 20 different fee schedules that they were dealing with, with respect to physicians. So, they're pretty much using those contract rates to help distinguish the tiers.

Getting a little bit more sophisticated, maybe we would look at per patient cost. For example, looking at it per specialty. Looking at all your cardiologists and what is their per patient cost? After doing that, you then try to develop a continuum or a profile so that you can put your physicians in different tiers. That's another way. Looking at quality indicators is another way. So the measurement of the tiering is very important. But once you get to the measurement how are you going to put them into those different tiers? How are you going to define it?

We've looked at a variety of different ways. First off, we looked at just the number of facilities. When we want to present this in the marketplace we want to make it look like there is a broad cross-section within each tier. So 25 percent of the facilities are in the lowest tier, 50 percent are in middle, and 25 percent are in the high. That's one way to do it. However, your distribution of admissions is somewhat skewed sometimes.

Or, you can look at the number of admissions and try to separate 25 percent of the admissions to be in the low-cost tier and 50 percent in the middle. You can obviously look at the percentage of costs. You may want to look at it by region. Because within each region your distribution on how hospitals are used, or the admission distribution, can be quite different. You may want to look at it from a par versus non-par perspective. You're also looking at your accessibility making sure that people can access the low tier hospitals very easily. And then also, you may want to look at admission privileges when you're looking at the physician side.

The other thing we have to look at is how you handle the treatment of multiple admissions in this as you start defining these different tiers. And, how are you actually going to apply those co-payments in the issue of multiple admissions?

I think one of the interesting things that we've found pricing these tiered network products out, is how your current contracts compare to what the future contract is going to be. You may not necessarily know that upcoming negotiation with a hospital that currently is identified as a low cost hospital in your historical experience is going to be a very difficult. So, you need to try to understand where those tough negotiations are, because in your initial data and analysis you may put that hospital as a Tier One hospital, but based on the actual contract it turns out to be a Tier Three hospital. So you have to be very careful about that.

Also, how do you measure the impact of steering services between tiers? I'll provide a case study and show you the impact. We hope people will transfer from one tier to the next tier once they have those financial incentives, but as you'll see,

that may not be a great savings overall. You also possibly have to monitor the co-pay waivers. We talked to hospitals saying that they'll possibly waive that co-pay, or a portion of it, if they're in that high-cost tier. You'll also have to look at what kind of influence that may have and the additional administrative burden of going through all of this measurement, setting up new contracts, and also the long-term impact after the network stabilizes. I think over the long term, the network between tiers will stabilize. The hospitals will feel comfortable where they're located and based on their negotiation, it will stabilize. But, in the initial stages it probably won't be very stable and you'll have hospitals moving back and forth.

Now I'll give you a little bit of a case study on the tier network. The price objective of this client was to get 10 to 15 percent below their low-option plan. They had a regional pricing strategy. They were just going to deal with the facility at this particular point, and they wanted to use a case mix adjusted measurement. There was no special treatment for tertiary or non-par. We also decided that when we presented this to the employee, we wanted to show that there is a good number of hospitals in tier one, a good number of hospitals in the middle, and the good number of hospitals in the high tier. So we used a 25/50/25 split of the number of hospitals. So, we laid them out on a continuum and the lowest 25 percent were tier one, the middle 50 percent were tier two, and the highest were tier three.

Table 1

	Region Range	State Average
Tier 1	1 – 28 percent	17 percent
Tier 2	57 – 95 percent	78 percent
Tier 3	2 – 15 percent	5 percent

What we see here is that there is quite a range, dependent on the region. The state average had about 17 percent of the admissions in tier one, a vast majority, almost 80 percent, in tier two, and only 5 percent of the admissions in tier three. As you can see, the range by region was quite significant. The big thing to point out here is in tier two we had one region that had 95 percent of the admissions. That's because there is pretty much one facility that dominated that particular region. So in that particular region, a tiered product may not necessarily be feasible. You have to lay out your own information in the specialty if you are very region-orientated.

We looked at the different benefit scenarios, and if you remember, the idea was to get to 10 to 15 percent reduction. What was the benefit that was needed in order to get close to that versus what was the benefit that would likely sell in the marketplace?

Table 2

	Daily Co-pay/ First 5 Days Only		
	Tier 1	Tier 2	Tier 3
Benefit Scenario 1	$300	$600	$900
Benefit Scenario 2	$500	$1,000	$1,500
Basic Option	$300	$300	$300

The basic option you were starting from had a $300 co-pay for admissions. Under benefit scenario one we had $300 for tier one, $600 for tier two, and $900 for tier three. Benefit scenario two was $500, $1,000 and $1,500 a day up to a maximum of five days.

We then looked at it two ways. One is if we just incorporated the co-pays, and one is if we assumed a shift in services.

Table 3

	Benefit Scenario 1 ($300)		Benefit Scenario 2 ($500)	
	State Average	With Shift	State Average	With Shift
Product 1 (IP only)	(3.2 percent)	(4.1 percent)	(7.9 percent)	(8.5 percent)
Product 2 (IP & OP)	(4.9 percent)	(5.8 percent)	(11.9 percent)	(12.5 percent)

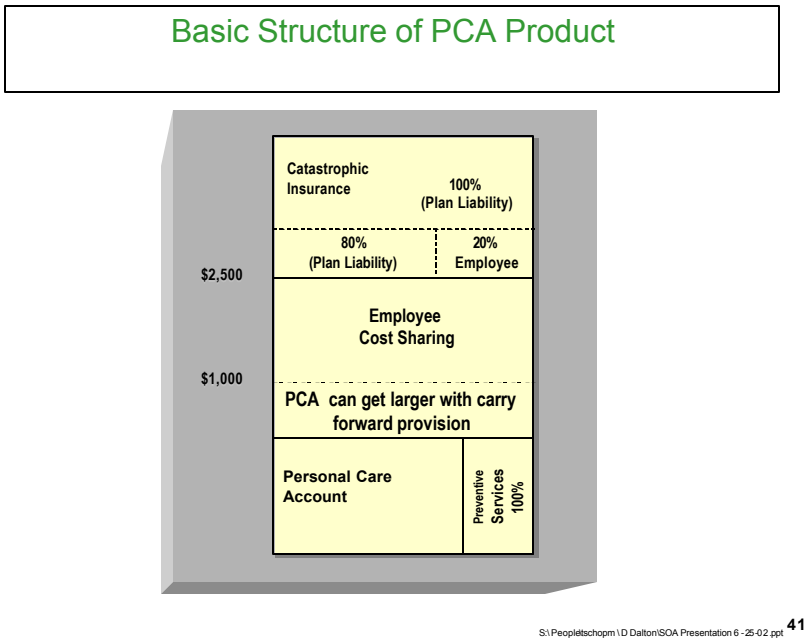
If we look at just benefit scenario one($300, $600, $900), we only had about a 3 to 5 percent savings from our low option plan. When we actually assumed a shift, we assumed about 10 percent of the admissions, which shift from the tier three to tier two, and 10 percent of tier two to tier one, and we only gained about a percent. We didn't gain a whole lot. You didn't get a lot of savings by transferring a patient from one to the next tier from that standpoint. As a matter of fact, there were some examples that in some regions if we shifted them to the tier one our cost actually went up, because they were so close they weren't equal to the difference in the co-pay overall.

We found that there's very little variation by region. The greatest savings from these things comes from higher co-payments versus a shift in the admissions between tiers. Some of that savings may be offset by higher administrative expenses, because you have to go to new provider contracts with the hospitals. We also found it difficult to determine the political impact of the new product on your hospital and provider relationships.

So that was some of the things on the tiering. Now I'd like to get to some of the business objectives for these personal care accounts. We want to lower our cost trends by offering consumers the ability to be active in managing their medical care. We want to educate the consumer through the use of technology.

Figure 5 shows the basic structure from which we will base the case study. You have your personal care account (PCA) and you have 100 percent of preventive services. And obviously, as you can see, the PCA can get larger as we go forward. You have the employee cost sharing in the middle before you hit this $2,500 deductible. Then you might have 80/20 cost sharing, and then 100 percent plan liability after that.

Figure 5



I wanted to model this out not just not in year one, but also in year two, year three, or longer term. That's what I'm going to share with you here in a little bit.

There are several different design issues you have to deal with as they relate to these types of products. What is that personal care account? What is the level of it? What should it be by contract? Usually it's different by single, double and family. Also, how do you address the personal care account with new employees coming in during the year? Do they get the full value of that personal care account and pro-rata a share? Also, how do you handle the personal care account dealing with a person who's single and then gets married? Does that person just keep what he or she had of the single or do you pro-rate it and give that person a little bit more on the double during the year?

Also, the level of insurance coverage, with regard to the deductible, co-insurance, and maximum out of pocket, as well as eligible services covered by the PCA are very important issues. Is that going to include dental, chiropractic and acupuncture? The types of carve-outs we might have to the PCA, such as these

preventive services that we talked about, are also an important issue. There might be other carve outs associated with that. We've actually seen some instances where drugs were carved out. The reason for that was because the employee didn't want to mess with the rebates that they got with respect to the pharmaceuticals in some instances, so they wanted to keep that with their PBM. The PCA carry over and forfeiture provisions are also issues. How much are you going to carry over? Are you going to carry over all of it? What about the forfeiture when a person leaves? Also, take a look at if you are offering this in a care replacement versus multiple option. I'll show you some of the impact of selection that we've seen when we've modeled it out. Obviously, the regulatory issues are important.

Again, I think many of the parameters are driven by your pricing options, your definition of services, the level of what the PCA account is, the level of insurance, employee turnover, and the long-term impact of the carry over provision. What is that incremental benefit that is provided when you carry over that PCA amount?

Another issue is the leverage of the provider contracts, meaning that the PCA may not be as valuable in the next year, and the next year, as your provider contracts are changing and possibly increasing. The funded versus unfunded liability is another issue. I'll give you an idea of what that value might be for the unfounded component of it. Looking at adverse selection is also key. And the real kicker here is measuring the potential impact of consumer decisions on utilization and the shift in providers.

Now some of the case study that I'm going to show you is really to evaluate the long-term impact. You have got to look at it three and four years out, because that carry over provision has a big impact and is totally different from health insurance that you see today. At Reden and Anders we had plenty of information and data following employers for four years. And so, we took that information and then ran through and developed a model to help us understand the impact of these personal care accounts over the long term on benefits?

We have assumed that the PCA and the PPO benefits are the same actuarially to begin with. And also, please keep in mind that we've not made any adjustments as they relate to the impact of consumer decisions.

Table 4

	PCA	PPO (In-Network)
PCA		
Single	$750	N/A
Double	1,100	N/A
Family	1,500	N/A
Deductible		
Single	1,500	$200
Double	2,200	300
Family	3,000	500
Coinsurance (Plan Liability)	80 percent	80 percent
Maximum Out-of Pocket		
Single	2,500	1,000
Single	3,500	1,500
Double	5,000	2,000

This chart shows the benefit structure from which we're starting. We have a PCA account of $750 per single, $1,100 per double and $1,500 per family. The deductibles are pretty much double what the PCA account is. And then looking at a PPO, which is very equivalent in actuarial equivalent benefit, but different from maximum out-of-pocket,. So again, the idea here is to look at two benefits that are actuarially equivalent and see how they change over time.

Chart 5 shows the first one. The model identified if all of the employees were in the PPO, which is our standard line for three years and what their cost would be. And then we assumed that all of the employees went to a PCA program. And what was the net payment under that PCA program? Now remember, we didn't incorporate any particular changes or impact because of consumers changing their behavior patterns. We ran it over a three-year period. So as you can see, at the end of first year the costs are the same for that PCA product as the PPO. Over time we saw that there was a slight increase of about 1 percent per year. A key thing here is that we assumed a turnover of 12 percent. Turnover is a big assumption as it relates to these products. As you might imagine, if you have 100 percent turnover, nobody rolls over your personal care account. So it's kind of like it's just a pure benefit of what it is. But if you have a very low turnover you possibly have a lot of people accumulating that personal care account.

Overall, when everybody was in the PCA, it was about a 1 percent difference. Now the interesting thing is the PCA liability. This represents the cost of the personal care accounts that are rolling over. If you as an employer had to fund that as of the end of the year, because that's the amount that is obligated to that particular employee, your cost would be about 30 percent greater than what your PPO would be. So here's the element that's somewhat missing from the financial statements right now. But, there is a potential liability there depending on how our folks in the

accounting standards are going to account for this, or how the government is going to account for this. As people move forward through this they are building up their PCA account, and this is the unfunded portion, which, by contract, they can use. They could use it on dental services, if that's in the contract, chiropractic services, and so on and so forth. But this is the unfunded portion. And as you can see, that grows from 30 to 33 to 38 percent greater than the PPO.

Now, to show the importance of the turnover issue, we've looked at the impact of employees who are here for all three years in Chart 6. So, we took out that turnover issue, and for the people who are in the plan all three years, again assuming our access here is their PPO cost for this population, we can see that their growth is a little bit higher. You had about 1.7 to 2.2 percent growth, so they're a little bit bigger.

As we can see with the turnover, what happens is that those people leave and the aggregate value of the PCAs go down. That kind of compresses that. But again, if you have a very stable population you can see that there's a slightly greater cost identified here. Now you have 20, 31 and 38 percent as the unfunded portion. This is lower than it was previously because you have some new employees coming in that year to which we did allocate the full amount of the PCA. There were new employees that came in half way through the year, or through the end of the year, and we allocated a full amount in this particular example. So this shows you a little bit of the potential impact.

Now, based on some of the savings that were given to us in the last session, if we just took the items dealing with the non-pharmacy, it did amount to about 1.5 percent. We took the items dealing with the non-pharmacy because that appeared to be the greatest savings associated with the examples that were given to us. So maybe it's to a level that possibly would negate this potential increase here, but the real big question is how ultimately these unfunded liabilities might be identified.

Table 5

All Contracts with PCA Balance				
	Year 1	Year 2	Year 3	Percent of Contracts
Single	$664	$1,089	$1,415	73 percent
Double	904	1,351	1,651	56 percent
Family	1,189	1,718	2,132	55 percent

This chart gives you an idea of what the average unfunded PCA amount is based on the data we looked at. The PCA account value was $750. So, you're going to have 20 percent of the people that don't use anything, and maybe 70 percent that hardly even match up to what that value is. I think the interesting thing to understand here is that at the end of the year two, almost 60 percent of the people will have enough in their personal care account that they have a 100 percent benefit. They have enough to cover that full $750 or $1,100 deductible. And so my feeling is how

much attention are they really going to pay to managing their own health care when they know that each year they're going to keep getting that $750 and have 100 percent benefit?

I heard of a person who had worked for one of the firms, saying his family wanted to have a baby, but was going to wait a year, because then he was going to have a 100 percent benefit. To the employer, that doesn't help. If they're under the PPO there would be a deductible co-insurance, whereas here they would have almost close to a 100 percent benefit. So, in the long term, you're picking up expenses you may not have previously. And is there enough in those discretionary services, in which they are making decisions, to really lower the cost beyond what might be happening incrementally here over a long period?

Chart 7 looks at who did better and who did worse. Over time we found that about 66 percent or two-thirds of the people did better under the PCA than the PPO, from an out-of-pocket standpoint.

Chart 8 identifies low-, average-, and high-cost utilizers, and shows how those people end up as we went over the three-year period. As you can see, about 75 percent of the low-cost individuals under the single did better than what they would have under the PPO over a three-year average. The average- or high-cost individuals did better 25 to 35 percent of the time than under the PPO type program, but logically that's what we would expect.

Table 6

Percentage Enrolled:		
Contract Type	PPO	PCA
Low Cost	75 percent	25 percent
Average Cost	90 percent	10 percent
High Cost	95 percent	5 percent
Overall	81 percent	19 percent

This table shows the enrollment assumptions for adverse selection. We wanted to see what the impact of adverse selection would be if we offered this PCA product. So we had the low-, average, and high-cost contract types, and we knew, based on other information that we gathered, that somewhere between 15 and 20 percent penetration might be expected. We also knew that there was really no change. All of the information that we have been gathering told me there's no change in the age/sex demographics, so we assumed the same age/sex demographics between these two products. However, we did assume that see that 25 percent of the low-cost, 10 percent of the average-cost, and 5 percent of the high-cost individuals would go to the PCA. Overall, there's about 19 percent penetration within this program.

So in Chart 9, we run that through the model. Under this selection scenario the PPO standard represents everybody. That's kind of our measuring stick. We saw about 65 cents on the dollar was paid for these individuals, of which their unfunded liability was about 91 cents on the dollar. So you still have this disparity of the unfunded, obviously. Once that person was identified to enroll, that person stayed there. We didn't assume that he or she would be going in and going out over the three years. And, I think this gets to the point that the low-cost person is not always low-cost, and a high-cost person is not always high-cost. We have to understand that, because over time that person will use services, accumulate PCA and almost get close to 100 percent benefit. And as you can see, the slope here on the trend, over time, is pretty high for these individuals. You're going from $0.65 to $0.95. That's almost a 33 percent increase over two years. Because of their accumulating the PCA and having close to a 100 percent benefit over time, benefit costs would be going up quite quicker than what you might find otherwise.

Chart 10 is a comparative cost analysis. As you can see, we started with those people who were covered under the PCA paying 65 cents on the dollar, and for those left in the PPO, it went up to about $1.11 that you were paying now for those individuals based on the selection. But again, once they're enrolled as high-cost this year, they actually went down. High-cost people don't continue to be high-cost forever. Again, all of this when combined represents that one percent aggregate cost difference between the two. But, this gives you an idea of the differential between the PPO and the PCA if you assume adverse selection.

Now I'll discuss some of the final observations. I think if you start from the same equivalent benefit, over time the PCA product may have a higher trend rate because of that leveraging of the PCA program. So to meet an employer's objectives of reducing cost, you really should start at a benefit level for the PCA at about 5 to 10 percent below what the PPO plan is. Employer turnover is very important because it does increase the cost. The unfunded portion of the PCA really pushes that total potential liability significantly above the PPO, so we always have to keep an eye on the regulators and what they're going to be doing on that unfunded portion.

In what I've showed you, we did not assume any additional cost associated with offering dental, acupuncture, or chiropractic that someone might incorporate within the PCA. This is strictly dealing with benefits that were covered by a traditional medical plan. I do see most of the winners are employees with lower medical care costs on average, so there could be an equitability issue. And, when offered in multiple settings, adverse selection will likely occur. Because of the selection, the combined cost will be slightly higher. In all of this, the wild card is the impact of those consumer decisions, and I think we just need more information. But, obviously, those are things that we're going to be putting into this model as well as the impact they have on total costs.

MR. ROBERT LYNCH: Earlier, on the list of the usual suspects for factors driving the inflation of health costs, my opinion is that you left off a major suspect in the form of the current and worsening nursing shortage. There is a shortage not only in this country, but worldwide. Back in the old days little boys would grow up to be very well-paid physicians, and little girls would grow up to be fairly well-paid nurses. And in the last 20 years, it's been little boys have been growing up to be extremely well paid surgeons, and little girls have been growing up to be fairly well-paid family practitioners. The bottom line is, none of them are becoming nurses anymore. So we have a professional nursing pool out with an average age in the late 40s. Nurses are retiring faster than new nurses are being trained. And in addition, the managed-care industry contributed to that in the '80s by instituting the trend toward secondary providers and training RNs to become nurse practitioners, which further depleted the pool. Also, a very significant number of RNs and LPNs too are no longer providing medical care. They're employed by managed-care organizations managing care. As a result, salaries and wages for nurses have been skyrocketing the last few years.

Just a few months ago I read how one union negotiated a 40-percent pay increase at a hospital in Southern California. I think that it was over a few years, but it's still a lot. And from personal experience, my wife works for an HMO in Wisconsin. Just this month, out of the blue, that HMO gave their nurses a 10 percent pay increase in an attempt to keep up with the local hospital where the union had negotiated a very significant pay increase. And even with that, that HMO is desperately trying to get agency nurses to fill in their spots. Because it takes two years to produce an LPN and four to five years to produce an RN, this is a trend that's probably going to continue for 10 or 15 years. So it's not going to go away very soon. It's just going to continue to get worse. I would like to add that this is a global problem In many Third World countries, the advanced patient such as ourselves, tried to help them by funding the construction of nice, new, modern hospitals, but the trained nurses there found out that they could get paid ten times as much by coming to the united States. So a lot of those nice, new hospitals that we have funded are closing their doors because there are no nurses left in those countries to staff them. I just wanted to throw that out there.

FROM THE FLOOR: I guess that was a statement rather than a question. First of all, I'd like to comment and make a clarification directed toward Mike Taylor. I guess I would agree with almost everything you said, with the exception of the sales process with Definity Health. I think I would agree with you that in the very early stages our strategy may have been more directed toward CFOs and higher-level executives in companies, but I believe today our sales strategy is very traditional. We're going through the regular channels—human resources, consultants, and so forth.

MR. TAYLOR: I would agree with that. My sense is that the initial momentum was generated from that stakeholder. There's no consulting house in the United States

that isn't talking about defined contribution to their employer clients, and working quite comfortably with companies like yours.

FROM THE FLOOR: I also have a comment about the case study that Brent did. I think we need to keep in mind the sensitivity of any multi-year projection to the assumptions that you use, and it was not readily apparent to me exactly what the assumptions were—at least not all of the assumptions were. I think is a very key assumption is the reaction to the employer and the employees in response to increasing personal care account balances. Most of the employer clients that we've worked with offer multiple benefit designs so that people have something to do with those increased PCA balances over time. They can actually buy down to a higher deductible level with a lower contribution. So I think using a two-plan design projected over a multi-year period creates a bias in the result.

Secondly, I think that the impact of the consumer component of the plan is actually quite greater than the 1.1 percent you suggested. I'm not sure how you derived that number, but we think that that effect is substantially greater than that and would also have a big impact on the results.

MR. GREENWOOD: I guess the thing that I was struggling with is that the issue of longevity and the impact over the long term was never addressed. What is the impact that personal care account would have on claim cost in the long term? That's what generated our interest in developing this particular model. Benefit design in that is pretty much taken from many examples of the employers who were actually incorporating these. What we did, which I'm assuming you do as well, was take that actual employer's data and run it over a three-year period based on their distribution of patients and their employees.

Again, as I stressed during the whole session, I did not incorporate anything on the consumer side. That's still a $60,000 question, and early indications, as you shared with us, are looking good. I mean that's positive. I think the biggest thing was on the pharmacy side, and again I stress this did not include the pharmacy. So this is just medical and that's why it was a much lower percentage. Most of your savings right now are coming from pharmacy, at least based on published information that I'm getting from presentations like this.

MR. CHRISTOPHER HEPPNER: The one thing that concerned me the most on the whole PCA presentation was the unfunded liability piece. I guess I'm asking for a clarification on one of the graphs. I think it showed the amount that was actually paid for the benefit plan, which is obviously less because you had a much lower benefit plan. But then, you had this $1,000 or whatever it was that you paid to basically everybody. That sounded like it wasn't a real cash number. It was just something that was written on paper, and talked about as unfunded liability. But if you took the amount that was incurred for the benefit plan and said no, this number for the PCA is actually a real liability that actually has to be funded by cash, I thought the one chart had the first-year cost at 27 percent higher and the second-

year cost at 35 percent higher. That seems like a dangerous path to go down, in a sense. You're going to be paying a couple thousand dollars a year for all these people, but beforehand you didn't really pay anything. And now you have this big liability. I guess I'm asking if I am understanding those graphs correctly? And how do you attack that issue?

MR. GREENWOOD: Now I think that the unfunded part was another thing during the presentations that we never really addressed. But, like you said, for those people that don't incur any claims whatsoever there's $1,000 out there now on the account. It may not be funded, but it's on an account that eventually the employer may owe them if they stay long enough and if they use services. Right now those monies are not being funded like an FASB 106 liability. They're out there as an account that all goes back to the employer if the employee leaves. They don't carry it with them.

But, I wanted to get an understanding of what that potential unfunded liability might be just in case the regulators ever came back and said "You need to fund that because this poor consumer just switched jobs, and had a $2,000 balance that they're not taking with them."

MR. TAYLOR: Again, I think this is a very healthy discussion around this issue. I was just down in Washington about a month ago, meeting with the IRS and the Treasury, who are looking at this whole issue. It's clearly a big issue for them. One of the things I took away from that meeting is that they're very cautious about where the money comes from and where it goes. And they're very into tracking the money in these new plans I think they're applying some of the fiduciary responsibility of the trust. Maybe there does need to be some accounting mechanism in which these trusts have these amounts that are going to be carried forward. They may have to find a way of, at least, accounting for it. Whether they fund it or not is another issue. And the business community is going to get involved because that has significant implications for them.

My understanding was that that they were going to continue to have this discussion, and they were going to issue some guidance later on this summer, so I think that will be very valuable to us when it comes out.

MR. GREENWOOD: I guess the other thing on the unfunded is that it's unfunded in year one, but there are monies available that over time, if it's enough in their account to satisfy that entire deductible, eventually may be paid out, but not immediately.

MR. HOWARD CONWELL MAYBERRY: We've seen a large increase in the membership of our individual products, which always makes me a little nervous because I've seen so many bad years in the group market. But the speculative explanation is that a number of small groups have been moving to a defined-

contribution plan, increasing the individual market. I just want to know if that's a reasonable explanation.

MR. GIROD: He's seeing an increase in their individual coverage right now, with a lot of new enrollees. And the question was, are small groups dumping their group coverage and switching it to defined contribution? I haven't seen that yet. I guess I would look for other carriers pulling out of the market. That's more of the trend we see.

MR. TAYLOR: I mean you definitely don't see that in the large group market. Employers continue to maintain their responsibility for doing it. But , my sense is that as employers get faced with these increases, which are enormous, they may well be taking that approach. In certain markets that could be a very reasonable explanation. Employers may be saying I cannot be competitive in my market unless I fix my cost.

FROM THE FLOOR: On the tiered hospital co-payments, did you make allowances for urban hospitals that have a lot of uncompensated care? They usually have a higher proportion of Medicare/Medicaid patients as opposed to other hospitals that don't, and just those alone could account for a lot of their cost differences. Is it fair that those hospitals' patients have to pay higher co-payments? If you do that, do you alienate, or at least run the risk of alienating, some of those providers? Might they be dropping out of your network because you're not giving them fair treatment?

MR. GREENWOOD: As far as the underlying cost, I'd have to say in many plans the underlying cost of the hospital is not considered. It's more of what they have contracted with that hospital for. It may be a diagnostic related group (DRG) , or it might be a per diem. So they're looking at the overall reimbursement per admission based on their contractual rates. And that puts them in the particular tiers.

The interesting thing as it relates to negotiations with hospitals, from what I've observed, is that the hospitals are starting to put in their contract that they will not enter into any sort of product that steers patients away from their facility. Or, if I do, then I'm going to enter into a separate contract just for that, then that's going to influence my decision on this particular contract on the bulk of your business, so they're definitely trying to use their leverage to really push back with respect to those shared network products.

FROM THE FLOOR: I wanted to comment on the unfunded liability discussion earlier. I think there are two things I would point out, not to say that everyone does it this way. We do modeling for clients by looking at plans that will create a balance in the cost for that client. We use all of the necessary assumptions, so the result of that exercise for one client may be entirely different than for another client. When we do that, we look at the full cost of the PCAs and the full amount. So from an unfunded liability perspective, there's a cash flow savings to the employer

in that first year, and potentially even two or three years down the road, which eventually they'll pay out. The cash flow savings obviously have some value to them as well.

The other thing is that I would totally agree that the accounting treatment of those liabilities, so to speak. I would call them liabilities because, frankly, we are working within a planned environment here, so there is no actual liability at least under the current rules and regulations. Now potentially, someone could legislate a liability on that, but it's really a planned design provision. The employer could cease to offer that plan tomorrow and that liability essentially no longer exists. So, I think that's something that looks scary when you see a huge amount. Again, I'm not sure what the assumptions were exactly, but I'm not sure that it's totally applicable either.

Chart 1

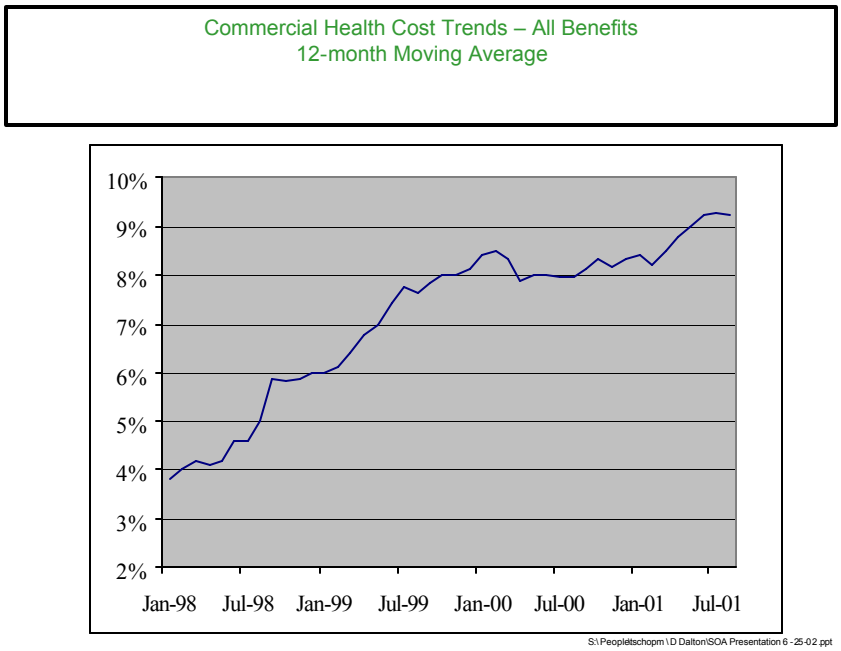


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Chart 2

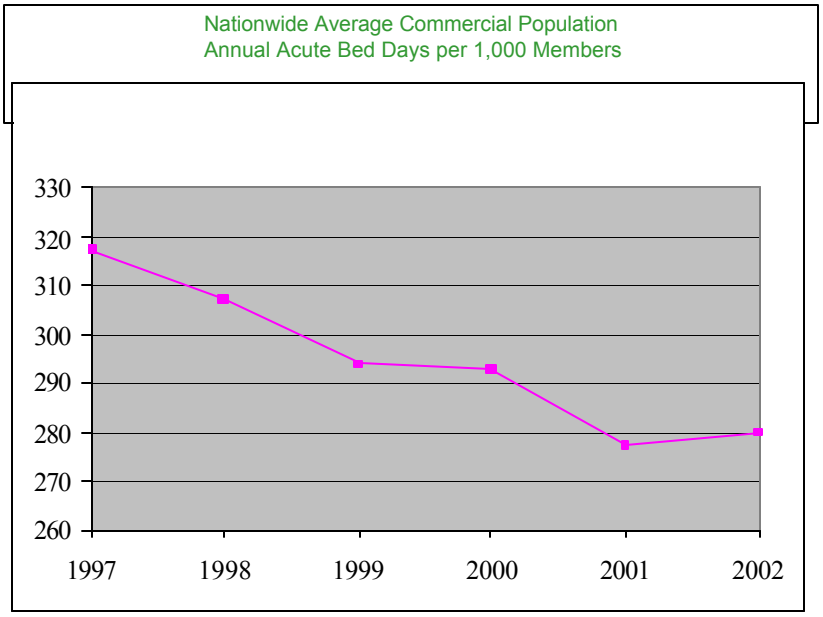

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Chart 3

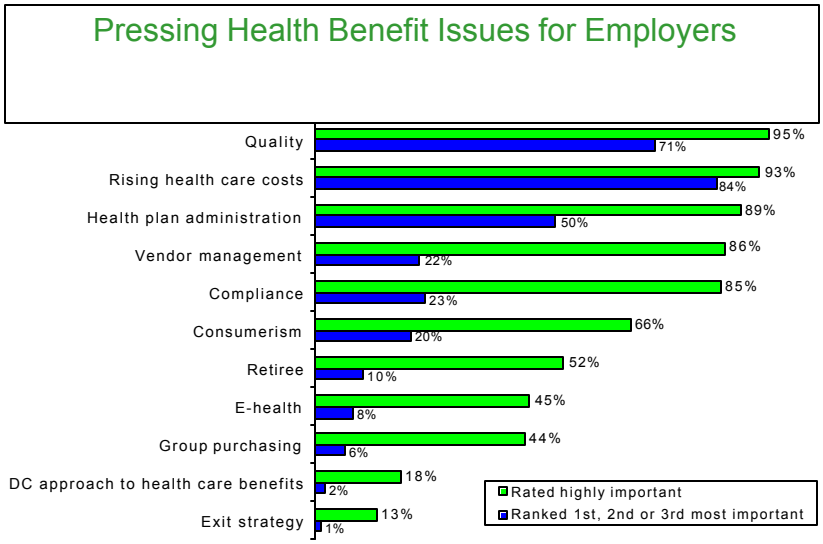

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Chart 4

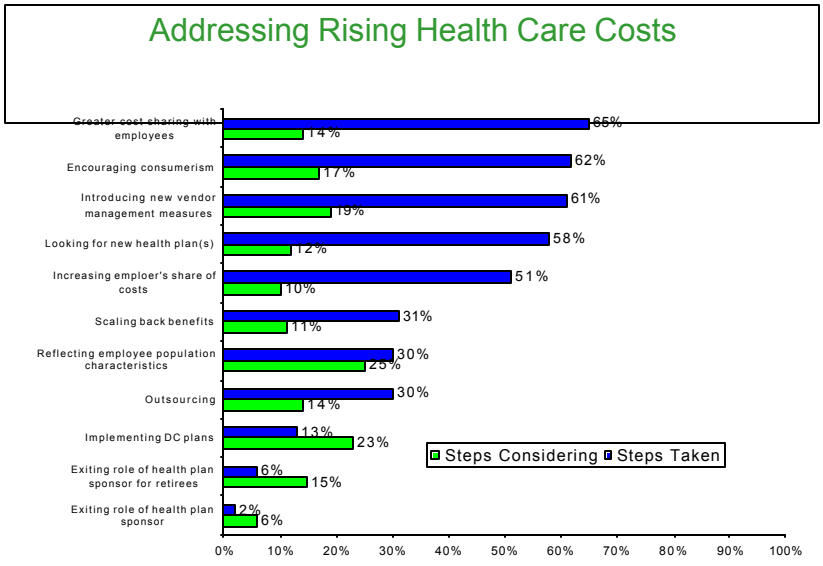

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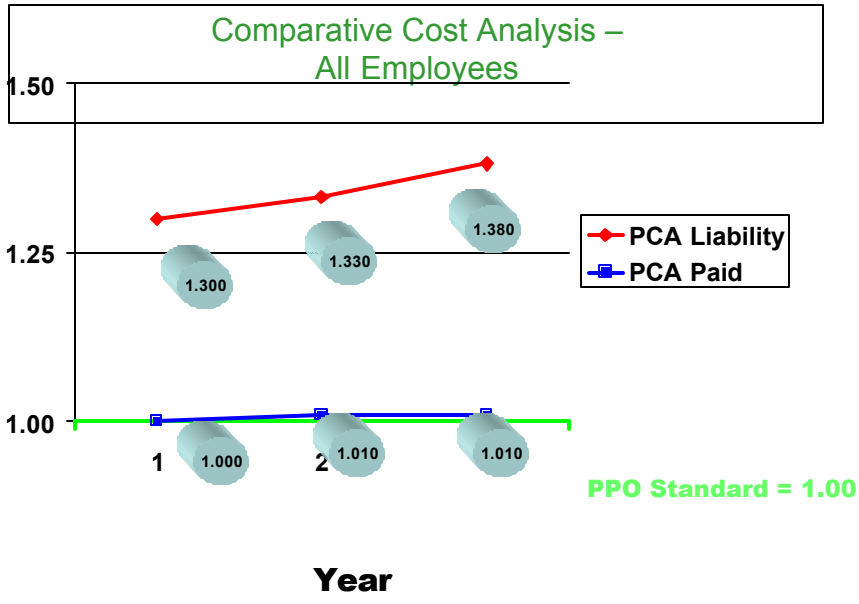
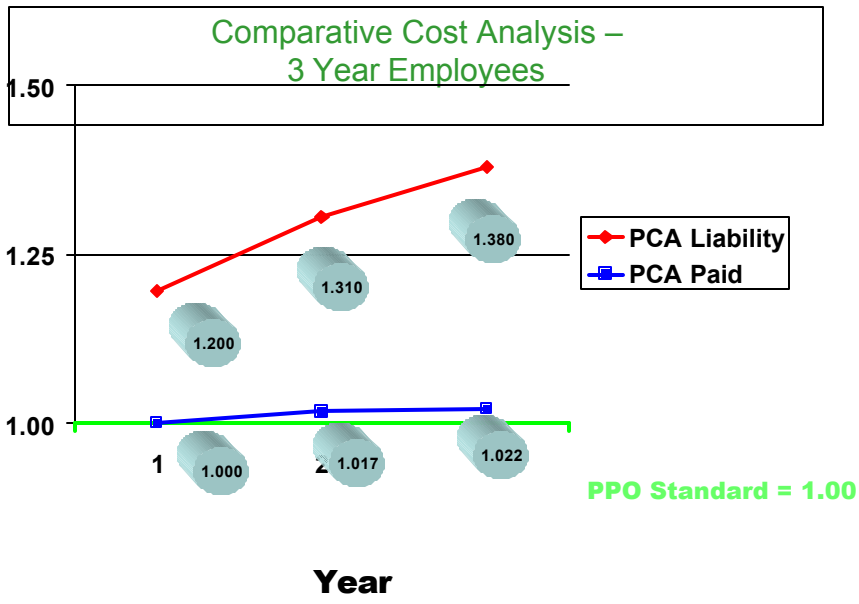
Chart 5



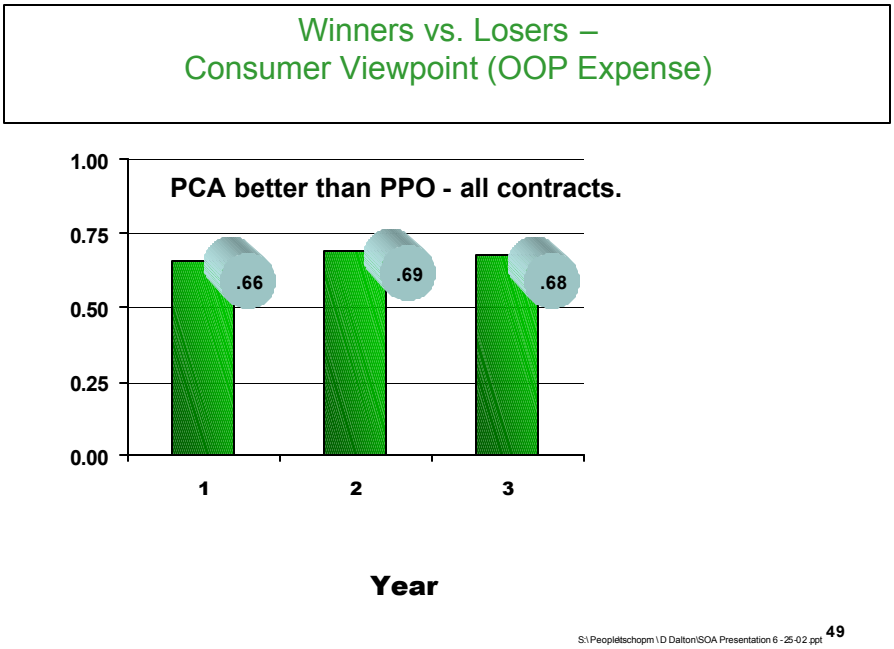
Note: Turn over average 12%.

Chart 6



Note: These employees approximately 11% more than average.

Chart 7



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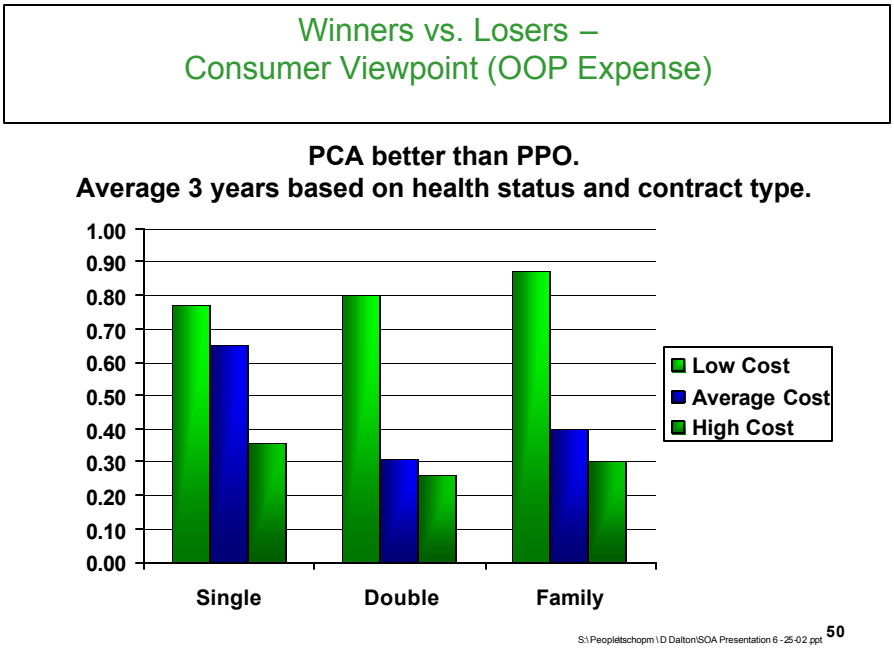

Chart 9

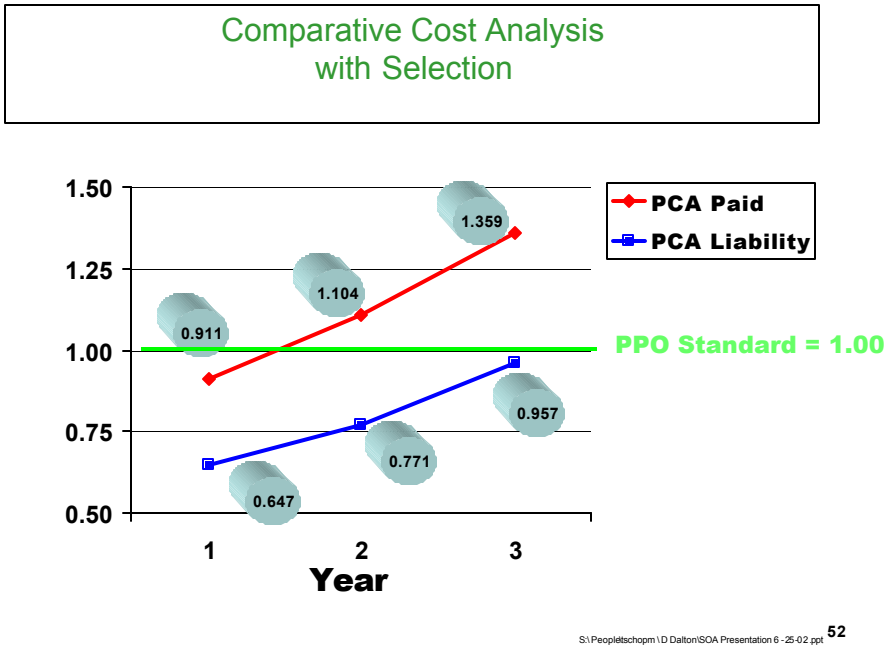

Chart 10