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Health Care Affordability–Effect on Employers and the Uninsured

Track: Health

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Summary: Recent premium rate increases and increases in health care costs have generated increased attention on the affordability of health care and health insurance. This has profound implications for both employers and the uninsured. Our panelists discuss mechanisms to measure affordability, employer response to the increasing cost of care, potential effects on the uninsured and expected governmental reaction to growing underinsurance. Attendees gain a better understanding of affordability, current and anticipated future actions of employers due to rising costs of providing health insurance and composition of the uninsured population and potential governmental reactions to growing underinsurance.

MR. DAVID V. AXENE: Bryan Miller will start by giving a plan's perspective. Then Jonathan Meyers will present an employer perspective, and then Tom Handley will finish up with a provider's perspective on the total issue of health care affordability.

Health care affordability is becoming an increasingly major issue for most Americans. It's gone beyond the cost issue, and it's really an issue of having enough money to pay for the health care system. A recent survey by Kaiser Family Foundation showed that the average American is more concerned about their health care costs than paying their mortgage, and that's rather substantial for Americans. I don't think it's quite hit that level yet. A lot of people—sometimes myself—have been badgering for years that our health care system is in a serious situation. For the most part, everybody has ignored that, saying, "We've dealt with this before,

going through the underwriting cycle."

But I dare say that we're at a point that we've never been in history, where we have federal, state and local budgets stretched farther then they've ever been in this country. We have international activities. Those of you who have been watching the news over the past six to eight months have seen some activities over in the Mid-East that have further drained it. Our world economy is perhaps at it's lowest. Our internal economy is rebounding, it seems at times, but it is at a very serious juncture. We're frankly in a situation where, unless something is done to the health care system, I'm not confident—and I'm a perpetual optimist—what the solution will be.

I happen to live in Southern California, and it's a lot harder to go to the grocery stores right now than it has been for quite some time because the grocery workers are on strike. At first it sounded like they were fighting over minor issues. In fact, their monthly out-of-pocket premium payments are going to go from $15 to $50. Those of us who have had health care contributions greater than that sometimes don't necessarily feel as sorry for them as we might. But when you look at some of the other changes that they're fighting for, basically health care is a major issue for them. Other contacts with negotiated plans that I've had over the past six months have indicated that this is just the beginning of the dogfights between management and the labor unions over health care. I see lots of activity. It can be very discouraging.

However, I think that the whole issue of health care affordability has emerged at a level that I don't ever remember seeing in prior times. All stakeholders are concerned. That's why we've tried to represent different viewpoints today—the payer, the employer, the provider and also the patient. Not to start a wonderful session off on a downer, but it just seems we are at a crisis level where we're going to have to do something about it. Some of you who are familiar with other international systems will say that just proves that we need national health care. I dare say that if you talk to some people who have been either consulting or working with those international systems that are having the same types of problems we have in this country already—even within the national system—I'm not sure that's as obvious a solution as you can manage.

Today we'll talk about the affordability issue from these perspectives and try to see what we can learn from that. Bryan Miller will be the first speaker. Bryan is chief actuary from Blue Cross/Blue Shield of Kansas City. He'll present the health plan or the payers' perspective of this and share some enlightening things that they're trying to do to create an alternative for people experiencing affordability problems.

MR. BRYAN MILLER: I don't intend to speak for the carriers in the audience or actually for my own carrier, except to the extent that I did supply this presentation to my boss and his boss and they OK'd it. To that extent, I guess I do speak for our own company. But I want to address, if not to answer, two main questions. First,

what are health plans doing today to combat the affordability problem that they face in their markets, and secondly—and perhaps more important—what could or should they or we be doing in that quest?

I've broken up what I intend to present into three different categories of ways that I think health plans can and are addressing the affordability issue, starting with the most incremental of the forms and moving to more significant commitments of time and resources. I'll start with simply making changes to existing benefit plans, which I know many of you are doing. I'll briefly cover a program called Blue Choice that we've had in place for a couple of years. Then the next step I'll discuss is consumer-driven benefit plans. This goes a bit further than making basic benefit plan changes but not as far as radically overhauling the way we market and sell health plans. Finally, I'll cover a specialty market product called Community Blue that we are just in the process of planning for a rollout next year. This is a significant departure from our standard product portfolio.

What I want to do at each of these three levels is to give you a quick analysis of the basics of the programs that we're developing in each of those segments and then try to analyze the impact that I think they will have or won't have on overall affordability. Let's start with the most basic of reforms, and that's simply making changes to plans we all ready have out on the market.

We have a program called Blue Choice, which we rolled out about two years ago for our large group, multiproduct program. Our standard portfolio consists of one PPO program and two HMO programs. What we will now do going forward is to give the employee six choices rather than three. The existing program now becomes what we call a buy-up option. In addition, we will establish three new programs—lower value, lower cost programs—which we call the base. Employers will now contribute at a lower level, and then the employees will be given the option either to accept that contribution and work with a lower benefit level or to pay the difference and buy a richer program for each of the three plans that we have on the market. So they have increased choice, but they also have to make an economic decision about whether to contribute more through payroll deduction and have the plan they had before or to accept the lower level of benefits.

In terms of assessing the impact of affordability of incremental benefit changes, I've laid it out in several categories. I don't see making small benefit changes as having a significant impact on overall affordability for the health care system as a whole. All you're doing is changing the cost-sharing element to individuals. The providers may have higher co-payments to go after but again, they shouldn't see a significant impact either. Employers will realize a one-time premium reduction and again, that's one time. You'd have to keep ratcheting the benefits lower and lower for the employers to continue to maintain or to realize a savings from a program such as this. From our perspective, there's a little bit higher cost for administrating twice as many programs as we've had before. But we've been able to standardize these options, especially in the smaller end of that market, so that the employers

don't have a lot of options to pick and choose. It's, "Take these two levels of programs." So we've cut administrative costs as low as we can on those.

And then as I said before the employees have a choice: either accept the lower level of benefits and pay less out of pocket through the payroll deduction process, or pay more to maintain the benefits that they had before. So the affordability problem for employees is worsened through this. They either pay more up front, or they pay more on the back end. As an overall cure for affordability, simply ratcheting benefits down is not a long-term solution. It may, however, keep some employers in the market instead of dropping coverage entirely. That's probably the one saving grace that might have.

As we move into the consumer-driven plans, I won't spend a lot of time describing the benefits because you've probably heard a lot of details about how each company works their own plan, and we're not that different. We have several standard options that we intend to roll out at the first of the year. I will say, however, that this is not intended to be a major product in our portfolio. We do not believe that this is a panacea, at least for our market. The only reason we really followed the lead of other carriers is because we're getting a lot of requests for proposals (RFPs), a lot of consultants coming in and saying, "You have to provide this option." We will, but we won't push it heavily.

In terms of assessing the affordability impact in consumer-driven plans, I think if you look system-wide, there is potential—it depends on who you believe—as to whether cost-conscious consumers truly will reduce the utilization. I think we've heard this morning from a couple of carriers that they believe it will. I'm somewhat on the skeptical side of halfway there. But again, I have no direct experience with it, and maybe our own product will show that. From a provider side, I think most people understand that if there is lower utilization through a consumer-driven plan, we'll see that in the primary care physician and pharmaceutical areas. From our own insurer perspective, obviously there are additional administrative costs that come along with maintaining and administering a separate account balance. We've had to contract with an outside company because we simply didn't have the capability to administer those health accounts. There's also risk that the carriers face with assessing and publishing quality information that is accompanying many of these consumer-driven plans. You bear some responsibility for the information you put out in people's hands to make decisions like that. This could end up leading to tiering of providers within your network based on the information you're providing to your employees when they face an open enrollment situation. So there are some risks involved that may not be apparent at first blush.

On the employers' side, the question is: along with the reduced utilization that may occur, will there also be any induced demand by people having these accounts to spend? If they anticipate leaving, do they want to exhaust their balances? So, there are a lot of competing influences as to whether the employers will realize any significant savings out of this. I think it's a very mixed bag for the employees as

well. Your low-cost employees who don't anticipate going any further than the health risk appraisal (HRA) balance will find health care very affordable. In fact, they'll find it free. On the other side of the coin, the high-cost employees, who now will encounter a significant deductible that they may not have faced with prior options, will probably find themselves worse off. The affordability for them will actually have worsened. So again I think this program, just like the incremental benefit situation, has some limited potential. But I think the affordability is by no means universal. It's very mixed. Certain people would realize savings. Certain people would be quite a bit worse off than they were before.

I want to spend a little more time on the third option that I was talking about: developing a specialty program. We have a product that we're calling Community Blue, which we intend to roll out the middle part of 2004. This is what we call an income-qualified health plan. The target market is for small employers who either do not provide coverage to their employees or have dropped it for whatever reason, usually for affordability reasons. We will mandate that 75 percent of the eligible employees have incomes between $15,000 and $34,000. Again, it's focused on a fairly narrow segment of the market that involves uninsured individuals and also employers who for affordability reasons have not been able to or not chosen to provide coverage. We don't want this to compete with Medicaid, nor do we want it to compete with our commercial product. It's meant for that niche in between.

The basic parties involved in this situation are providers, brokers and agents, regulators, ourselves and small employers. Each of those five parties must give a little bit to make this product work. I'll explain each of those to you. From the provider side, we have to work with them to take a lower fee schedule. There's no way we can design a program that these small employers will be able to buy without getting some concession from providers. We've begun that process. At least at the hospital level, they seem very willing. A lot of the potential members of this program are folks who have no insurance today and who present themselves at the emergency room (ER). There's no compensation for the provider at all, except what they can get from the member. So we'll work with providers to try to work on a lower fee schedule. Thus far with the hospitals it's fine. We do have some concerns on the physician side later on, especially those in various specialties who are unhappy with our commercial reimbursement rates, to say nothing of what we want to get out of this program. So there are a lot of challenges ahead there.

The Kansas City market is heavily driven by brokers and agents. We'll have to ask them for a lower commission. There's no way we can afford to pay a full commission on a product like this and keep the rates down where they have to be. From the regulators' side, we work in the states of Missouri and Kansas. We've met with both of them to see if they're willing to relax some of the mandates that they have in place to make this product affordable. There's a law in Missouri called the Limited Mandate Law, which has rarely been challenged by insurance companies. We intend to invoke that and work with them to see if we can cut out a lot of the ancillary coverages that are going to add to the cost of this program. We believe

we'll be successful in that. Also, the insurance department in Kansas has shown some willingness to bend a little bit. So again, all five of these parties need to give.

From our side, we have to come at this with a very different administration and profit focus. In fact, we expect to lose money on this program, but we think the social good exceeds the bottom line good. On the small employer perspective, we will ask them to pay at least 50 percent of the premiums, and keep in mind that these are employers who have refused to do so in the past. Again, this poses a significant challenge to us. But to make this whole thing work, each of these parties must contribute a little bit, and we are going to require the employers to make a contribution.

What we'll do in terms of benefits, obviously, is to ratchet it as low as it can be while providing a comprehensive level of benefits. We'll exclude as many services as we think reasonable and again, limit the mandates that are required. What it will end up being is one of two cases. One would carry a very high deductible, which will not work well with low-income people. The other one is to have a low annual maximum benefit, which we don't like either. But there seems to be no other way to get to the premium rates that we want, and we're trying to target a single rate of under $100. Again, we intend to have this ready by summer, given that we can get the filings done and the provider contracts set. It is a significant challenge for us, but we believe it's a market that needs to be entered.

In terms of assessing affordability of products such as this, we believe that if we can make a significant dent in the uninsured—at least in our limited geographic area—we think there may be more prudent use of health care if we teach people how to use health care effectively, and not just to present themselves at the ER. We believe that may have some effects down the line. We believe providers may have less uncompensated care to deal with. That leads to subsidies. If insurers are required to subsidize these folks less with their commercial blocks, that extra savings may be able to trickle down to both employers and employees in turn. It may not be a huge impact, but we think not only from a social standpoint, but also from a looking-forward standpoint, that this is the direction we need to be going.

For the second part of this presentation, I want to look more at where we have been in terms of affordability. Obviously this is not an issue that's just started, but there was a period of time where we didn't have to deal with affordability issues in health care. There are some reasons why. Many of you know these things, but I think a few minutes of review may be worthwhile. You know that the original Blue Cross Plan was founded during the Depression to provide affordable—and there's that key word—hospitalization benefits to schoolteachers in Dallas. At that time each state required that the Blue Cross/Blue Shield Plan serve as the insurer of last resort. That made the Blue Cross/Blue Shield Plans naturals to deal with the market that we're trying to address with our income-qualified health plan.

Obviously, as we all know, things did not remain that way. Competitive reasons

forced a lot of Blue Cross Plans to change their rating bases. The favorable regulatory and tax treatment has faded away as well, causing a number of our sister plans in the Blue Cross system to consider whether or not to remain in a lot of somewhat tenuous product lines, such as Medicare supplement, individual and small groups. The other complicating factor in the last ten years, as recent events in the news will indicate, is a number of our plans are pursuing a different structure. They're going to a for-profit status, while many of the rest of us are committed to remaining not-for-profit. The leading question there is, what implications do those changes have on how interested or how important affordability is to those carriers going forward?

I will say in defense of some of these for-profit conversions that a number of public foundations have been created whose goal is to deal with the markets that we're talking about and also to maintain what is called "community benefits." The definition I have of that is "unreimbursed goods and services provided by local health care institutions that address community-identified health needs and concerns, (including) such things as free or charity care, premium subsidies and health education campaigns." So there certainly is some good that has come from the conversion of a number of not-for-profit plans to for-profit in that those funds have been made available for public health reasons. Second, these conversions haven't been proven to have a negative impact on accessibility and affordability. We're not that far down the road with some of these conversions, so the long-term effects may not be known. Will those promises remain to keep community benefits when a number of functions will be centralized? Local accountability and service may not always be there. Those are questions that certainly come up.

This leads to my final question: what obligations do health plans feel they have today to deal with affordability? Will that change in the future, and what external factors may influence the way we feel? My position today is that plans should address affordability, that we have a reasonability to do so and that some of the implications for not doing so are already underway. One is closer scrutiny of future for-profit conversion. I think you've all heard about a couple of those in recent months within the Blue system that didn't happen. Others are tighter state rate regulations and prohibitions on exiting unprofitable markets. I think many of you have probably seen that as well. And also this group of people needs to find coverage somewhere. Many of them will go to state high-risk pools to the extent they can. I know in Missouri, the pool has doubled in about one year, and our assessment gets higher and higher. That's an investment you can make either in developing programs to deal with it yourself or simply paying your share of the cost for a state program. And then from the legislative side, there are obviously rumblings of things happening—association health plans or worse, or eventually a single-payer health care system.

The final point I would leave with you is this. To insurers that say this is somebody else's problem, that affordability is not anything we have to deal with, that we're simply reflecting what the state of the health care situation is, I think that's rather

short-sighted. If we want to maintain the structure in the corporations that we have now and not subject ourselves to some radical reforms from outside, I think we have the responsibility to deal with this issue in whatever way we can. Thank you.

MR. AXENE: Thank you, Bryan. Our next speaker will be Jonathan Meyers, who's a consulting actuary with Milliman USA and works in the employee benefits area out of Long Island, New York.

MR. JONATHAN MEYERS: I figure I have the easiest presentation to give today because in some way, shape or form, we're all employees, and we know what employees are doing. They're lowering benefits and increasing contributions. Unfortunately it's not quite that simple, and I will start off by touching upon that a little bit—a little bit of plan design and a little bit of employee contributions. But what I'll focus more on are the different aspects of plan management that employers are not trying to get into and then finish by touching upon retiree medical and what the future might hold.

I'll touch briefly on some of the plan design things. As Bryan mentioned, these things don't stop trends; they just put them off. But they do help employers to continue to afford coverage and to provide it to their employees, so it does provide a critical step in the process. Some of the things that are happening include an overall plan design in which they're going away from 100 percent plans and even going to some 90-70 plans and some hybrids. For example, on physician's services, some are going to some split co-pays. The media has put to death somewhat the idea of doing medical management in an effective way. So what some employers are saying is, "Fine, you can have the choice you want, but you'll pay more to go to a specialist." The hope of that is to guide them back to the primary care physician and hopefully to more effective care. The one issue that employers are struggling with is that co-pays give a false impression of what a doctor's visit cost. Everyone's heard the analogy that if every car costs $10,000, I'd get my Lamborghini. This is the same situation. Does a doctor's visit really cost $10? Employees or patients don't understand what the real cost is, so they're not making the proper selection in deciding do I really need to go to the doctor with the sniffles and things along those lines. So there has been the introduction of putting co-insurance on the physician's visit as well.

For hospital services, we're seeing, even in the HMO setting, the reintroduction of deductibles and co-pays. Instead of being covered 100 percent at the hospital, maybe you'll pay a $100 co-pay, even in the HMO setting. The other thing that health plans are introducing for employers is tiered networks. Based on cost theoretically, they're also trying to roll out based on quality. But they're having a little trouble in determining how to factor in the quality part of the equation, so it's primarily done on the cost side of things.

A bigger component of where employers are now attacking—and because the trend is so high—is the pharmacy side. We're starting to see even smaller employers

looking to carve it out or at least take more control of it—they're not the very smallest but maybe some mid-size employers—and saying, "Let me understand what the pharmacy benefit is doing rather than just giving it to my carrier and letting them run with it and getting all the benefits of the rebates and everything else that is available."

We've seen the introduction of the third tier. Interestingly enough, I think employers are starting to learn now—which we've been telling them—is that the third tier doesn't necessarily save them a lot of money. In fact what it actually does is save the pharmacy benefit manager (PBM) a lot of money because it's just guiding the employees and the patients back to their preferred drugs, for which the PBMs get the better rebates, which may or may not be fully passed on to the employers. What's really happening is that if two drugs that are the same price, just because a drug company or PBM is getting better rebates on one of them, it ends up on the second tier. For the employer, the only savings may be the extra co-pay on the third tier. It's just something to be wary of as employers are implementing some of these things.

A similar thing could be said for mail-order incentives. It was thought that employers could save more money through mail order, but the doubling of the co-pay for a 90-day supply doesn't necessarily save that money either. What mail order does do, as employers are cutting back on benefits, is provide higher compliance rates for patients, so hopefully better outcomes, and also lower filled error rates than at the pharmacy. The other thing that's being introduced by employers is co-insurance. They're putting in a minimum co-pay and possibly a maximum co-payment and then a co-insurance over that on the drug. This does a couple of things. Again, this drug does not cost $15; it costs $120,and maybe the generic could be better. The $5, $10 or even $15 differences between generic and brand drugs cause some people to say, "That's OK. I want the brand. That's what my doctor ordered." If the saw the real price of the drug they might say, "Is there a generic," and start asking the right questions.

The other thing co-insurance does for the employers is that we're going through this cycle every year of changing employee benefits and lowering the plan design. Co-insurance allows them to track as the individual drug prices go up without having to actually go in and recommunicate a plan change. It sort of eliminates the year-to-year decrease in benefits, even though it is actually happening. The other thing is that employers are focusing on the drug benefit, and they're trying to decipher what's going on with the PBM. They're saying, "Be more transparent in the pricing for this." If you ever look at a PBM employer contract, they have these rebates promises and discount promises. All the contracts are saying almost the same exact thing; they're just moving the money from one place to the other. They're starting to look at these to understand some of the things, such as the three-tier issue. These two drugs cost the same but because you're getting a better rebate, it costs us more. Those are some of the issues that they're struggling with to understand some of the pricing.

I'll move into contributions now. Obviously there are a lot of things that are going on in plan design, and we could talk all day about that. Beyond just the raised contributions to get employees to pay more and share more in the trend that's going on, which is the obvious, some of the things they're doing involve restructuring the employee/employer cost sharing. Part of this is that non-contributory plans are going away. We work with many unions, and a couple of them are hanging on tooth and nail to that zero-dollar contribution. But even unions are doing away with zero-dollar contributions and starting to introduce shared cost plans.

One thing that they're doing in restructuring the cost sharing is changing how they contribute for an employee versus a dependent or at least being more cognizant of it. If they're saying we'll pay 10 percent or 20 percent for the employee, maybe for the increment for the dependent portion the employees will share 25 percent or 30 percent of that. Part of the reasoning—and I'll touch upon other things that they're doing about that—is the higher-cost families. Is there a way—and quite honestly, I don't know if employers would say this out loud—to get the higher cost families to choose maybe their spouse's plan? Maybe if we charged them more for the dependent increment that will lead to that. Another trend involving affordability on the contribution side is tiering by staff level. Some are doing it by income level. Some people do that by percentage. Executives can afford to pay more of the care, more of the contributions, so make them pay more of the share and maybe make it a little more affordable for the staff-level folks. You're raising contributions; is there a way to more equitably distribute it?

One thing that Bryan touched on is the product positioning, which is that they give employees more choice and maybe say, "Do you want an HMO, or do you want a PPO? If you don't want the plan management and you want the PPO, that's fine. But your contributions will be set at the HMO level, and then you're going to pay the difference." This is making them more cognizant that these HMOs cost less, but you're going to pay more for your choice. I mentioned before, some other things that employers are doing is to get families to move away from their coverage and toward spouses with coverage options. What can we do with contributions there? They're implementing either incentive or penalty methods. If your spouse has coverage, we'll give you an extra $50 a paycheck if you opt into their coverage and out of our coverage." Penalties don't always work that well, but some employers are saying, "If you have spousal coverage and you want ours, you'll pay $50 extra" or something like that. The one big issue there is that you obviously have to get into the honesty issue. Someone has to raise his hand and say, "I have spousal coverage. Charge me an extra $50 for getting your plan." So there are some issues with that. As with anything, the incentives probably work a little bit better.

I want to get into plan management. This is beyond the decreased benefits and increased contributions that we all see out there. The first step in this is communications, and the big part of this is doing benefit statements. We all have benefit statements for our pension plans. We've all been used to the 401k or the

defined benefit, getting the annual statement that says, "This is how much money you have. This is how much benefit you have." Now it's creeping into the health and welfare side and into health plans. It's saying, "Yes, your contribution has gone up 20 percent, maybe from $100 to $120 a month or something like that. But we're still bearing more of the cost. Our cost is still going up $70 or $80 a month, from $600 or $700." It's designed to make people understand that while they're paying $100 and it seems a lot, the company is providing a very valuable benefit. It's making them realize what the cost is.

Another thing is promoting a flexible spending account, which is sort of trying to get a positive message out there. Here the federal government is trying to give you 25 percent or 30 percent or whatever you're tax bracket is. Use it. You spend the money. You get a pair of glasses that are $100. Why don't you want the government to give you $30 back? It's one of the most underutilized benefits that are out there that people don't realize. They just don't pay attention to flexible spending accounts and what's out there. So employers are trying to put the positive message out there that they are providing valuable benefits. They're trying to get flexible spending accounts and trying to make the health care a little bit more affordable as they pass some of the benefit costs on to their employees a little bit more. The other thing that's going on is the introduction of some decisions tools for those who have plan choices to help them understand what the plans cost. If you have an HMO and a PPO plan, some of these decisions tools can allow you to enter how much you are going to use the next year. How many prescription drugs are you going to get? They're making people realize that they are spending the money in their benefit. Make an educated choice as to which plan to decide to take. Also, they're maybe again using the flexible spending accounts and some of the other resources available to make it a little bit more affordable to themselves.

One thing that I'm only going to touch on briefly—there was a session earlier and Bryan touched on this as well—is the consumer-driven health plan. I'll focus on more than the plans. What's interesting to me when I see these plans come out is that a lot of these have already been out there. When you look at consumer-driven health plan with the health reimbursement arrangement model, it's really the old corridor plans with some major medical coverage covering it. It's really a rehashing of an old model under a new name. Some of the things that the consumer-driven health plans have put out there and the consumer-driven health model really are just put out there by the health plans to provide heath care resources. The books that we all received when we got our HMOs are Internet capable now. All of the health plans have it. It's not attached to their consumer-driven health plan but attached to their HMO, their point-of-service plan. It's out there. The real goal is to get people to ask the proper questions. Do I need this service? Do I need this MRI? Do I need this prescription drug? The goal is to get them to start to be more educated and to ask questions of their doctors and challenge them. It's not to say that they should not get the proper care, but at least make sure that they're getting the appropriate care as best they can.

These are some of the variations. The health reimbursement arrangement is obviously probably the best-known. They also have plan design selection, which is that you get to choose your co-pays and possibly co-insurance or whole sets of plan designs. You may have three plans next to each other, and you pick the plan and they're priced appropriately. The other thing out there is provider network selection, where you select your network up front. Again, this has been done. There have been pod systems out there that were thoroughly rejected, so it will be interesting to see, as we let members choose their "pods," if that will work.

Another thing employers are doing is claims review. Health plans have this. Health plans have the 100 percent automated claims audit. Now, we're bringing that to employers to give them better control over their claims. We can provide the errorless thing. We're all actuaries. We all do the statistical sampling, and we know they're very valid. But when you go to a health plan and say, "I tested 400 claims, and I have 2 percent duplicates. Give me my money back." Health plans will look at you and go, okay, we'll give you the $100 on the two claims you found. We can actually say, "Here's the $100,000 worth of duplicate claims. Give me back my money, or explain why there are duplicate claims." It's a much more powerful thing. You don't want to be that contentious, and hopefully you have a good enough rapport with your health plan. But it's much more powerful to be able to drop in their laps, "These are the claims that we think you have issues with. Tell us what you're going to do about them, or give us the money back." This can be used to enhance a statistical sampling or used on its own.

Another thing employers are doing is disease management and the real focus on this is that it can be a win-win situation if properly implemented. Obviously there's a long list of programs that carriers and boutique vendors offer. The real win-win is that the patients themselves get better control of their issue, whether it's diabetes or congestive heart failure or asthma, and hopefully we'll get better outcomes because of that. In the end, hopefully what that will produce for the employers is less cost in the long run. It's sort of win-win communication that you can give. You say to the employees, "Yes, maybe we're cutting back the benefits a little bit, but here's the issue. You have diabetes, and we're giving you a real resource to help control that better. Someone will help you manage that service better and then hopefully, there will be better outcomes because of that."

The one major issue that employers face with this is how to measure return on investments. Everyone has their own measure on return on investment, and obviously the vendors are putting it in the most favorable light for themselves. We try to help the employers determine a better way of measuring a return on investment so that they can understand that if someone has a heart attack this year, the cost for that person next year is probably not going to be as significant to begin with. So the vendor may not be producing that savings as much as it's just a natural occurrence. We try to help them measure that appropriately. For example, is the vendor just catching the employees at the right time as a catastrophic occurrence happens and achieving savings when it naturally doesn't happen again?

Are they counting savings from natural behavioral changes that have nothing to do with what the vendor did? Appropriate measurement only takes credit for what was done by the vendor.

Bryan touched on this a little bit as well. It can be a negative, but it can also be a positive if you're a small employer looking to try and stay in the game, so to speak. Employers are looking for outlets, and association health plans are one way that smaller employees are trying to get into this. It gives the large group advantages, such as maybe separating the PBMs and trying to get their own pharmacy benefits so that they can have more control over it. They're just trying to get some of the advantages that some of the larger employers have but they can't have in a community-rated situation, where they're being rated up. And they're trying to do something about the limited number of plans that they can offer to their employees. The one problem that folks are worried about with this involves some anti-selection issues. Some of these associations are being self-selective. What may happen is that only the very worst-risk small employers are left out of this. This results in their rates being raised yet again and becoming even more unaffordable for those groups that are left out.

Employer coalitions are another issue being raised. This is employers getting together and trying to raise the stakes on both the health plans and the providers to make them more accountable. They say, "Where's the quality, and where's the cost advantage to us?" Some of this is the leapfrog initiative that's out there. In some regions the hospitals are all joining into this leapfrog. In some regions they're just not. So employers are getting together and saying, for example, "We want this hospital to be in this." If all the employers band together, they can have some effect on them.

One thing I'm only going to touch on very briefly and not give its full due is retiree medical. You can have a whole day on this, so please excuse me if I'm only touching upon it briefly. This will be the real big issue with the uninsured, especially with early retirees before Medicare even kicks in, because some of the employers—or actually a lot of the employers—are just saying, "I'm getting out of this game. I can't afford it. My FAS 106 liability, I'm going to have to book for this. It's putting my company under." There are some even larger companies that are looking at this because of that one issue, that this liability that they have to hold for these future retirees is making their balance statements and their income statements and everything look bad. Wall Street just won't accept this retiree liability that you'll owe for a very long time on your financial statement.

I want to touch on a couple of other things dealing with Medicare. What to do with the Medicare coordination? Instead of doing the coordination of benefits, which is sort of filling in the gaps, some employers are going through the carved out method, which is sort of saying, "Let Medicare pay first, and then our $300 or $500 deductible will kick in, instead of having them run concurrently." And so that's sort of their one way for the Medicare population to reduce benefits. Another thing is

putting caps on the employer contribution. "We're staying in the game, but we're only going to contribute this much to your care when you become a retiree, and the retiree will be forced to pay the rest." Again, there will be an affordability issue there as well. Another thing is decreasing the plan design, of course.

I just want to finish up with a couple of ideas of the future and where this may be going. Of course the obvious, the hottest topic with Medicare, is the pharmacy plan. Will there be one? What will it look like? Is it going to help folks? If you've been reading up on this, the American Association of Retired Persons (AARP) is caught in a hard place. They want there to be a benefit, but their fear is that what is implemented will actually end up decreasing benefits to the retirees. Employers will say, "Fine, you have a pharmacy benefit from the government. We're out of this." They end up with less of a benefit because the benefit the government is offering is just not very rich.

Health Reimbursement Arrangements (HRAs) that are attached to consumer-driven health plans are allowed by the tax code to roll over now, tax free, and can be applied to retiree medical. One idea is to have these carry forward, sort of like a retiree medical plan, and say, "This is your premium. If you use it today for medical benefits, you don't get it in the future. But if you keep it, this will go toward your premium when you retire." That's one positive to come out of this. The application of this has been few and far between because there are a lot of issues that haven't been settled about it.

Once the HRA came out and was able to be rolled over, the next logical step is for the flexible spending account to be allowed to roll over. Employers are rolling over these funds on their own. Eventually that's going to become an affordability issue for them, and what's the next step? Let the employees do it. Let the employees contribute the money, and let the employees roll over their accounts. I kind of make an analogy to the defined benefit (DB) plan going to a 401k plan. Let the employees pay the money. Let them take it out of their paychecks. They may end up pushing the government to roll these things over. For consumer-directed health plans (CDHPs), instead of covering the first dollar, which could become expensive, why not cover the corridor?

Again, this is just a rehashing some old things. What was old will be new again, as I find when I look at consumer-driven health plans and some of those things. They're really new names on old versions. That' s not to say that there haven't been improvements made over the years. The demise of HMOs, I think, is a little exaggerated. I think a lot of employers still have them. We may see—obviously, not in its old form—managed care make a comeback in some way, shape or form with a completely different name, because the media has taken that name and beaten it to death. These things seem to be very cyclical and are going full circle. We're back to high-deductible PPO or indemnity plans, but they're now called consumer-driven health plans.

MR. AXENE: Our next speaker is Tom Handley, who's a vice president and consulting actuary at Lewis & Ellis, also based out of Kansas City.

MR. THOMAS L. HANDLEY: It's interesting: The particular topic I get, health care affordability and the provider's perspective, is kind of like an oxymoron. Typically when you look at the provider—the physician and the hospital—the one thing they're trying to do is increase their revenue, which kind of runs against what employers are trying to do with their health plans or what even the consumer out there is saying. This is an expensive commodity, and it's running contrary to what we're trying to talk about today. I was the last one that David recruited, so I guess I got this particular topic. It took me a little while to figure out how I would approach this. Certainly one thing that helped me is I work with all the different clients. I work with health plans and employers and providers, so I could approach it from trying to put these different perspectives together.

I want to talk about some of the key issues that are facing providers. Some of these may be things that will not make health care more affordable. But for those of us as actuaries and for most of us in this room, our clients or our employers are health plans. Some of us do consult with providers, but I'm willing to guess the bulk of us probably don't have providers as clients. What are some of these key issues? There will be pressures on reimbursement. The pressure on the provider will be trying to force reimbursements down. Providers have been dealing with limitations on treatments. They've had a third party looking over their shoulder for quite a few years, and I don't think they've been real happy about it. The malpractice situation is an issue. I've been doing this business for more than 30 years, and this is about the fourth time that I think malpractice has come up as an issue and a problem. Another issue is sickness versus health. I think we all recognize that for physicians in particular, their training is to treat sick people, not to help people maintain their health. As I mentioned, none of these things will lower costs.

Let's take a look at what they're dealing with from their perspective. I sent a survey to providers who are clients or at least friends of the firm just to try and capture their perspective. I asked them certain questions and wanted to get their feedback on issues related to some of these key issues. The first issue I'll talk about is physician reimbursement. Physicians for the most part, I think, are reimbursed by health plans probably as a percentage of resource-based relative value schedule (RBRVS). When I sent that survey I asked them, how are you paid? Is it a discount off of billed charges, or it is some fixed rate? Generally, I think 75 percent of them said that they were compensated primarily using an RBRVS or some kind of fixed rate schedule. I talked to them about capitation, and I asked them how they prefer to be compensated. Is it fee-for-service or capitation or what methodology? The answer I got on this one was not a surprise—100 percent of them preferred to be compensated on a fee-for-service basis. What did surprise me in that survey is that 50 percent of them said that capitation does work as a reimbursement methodology. That really surprised me because we've seen that capitation was a pretty common and popular methodology of reimbursement for physicians through

the mid-'90s but then it kind of disappeared from the landscape. There are a few pockets. I think it's still done on the West Coast quite a bit. In the Midwest, where most of my clients are, we don't see very much capitation, except for maybe the primary care guys.

Medicare and Medicaid put pressure on the physicians to lower reimbursement. We all know what's happened to RBRVS and its conversion factor. How have the physicians reacted? I asked, "Are you dropping from plans? Are you not accepting new patients?" About 25 percent of them responded that they are dropping from plans. They're not getting enough money, so they're dropping out. Twenty-five percent of them said they're not accepting new patients. From our perspective as actuaries, maybe that will help make things more affordable. If you are successful in maintaining some kind of a network at a lower or more competitive reimbursement level, you have a more affordable product. But then we deal with the issue of access, which was the dominant theme through the late '90s. Everybody wanted their doctor and their hospital in their network, and as we pushed that on reimbursement that's not going to happen.

Another interesting issue that I've had to deal with as a consultant is that I've been hired by a couple of different provider groups to survey the market, comparing what they are paid in their area with what doctors in another area are paid. Their feeling was, "We get paid less for an office visit or providing this X-ray or procedure." If you're familiar with Midwest geography, those docs in Kansas City tell us that they were paid less then the doctors in Springfield or Topeka or Wichita—smaller communities outside of the Kansas City metropolitan area. When we completed that survey, that was indeed the case. If a doctor performed a procedure in Kansas City, he was paid less money than the doctor doing the same procedure in Wichita. There's quite a wide variation, as we did this survey, in terms of what doctors will be paid in different parts of the country. It's pretty surprising how broad that range is. We found it ranging as much as 40 percent.

Another provider group asked us to do the second piece of that survey. They said, "We know Kansas City doctors are paid less for the procedures, but what does that mean in terms of the overall costs of physicians in Kansas City?" When we did the second piece of it, we realized that Kansas City physicians performed more procedures. Therefore, the actual dollars going out the door to physicians in Kansas City were greater than they were in Wichita, Topeka and Springfield. So they compensated for lower reimbursements by doing more procedures.

Let's look at the hospital side of things. Again, some of the issues we looked at from a hospital standpoint were how are they reimbursed? What's the contract length? We look at carveouts in contractual agreements. When we surveyed the hospitals, for the most part they are seeking to get increases in reimbursement. I think through the latter part of the '90s, maybe into 2000, their reimbursement levels were pretty flat. But then they started to exert a lot of pressure and influence and so suddenly started to get increases in their reimbursement rates. So that

definitely has been a factor. One of the questions we asked in the survey was the length of contract—are they just one-year, two-year or three-year contracts? Fifty percent of them indicated that the contracts were two years or longer, that they were negotiating longer-term contracts. Seventy-five percent of them said that the reimbursement was on some kind of fixed-rate basis, be it a diagnosis-related group (DRG) basis or a per diem basis or something along that line.

One of the other questions I asked involved some of the benefit changes that have taken place, with higher co-pays and much greater deductibles—the $500 and $1,000 deductibles. I asked them what kind of impact that had on their accounts receivable, and what type of impact that had on their write-offs. For the most part, they did indicate that their write-offs—the proportion of the services that they were writing off—were going up. So with regards to that $500 or $1,000 deductible, your member may not actually be having to pay that full deductible amount because the hospitals are writing that off.

One of the other issues we talked about is the treatment pattern. Certainly one of the comments that I get on a regular basis as I talk to physicians and work with them is that the patients, because of the Internet, have become a lot more knowledgeable and educated about their symptoms and different ways and methodologies to treat these symptoms. Many times, they'll look at what's bothering them and go on the Internet. They'll do a little research and come up with the disease. This is very frustrating for physicians, which probably doesn't surprise you. It's kind of like the marketing people coming in and telling us what rates we need to charge.

This has had an impact on how they have treated their patients. There has been a lot of pressure that the patients have put on them to provide certain kinds of treatment. Probably for the most part, they've come in demanding certain kind of drugs. I want to take the new $90, $100 or $120 drug. That's a lot of the situation that they're being faced with. Keep in mind again, this is not doing anything in terms of helping us with the affordability issue. We have patients who are complaining about health care not being affordable going into physicians demanding that they get a particular drug, and the physicians are prescribing it. They will try and talk them out of it, but if they don't agree to that, the patient will go to another doctor, incur another office visit charge, and they will find a doctor who will prescribe that drug for them. That does indeed happen. So again, that's another situation that is making it difficult for us to assess and try to deal with the affordability problems.

Another response that I came across in the survey resulted when I asked them, "Are the patients really sometimes questioning the treatment that you're trying to do?" Fifty percent of them did respond and indicate that yes, indeed, patients are coming in and questioning some of things that they're doing. They questioned whether that's relevant, or maybe the physician wanted to do some type of a

management approach to an orthopedic problem, and the patient came in and wanted the surgery. So you have issues like that coming into play. One of the things that we asked the physicians in terms of treatment was how effective has our managed care, our preauthorization of certain items been, whether it's hospital days or surgery. Seventy-five percent of them said that requested treatment was usually approved by the carrier. If it wasn't approved the first time, it was approved the second time—so much for our oversight.

Let's talk a little about utilization of services. Table 1 contains data that I've captured from HMO financial statements from 1995 through 2001, and you can see it's been steadily increasing. It may jump up and down a bit from region to region, but for the most part it's going up. One of the questions I asked in the survey was, what is malpractice doing to you? I asked, first of all, whether it was available and affordable and then, is it having an impact on what you're doing? As far as malpractice having an impact, 75 percent of them are ordering more diagnostic tests because of malpractice and malpractice concerns. So that is certainly one of the factors in this physician business area. So if there's something we can do as an industry or as a profession in terms of addressing the malpractice situation and issue, that may be something we want to give some thought to. But that is having a cost effect. Again, this is something that's been going off and on in the 30 years I've been doing this. I can think of at least four or five times that we've had to deal with this malpractice issue; it's come back again.

Table 1

HMO Data by Region

	Average of Physician Visits per 1000						
Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
1	**8,575**	**8,334**	**9,144**	**9,218**	**9,724**	**10,172**	**10,507**
2	**7,525**	**7,668**	**8,633**	**8,895**	**9,433**	**9,809**	**10,227**
3	**8,017**	**8,359**	**8,739**	**8,918**	**9,598**	**9,745**	**9,789**
4	**8,108**	**8,819**	**8,654**	**9,205**	**8,844**	**9,028**	**9,363**
5	**9,935**	**9,573**	**10,470**	**8,976**	**10,224**	**10,593**	**10,689**
6	**8,503**	**8,960**	**8,735**	**8,632**	**9,473**	**9,317**	**9,381**
7	**7,261**	**7,995**	**8,237**	**8,825**	**8,986**	**9,346**	**9,658**
8	**8,699**	**9,099**	**9,583**	**9,301**	**9,290**	**9,970**	**10,053**
9	**7,578**	**7,450**	**8,265**	**8,206**	**8,436**	**8,604**	**10,136**
All Regions	**8,128**	**8,419**	**8,864**	**8,930**	**9,276**	**9,553**	**9,911**

Source: HMO Financial Statements

In Table 2, if you look across at all the regions, you'll see that the days per 1,000 have kind of flattened out. It hasn't been decreasing. It decreased nicely through the mid-'90s, but we've been able to identify that it just kind of flattened out. So some of the savings that we used to see from a pricing standpoint are not there now. We had services going up on the physician's side, but inpatient days used to go down enough that we could keep the premium rates down. That hasn't happened. That's not occurring anymore. We've hit the bottom, unless we can get everybody to practice medicine like they do in California. I don't think you'll find too many doctors who are willing to do some of the things they do in California, nor do they have some of the other capabilities that they do out in California in terms of triage, et cetera.

Table 2

More Data by Region

Commercial days per 1000							
Region	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
1	**262**	**243**	**252**	**245**	**238**	**259**	**251**
2	**309**	**295**	**291**	**269**	**270**	**287**	**294**
3	**244**	**231**	**232**	**225**	**226**	**234**	**235**
4	**283**	**265**	**261**	**251**	**250**	**248**	**246**
5	**250**	**239**	**231**	**235**	**232**	**234**	**249**
6	**250**	**243**	**250**	**244**	**252**	**266**	**279**
7	**260**	**238**	**246**	**243**	**252**	**248**	**243**
8	**217**	**214**	**205**	**221**	**215**	**225**	**233**
9	**203**	**202**	**192**	**207**	**197**	**198**	**205**
Grand Total	**258**	**245**	**242**	**239**	**238**	**246**	**245**

Source: HMO Financial Statements

Whether we're an employer or an insurance company or a Blue plan or an HMO, we always need to remember that providers are paid for services, and the more they do, the more money they are paid. I guess one of the questions we need to give thought to is how do we change this incentive? Do we go back to capitation? I think Jonathan talked about what is old is now going to be new. Again, what's surprising in the survey that I sent out is that 50 percent of them said capitation can work—and these responses are from guys who've been under capitation and were no longer in capitation. But they did tell me, "Yes, it can work. We can make it work. If you put us back on that, we can make it work."

Another issue to address—and this comes under health versus sickness—is, how effective can a physician be in changing the lifestyle? Can they get their patient to stop smoking? Can they get their patients to lose weight? In the survey that I sent out, the physicians responded, "Whenever we have a smoking patient come in or an overweight patient, we certainly remind them that they should stop smoking, and we remind them they need to lose weight. But I make more money if they stay overweight. I make more money if they smoke." That signal came to us loud and clear. Maybe this is something that we as a profession should address since we work with the health plans and the employers. What can we do to encourage that physician to get more involved in the health of their patient as opposed to the sickness of their patient? Are there some designs we can put into place to encourage the doctor to be more concerned with a better lifestyle, a healthier lifestyle, of their patient rather than treating somebody who's sick? I used to be married to a dentist, and she loved to have a new mouth come in. That meant,

"Look at all the crowns and everything I get to do for this person because of that last dentist they had." It's the same thing with physicians. "Bring me your overweight. Bring me your smokers. I'll make a lot of money."

MR. AXENE: Thank you, Tom. We want to turn this into a productive session, so we'll now talk a little bit about an action plan. So we'll try, anyway, for your own better health. What can we or are we, as actuaries, doing about this affordability problem? What can we do? Do we continue to sit here on our collective insulated shells, or do we step up and take the challenge to craft a solution? Do enough people care about our opinions, and what two things can you do to help?

I think that we, as actuaries, often are representing the interests of our employers, and sometimes in those employer settings, we don't get to do anything related to affordability, other than to make sure those premiums are adequate or whatever. Seriously, what can we do? We've heard the different perspectives from the employer, from the provider and from other health plans, but what can we do to actually try to improve the affordability situation? So we're going to try something a little unique here. The only people who can come to the microphone for the next few minutes are those who want to voice what either they think they can do or we as an actuarial body can do.

MR. ROBERT E. COHEN: The first thing that we can do is give employees a greater vested interest in their health care costs. I think everyone has said that in some way, shape or form. I think one of the ways in which we do that is with co-insurances rather than co-payments.

MR. AXENE: Very good. Anybody else have an idea that they want to share?

MR. ED BUTLER: Life insurance has both smoker and non-smoker rates, and they do have rates that will vary by fat content because they do a physical. I don't know if there's anything wrong with health insurance or employee contributions being calculated based on those same variables.

MR. JOHN P. COOKSON: If you look at the history of health care back in the 1930s and what people paid for cost as a percentage of gross domestic product (GDP), direct payments to providers in the late '30s were about 3 percent of GDP. By the late '90s and 2000, it was down to about 2 percent of GDP. We all know what's happened to the total health care component of GDP; it's up about 14 percent. So basically, all of the growth in the GDP over the last 60 years has been through third-party payments. So I think you need to start looking at some of the components within health care and what we're paying for it and what perhaps, we shouldn't be paying for or shouldn't be paying for at a very high premium.

There's a lot of care being delivered that's not evidence-based. It's "guesstimated." It's, "Let's try this. Let's try that." I think as actuaries, we need to start measuring and quantifying those things. We need to identify what is efficacious care and

should be paid for at a high level and perhaps what is not efficacious care—where there's no demonstrated viability or no demonstrated performance of the care—and substantially cut back the amount that third parties are willing to pay toward that care. We need to make individuals much more responsible for those components of what's being delivered. We also need to quantify errors and other things that cause health care to increase and identify the providers that are more responsible for those kinds of errors. I think those are a couple things that this profession can do and can contribute.

FROM THE FLOOR: One of the things that is causing the affordability problem is aging. Whenever we look at an employer, for example, it's a very small number of people with very big claims who are driving the cost in that particular year. Getting at what are the risks that are causing people to have big claims is something that I think we can help with. But I wanted to address not the last speaker, but the speaker before. He said, maybe we can have smoker and non-smoker rates or charge based on health condition. The insurance industry can do that, but employers really can't do that because we can't discriminate on the basis of health. But we can discriminate on the basis of behavior. We can say, "We'll have smoker and non-smoker rates, and if you can't quite smoking, I guess I have to charge you the non-smoker rates." Or we can say, "If you are overweight, I have to have you go through a weight reduction program. If you don't, then I can charge you higher rates. But if you go through it and you can't lose weight, then I guess I have to charge you the standard rate." Employers aren't doing that today, but maybe that's the way to incent behaviors.

MR. AXENE: Any other suggestions? There are a couple I was going to mention. Those who know me know I come out of the managed care family, so I have to say something about the values of managed care. We recently finished a project for a company that had essentially eliminated their utilization management functions within their organizations. They were a little bit concerned about the competitiveness of their premium rates and their experience, so they had us compare it to eight or nine of their competitors in a particular market area. They found that there was between a $20 and $25 differential for the same plan design—that's on a per member, per month (PM/PM) basis—between the "cheapest," lowest-priced health plan in that market to the highest, which happened to be them in that marketplace. Let's say in roughly $200 PM/PMs, there was a $20 to $25 difference between the players in a community. I don't know about you, but I think a $25 difference is material on $200 PM/PMs.

Ironically, the annual inflation rates in those particular communities that had the lower PM/PMs were anywhere between 4 percent and 6 percent less per year. Going a little bit further into the analysis, we found out that the ones that had the lowest PM/PM with the lowest trend were the most managed and were doing the most to continue to manage the care. The health plan that we were dealing with thought that everybody had stopped managing care, and they found out that maybe they were the market leader and the one who had stopped the most.

I have predicted the pendulum would swing back for quite some time and was suggesting that in some cases, maybe the pendulum never swung because these people were still doing what they had done for many years. But then in September, a major national health plan announced that it had reinstituted seven-day-a-week, 24-hour-a-day nurse case management. I thought that was a rather shocking event to suggest that maybe the pendulum is coming back. I agree with whoever it was earlier who said that we can't call it managed care anymore, but I do think that that's one area where we have seen dramatic savings in the past. Yes, we've had political pushbacks, and it isn't the most popular thing to talk about, even in actuarial circles and especially with the Harvard people telling us that there is no opportunity for further managed care savings. But I think that the pendulum is coming back. So one area of affordability that I think we can do is to take another look at what has worked reasonably well in the past for several organizations.

Another creative cost savings tool has been labeled the "Wal-Mart Effect." I learned quite recently in dealing with one of my clients that part of their hiring screening process is that there's a much higher chance that you'll get hired if you are covered by your spouse's health coverage. They will also hire you on a part-time basis more frequently, so that they can avoid giving you benefits. Now, if you compare a store like Wal-Mart to another store that perhaps is offering full and rich benefits, you'll find that perhaps there's a difference in price. Others are trying to mimic the Wal-Mart effect, and we're seeing that.

On a recent business trip, I flipped on the news and heard about a new cost containment measure. If I recall correctly, this was implemented in Illinois. It's called "pill splitting." I had frankly never heard of it until very recently, and I think it's a pretty neat deal. Legality varies in different states. Let's say that you have a medication that you're taking that you need a 100 milligram tablet. The cost of the drug is about $100. If they manufacture a 200 milligram drug of the same version, it'll probably only cost 10 or 15 percent more. So, if you get a prescription for the larger one and cut the silly pills in half, called pill splitting, not only does it not cost any more to speak of, not materially, it lasts for twice as long.

Think of the cost containment of pill splitting. I'm not recommending this if it's illegal. However, the co-pay stays the same, so the employers benefit for twice as long. The health plan wins because it didn't have to pay twice as much. For the general public, there are little tools that you can get to put the pill in and pop it down and it works just fine. Overall, pill splitting is something new that I was unaware of and found out that it actually is a true health care affordability issue. This was being encouraged in Illinois, I believe, by the governor for the Medicaid program. They were trying to help balance the budget for Medicaid by doing pill splitting. Basically, it's something that is very crude, something very simple, but it's actually being explored in some markets.

MS. KARIN M. SWENSON-MOORE: I have two comments. First of all, on the pill splitting issue, there are some people in the pharmaceutical industry who tried to

say that is a big quality concern there. However, there are certain pills that can be split, and pharmacists are also often willing to do that for their patients. So I think that's one of the issues that people are working on. But I did have a question because I felt like the presentation about providers seemed to give the impression that providers are really not thinking they're part of the problem or the solution. In your surveys, did they feel like they were part of the problem or the solution? What are they offering as solutions?

MR. HANDLEY: They didn't necessarily offer anything as a solution. I don't think, at least if you talk to the physicians, that they think they are part of the problem. They will tell you to a man or woman that it's those health plans out there. Again, I think their frustration is with patients coming in who have done research and say, "This is how I want to be treated. I think I've got this." They say, "Wait a minute. Your research is great, but let me examine you and do what I need to do. I'm the one who's got a lot more education than you do, and we'll see if we can come up with an appropriate treatment plan for you." So that's been very frustrating for them. They're frustrated, and they don't like managed care because they don't like people looking over their shoulders. Even though they've been able to work around that and deal within that system, they are very frustrated. That's why maybe the return to capitation, at least in some areas, may work. That gets them on the same page where their pocketbook is affected. The ones that I worked with in a capitation environment addressed all affordability issues. They did what needed to be done to maintain the health care costs within that revenue limit that they had.

MS. SWENSON-MOORE: I'm just curious whether if that's really the case, if they're going to start being capitated for their outpatient surgery centers and their lab and X-ray and some of the things that they found a way to get around that.

MR. HANDLEY: That's another issue. I know a lot of health plans that have addressed by saying, "You're in our network, but your surgery center is not." I know a lot of employees who went to the doctor, got the surgery and suddenly found out that surgery center was out of network.

MS. JANET M. CARSTENS: I did want to echo John Cookson's comments. One thing that the health section and the health practice area did this year was to get together and try to identify some key issues. One of the key issues that we came up with was health care variability and measurement of that variability. I do think anything that we can do as actuaries to maybe draw public attention to the variability and help to measure it would probably go a long way.

MR. KERRY P. HINDSLEY: Tom Handley, you had a bullet on outpatient prospective payment system, and you mentioned the impact of outpatient APC, but I don't think you expanded on what the impact was. Can you just go into some detail on what the impact was?

MR. HANDLEY: I didn't get very good responses to that on my survey. On the APC

question, there weren't enough responses to bring that up.

MR. AXENE: Kara, we'll let you be the last person.

MS. KARA L. CLARK: This is really just a comment. I'm a staff fellow at the Society of Actuaries supporting the health practice area. I wanted to let you all know about a recent initiative from the Society of Actuaries. We've issued a call for papers looking at the cost of fragmented care, particularly in light of chronic condition management relative to the current focus on acute conditions. It's really an open call for papers. We're trying to take a fresh look at the issue of how financial incentives can be designed, including the issues of providers dropping out of networks, people dropping from an insured to an uninsured state or moving from public to private, and how that cost of fragmented care is really contributing to the affordability issue. That call for papers is on the Web site. We hope that we will be able to promote it not only with the actuarial community, but also with other disciplines that are related to these same issues, and we plan to sponsor a multidisciplinary symposium sometime in 2004.

I think one of the things the actuarial profession can do in light of some of these issues is to be more external in our focus. We should talk not only to each other, but also to other related disciplines about some of these issues and engage in a multidisciplinary perspective.