

RECORD, Volume 27, No. 1*

Dallas Spring Meeting
May 30–June 1, 2001

Session 121 OF Consumerism and Consumer Choice—Implications for Health Plans

Track: Health

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Panelists:
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DAVID F. OGDEN
DAVID MARK TUOMALA

Summary: The consumer is king! Consumers are exercising authority in the marketplace and through elected officials to get what they want from their health plans. Employers are looking to move more responsibility for health plan costs and decisions to the consumers through consumer choice plans. The session covers strategies and products health plans are developing to address these issues.

MR. WILLIAM M. SNEDEN: I'm from Sageo, which is a Hewitt business. It was created in the last few years. I'm based out of San Francisco. Our panelists today are David Tuomala from Definity Health in Minneapolis, Ryan Levin from Destiny Health in Chicago, and Dave Ogden from Milliman & Robertson in Milwaukee.

I'm going to start off by discussing why consumerism has risen a little closer to the forefront in the minds of employers and product designers in the health care industry, and then we will talk about how that affects actuaries. In the beginning of 2000, the Institute for the Future made some projections about the future of health care.

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Table 1

Institute for the Future Projections for 2010

STORMY WEATHER	THE LONG AND WINDING ROAD	THE SUNNY SIDE OF THE STREET
Health Care Spending Growth 2.5% per year above nominal GDP growth	Health Care Spending Growth 1 to 2% per year above nominal GDP growth	Health Care Spending Growth 1% per year above nominal GDP growth
Health Care Spending 19% of GDP, \$10,200 per capita	Health Care Spending 16% of GDP, \$8,600 per capita	Health Care Spending 15% of GDP, \$8,100 per capita
Uninsurance Rate 65 million uninsured, 22% of population	Uninsurance Rate 47 million uninsured, 16% of population	Uninsurance Rate 30 million uninsured, 10% of population
“None of the fundamental problems of cost, quality, or access are addressed in a meaningful way”	“Incrementalism reigns”	“Competition helps drive excess capacity out of the system”

It projected out to the year 2010 under three different assumption scenarios, (Table 1) and the results were a little bit disturbing. On the extreme end, in the “Stormy Weather” scenario, the health care spending growth was 2.5 percent above nominal GDP growth; health care spending was actually 19 percent of gross domestic product, \$10,000 per capita, and an uninsurance rate of 65 million—22 percent of the population. The quote that went with that was, “None of the fundamental problems of cost, quality, or access are addressed in a meaningful way.” That’s obviously not a very bright picture.

The middle projection was called “The Long and Winding Road.” The rosiest projection, “The Sunny Side of the Street” scenario, said that health care spending growth is actually only going to be one percent a year above the nominal GDP growth, and spending would only be 15 percent of GDP, \$8,100 per capita, an uninsurance rate of 30 million—10 percent of the population. Those numbers actually aren’t great, but they’re certainly much better than the worst-case scenario. The quote that came with that was, “Competition helps drive excess capacity out of the system.” If the scenario is going to come true, that competition is largely going to come from consumerism, turning the current patient environment into one of more active consumerism.

The fundamental problem is the lack of consumer information on coverage, providers, treatment alternatives, and costs, which are necessary in a rational, interactive model. Where that condition exists, it leads to dissatisfied consumers and providers, a big social problem, and related legislative issues. We’re not talking about this from an actuarial perspective; we’re talking about it from the standpoint of how the health care system dynamics work. Simple economics says it is very, very difficult to have an efficient economic market if you don’t have an active, engaged consumer.

When we talk about health insurance, I'm going to propose that there could be a few different potential paths that the insurance system could follow. One is to maintain the current course, the current system, of short-term cost control where employers and health plans continue to battle and look for marginal underwriting gains against each other. The prospect of turning to the left in this case, the single-payer system, is certainly a possibility if costs and dissatisfaction continue to spiral out of control. I'm going to propose that there is a third alternative, one that focuses more on consumer-driven alternatives—bringing in the consumer to play an active role in the cost control and the actual delivery of health care.

First, let's talk about the connection between consumerism and defined contribution (DC) health care. Think about the evolution of today's current flexible benefit system all the way out to a pure defined contribution compensation system, and what some of the barriers are for reaching a system like that. Clearly we know there are past issues; clearly we know that there are insurance issues, underwriting issues, risk assessments; but there's also an issue of preparing the individual to be a consumer.

In today's world, the employer really serves as the decision-maker for the employee in a lot of ways, and the doctor serves as a decision-maker for the patient, so the individual isn't really taking the role of an active consumer in the system. The evolution to reach DC probably needs to include a pretty heavy emphasis on driving consumerism into the system. This includes preparing individuals, step by step, to potentially start taking on more of an active role in making decisions about what plans to enroll in and what providers to seek out.

In that context, if we think about different ways that someone could be a consumer in the current health care system, over time we do have the opportunity to introduce consumerism step by step. Closer to home, we are at a point today where we can help employees make smarter decisions about the plans they choose, using administrative systems that provide common data, standard platforms, and selection tools to help people make those decisions. Now, that's not necessarily a good thing from an actuary's perspective because an informed consumer—Dave, I'm going to steal your quote; what was your quote?

MR. DAVID MARK TUOMALA: Adverse selection is the annoying tendency of people to do what's best for themselves.

MR. SNEDEN: I hate that, but it is one step that needs to be part of the process of engaging individuals into being smarter consumers. If you take that out a little further over time, you can engage enrollees in plans to be better consumers making better choices. This includes giving them choices about what providers they go to, having an open network for all providers that are available to them, and providing data and tools to help them understand the differences between providers—not just in price, but in quality, outcomes, access, etc. If you want to go even further, you can use the idea of personalized content for individuals to help them get more information on treatment alternatives and to help them make

decisions about which alternatives to pursue for certain conditions or certain situations. Going even further, we get to the point where it could potentially be a truly shared medical decision between a provider and an individual. If we reach the point where there really is buy-in from both sides, I think that we've got an active consumer, we've got an active provider, and we've got a situation where potentially we can start modifying behaviors and controlling costs and utilization through that process.

With that as a background, we're going to look to our panelists to talk about consumerism. Dave and Ryan both represent the viewpoints of emerging health plans in the U.S. market that are focused on driving consumerism rather than on tightly managing care. Then Dave Ogden will speak. He does a lot of consulting with providers and plans on a variety of topics and that includes a lot of consumer-driven concepts.

MR. TUOMALA: I'm with Definity Health, a company that's involved in developing consumer-driven health care. We believe that the important concept is the consumer-driven portion of it as opposed to either e-health or defined contribution.

Our company's viewpoint on the health care system is that big changes are actually needed. That isn't as simple as doing managed care a little bit more effectively or tweaking it a little bit. We're really looking at making some serious changes to the way that health care is delivered. We like to describe it as building a better health care experience, and we're really thinking about fundamental changes to the way that that's done.

Our company was founded in 1998, and our headquarters is in Minneapolis. The founders of the company were a couple of consultants from Deloitte, who had worked a lot with mergers and acquisitions in the health care arena. Although they had done a lot of rearranging of the pieces of the health care system, created bigger companies, and had a lot of money change hands, at the end of the day, they really hadn't made any fundamental changes. Basically, you've changed who the players are, but everything else is really the same. That led to the founding of this company. We do have some pretty significant financial backing. One of the things to point out about us is that when we did go out looking for funding, we really looked for long-term partnerships. We wanted people who were industrious, that were interested in the long haul, and who realized that this isn't something that's going to change overnight. I think every one of the investors in the company is very committed to the long-term success.

We have three employer groups currently enrolled, and starting January 1, 2001, we had about 5,400 members. Our current market focus is largely self-funded clients, primarily for ease of entry into the market. You don't need to worry about insurance licenses and things like that, and also from a sales perspective you get a little bit more bang for your marketing dollar in that case.

There are three main constituents in today's health care system: employers, employee/patients, and providers. Our viewpoint is that none of them are really very satisfied with the way things are going. The employers are seeing their plan

costs increase substantially. Even though employers are spending more and more money for health care, employees are not necessarily thanking them for that. Employees and patients have incentives to consume. They don't necessarily like the restrictions of managed care. I think with the Baby Boom generation, with the Internet, with a lot of other things, people are interested in having more control in a lot of areas of their lives, and health care is one of them. Of course, providers are not necessarily happy with the system as it is today either.

Health care doesn't cost \$10, but in today's system, that's what the consumer sees if the consumer has a \$10-per-visit co-pay. There's an insulation on the patient's side from what the true cost of the care is. Patients and providers, aside from self-interest, don't have a lot of incentive to discuss the cost of services. Whether one service costs more than another does—the consumer is not paying for it. The consumer is paying a nominal cost up front to access that care. What it boils right down to is that it's other people's money—you have the ability to spend somebody else's money. That's where the system kind of breaks down a little bit.

I've come up with a simple example. I use a membership club like Sam's Club, or Costco, whatever kind of warehouse discount retailer you may have. It's kind of a good paradigm for the health care system and how it works today. You have to be a member to access it. The difference is that at Sam's Club you don't pay \$10 at the door and then fill your cart with whatever you want and then walk out. It just doesn't work that way. If you think about it, that is kind of how the health care system works. I pay my \$10 at the door; I don't really care how much the services I get cost. I can try to capitate Sam's Club and say, "I'm going to pay you \$1,000 per member and you can provide all these services," but frankly that doesn't work either, and it's pretty obvious why that doesn't work. I can have people walking around the store saying, "Don't pick up that." But I'm still in there demanding the big screen TV when I could get by with a 19" black and white. The consumer is the one who has the ability to control utilization of health care and to make the right kinds of choices. We actually think that bringing the consumer more into the decision may, in fact, reduce costs in the long term and balance supply and demand.

As we talk about this, we want to make sure that we address things that are and aren't working. You don't want to throw the baby out with the bath water because a lot of the things in the system actually do work pretty well. One of the things that we're really pretty serious about is that the employer function in today's market adds a lot of value to the system—particularly group purchasing and risk pooling. The group-sponsored market for those particular pieces is a lot more efficient, generally speaking, than the individual market. The employer performing an agency function is something that adds some value and particularly innovation of medical services. I think this country has done a very good job of innovating medical services, and by and large most people are pretty satisfied with that aspect of the medical environment. Some of the things are broken though—hyperinflation of employer-sponsored benefits, limited consumer incentives, price/quality trade-offs, and population-based disease management as opposed to individual-based.

What we think will happen though with consumer-driven health care is that it will provide some incentive for providers to create a market for health care where providers are interested in competing. In today's environment, providers compete for volume in a sense, but, generally speaking, a provider gets paid the same amount whether they're a good or bad provider. Really, there isn't much market for this happening with respect to anything other than volume.

Another important development is Web-based health care services. In fact, one of the most popular uses of the Internet is for people to look up health information. We think that Web-based health care services can play an important role. We can provide some financial incentives for employees, reduce employer fatigue, and we think fundamentally you get some increased employee satisfaction. We really want the employee to understand the value of the health care service that's being provided to them through their employer.

We want to change the employee from a passive participant to more of an active consumer; the employer from the primary purchaser to more of a financial contributor; the health plan carrier to an enabler, and the provider from a victim to more of a care manager.

Chart 1 is an interesting graphic. There's low to high employee control, and fully employer funded on the bottom to shared contribution on the top. We see the defined contribution market as being more on that left quadrant there, which has lower employee control. They certainly have more control on the front end of it, but as a day-to-day consumer of health care, you basically get to be a consumer one time a year, strictly in this model. We see consumer-driven health care as being more of a shared contribution strategy with high employee control. Its lower quadrant managed care on steroids as opposed to viewing the health care market as—let's do more managed care; let's do it a little bit differently, but let's keep the market kind of the same way as it is today. Of course, the indemnity quadrant has largely been abandoned by the market. So we're really trying to drive towards the upper right quadrant, with high employee control and shared contribution.

What is our plan design? We like to think about it as a next-generation health benefit solution. We want to manage costs by educating consumers. Give members powerful information tools and responsibility—that's probably the key point. We want people to be responsible for their health care decisions in a much greater sense than they are today. We think some components of our plan design are actually a good retention tool and some of the clients that we worked with feel the same way about it.

Our plan design really has three components. First, we have the personal care account, which is basically an up-front funded account. The employer puts some money aside to pay for discretionary health care services. Second, we have health coverage, a component of it, which has a high deductible or annual deductible. We pay for preventive care alongside that at 100 percent. And third, we have a component with Web-based, phone-based care management and health tools where people can access it to find out a lot of information. They can check on the

amount of money that they're spending on services, find out costs of different providers, look at different prescription drugs, options, and other things like that. We don't think that any of these three components necessarily have to be linked together, but we believe that putting all three of them together makes the whole system more effective.

As I said, we have a health care risk component. Today we're just in the health funded market, so that's like any other self-funded, high-deductible health insurance plan. It provides a safety net. We have a preferred provider network, basically a rental PPO. No referrals, and preventive care is provided at 100 percent in network. Basically, we didn't want to create a disincentive for people to get preventive care, but basically that component of it is just like any other PPO plan. We have a personal care account—the employer allocates benefit dollars to it and that's purely member-directed. Basically, they can spend that on anything that they want. The employer defines the scope of it to be anything that fits under the 213(d) umbrella, which is essentially anything under the tax code that's a qualified health benefit or eligible to be deducted by either the individual or the employer. A key feature of it is that the unused benefit dollars can roll over at year-end. That's one of the things that we feel very strongly about. The ability to roll those dollars over creates a better incentive for people to be a better consumer with those dollars, particularly when you limit their use to only health care services. They can't actually cash out that money and use it for something else.

Health tools and resources are also something that we're proud of. We spent a lot of resources on developing interactive tools so people can really think about it as an online brokerage kind of capability where you can look at a lot of the information about your claims, you can look at explanation of benefits online, you can determine how much a service costs, and you can look at different providers. In fact, we even have the capability to get driving directions to the provider. We spent a lot of money and a lot of resources on it, but we think that it really ties all of this stuff together because you have to be an informed consumer before you can be a consumer in health care. People do need to be able to access that information.

Chart 2 puts all of the pieces together. On the left-hand side we have the traditional health plan, which basically is more of a first-dollar kind of thing. You have some cost sharing, but more on the front end of the system, and then you have the employer covering the rest of it. Really, all we're doing is moving those pieces around a little bit. We're saying that we're going to give you a limited amount of money that's 100 percent up-front; you have the control over it. It's good for things like prescription drugs and office visits, which you have a high degree of control over, but recognize also that there are a lot of things that are unpredictable such as hospitalization, unexpected illnesses, and things like that where you may spend a lot of money. So we've created this health coverage that provides coverage for those kinds of unexpected things. In the middle we've got some deductible member responsibility. That gives you an incentive to spend that first-dollar benefit wisely so that you don't run into the deductible. I think most people will avoid spending their own money on health care if they can, so that's a significant part of it, but really what we're doing is we're moving the section that's

on the bottom and putting it in the middle. You will see that the middle section in our case is bigger than it is on the other side, so we're really trading benefit dollars from the smaller amounts up front. We're providing first-dollar benefit, and then we have a greater cost sharing. We do have a reduction in utilization assumption that we typically use, but the economics of the plan actually don't depend on it. We're able to make the plan work if you assume no reduction in utilization. We do expect, based on some of the work that we have done, to see it. Ryan is actually going to talk about his experience with an operating plan which has some similar features, so he can get into that in more detail.

What we've done as a company is created what we see as the first step, and we see it as a baby step. We're really trying to create a market and an environment where consumer-driven health care exists. We certainly don't see the current design as the end-all, be-all, but we feel that there's a transition that needs to happen and the starting point is people need to be more involved in the decision-making in their health care. We've built the information into tools for health consumers to make health care decisions, and a key ingredient for the success of our approach is that people need to be informed. Alongside it we've created some enhanced individual care management features, which I didn't really go into. Fundamentally, the idea is to preserve the benefits of group purchasing because we think that it has a great deal of value in the system, and we don't necessarily believe that defined contribution means no role for the employer.

The last point is that we believe that it's an evolutionary rather than a revolutionary type of change, and that there are a lot of steps that will take place. We're really in the very early stages of this approach. There are a lot of different components that will happen over time and a lot of different variables. It's hard to say five to ten years from now what they all might look like.

MR. RYAN LANCE LEVIN: I'm from South Africa where a consumer-driven model has been in operation for a number of years and has worked very successfully, so what I'm going to talk about is a little bit of a different angle to what Will and Dave have spoken about. My focus is going to be to show you what the South African consumer-driven model is, and then give you some details as to how it has worked.

First, Destiny Health is the U.S. subsidiary of a company called Discovery Holdings. Discovery is based in South Africa and is a multi-line insurer. Their primary focus over the last nine years has been in consumer-driven health insurance. They introduced a new model to the South African market about nine years ago and have now grown within Discovery to a little under a million members. Destiny is a brick-and-mortar insurance company—we're both a carrier and an administrator—but we have a slightly different focus from more traditional insurers. Our focus is on product innovation.

The question we asked ourselves nine years ago in South Africa was, "What if we could control premium trends, increase freedom of choice for members, provide members with the protection they need, but more importantly, when they need it,

and, finally, introduce value for money where members perceive no value for money?" Those members who perceive no value for money in the system are those members who either have a good year or who are healthier than average. The South African model has achieved all of these and I'll explain to you why. You're probably asking yourselves, "Why is South Africa relevant?" First, South Africa and the U.S. are two of the very few countries in the world that have private health care systems. Second, health care in both South Africa and the U.S. is typically insured through employer-purchased insurance, so there are a couple of very key similarities there. The key differences are, first, that South Africa has overall an undersupply of providers. The result has been less of a success in terms of setting up networks, and an inability to negotiate with providers if you're offering an increased volume and they already have more volume than they can deal with. Second, South Africa, to a large extent, skipped the HMO phase. HMOs do exist in South Africa, but only in a very small proportion. And third, there is no Medicare program in South Africa. You have very different pension issues compared to what we have over here.

I'll talk a little about the product design before I get into the specifics on the product. We use a concept that we call "the triangle of health care needs" to depict the entire spectrum. The way it works is, along the horizontal axis is frequency. The most frequent events occur down at the bottom of that triangle where it is widest. As you move up, costs and severity increase for the most frequent events, so it's typically the least costly and least severe. The more costly and more severe events are typically less frequent, so at the bottom you have things like doctor office visits, prescription drugs, etc. As you move up, you get into specialist treatment, which is less frequent, more costly surgery and hospitalization. At the apex you have things like intensive care and transplants, which are very infrequent, but when they do happen, are very costly and very severe.

The South African consumer-driven model deals with this triangle in a slightly different way from the traditional approach. The first thing we do is recognize that as you move up that triangle, member control reduces. Members have more discretion and more control over the health care events that happen down at the bottom—the more frequent, less severe, less costly events. As you move up, members have substantially less control. The key is to provide incentives for consumers. Down at the bottom in those areas where members do have control and discretion—effectively empowering members to manage their own health care—you have demand-side management as opposed to supply-side management. Up at the top where members have less control—where costs are higher—frequency is lower. That's where we believe insurance makes sense. That's where you do need to play the role of patient advocate and introduce medical management to insure quality and cost control.

The South African consumer-driven model distinctly separates the triangle in Chart 4 into two areas. First is the bottom, which is where we use a concept called the personal medical fund. The personal medical fund is basically money that's used to cover day-to-day health care costs—the more frequent, less severe, less costly health care costs. The key is that the member controls how to spend that money

and keeps whatever is left, either in the form of a carryover from one year to the next or in the form of a cash payout when the member leaves the plan. The key is to change the way members think about health care. Up at the top we have a suite of insured benefits, which typically insures members from the first dollar with no deductible for those areas of health care where insurance makes sense—the insurable areas which includes things like hospitalization, surgery, chronic medication. Very simply what the model does is insures insurable events, introducing the concept of true insurance. If you think about an auto insurance analogy, you don't insure your car for weekly gas fill-ups or for tire changes. You do insure it for those high-cost, high-severity, and infrequent events like thefts and accidents that are really insurable events. We're introducing the same concepts to health insurance. Down at the bottom, we changed the way people think about health care. Rather than a "use it or lose it" mentality, this changes people to think of health care consumption as—"if I don't use it, I get to keep the value in the plan."

We believe that this results in a few things that are fairly clear. This model does provide comprehensive protection for members when they need it. It does provide value for healthy individuals because of the same total premium. Now healthy members are seeing retained cash in the plan, ultimately cash paid out if they don't use it. It's integrated into one easy-to-use plan, and it works very much the same way as a traditional health plan, except that the incentives are different and it introduces substantially more flexibility in choice both in terms of plan design and benefit levels, and in terms of how you can stretch the contributions between employer and employee. The real question is, "Does it work and does it control the cost of health care?"

That leads me to the third piece of my presentation—analysis of the success of consumer-driven plans in South Africa. I've broken this down into three distinct areas: the market acceptance, health care costs or loss ratios, and the effects on inflation or the trends of these plans.

Back in 1992 before Discovery entered the South African marketplace, pretty much all of health insurance in South Africa was indemnity—or PPO-type models. Today that mix is very different. More than 50 percent of the market is using consumer-driven plans like the one I've just demonstrated to you. Of that, Discovery has about 13 percent of the total market—a little less than a third of the consumer-driven market. HMOs, as I mentioned, have almost been skipped in South Africa's evolution, but they do exist in some small segments of the marketplace. Clearly there has been substantial market acceptance of this plan design.

Second, we've broken down claims experience into the two distinct areas that we deal with differently: discretionary costs, which are primarily the day-to-day routine types of health care costs (doctor office visits, non-clinic medication, eyeglasses, that kind of thing) and non-discretionary costs. We've compared experience for these types of health care costs between traditional health plans, indemnity-type health plans and consumer-driven health plans. We separate the results by age category, and we have found that there is substantially lower utilization of health

care for consumer-driven plans compared to traditional plans in all four age categories—20-35, 36-50, 51-65, and 66+. The numbers vary between a 47 and 56 percent reduction in personal health care spent in this area of health care for the consumer-driven market.

The question though is, has that reduction in discretionary spending met the expense of an increase in non-discretionary spending? In other words, have people with health care where they're incented to withhold it, or where they're incented to be responsible, ended up having more costs on the non-discretionary side of health care? That's the second part of the analysis, non-discretionary health care costs.

The data are broken down per family. The differences between admission rates for traditional plans and consumer-driven plans are not very great at all—in fact they vary between 18 percent lower on the consumer-driven plans and 10 percent higher on the consumer-driven plans.

To summarize the analysis, discretionary costs using this model have been reduced by around 50 percent on average. Clearly there is some selection. These plans have been more attractive to healthy members than traditional health plans because they provide value to healthy members where traditional plans don't. Hopefully I've demonstrated to you that these plans in many cases also provide more value to sick members than the traditional plans do because they have first-dollar coverage for the high-cost, high-severity events, as opposed to a traditional plan, which may have a deductible in place for those services. Most of the reason for this reduction in discretionary health care costs is because of a reduction in utilization. We believe that this proves that the model does work; it does reduce utilization for discretionary health care costs.

On the non-discretionary side, admission rates on this model are approximately 10 percent lower than on the traditional model. Again, some of that is because of selection, and there's no evidence there that costs have shifted from discretionary to non-discretionary using this model. The indications are that there has been a reduction in utilization of discretionary services and that cost-shifting has not taken place. Just as a side note, we have also done studies as to what types of services people use their personal medical fund for. We look at things like preventive measures. There has been no reduction in utilization of preventive care in those people using their personal medical funds to pay for it.

The third area to compare is the inflationary effect. On average, inflation in traditional health plans has run more than twice that of the Consumer Price Index (CPI) in South Africa. Consumer-driven health plans have an inflation rate that is higher than the CPI but lower than traditional plans. Over the past couple of years, the South African CPI has been around six percent, the consumer-driven plan rate has been around 13 percent, and the traditional plan rate has been around 18 percent.

The question then is—is this applicable to the U.S. market? Obviously, we believe it is—that's why Discovery has expanded to the U.S. and is setting up this model over

here. We believe it does a few key things that this market needs. It provides comprehensive protection where people need that protection, but it also introduces value for those who are not seeing value in the system. We believe we've shown that engaging the consumer does reduce costs. Very importantly, this plan is integrated; it is easy to use. It provides an added dimension of flexibility in terms of plan design and provider choice among members, providers, and the health plan. We feel this is a sustainable solution—a sustainable consumer-driven solution that does work.

MR. DAVID F. OGDEN: I'll make a few comments from the perspective of what kind of impact some of these changes have on health plans and other entities that are taking risk. You have seen a lot of changes. Ultimately, a lot of the change is driven by money; it's not solely by money though, and obviously I'm talking from a group perspective here.

Typically, employer contributions are set. They may vary based on benefit option or they may not. They may be fixed where essentially the employer's contribution is the same and the employee makes up the difference. In most cases these days, the employee contribution is driven by what the premium increase is. To another extent, and I don't think we usually look at it this way, the employer's contribution is also driven by the age of the employee and the employee's health status. In most situations the employee's contribution does not vary, so whether the employee is age 25 or is age 50, and if they pick the same plan, they would pay the same amount. Since their underlying costs are different, and the employer's contribution is different, that's something to keep in mind—what the employer pays and what the employee pays really varies quite a bit.

What is the scope of employee choices? There could be benefit options which could be a lot of different things—whether they're varying deductibles or different combinations of things—and there can be choices among carriers. Certainly you can have a lot of choice and still have the single carrier. You can have multiple carriers whether you're in a health care exchange that's set up to operate that way, such as something like the federal employees, or you could be an employer that is simply offering more than one carrier. Obviously, from the carrier's standpoint, if there's more than one of you, it gets to be more complicated and more challenging.

One of the keys here is what I'm calling market access options. Under this approach, the employees go out and look for coverage on their own, and the employer gives them a voucher and washes its hands at that point. If something like that really happens, you've really moved from group coverage to individual coverage because if the carrier has someone coming to them and really doesn't know anything about them, it's really like individual coverage. In my opinion, this particular approach isn't going to work in the long run. There are a lot of variations of it that can be done where the employer still negotiates to some extent. The employee has a large number of choices or a small number of choices, but they still have more choices than they have now. I think that the second situation, where the employer still negotiates, is much more likely to happen and is much more

viable.

What kind of effect is this going to have on a carrier? Some carriers clearly believe that these are products that will help their business grow because they're new right now. For other carriers, all it's going to do is help maintain their business, but this is what always happens when the marketplace shifts. If you don't change with it, you're going to lose business. I think some of the administration may get more difficult because there are more choices. The flip side of it is that with all the technological changes that have occurred in the last few years, they're easier to do. I think the marketplace is going to expect choices because that's what we're seeing in other kinds of financial services, and health care is going to have to be similar.

The particular issue that is nearest and dearest to all our actuarial hearts is selection. Selection occurs because people by and large make wise choices. We know our health care situation better than anyone else does. We obviously don't know perfectly what's going to happen next year. I don't know if I'm going to have a heart attack and need open-heart surgery next year. I would say that I don't know what the statistics are, but presumably in a group of a certain number of people of a given age, you know that you're going to have several hospitalizations and several surgeries. However, you don't know exactly whom it's from—but people have reasonable ideas whether their costs are above or below average. Certainly, selection occurs, but from our experience and modeling, it can be manageable. In a lot of situations, especially when you only have one carrier, I think it's a manageable situation. Yes, it adds to the cost, but it's not a significant add-on, and I think it's something that can be worked with. Clearly, the better your risk adjustment techniques are, the easier it is to deal with it. If you're able to move beyond age and gender, if you've got some kind of diagnosis-based risk adjuster, which is obviously more complicated to work with because it has to come out of claims data, that will certainly improve because selection will occur and you can adjust for it, just the same way you can adjust for age and gender selection fairly easily. You need to insure that participation requirements continue to be met and that people don't drop out of the system. I think it's something that obviously can work. Certainly a number of large employers have had multiple choices for a long time. Obviously, some of the situations have worked better than others.

I think the big questions are, "What's the level of consumer interest? What proportion of the marketplace is going to be interested in the new products because most of the products that I've seen assume a high level of consumer involvement in the financing of health care?" Some of the approaches envision that the consumer would negotiate with providers. If that happens, we're all going to be better off, and the economics of health care will work more sensibly. The difficulty is that I don't think consumers want this kind of involvement.

I think right now that the average U.S. consumer wants their health care when they want it and they want it for free, or at best, at nominal cost. Obviously that doesn't always happen. Do employers want to be involved? I think that's clearly a definite yes. Employers, at least currently, are recognizing that they've been able to sort of ignore health benefits for a while because of the high rate of increases, but the U.S. health care system is still an inefficient market, it still doesn't work right.

Table 2

Average Employee Out-of-Pocket Expense **1990 Dollars**

	1990	1997 Actual	1997 with 1990 HMO Penetration
Medical	\$360	\$260	\$320
Drug	140	128	136
Premium	532	684	688
TOTAL	\$1,040	\$1,084	\$1,156

Source: Health Affairs, March/April 2001

Since I am an actuary, I figured I'd throw up a couple of statistics that I've seen from a recent study. There was something published in *Health Affairs* recently (Table 2) that compared employee out-of-pocket expense in 1990 to 1997. The HMO penetration increased from 1990 to 1997 and that affected things, but essentially the bottom line of this study is that the employee's contribution, the employee's cost, increased really rather slowly. Even though these are all in 1990 dollars, the total employee cost went up from \$1,040 to \$1,156 if the HMO penetration hadn't changed.

Considering that the rate at which health care costs go up, that's relatively low. Most of the increase comes from the employee's portion of the premium that they pay for payroll deductions. Their per-service, out-of-pocket costs, which are in medical and drugs lines, actually went down. Employees have been getting a relatively good deal, and consequently, I don't think they're the ones that think the system is broken. Yes, we've seen an awful lot of managed care bashing and people are unhappy about that, although they tend to be less unhappy about their health plan, especially if they've had a choice. I think choice is a good thing and I think employees will be interested in choice. My big question is, "Are employees going to embrace the opportunity to get involved in the financial participation?" I think that's the \$64,000 question we have yet to see the answer to.

FROM THE FLOOR: I have some questions, particularly for the gentleman from South Africa, Mr. Levin. I'm interested in the favorable results you talked about in terms of cost and inflation. I was wondering whether you also had information about results in terms of some sort of measure of health outcomes? Do you know if people are healthier? Do you know if life expectancies have changed? If this might have had some influence on any measure like that? I was also curious as to whether you do underwriting, and whether sick people have trouble getting access

to coverage or what the situation is there. Also, for people who are relatively sick, is there a high-cost plan, besides the access-to-coverage issues? And are they satisfied with their system and how it's worked out?

MR. LEVIN: To answer the first question related to change in health care and change in life expectancy, I think it's too early to say whether there has been any effect on life expectancy. Discovery has only been using this model for nine years in South Africa and obviously the great awakening of membership is towards the later part of that nine years; so, no, we haven't seen any effects on life expectancy. As far as health goes, there we have seen some effect. As I mentioned, we have done some analysis of whether people are taking preventive care measures, whether they are looking after themselves, and that has been the case using this model. Something else that I didn't mention that we've been very successful with in South Africa is the implementation of an incentive-based wellness program, which wraps around this plan design. It gives people rewards for looking after themselves, keeping fit and healthy, and there we have seen behavioral changes, too, so not directly related to the plan design I spoke about, but, yes, in that respect.

To answer the second question related to underwriting, things have changed in South Africa. Since the beginning of 2000 the entire country is now on a community-rated, guaranteed-issue basis, so prior to that there was underwriting in the group markets—group-based underwriting very much the same as here. Now, it's sort of like New York.

To answer your third question, this plan design in many respects is richer for those who are sick because it doesn't have deductibles for the high-cost, high-severity events. One of our concerns might be that it's too anti-selective, because in some cases it's better for the sick people than traditional health plans, so the answer very briefly is, no, there hasn't been any dissatisfaction.

MR. WALTER H. HOSKINS: I'm from Selectica Inc. Could you give us a little bit more information about South Africa to help us evaluate the applicability to the United States? For instance, on health care insurance, how much of it is governmental? You were talking about your share of the private. How big is the uninsured population? Of those populations, what is the relative size and demographics? And the other side would be, what are the attitudes on health care and insurance in South Africa with respect to entitlement or responsibility for those same populations—the government plans, private plans, and uninsured?

MR. LEVIN: South Africa is quite a unique country—it's a unique mix of first world and third world. South Africa has a total population of about 43 million people and of those, only about seven million are insured, so there is a big disparity. Now, the seven million insured are more related to the first world part of the South African economy, and that's obviously the area that we focused on. In that segment of the marketplace, the system is very similar to the U.S. For the balance of the marketplace, there is state-funded health care—not health insurance—but there are state hospitals, state primary care facilities available to people, and that's pretty much where they get their health care. Unfortunately, the quality of health care at

those state facilities is not at the level that you'd expect or that you'd want. Therefore those who can afford private health care use the private system as opposed to the state system, so there are big disparities. In the private health care marketplace, there are a number of uninsured individuals that use the private marketplace or are uninsured for other reasons than affordability, and I think attitudes are very similar to what they are here. People buy health care because they want it and they feel they deserve health care and they have very similar entitlement mentalities to what I think you see over here.

MR. KEVIN DOLSKY: I have a few observations that perhaps the panelists could react to and share, and I do have a question about South Africa that I would like to ask. First of all, I'm very interested in consumer choice and its potential and I think one example of discretionary care, like you said in the South African plan, is the laser eye surgery. In my market, I know it costs around \$3,000 to \$3,500 an eye, and after three years of competition and out-of-pocket dollars now, they're advertising \$895 in the newspaper. Competition for patients has really driven the costs down. It's also interesting that there's a fair amount of competition on quality.

Another observation that I have comes from my own experience, and that has to do with the difficulty of consumers doing anything individually. I personally have a \$4,000 deductible, and since I negotiate health providers and insurers negotiate professionally, I thought I would try it for myself with about 10 providers of various kinds, and it's virtually impossible to negotiate with providers as an individual, at least it is in my environment. I think we have a long way to go on that dimension before we can effectively represent ourselves as consumers.

The other observation that I have that perhaps you could react to, and that hasn't been talked about a lot, is the idea of being responsible for the financial dimensions of your health care. Someone mentioned chronic conditions under these plans. I would go so far as to say I think we're denying people the opportunity, even, in some cases to take care of their health by removing the financial dimension of that decision. Those are just a couple of observations—maybe you have reactions.

My question on South Africa has to do with the tax treatment. One of the reasons we insure a lot of things that are not necessary to insure is that they have favorable tax treatment. I just wondered if South Africa has a similar situation?

MR. LEVIN: I'll answer the last question. The tax treatment of these funds in South Africa is better than it is over here, but it's not as good as an insured's health care, so part of the personal medical fund contribution is tax deductible. It's slightly better than it is over here right now, but not quite as good as it should be. Before I turn it over to whomever would like to comment, I have just one comment. I completely agree with you that negotiating with providers is difficult. In our experience there are two pieces to reducing discretionary health care costs. One is accessing the system or utilization, and the second is the price of the services you access. We've seen very little effect on price once the system is accessed. People are not very good at negotiating with providers. Providers are not very open to negotiating on a

one-on-one basis, but the frequency of use or utilization piece of it is where the effect comes in.

MR. TUOMALA: Let me respond to your first question. Laser eye surgery is something that we've looked at, and we think it is a good example of the effect of consumerism. In fact, if you think about the health care system, and you think about other areas of the health care system that are primarily consumer-dollar driven—things not typically covered like cosmetic surgery—you don't see a lot of cosmetic surgeons complaining about the cost of health care. You don't really see the cost of those services rising out of control, either. In fact, in a lot of cases, as new technologies have entered into that type of health care, costs have decreased much like you have seen in the laser eye surgery example. Another example is the recent discussion at the FDA about the non-sedating antihistamines and whether those should become over-the-counter. Naturally, the drug companies were very opposed to it, but I think the economics of that are pretty obvious to them. The argument from a clinical perspective is, in fact, the non-sedating antihistamines are much safer to use than the ones that are currently available over-the-counter—Benadryl and things like that pretty much put you to sleep. The side effects and everything else are much less extreme for the non-sedating versions. It's really an economic issue. You can spend \$50 or charge \$50 for a prescription antihistamine versus the cost of Benadryl for maybe \$4. I think the math on that is pretty easy to do, which is why the pharmaceutical companies were very opposed to it. But I think that it is an example of the power of the consumer. People aren't going to be willing to pay \$50 a month out of their own pocket, even if the quality of the health care experience is much better.

I would also agree to your second point on negotiating with providers, and there are really two points to that. In today's environment we believe that networks are necessary to control the unit cost component. Looking to the future, we believe that consumer involvement is very important to creating any kind of quality-based system or any kind of differentially priced system that the consumer doesn't have any incentive to pay more or less to a certain provider based on quality. It really doesn't make any difference. We can set up all sorts of systems to define who is quality and who isn't quality, and try to reimburse those people differently, but it's at the point of care that people need to decide—is it worth more to pay more to a certain provider because they have better quality?

MR. LEVIN: The only comment I would add is about the kind of information that is available to patients interested in laser eye surgery. They can understand the trade-off with laser eye surgery from a financial perspective and from a convenience perspective. One consideration is cost, and the second is the success rate. Do I spend \$599 on the new guy on the block or do I spend \$799 on someone who's got five years of experience and 30,000 procedures performed successfully? You might say—I'd rather go ahead and spend the \$799. The point is that there was data that was made available that isn't just about cost; it's a reflection of quality. We don't know the source or the quality of that data in this instance, but if there are data sets out there to help support consumers in feeling better about selecting a provider, based on quality and outcomes, then they do tend to make decisions

that are balanced between costs and expected quality. And frankly if you have that choice and you make that decision, you're more likely to take responsibility for the outcome than if you just blindly pick somebody and something doesn't go quite the way you wanted it to go.

MR. JOHN E. RAGAN: I have a point that is related to something that Mr. Ogden said about having a lot of consumer choice. There's actually a lot of information out there that consumers could get their hands on. What I've noticed in our marketplace is that consumers wanted all this choice, they wanted all these options, and they didn't have a lot of cost sharing, so they figured they'd try something and then if it didn't work, they'd try something else. Now that we have increased cost sharing on the consumer's behalf, along with increased choices, I see the consumer being overwhelmed. Our company has about 4,500 people located in the area that I am in and all my fellow co-workers, who aren't actuaries, are overwhelmed by a lot of this, now that they have to start footing some of the bill. I was just wondering what your opinions on that might be.

My question has to do with the South African approach for the defined contribution plan because it neatly fits into something we might have to do in the future. Wouldn't increased coinsurances and co-pays provide an effect similar to the South African approach because the high-frequency, low-cost services would be significantly covered by the increase?

MR. OGDEN: I'll comment on the wide range of choice issue. I think that if you're going to give consumers choice, you also have to give them information structured in such a way to help them make that choice. For example, anyone who is a federal employee may have 30 or 40 different choices of health plans during open season. I think just having a whole slew of benefit booklets is kind of tough to deal with. If health insurance is going to have these kind of choices, you want to have something equivalent, if you will, to consumer report summaries trying to explain what the key features are in helping you work your way through it. In the case of Highmark when you came out with the Blue choice product, you had a plan selector that, at least based on certain criteria, allows the consumer to say, "This is what's important to me." Then of these plans that I have available, which one meets my needs best? I think that is going to be a big challenge for anybody who's in this field, which is how to help guide people through the choices in such a way that it makes sense for them and it's useful.

MR. RAGAN: I wanted to make one more comment on your response. We have tried to be informative on all the choices that we offer, so people can make appropriate choices. It still seems like the consumer is overwhelmed by having a lot of information thrown at them even if you do try to spell it out in as clear a format and with as much representation as possible.

MR. LEVIN: I will comment on the South African question. Co-pays or coinsurances clearly are a move in the right direction to involve the consumer in the cost of health care. My view is that the biggest difference between increasing co-pays, increasing coinsurances, and the model I spoke about, is that they're

effectively a stick as opposed to a carrot. Our model rewards people for being responsible because they get money back as opposed to penalizing them with co-pays and coinsurances when they access the system.

MR. OGDEN: Employees are already saying they're dissatisfied with their options and so to increase coinsurance or co-payments or deductibles just sort of amplifies that. I think employers are searching for ways that they can share the responsibility, if not pass along some cost increases in a way that has a better PR result or ER—employer relations—result. I think giving employees choices to enter into new models where they're willing to take on more of the responsibility for the financial ramifications of their decisions, then that's one way to introduce that, as Ryan said, without forcing it or using a stick to get the results they are looking for. Two years ago, before the economy went sour, there was already all of the managed care backlash and employee dissatisfaction out there, but employers were doing very well. The economy was very strong, businesses were going gangbusters and at that point, employers were still concerned with how to balance cost. But in the big picture, they were most concerned about keeping employees happy and focused and retained. In today's market, there is a little more of a balance between those.

MR. TUOMALA: To comment on both questions, I think there certainly is the potential for consumers to be overwhelmed by choice, but from our plan design perspective, I want to point out that the access of care is really not substantially different from what you would normally expect. When the consumer goes to the doctor's office, they still just show their card—if it's a preferred provider—they still file the claim for them. The difference is really a change in incentive, now they have an incentive to choose a less expensive service or at least be concerned about those to some extent, but the actual accessing of care is not remarkably different. We also have built both on the pre-member kind of environment as well as the ongoing member environment. A lot of those tools that we put together help people choose a provider, determine whether one is more or less expensive than another, and those types of things. I think actually it's an enhancement over today's environment where really you have a booklet of preferred providers to choose from or you basically go to wherever your doctor tells you to go, if you need a specialist.

With respect to the second question, about increased deductibles and coinsurance, I think the key reason why increased deductibles and coinsurance don't necessarily do the trick in this market is largely a tax efficiency issue. The tax environment looks favorably upon employer money as opposed to employee money, and obviously you do have the availability like an FSA account or whatever, but that requires you to predict ahead of time what you think your expenses will be. To some extent, an employer-funded new coverage account is more tax efficient than simply increasing deductibles.

MR. ROBERT GUTH: I'm from Mennonite Mutual Aid. My question concerns what you just finished up with—a little bit of detail about the U.S. tax implications and personal spending accounts. I suppose by Section 105, such an account is not

taxed while held by the employer, but then at the point that an employee gets money that's left over, either annually or at the end of the plan, I presume it's taxed, if you could just talk about that. Perhaps also, at the end of a plan, if you've accumulated rollovers for several years and you get a lot of money, does this result in a big amount being taxed?

MR. TUOMALA: There's probably some complicated arguments that our attorneys have developed related to that, but I think fundamentally the way that we look at it is, under Section 105, as long as it's employer money, there really is nothing in the tax code that limits your ability to carry money over from year to year and it's really the allowing of people to cash out of the account that might create a taxable event. Currently that's not something that's on the table. What we're saying basically is that those balances are available as long as you're an active employee, you can carry them over from year to year, but you can't take them with you if you leave employment, and we are working on some options to allow that in the future. Possibly, if you leave employment after a certain vesting period you could retain that balance—still, within the confines of the plan description, you need to spend them on those tax qualified health services. It really remains as a benefit—you're getting a health benefit.

MR. SNEDEN: Dave, correct me if I'm wrong, but the accounts are nominal accounts, meaning that there's not actual money that's set aside somewhere funded at the time that someone elects the plan. They don't get \$800 actually set aside somewhere. It's like a book entry—the dollars are paid out as someone actually incurs or submits for reimbursement.

MR. TUOMALA: Right, it essentially acts like a benefit provision, really, like any other kind of benefit provision. It's a benefit provision that sort of looks like a cash account.

MR. LEVIN: We've taken a slightly different approach in that contributions to our fund are made with after-tax dollars and that allows carry-forward as well as payout of any benefits remaining with only the interest portion being taxable.

MR. WESLEY S. CARVER: I'm with Trigon Blue Cross Blue Shield. Given that the panel has been exposed to Definity and Destiny models at least a few hours longer than the rest of us, I would be interested in your comments as to the differences between the two—the primary differences.

MR. LEVIN: Two of the key differences are tax treatments and the fact that we've taken the view that the plan works better if members can get cash out at the end. If contributions to this personal medical fund can be shared between employer and employee or fully funded by the employee or fully funded by the employer, we felt a need for that flexibility, so the tax of the contributions to this fund is one difference. The other is that we have distinguished between discretionary and non-discretionary trusts, or less discretionary and more discretionary trusts, whereas Definity's model uses a deductible across all services.

MR. TUOMALA: I guess from my perspective I would agree. In viewing the tax consequences, we took the opposite approach. There is real value associated with the pretax availability of health care benefits, and we wanted to maintain that, so you essentially can spend 60 cents on the dollar or 65 cents, or whatever it amounts to, so that is our approach. The other thing that's probably a key difference from our perspective is that the benefit differences are certainly there. I think the look and feel of ours is more like a traditional health plan than maybe the Destiny model is. The other aspect that I think is significant is that we probably invested more in the tools and the intra-activity and the Internet content and things like that than maybe their model has, so we think that's a fairly important component of the whole.

MR. SNEDEN: What we've done is presented two plans that are out there in the market today that reflect consumerism or consumer choice. There are a number of different plans out there, literally dozens, with different design approaches. These are two that happen to focus on having some sort of personal care fund, a spending account. There are other plans that are more focused on open enrollment decision-making, crafting your own plans, and crafting your own networks to providers. These are just two examples.

MR. THOMAS M. AHMANN: What is the difference between these plans and medical savings accounts (MSAs)? I understand that medical savings accounts were established some years ago, and so I think probably the biggest difference is just time—that things evolve over time, but could anybody respond to that?

MR. TUOMALA: Certainly there's increased flexibility with the approach that we've done as opposed to the traditional qualified MSA approach. My viewpoint on that is the MSA-enabling legislation was primarily, in my opinion anyway, an individual phenomenon in that the nature of the tax code already looks favorably upon employer-funded health care benefits, so MSA legislation technically speaking is not necessarily in a strictly employer-sponsored environment. Really what changed is that you were allowed to deduct on an individual tax return a certain amount of money subject to certain criteria. Really, what we're looking at is a fully employer-sponsored plan with a little bit more flexibility. Having said that, I think the actual operation of our plan is pretty similar to the way that an MSA works.

MR. AHMANN: What you're saying is that the difference is that large employers always had the opportunity to do MSAs and now they're just taking that opportunity.

MR. TUOMALA: I think that's exactly right. It took us a lot of work to figure out how to make that approach work under Section 105 and come up with an approach that we felt was justifiable and that we felt was relatively safe from a tax perspective.

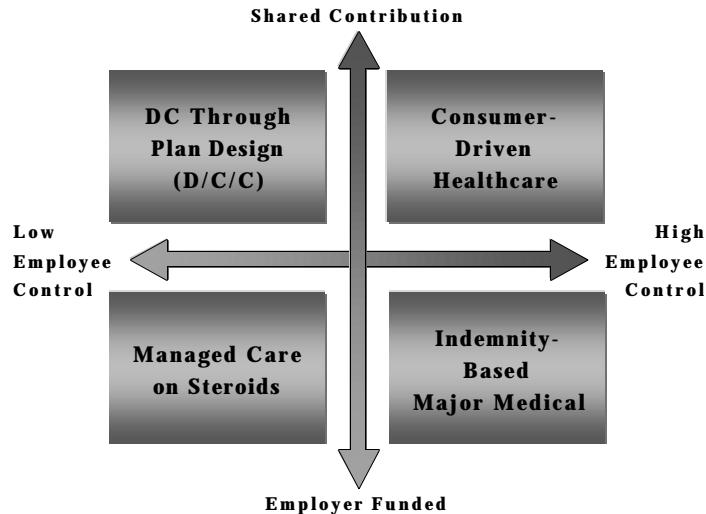
MR. SNEDEN: Clearly these new models involve a lot of change, and typically the first reaction when someone encounters change issues is resistance. Resistance is to be able to see why things won't work or what the drawbacks are, but there's

also the flip side, which is to try to see what things could be and how to search for solutions. As models like this gain in popularity, at least in concept, and are attractive to employers in particular, the change gives us an opportunity as actuaries to make ourselves more valuable by helping to solve some of the issues, and to help create understanding among communities on why things may or may not work. I think we pride ourselves in being particularly able to analyze a situation and make unbiased recommendations or give unbiased opinions on how things will work. I view the direction of consumerism as one where actuaries have an opportunity to make themselves more valuable in the picture for employers, for insurance companies, for plans, etc. I urge you to not close your minds to what might be problems, but to open your minds up to what could be possibilities.

Chart 1



Generic Responses to the Health Benefit Dilemma

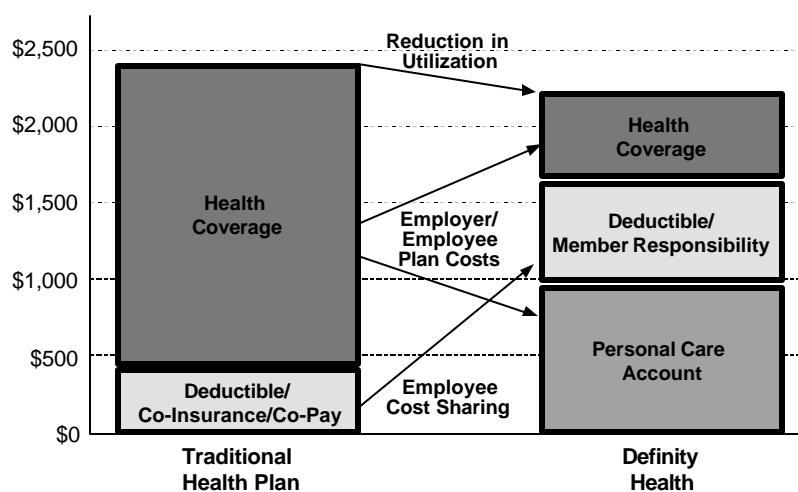


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Chart 2



Traditional Health Plan Versus the Definity Health Design



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Chart 3

The triangle of healthcare needs

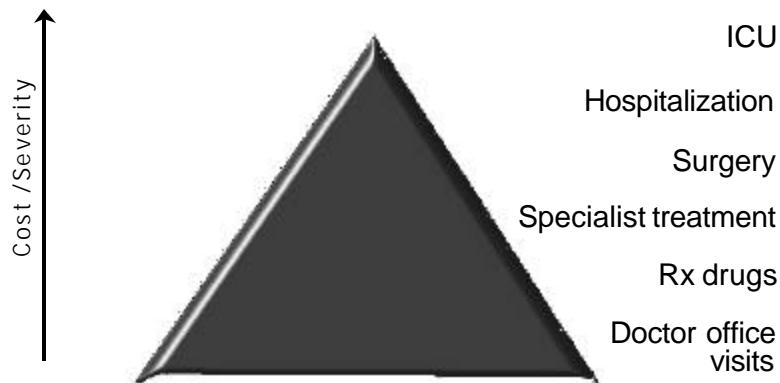


Chart 4

The SA Consumer-Driven Model

