

The Future of Employment-Based Health Benefits

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“You’re not going to get cost containment unless you’re willing either to put a restriction on tax deductibility or impose serious regulation. So it seems to me we’re going to continue to move toward efficiency piecemeal.”

—Len Nichols, Office of Management and Budget

“The decline in Medicare trust funds is so significant, so rapid at the end, that at most, through provider and reimbursement cuts, the date of insolvency can be pushed back maybe a year. That’s the big issue. It’s something that employers should be very concerned about.”

—Larry Atkins, The Corporate Health Care Coalition

“The kind of system we want, if we believe in competition and enterprise, is one where the market encourages insurers, hospitals, and physicians to innovate—to come up with better ways to take care of the people who are costing us a lot of money. By “us,” I mean employers or whoever is paying the bill.”

—Stan Jones, Consultant

“One of our fundamental problems is there’s an insurance market and a health care market. If there were one market, we would realign the incentives, which would allow us to better address the issue of cost.”

—Dan Leach, Lutheran Medical Center

“The question seems to be about whether we intended, when we went down this road to an employment-based system, to have employees, or even the employers, in small firms pay a higher price for a comparable product.”

—David Helms, The Alpha Center

“While some employers want to reduce the number of HMOs offered to their employees, others view HMO competition as a key part of their benefits strategy.”

—Bill Link, Prudential Insurance Company of America

“I think that the key thing for so many physicians is to be able to be part of a managed care plan that understands some of their problems with respect to the quality of care.”

—Alan Nelson, M.D., American Society of Internal Medicine

“The decline or even elimination of employment-based health benefits implies neither that American health care will improve nor that American health care will deteriorate. It does imply that American health care will be different.”

—Denny Dennis, National Federation of Independent Business

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Foreword

The future of employment-based health benefits is open to debate and discussion.

On October 26, 1994 the Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) sponsored a policy forum in Washington, DC on this topic. Employers, providers, insurers, policymakers, and members of academia came together for a full-day discussion on what the future may hold for employment-based benefits, the U.S. health care system in general, and what impact of the failure of health care reform in the 103rd Congress would have on health care.

This *EBRI Special Report* is based on the proceedings from that policy forum. We begin with the predictions for the future of the employment-based health system that were made by the discussants at the forum. We then present a paper written by Stan Jones, a consultant to private foundations on competitive private health insurance markets and the role of public policy in improving these markets. The comments in the remaining sections of the report are taken from the discussions throughout the policy forum and are divided into the following topics: physician practice patterns, access, marketplace, choice, managed care, managed care/physicians, state reform, and ERISA. At the end of this report is a complete list of attendees at the policy forum.

Dallas L. Salisbury and
Carolyn P. Pemberton, Editors
May 1995

The Future

DEAN ROSEN: I think the prospects for building a consensus out from the

middle is going to be even dimmer in 1995 than it was toward the end of 1994. For that reason I think a lot of things that people think are going to be easy to do because we had consensus on them in 1994 are going to be very difficult to accomplish legislatively.

First are the ERISA issues, which will be a huge battle. It's not going to be simple to say, let's just do this little thing for Washington or Florida or Hawaii, or whatever, next year. People are not going to want to head down the ERISA waiver road.

Second is the notion that we can come back and just do insurance reform. It will not be that simple. When you talk about insurance reform, you're potentially talking about significant new responsibilities for ERISA plans. These changes are significant on their own.

I think that beyond the mandates and some of these major issues there are even bigger issues and relationships that no one has even contemplated and that will take some time to resolve. It will be difficult to reach consensus among those people who are now even more hyper-attuned to what's going on back in their districts. I would be very surprised if, in the next two years, we even do what some would now consider to be much too minimalist.

If I had to predict, I think there will be some changes at the margins. There will be a lot of debate, but a lot of it will be a sort of dog chasing his own tail for the next couple of years. I don't see even quasi-substantial movement until after the next presidential election.

LEN NICHOLS: I concur almost completely with everything Dean said about the current political environment.

I would like to come back to more of a post-

mortem on health care reform because that's where we are. We started this whole enterprise with two goals: a goal of cost containment and a goal of universal coverage. It seems to me the cost containment goal is a consensus goal, and the universal coverage goal never was.

The cost containment goal is a consensus goal for obvious reasons, but what we have learned from our own struggle is that the incentive is always greater to select risk than it is to manage care. So it seems to me you're never going to get cost containment on an adequate basis across the board until you introduce some kind of mechanism. As soon as you start talking about a mechanism, be it market based, tax caps, medical savings accounts, premium regulation, or direct provider price controls, you immediately have a majority against you.

We are not willing to pay as a society. The Clinton administration never drove home that willingness to pay was necessary to bring about change.

You're not going to get cost containment unless you're willing either to put a restriction on tax deductibility or impose serious regulation. So it seems to me we're going to continue to move toward efficiency piecemeal. It's going to work in some cases; it's not going to work in others.

I would say the liberal part of my world's fear is that efficiency will be achieved for the middle class. Bill [Link] and Dan [Leach] will figure it out, and a product will be developed that will sell to 60 percent of the population that will grow at 4 percent or 5 percent per year, and the rest of the world is going to be increasingly bifurcated. Some of us would consider that a success, but some of us would not.

It seems to me that universal coverage never was a consensus goal. It will be a consensus goal only if we are able to establish clearly the link between uncompensated care and private insurance premiums. Most likely, any kind of incidence analysis would suggest that that cost is shared. It's probably shared in different ratios in different parts of the country. Therefore, there may not be a simple across-the-board solution. But until

we have a consensus about what that incidence is in any particular market, you're never going to be able to build a case for universal coverage because a majority of people will believe that they can always gain by exempting themselves from that social good. What can we do? Clearly, we should encourage pools, encourage participation in cooperatives, encourage organizations to form units that will enable them to purchase in a way that achieves economies of scale.

The purchasing cooperative approach has to be an element of major reform. We should encourage that and encourage high-risk pools and reinsurance types of mechanisms to deal with that very expensive 3 percent or 4 percent. That is the fundamental human need that is out there and that we failed miserably to deal with. It seems to me this can be done in a simple way.

DAVID HELMS: I'm not going that far. I think states can be laboratories for limited demonstrations of some elements of reform. We've done a fairly good analysis of the reforms that are going on in the states. No more than 10 states will be able to get anywhere close to a comprehensive reform that even approaches universal coverage. Twenty to 30 more will restructure their insurance markets and expand their access through the Medicaid program. States are racing as fast as they can while the Medicaid waiver window is open in the federal government for sec. 1115 waivers. I think you're going to see states trying to get as much of their population covered through that vehicle as they can. I would think employers would be concerned about what states will be paying for these Medicaid beneficiaries, and the issue of the cost shift will be back on the agenda.

I don't think the states have many options, though. They can't raise taxes. They can't easily impose mandates. They can't really reform the entire system given that so many are now covered through ERISA-exempt plans. And yet they've got all these pressures, which result from the increasing number of uninsured.

I think you're going to see most states try to consolidate their purchasing power for all public employ-

ees, i.e., state/local teachers, at the state level as Washington State's reform tries to do. Many states have thought about actually opening up those state pools to small employers, but they run up against opposition from their own state employees. I would really like to see that happen. But when the states do this, they create a little separate risk pool for the small employers, which, of course, defeats some of the purpose of opening up the state purchasing authority to small employers.

Some states such as Minnesota and New York and a number of others will continue to subsidize programs for children and even to try to help workers in small firms. Even in the smallest of the employer categories, more small employers offer health insurance than don't. I think there's going to be a real backlash from small employers who offer coverage when they realize that they are paying substantially more than large employers for similar coverage. They are going to continue to have to live in a world in which we apparently by design want to treat small employers and large employers differently.

JOHN ROTHER: I'm not speaking for the American Association of Retired Persons here. I'd like to make some personal observations.

I'm convinced that 99 percent of the public is completely unaware of what we've been talking about today, and if they were here listening, they'd have their pants scared off of them by what we have been talking about.

I think there's going to be a political swing of the pendulum focusing to some extent on the risks of the status quo, the trends to deterioration, and some of the scary parts of the consolidation that's going to take place. I think that's inevitable and we should be prepared for it.

The second point is that financing is the ball game. Ultimately, if we're serious about reform, we need to start laying the ground on financing once again. I think we collectively have an interest in trying to develop consensus for something that would be adequate to finance health care in future years when the boomer

generation retires.

I think that the first chance to do this will be in 1997, after the next presidential election. That's also when long-term changes in Social Security may be on the table, and there will be a lot of competing pressures for public finances.

One option that wasn't looked at very much this last time around was consumption-based financing. I think that's of interest to both sides of the aisle, and it needs to get fleshed out and developed intellectually, so that we don't get caught short next time the window opens up.

A third thing I'm struck by is the theme throughout the day of a pluralistic delivery system. I believe in a pluralistic delivery system. I think Medicare needs to move more in the direction of a pluralistic delivery system. But what I'm hearing here makes me unsure of how pluralistic that delivery system will stay because what we see is consolidation. The purchasers will consolidate and the providers will consolidate, and this consolidation could likely lead to public regulation.

Those of us who believe in pluralism in delivery need to think about what kinds of regulatory mechanisms will preserve it because I'm not sure an unfettered market will.

Finally, I just think that the short-term future will see very aggressive cuts in Medicare reimbursement and a dramatic increase in cost shifting. I think that's going to put pressure on hospitals, particularly those serving vulnerable patient loads. It's going to put pressure on uncompensated care, and in some parts of the country it may put pressure on Medicare beneficiaries' ability to find doctors who are willing to see them. None of these are happy outcomes, but I really don't see how we're going to avoid them in the short term, absent a broader solution. The scary part to me is that I think there are many people who believe in health reform who promote this agenda of aggressively increasing cost shifts to the private sector because they think it's the way to get everybody back to the bargaining table sooner.

LARRY ATKINS: One of the things we learned this year is the limits of national reform that deals with the issues of health system restructuring. I think that the discussion of managed care has increasingly become the focal point for the rationing debate. There is a lot of confusion in the public about the significance of choice. Also, there is a lot of fear about managed care, the myths about managed care.

Until the population is better educated about what managed care really means in terms of the availability of choice and quality, and until managed care has had a chance to prove itself to the public, I think it's going to be very hard to tackle these things in the political arena.

We learned that national [health] legislation became an opportunity to protect inefficient suppliers. The people who were scared they couldn't make it in the marketplace sought to get protection through public policy and legislation. I think that scared off a lot of people, certainly the employer community, who were concerned about the benefits of going forward with national reform.

I think there will be a lot more pressure on claims disputes and remedies and a lot more focus on the question of consumer protection in relation to self-insured plans. To the extent that people work to rectify the problems with malpractice, the action is going to significantly shift to clients' disputes. The pressure will be on Congress to open up more remedies and penalties and mechanisms for people to pursue claims. We've got to be very careful because the pressure in the system to manage costs is on that relationship among the plan, the physician, and the patient, and the release valve is going to court with claims disputes. It's always easy in this country to set up a social policy that will manage costs and then turn it over to the courts to undo the social policy on case-by-case basis.

I agree that the financing issues were the issues in health reform. I think the fact that we didn't address them doesn't mean that they've gone away. Although we will try very hard to run away from them both at the

federal and state level, they're going to keep showing up.

In the end I think you come down to a basic conflict that's unique to the American system and is going to be its Achilles' tendon in the long run. The fact is that the entitlement to health care in this society is funded with a voluntary payment system, and it will never work until we either limit the entitlement or fund the payment in a mandatory way. We have the choice of turning away people who show up at a hospital and don't demonstrate immediately the ability to pay, but I don't see this society willing to do that. Therefore, the alternative is to require that people pay for health care and that they do it through an individual mandate, an employer mandate, a payroll tax, or whatever, but eventually we've got to come around to that point. I don't see that this current financing system is stable in the long run.

I think to try to do the financing at the state level obviously creates huge economic development problems for the states. If states try managed care, they will continually run into efforts to protect particular facilities and provider groups. Trying to deal with pooling arrangements and financing arrangements and bringing multistate employers into pools is going to be fraught with problems.

I think that the states really do want to try to extend community rating to self-insured employers. That could be the end of the employment-based system as we know it.

I don't think that the ERISA issue is going to go forward next year. To do anything about ERISA preemption requires federal legislation, and any federal legislation will bring us right back to the things that fell apart last year.

Finally, I think the issue for large employers, now that national reform is essentially gone, and it's certainly gone in the short term, is Medicare insolvency. We've lost more than just the solution to our national problems for the non-Medicare population. We've lost a way of dealing with Medicare itself. We don't have any solutions on the table.

The kind of Medicare cuts that were proposed

last year in the context of national health reform were going to do very little to solve Medicare's insolvency. The decline in Medicare trust funds is so significant, so rapid at the end, that at most, through provider and reimbursement cuts, the date of insolvency can be pushed back maybe a year. That's the big issue. It's something that employers should be very concerned about.

SYL SCHIEBER: I think some of the recent cost news is encouraging, but we should be careful about becoming too encouraged. Part of the reason for the slowdown in cost increases has to do with the slowdown of general inflation. I think many of the people who are excited that their health premium costs are in single digits this year are not facing the fact that they can still be three times the general inflation rate, and that's pretty significant.

I think capitation offers hope, but there's a reluctance on the part of employers and workers to move to capitated systems with vigor. I think on the supplier side there's a lot of effort to keep employers or some of the networks from moving to fully capitated arrangements.

Medicare and Medicaid certainly seem to be getting the budgeters' attention. If significant cuts occur, maybe Medicare will not run out of money as soon as now projected, but this implies significant cost shifting to employer plans.

Within the employer community itself we talked about the increase in inter-employer cost shifting. I think some employers are simply not going to put up with all of this indefinitely. They're going to start to curtail some of the opportunities to have these costs shifted to them.

Deborah Chollet has done some work that shows industries that are contracting, that are losing employment, are disproportionately picking up health care insurance for workers in industries that are growing and not necessarily providing full coverage to their workers. That cannot go on indefinitely. You simply can't have the contracting part of your economy picking up the cost of the growing sector.

In the retiree health area, in some cases cover-

age is disappearing completely. In other cases it's disappearing on a gradual basis. We've got caps and liabilities.

However, as this grows, the people who are going to be thrown into the uncovered population are a politically sophisticated group of middle class people. One thing about retirees is they often have time to dedicate to issues they find important.

I think Stan Jones' observations about further sophistication, application of rating, and screening also portend that coverage from the employment-based system is going to decline if we play this out very much longer.

Consequently, I think the straight-line projections about the growth of the uninsured may be conservative.

Perhaps from an economic perspective you can make the argument that all this doesn't matter; it's just the world evolving the way the world's going to evolve. However, from a political perspective this all portends that the heat's going to get a lot more severe, and it's just not going to cool down.

PAUL VAN DE WATER: I'll list what I think may be identified as four interrelated trends or national factors.

First, income growth has been sluggish among lower income people and more rapid at the top of the income distribution. This stratification has generated a feeling that the health insurance system is not working that badly for people who are fortunate enough to work for large employers. Therefore, there is a lack of support for a universal health care system.

Second, there is an intolerance for income redistribution. In the context of health reform, it showed up as an unwillingness of people to subsidize a basic benefit package that, in most proposals, would have exceeded what many employed people currently have.

Third, there's also an intolerance for government in general and an emphasis on market-based choice. I cite public education as one other example where there is also great dissatisfaction with the quality of the product

that's being provided and increased emphasis on giving people more choice of where to send their children to school. This intolerance contributed to dissatisfaction with a variety of health proposals that might have restricted choice.

My fourth point is the poor quality of public debate, not just over health care reform but about public issues in general. I was struck by John Rother's remark about members of the public being shocked if they heard what was being discussed here. It's a pity that the occasion to discuss health reform was not used as an opportunity to discuss some of the real issues we face in the country. Instead, we ended up with the sound bite approach, which seems to be taking over political discourse in general.

My diagnosis is that, for the moment, the system is not sufficiently broken that the will to fix it can overcome these significant national trends.

Trends in the Private Health Insurance Market

Stan Jones, Consultant

Introduction

The purpose of this paper is to paint a broad brush picture of the radical changes

under way in the private health insurance market so that employers, as buyers, can make demands that perhaps capture the best from these developments and avoid the worst. Because health reform did not pass in 1994, we continue to deal primarily with the results of competition in the private market—not government.

The following “picture” is one way of thinking of how the health insurance business has changed over the last few decades. Incidentally, self-insurers as well as health maintenance organizations (HMOs) and other insurers are included as “insurers” throughout this paper.

In its early days, health insurance was designed to protect subscribers’ assets against the cost of illness. Such indemnity plans “indemnified” the subscriber against costs by reimbursing the subscriber (or later the provider of care directly) for the cost of covered health care. Health insurance in this phase was primarily a financial institution.

The health insurance industry has evolved along two different tracks since its inception.

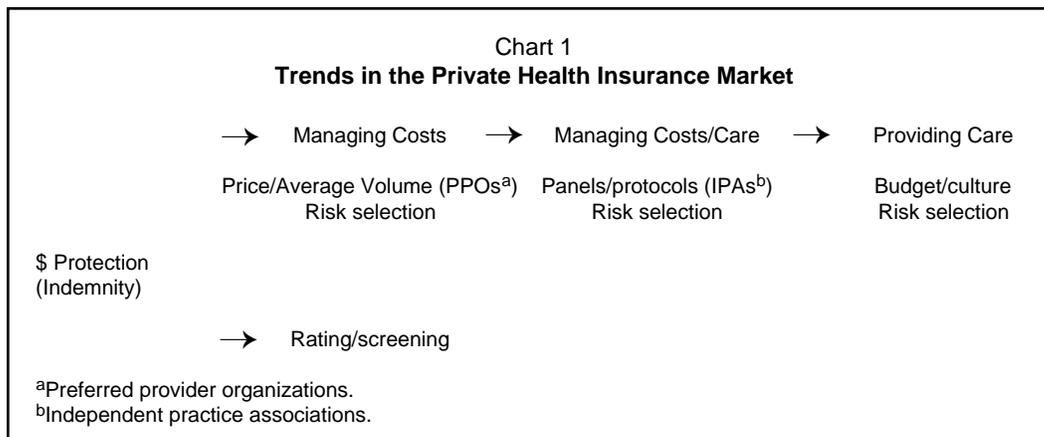
Market Trends

In response to resistance by large employers to rising premiums, large insurers (including self-insurers) and HMOs have moved along the higher track in this picture to what is called managed costs, then to managed care, and finally to providing care (chart 1). In response to resistance by small employers to rising premiums, smaller insurers have moved along the lower track to

new rating and medical underwriting/screening techniques.

The lower track movement by small insurers is a hallmark of our time. If someone wrote an objective history of health insurance, it would say the development of new rating, underwriting, and marketing techniques by insurers has been at least as important as the development of managed care. A large percentage of American businesses and individuals buy their health insurance in a market driven by these techniques. And they are heavily responsible for proposed government regulatory interventions such as guaranteeing issue of coverage to any applicant, guaranteeing renewal, eliminating many limits on coverage such as preexisting condition clauses, and even setting limits on how much insurance premiums can vary from employer to employer or individual to individual. It is fair to say these techniques hold down premiums *by avoiding costs* (of high-cost individuals and employers) *rather than by containing costs*. One way to keep the cost of insurance down is to avoid insuring people who are likely to get sick. These companies and techniques were the prime target of the failed health care reform effort in the 103rd Congress.

Larger insurers and HMOs on the higher track have attempted to contain their enrollees’ costs. The first step they took beyond basic financial protection was to “manage costs,” which was an historic step. It meant changing the industry’s idea of its basic purpose. “Managed cost” companies think of themselves as responsible for both indemnifying the subscriber against the cost of illness and containing the costs of the illness. Of all the techniques used by insurers, two in this chart characterize this phase of the industry’s development: obtaining favorable prices by negotiating discounts from hospitals and physicians and curbing volume by reviewing services against simple “averages” of medical practice in the area for a particular disease or condition. For example, an insurer might decline to authorize hospitalization for a particular condition if the average or mean practice is to handle the condition on an outpatient or office basis. In



the early days of managed care, several of the best managed care firms in the country stated that their goal was to make physicians think twice by holding up in front of them the average practice. And it worked. It has helped reduce the number of hospitalizations and the lengths of stay. Very large panel preferred provider organizations (PPOs) and tough utilization review fall in this “managed cost” step.

While much of the industry is still working at this level for much of its business, some insurers have moved on to what my picture calls “managing costs/care.” Of the many techniques used by insurers in this step, two seem to typify it: containing prices by selecting panels of physicians, hospitals, and other providers based on criteria pertaining to cost and quality of care and containing volume by reviewing services provided against practice guidelines or protocols designed to reflect not “average care” but “good care.”

Stop and consider a moment how big a step this is for the insurance industry. It involves taking responsibility not just for indemnifying the subscriber against costs and not just for working to contain these costs but also for selecting which doctors and hospitals the subscriber can use under the plan. Perhaps more profoundly, it involves moving beyond whatever providers do “on average” to develop or adopt someone else’s definition of what is good medical care. The tight independent practice association (IPA) type HMOs fall in this category.

Finally, leaders in the health insurance industry are moving to the last step and providing care. What Kaiser does is provide care in exchange for an annual premium. Once an insurer gets to managing costs/care with panels and protocols, it is well on the way to providing care—and might pick the “managed costs/care” strategy or the “providing care” strategy based on the local market opportunities. There are clear advantages in some markets to the insurer hiring or contracting with the medical staff or buying or contracting for equipment

and hospital beds. Prudential Insurance Company has an impressive product development and marketing strategy, which is moving as far along the high track as the local market conditions permit. Indeed, the movement of insurers along this line is inevitable. Employers will be offered more and more advanced forms of this type of management and provision of medical services.

It is worth noting again that movement along this higher track involves fundamental changes in what the insurer believes is its responsibility and mission. It involves new types of insurance staff, notably physicians and other health care experts. It also means moving from having relationships primarily with employers and subscribers to having critical relationships with physicians and hospitals.

Movement along this higher track also involves moving into other peoples’ turf, notably physicians and hospitals. It is no wonder that there is so much hostility these days between insurers and providers. This movement also reflects the employer’s best chance of getting good health care for its employees at costs that rise less rapidly from year to year.

However, the issue of risk selection may prevent employers from getting the quality and premiums they want. In chart 1, risk selection is included as another characteristic of managing costs, managing costs/care, and providing care. Many employers who are taking advantage of such high track offerings do so by offering their employees multiple choices of health plans. In these settings, favorable or adverse risk selection may lower or increase an insurers’ premium two or three times as much as their best efforts to contain costs. Techniques for risk selection in multiple choice settings also represent a burgeoning technology in our age. Insurers have studied it and work to have a pool of subscribers in any employer’s group that is at least as healthy or more healthy than that of their competitors. And the techniques work for all the steps on the high track.

Challenges Facing Employers

The large employer's number one challenge as a buyer of

health insurance is to make demands on insurers that keep them from resorting to risk selection rather than cost containment. The key is setting a standard by which the employer is going to judge competing health plans and holding insurers accountable over time. If the employer doesn't have such a standard to come back to, the myriad of products and marketing strategies offered by insurers may be overwhelming.

The standard for health plans should be to compete for an employer's business by assuring quality and containing costs for all employees but especially for those who need the most care and incur the highest health care costs. To clarify why "especially for those who need the most care and incur the highest care costs," refer to chart 2.

This chart shows the claims distribution under a large employer's health insurance plan. It is a curve well known to those in the insurance business. The vertical axis is claims costs, the horizontal axis is the percentage of people who incur this level of costs in a year, and the straight horizontal line is the premium paid on behalf of each subscriber.

Notice that for the vast majority of subscribers, over 80 percent, the amount of claims paid on their behalf is less than the premium. Notice also that for over 30 percent of the subscribers, no claims costs were incurred, which means in this case their medical care costs for the year were less than their deductible. Notice finally that a small percentage, 5 percent to 10 percent, accounts for a very large share of the total costs under the insurance contract.

The medical underwriter's goal on the lower track and the risk selection expert's goal on the higher track is to avoid the high-cost 5 percent to 10 percent

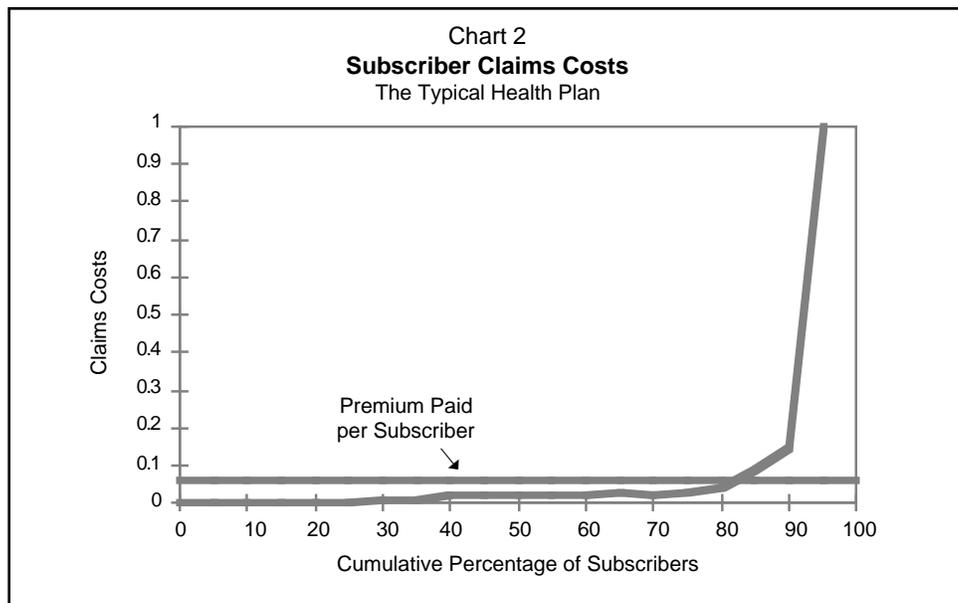
and attract the low-cost 30 percent. The incentives for this are very powerful for small insurers in the individual and small group market and for the larger insurers dealing with employers who have multiple choice. It is a damnable reality of the insurance market that the plan that gets the most high users and fewest low users will have a higher premium and lose market share.

But consider the irony of this and the damning indictment of the insurance industry. There is an incentive to avoid the people who are costing the employer the most money and who need efficient and high quality care the most. And as health plans integrate vertically, there is little incentive to invest capital in improving the cost and quality of care for people whom we can predict will have high medical care costs. Why? If a better product is developed for the very ill, an insurer is likely to attract them into its plan and lose premium advantage because of it. If an insurer invests in such an effort and succeeds, advertising it to expand market share is not possible. Risk selection produces enormous disincentives to invest in containing costs and improving quality for the employees whose care is most costly. Where can insurers justify investment? In taking better care of the basically well and mildly sick.

The Role of Health Reform

Federal health reform proposals had some provisions aimed at righting these incen-

tives. However, at a meeting in the Fall of 1994 of experts on risk selection, one expert argued, with little opposition, that the techniques for adjusting for risk selection might help some, but they would never change the incentives enough so that a health plan could invest in developing better and less costly care for the chronically ill in order to sell its product to increase market share.



If the computer industry operated this way, we would have to say we have a very competitive industry that invests a great deal of capital in improving the product and lowering costs for the medium to small computer users; but of course it can't be expected to invest in improvements and go after companies that do a great deal of computing and depend for their livelihood on it!

It is not unfair to say we are developing a health plan market that encourages plans to get better at taking care of the people who are not currently costing the employer much money and avoiding the people whose treatment might allow real money to be saved by improvements in productivity.

How can this situation be turned around? It has to start with the buyer, the employer, insisting its health plans should compete by assuring quality and containing costs for all employees but especially for those who need the most care and incur the highest health care costs. Otherwise we are missing the boat on long-term cost containment. And incidentally, we are failing to help as much as we might employees who need health care the most.

Conclusion

Without health care reform, the current trends in the direction of managed care undermined by risk selection will continue in the large insurance market. Ultimately, these large insurers will get good enough at managing care and risk selection to gobble up the small employer and individual market and

the hundreds of small insurers who service it, despite their continuing advances in the fine art of medical underwriting. Government reform won't be needed to deal with Harry and Louise's funders.

Where will the higher and lower tracks of the insurance market go, and what will they offer employers in the future? The appendix has a list of predictions.

Appendix

What Will the Private Insurance Market Offer

Employers in the Future?

All basic existing trends will continue in a wild marketplace:

- increasingly sophisticated rating/screening and
- increasingly sophisticated managed care/providing care—and risk selection.

More people will be uninsured or face exclusions and limitations, fewer employers will buy generous insurance, and more costs will be shifted by providers to employers who do buy coverage.

Doctor and hospital-based (and who knows what other) plans will enter the local or regional markets with good prices. Many will fail. Some small insurers will be thrown in with some of these plans.

Staff and group model health maintenance organizations and tightly managed independent practice associations will grow, using point-of-service to widen their appeal

- unless the physicians lobby them into submission through “any willing provider” laws,
- or another wave of “Harry and Louise” successfully impugns their credibility.

In the long term, managed care companies will drive small insurers from market.

Some (most?) big insurers and Blues plans will use risk selection to delay changing into managed care or care providing companies:

- Note “Harry and Louise” ads not only aroused public fear of big bad government but also of big bad managed care.
- They will use risk selection or play off of it to market to multiple choice employers who can’t manage competition.
- Failure of the market to push insurers to compete to provide better and less costly care to the very ill who need it most and run up all our premiums most.

Premiums will begin to rise more rapidly very soon as reserves are burnt off, the current wave of radical discounting plays out, and government accelerates cost shifting to the private sector.

The next national debate of systemwide reform could well focus on “Medicare for all” legislation supported by physicians and hospitals.

Discussion Following Presentation

JOHN GOODMAN: I think the one area in all of health care reform that’s been the most confusing for

everybody is the fact that until you know what the premium is, there’s no such thing as a good or bad risk. First, you have to know what the premium is. People who are overcharged are desirable to competitors and people who are undercharged are not desirable. It’s when the

premiums are wrong that you get adverse risk selection and all of the problems that we’re talking about.

STAN JONES: If I’m an insurer and I’m competing within an employer group for employees, my premium will go up if I get more people who I know are high users of care or if I lose my low-utilizing subscribers. If I continue to lose people who don’t use much care and I’m bringing in people who use more, my premium goes up.

In that environment it’s in my interest to avoid the high users. It’s in my interest to hang onto low users and attract more by advertising and structuring my benefits to attract them.

JOHN GOODMAN: If there’s one reason you could point to that is causing the trend toward increasing numbers of uninsured, it’s that healthy people are being overcharged for health insurance. If we could charge healthy people lower premiums for health insurance, far more of them would be insured.

STAN JONES: Let me offer you what I call the real obvious problem. Kaiser in Los Angeles developed a way of taking care of AIDS patients that was very satisfactory to the AIDS patients and their employers. They got rave reviews, and it was much less costly. They were written up in the *LA Times*. In fact, they got publicity all over the country. During the next open season, Kaiser was flooded with AIDS patients signing up. Now consider, that’s a good thing because if Kaiser can take care of AIDS patients at 20 percent less than others are taking care of them, you’d like them to go to Kaiser. The only problem is it pushed Kaiser’s premium way up. It was a mistake to let that information get out. The kind of system we want, if we believe in competition and enterprise, is one where the market encourages insurers, hospitals, and physicians to innovate—to come up with better ways to take care of the people who are costing us a lot of money. By “us,” I mean employers or whoever is paying the bill.

JOHN GOODMAN: If we take the example you just gave, that shows you why you wouldn’t want to expand

that example to the nation as a whole. All the plans that receive the same premium regardless of health status are going to start underproviding to the sick. That is the mistake that the nation must not make. The Kaisers of this world are not going to advertise that they're good at taking care of AIDS patients, taking care of cancer, as long as they're competing in the market where people pay artificial prices and can move from plan to plan. For plans that provide efficient care to high users, it doesn't matter how efficient they are if they get people who pay premiums well below the cost of their care. They're not going to save any money on them. The incentive is for each managed care plan to send the sicker people to a competitor.

DAN LEACH: Earlier a statement was made about markets. One of our fundamental problems is there's an insurance market and a health care market. If there were one market, we would realign the incentives, which would allow us to better address the issue of cost. But right now health care providers are not at risk for sustaining or maintaining the health status of a group of people or community. In fact, frequently they are not at risk at all.

With various forms of managed care, the insurance industry is responsible for taking risks and making money. There's a direct relationship between risk and reward, but there's also a direct relationship between risk and the incentive to do certain things. As long as providers are not "incentivized" to deal with these problems, i.e., risk, the chances are they're not going to solve them.

I agree that insurance companies are now trying to become health care companies, and health care companies are trying to be insurance companies. I think that's a good move because it does tend to indicate we're moving toward a common market rather than separate markets.

As long as we continue to encourage separate insurance and health markets, we're not going to deal with insurance companies trying to make money by

managing risk and providers trying to make money by providing care. This is part of the problem with incentives. The health care system has grown and expanded because of the cost-based reimbursement nature of the past health care market. If we change that, we can solve the problems.

DIANA JOST: Risk selection aside, do you see any real possibility of actually changing the fundamental ways that care is provided and providing it more cost effectively?

STAN JONES: I see the movement here as very constructive. To the extent the industry becomes vertically integrated, in the long run we may just develop incentives that get ingenuity and inventiveness focused where we most need them to be focused.

Incidentally, it doesn't have to be the government that fixes risk selection. An employer can do that, and some are trying. Still, the efforts are primitive. If you have 10 competing plans, the employer who's hiring or buying the plans can work at that risk adjustment, so that the plans are better motivated or incentivized to do what's most beneficial costwise and qualitywise for the high user.

DEAN ROSEN: I think the real challenge for the next Congress is to try to have a reform that could work hand in hand with some of the changes that are going on in the marketplace and to bring about some of the competition that would help to reduce costs and increase coverage, as opposed to totally supplanting the market.

PAUL VAN DE WATER: What are your views on the current proposals that emphasize catastrophic or high-deductibles insurance sometimes in conjunction with medical savings accounts? There are pluses and minuses to these proposals.

STAN JONES: Ultimately, if we don't base our system on individuals making choices based on price, we're not going to have the right incentives. My nervousness is

that the insurers may operate the way they often operate with Medi-gap coverage. Here's a type of insurance where Medicare is taking the lion's share of the risk, and the insurer fills in around the edges. This hasn't been enough risk to motivate the insurers to really get innovative about managing the care or influencing physicians or doing anything very innovative in that Medi-gap market. It's a well-known and much discussed problem. If we say insurers don't pay until the subscriber has paid most of the costs, they may decide there's not enough risk or opportunity for them to manage costs. I'd rather see the deductibles lower if we're to motivate insurers to do what we want them to do. But it's a political tradeoff.

JOHN ROTHER: Does an annual open season such as in the federal employee health system in any way negate or limit the kind of progression you've described by in effect providing a consumer-based check on how tight the systems get? If any time you get sick you can opt out back into an indemnity type of insurance plan, there may be some bumps in the road here.

STAN JONES: The federal employee health system is probably the system in which competitors have spent the most money researching why people move between insurance plans. So that if you ask the bigger competitors in that system how often this happens and when and why people move, they can give you some information from opinion surveys and interviews with the people who join plans and leave plans. You can bet their proposals for the following year reflects that kind of feedback. The insurance plans don't want low users to leave them, nor do they want to be a big attraction to higher users from other plans.

As an example, in one big multiple choice environment an insurer knew it was losing low users to a new very tightly vertically integrated health maintenance organizations (HMO) in the area, and it was losing them in droves because of price. It couldn't get its price down to be competitive. So it hired a sophisticated firm to research what was motivating people who were

leaving this plan.

The insurer wanted a strategy that didn't deter the high users from leaving them but did deter the low users. In addition to asking the reason for leaving the plan, the research firm asked, "Was there anything that worried you and almost made you not move?" Many people said, "We don't know really what this thing HMO is." HMO was a new concept in this particular market.

The following year, this plan that was losing the low users launched a big advertising blitz during open season that said, "Stay with _____. You know what we are." It was as if someone had just turned the faucet off.

Advertising is really a powerful tool and we all know it's a powerful tool. Companies will and are advertising. People are very nervous about health care. They want to make the right choice. Security is a big issue for consumers, and they're vulnerable to advertising.

DAVID HELMS: I would like to discuss the fundamental equity of requiring employees who happen by accident to have found their way to a very small firm to pay 30 percent or 40 percent more for the same level of coverage than employees who work for large firms. I think that there's not as much choice as we may think in where people decide that they want to work. The question seems to be about whether we intended, when we went down this road to an employment-based system, to have employees, or even the employers, in small firms pay a higher price for a comparable product.

DAN LEACH: Part of the problem is the assumptions we make, and that we project our future based on what we know about the past. One of the problems with the historic methods associated with underwriting or pricing products is that the trends in the past were based on the way care has been managed historically; and there is a lot more slack in the system that can be managed, and a lot of changes are occurring in the way care has been managed. So you can price products at rates significantly below what they have been priced historically, and

because of the changes in the way care can be managed, you can still make a tremendous amount of money.

The other point relative to the issue of pricing is we can't have it both ways. We tend to evaluate things in short snapshots of time and to measure things at a micro-economic level that only can be measured over a long term on a macro-economic level. I think that's part of the pricing we set today, which is based on what happened historically. But the minute you change how you price services—which is fine if our philosophy is let's not allow the market to work, let's regulate it—then you swing the other way to arbitrarily setting the price.

The last point is the great distinction between price and cost. The market is driving things right now, at least in Colorado, on the basis of price, and price has only an indirect relationship to the historic cost associated with delivering care. Organizations with 300,000 lives are basically the 1,000-pound gorilla that knock on providers' doors and say, "Hey, such a deal I've got for you. Here's a price. Take it or leave it. And, oh, by the way, if you don't take this price, 100,000 members that have been coming to your institution are leaving." All of a sudden, those providers tend to be less concerned about the historic costs, and they start finding ways to manage care within that price.

RICK SMITH: The concept that evolved as to how to treat the small group market has moved away from thinking of employers as a group; this concept really would have individualized the small group market. What issues are raised by individualizing the small group market and how do they play out?

STAN JONES: Basically, the question is how do you move the small group market to a point where it operates with the same sophisticated competition that characterizes the large employers' market? If we could come up with a better way to do that, it would be a great gift to the small employers in the country. I personally believe that the small employer probably needs to get out of this business of purchasing health insurance. I don't think the

small employer is a good, convenient, workable vehicle for getting group health insurance for employees. If there were some way to equip the individuals to shop in that market, that's what I'd go for. If you unleashed all those individual buyers, I think they would bring the insurers around; the big insurers might even go for that market.

LEN NICHOLS: I'm trying to focus on whether or not we are trying to make the market do more than it can ever do. Maybe we should focus on dealing with the high-risk expenses in a separate way, because fundamentally, I would argue, what led to the demise of most of the mandated plans is the opposition to redistribution. To accomplish universal coverage under an insurance structure requires serious redistribution in lots of different ways. I'd like to ask Stan if it is possible to construct a blended prospective-retrospective risk adjuster to try to share some of the risk. Maybe it would be cheaper to separate the high-end market out and have a social subsidy combined with a reinsurance mechanism to spread the risk. Let the small insurers just go after the small groups officially, allowing that market to work.

STAN JONES: A lot of that high-risk end is in the small employer market. The problem of how to increase efficiency concerns both big and small employer groups. I'd hate to see us let a substantial percentage of the market be disconnected from efficiency gains.

JOHN ROTHER: I'd like to go back to the chart. My understanding is this chart represents a point in time, and I wonder what it would look like if we redrew it over a person's lifespan, capturing a longer time frame. Would we have this kind of distribution at all or would we see something much more uniform? Do some of these distributional problems come about because we only think of this in very short time periods as opposed to taking the longer view?

STAN JONES: That's a good point. Insurers will tell you that no matter how good you are at screening out people who are currently ill or have a history of illness, that

advantage only lasts three, four, five years, and then you start to lose it. People who were healthy at the time when they signed up get sick. But, there are still problem cases.

Access

DALLAS SALISBURY: What's the situation in Colorado, Dan, on uncompensated care and

taking care of people who come to your hospital?

DAN LEACH: It depends on whether a hospital is for-profit or not-for-profit. My hospital is not-for-profit, so we have to deliver care to anyone who comes in the door, and, in fact, it's part of our mission to do so. The for-profit hospitals, however, tend to send those people across the street to the closest not-for-profit hospital to take care of them. The Colorado law is clear with respect to not-for-profit organizations. It certainly is not clear with respect to regulating for-profit institutions and how they should really be dealing with people who come in the door without insurance.

DALLAS SALISBURY: What do you see as the long-term implications given the dramatic expansion of for-profit hospitals?

DAN LEACH: I think that we're heading for changes in the marketplace. If there's money to be made in managing a certain aspect of care or delivering it, then people will, in fact, deliver that care. If there's no money to be made in delivering or managing that care, then it won't happen, except for not-for-profits that are forced to deliver that care.

LOUISE NOVOTNY: We are faced with having to continue to assure our members the access to the quality health care that they've been accustomed to receiving when the health care industry itself is going through the same kinds of changes that the telecommunications

industry is experiencing. There are acquisitions. There are mergers. There is increased competition. There are changes in business methods, reorganizations, etc. It's the same story. So in these key areas that determine how these people get their health care there's chaos, and they're a little insecure about what's happening to them.

Managed Care

DAN LEACH: When you get down to the grassroots level to actually start

implementing some of the plan designs and programs, you get a different picture. We recently took on a direct contract with a 25,000-member education group. What we're finding in all our theories about managed care is that it's a lot different at the personal level. What we found is that, with all the talk about gatekeepers, a lot of individuals just don't trust primary care doctors to be in charge of very serious problems.

DEAN ROSEN: I'm wondering if you found in the markets that are more developed, such as California and some places in Minnesota, more acceptance of the ideas of managed care and other innovative deliveries?

JOHN DUNLOP: Yes, I think that's true.

LOUISE NOVOTNY: There are three kinds of issues that come up on a daily basis with our members regarding our managed care programs. The key areas are access, quality, and accountability. Regarding access, we want to assure that our members don't have to travel too far. In terms of quality, we were asking that employers press the insurance carriers to adopt the National Committee for Quality Assurance's¹ accreditation program. In the area of accountability, what we see most

¹ The National Committee for Quality Assurance is an independent body that accredits managed care plans.

often in our contracts is accountability between the insurer and the employer for financial performance.

DON HARRINGTON: Irrespective of the managed care design, we have the problem of interpretation when claims are denied and management gets involved. I deal more often with the management employees, and we process 300,000 claims a month. We have complaints no matter the plan design. When you look into the decision process, you find significant degrees of interpretation differing from physician to physician.

RON HOVIS: It appears that managed care systems and organizations are developing in a lot of medium-sized cities. When we first started offering the managed care plan, there were networks in a few cities but not really spread out. At this point we've expanded to about 15 cities, and more will be able to come online soon, and that covers about 80 percent or more of our population.

There is a lot of restructuring to provide more efficient and effective outcomes through the adoption of best practices. There seems to be a serious effort to identify and manage costs. A number of the changes are internally driven in provider organizations. There seems to be a growing development of health care providers organizing around the principle of providing both care and financing.

We believe antimanaged care efforts such as any willing provider and essential community providers would directly affect the ability of our plan manager to contract and help construct a system where our costs are controllable.

DAN LEACH: I think that any willing provider legislation would probably have one of the most negative impacts on health system reform from any perspective, be it legislative reform or market reform.

There are a lot of great people in health care, but there's also a great deal of incompetency, for a multitude of reasons. I think any willing provider legislation will not weed out the providers that are not practicing high quality, cost-effective care.

CHRIS O'FLINN: I would say patient attitudes toward managed care providers and fee-for-service providers are not always predictable. I've had Medicare-eligible retirees tell me in tears how they loved being in a managed care environment because they felt someone cared about managing their condition in contrast to their former fee-for-service environment, where basically they went to one physician who said, "I'm sorry, I've tried everything. I can't solve your problem." In other words, there is an element of the population, from our experience, which is happier with managed care than with fee-for-service.

Also, some people are not happy with the fee-for-service arrangements in some places. Price is a big consideration. Tender loving care is not always present there, either.

BILL LINK: While some employers want to reduce the number of HMOs offered to their employees, others view HMO competition as a key part of their benefits strategy. They may want to deal with a single carrier for all their locations or work with multiple carriers based on perceived strengths in each market. Specialty vendors may or may not be involved in portions of the plan.

We measure our success each year with a member satisfaction survey. Last year, 91 percent of our PruCare HMO members said they were satisfied with their plan. In addition, when members have the choice to go inside or outside the network with a point-of-service option, about 85 percent choose to stay in network.

The regulatory pressures on health care organizations, such as The Prudential, are tremendous. We must adhere to more than 1,000 state-mandated benefits laws. It creates compliance pressures. For instance, The Prudential has restructured its compliance systems, creating a new position of chief compliance officer and dedicating a significant number of associates to compliance issues. Our new compliance structure is helping us do business in a coordinated, responsive, and effective manner within regulatory boundaries.

Managed Care/ Physicians

STAN

JONES: It strikes me that the most important thing we could do to

ameliorate people's paranoia about managed care is for the physician to say, "I can handle this." I'm not sure how many physicians are ready or willing or have even looked closely enough at it yet to be able to say that. But, it strikes me we're moving into a period when we're going to need that from physicians. Some forms of managed care put physicians on the spot, maybe in a way that they don't feel is professional. Others don't do that, and we're going to have to become discriminating. The voice of the physician needs to be heard.

ALAN NELSON: I think that the key thing for so many physicians is to be able to be part of a managed care plan that understands some of their problems with respect to the quality of care.

For instance, I had a hard time finding an internist on our plan. When I found one, he was barely able to take any time with me. He apologized, but since he had been listed on a couple of new managed care plans, he had this enormous glut of patients signing up for him to be their primary care physician, and he was having a hard time coping. He hoped that he would be able to spend more time with me sometime in the future.

That contravenes a physician's dedication to doing a good job for patients. If physicians are involved enough with a plan that they can avoid the obstacles that they feel are lowering their ability to practice the quality of medicine they want, they may be able to say, "Boy, this is a great idea."

BILL LINK: It's dangerous to make generalizations, because the feeling on the part of physicians varies greatly across the country. In many areas of the country where we operate we have a great partnership with

physicians. We work together. Those physicians can then be the advocates of the plan with the patients and members. In some parts of the country, physicians feel less positive about managed care.

When you're a patient and a physician says, "Well, I would have done X for you, but the plan is making me do Y," then the whole relationship of trust is gone. On the other hand, when the physician doesn't even bring the plan into it, but says, "This is really the right thing for you," and has the autonomy to do that, then the partnership really works for the member.

DAN LEACH: I think that the changes we're going through in health care remind me a lot of the changes we went through with the Bell System. There are going to be a lot of people who are going to be out of business. The problem is those who feel very strongly that they are going to make it sooner or later think the managed care changes are just fine. Those who feel that they aren't necessarily going to make it are not going to be that supportive.

Physician Prac- tice Patterns

MARK

PAULY: My impression is in the old days if the doctor said something

was good technology, the insurance company, the benefit managers who didn't know any better, said it must be. Now with more emphasis on cost, even if people are imperfectly informed, it seems to me there is more leeway to say, "Well, you say it's good, Doctor. I don't believe you anymore. Since you can't prove it, I won't pay for it or I won't approve it." So that ignorance or misinformation can just as well cause costs to grow even too slowly.

BILL CUSTER: I think, in fact, it works the opposite way. I think that costs are important, but so is quality. I

think basically in the case of a lack of evidence, technology would still be accepted, not denied. That is, the doctor says this is good; well, I don't want to pay for it, but if the doctor says it's good, I guess I'll have to. Without the information to measure cost effectiveness, that's going to be the case at least for the next six years.

I think that purchasers in general, whether they are individual consumers or large employers, are still going to try to err on the side of providing good medicine, and that means doing more, not less.

CHRIS O'FLINN: Bill, you mentioned that one of the reasons for the growth in employment-based health care coverage has been that the employment base has been a good way of pooling risk. While that's clear for large employers, I think the opposite is true when you get into the small company environment.

To what extent do you think the growth of the uninsured population is due to the lack of an ideal risk-pooling arrangement in the small employer situation?

BILL CUSTER: That explains a great deal of it. Health care reform proposals that loosen the link are trying to address that very problem. Whether it's a health care purchasing cooperative, general community rating, or some other way, you have to find a mechanism for individuals and employees of small employers to pool risks and to market. Once you create that mechanism, you create other problems.

Choice

educate our rank-and-file members on the dynamics of change in the health care system. Until we have that foundation, it is very difficult to move people from where they are now to something different. Change is really

daunting for the rank and file.

When our leaders talked to rank-and-file members facing changes, they heard, "You mean to tell me you're going to limit my choice? Is that what I'm paying my dues for? Do you mean to tell me I'm going to have an increased deductible?"

DIANA JOST: One of the things your members are concerned about—and certainly we see it in other unions also—is the issue of cost and what that means to wages. Yet, you're basically sticking with the most expensive arrangements. What about providing more real choice?

JOHN DUNLOP: We are doing a lot in the area of education. We're trying to educate our own people. But before choices are forced on them, we have to help them grasp the fundamentals. Part of that is our own education process, but part of it is going to be their own experience.

DENNY DENNIS: Employment-based health care benefits are going to evolve over the next few years. We're talking about greater use of managed care, less patient-consumer choice, erosion of private health care coverage, increased cost, etc. The most frequent activity in the states, I think most everyone agrees, will focus on any willing provider legislation. Again, we begin to see the unavoidable conflict between choice and cost inherent when consumers are the designated spender and someone else is the designated payer. In addition, the debate over the any willing provider legislation is the best evidence to date that the left and the right are both correct in their assessments of the impact on choice.

The implications for employment-based health benefits are enormous. If the eventual choice is a single payer system, the implications are clear. If it's a market-oriented system, the current system will to some extent remain in place. However, we're going to find nonemployment-based organizations arising. These nonemployment-based organizations will begin to pull away customers. In particular, they will pull them away

from small firms. In fact, I would argue that probably over the longer term no small firm owners currently providing insurance will do so.

JOHN ROTHER: Denny, I want to challenge your bifurcation of left and right here by using the example of the federal employees' health plan, which I see as a single payer vouchered-type system that allows market forces to structure the choices for the delivery systems. How do you view that? It seems to me that it is possible to have a market mechanism that's still basically financed in a way that's similar to single payer.

DENNY DENNIS: No. Look where decisions are made. Other than moving from plan to plan, such a system is based on what I call the "knowledgeable person theory." In effect, the knowledgeable person decides ultimately what the consumer will receive in terms of services. The only thing the consumer is able to do in a case like that is select among a few competing plans, but beyond that the decisions are essentially away from the individual consumer. Further, when costs rise, the only way to control them under that system is to restrict choice.

JOHN ROTHER: You have a choice of benefits. You can elect which plan to enroll in. You can decide to change that plan if you're dissatisfied.

DENNY DENNIS: Yes, that's true, but the bureaucracy ultimately makes the decision on the kinds of services you're going to get, particularly in the face of uncontrolled costs.

I just don't see that plan as a viable political option.

STAN JONES: Overall, what I hear from many employers about their employees is that choice isn't an issue. There are other things that are issues. They'd rather have the employer pay more of the premium. They may dislike the cost sharing that's being pushed or cutbacks in benefits, but choice doesn't rear its head as a huge

issue. The evidence seems to say that choice really isn't a problem when there is multiple choice of health plans.

DENNY DENNIS: The public is suggesting that, to date, it has been very pleased with the quality of health care, of which choice is a component. It has not been pleased with price. We are now working on price at the expense of quality/choice. That's the tradeoff that we're making, and that's the choice I think the public refuses to make. When it decides which way it wants to go on the issue, effectively we will veer sharply toward one of these two directions.

STAN JONES: It strikes me that that is a kind of intentional confusion of the public. In most of these multiple choice systems, people have the choice of going into a limited panel, and they may get better benefits and save money. Most of the employers I know say they started offering HMOs because it was such a good deal for their younger workers with families, a very rich benefit package at a relatively modest premium. So they have that choice, but they can stay somewhere else.

When that arrangement is satisfactory for so many millions of Americans, how can you draw this tradeoff so clearly? It doesn't make sense.

DENNY DENNIS: We'll have to agree to disagree.

ALAN NELSON: I want to clarify the different dimensions of choice because I think we may not be talking about the same thing. Stan, I don't think that choice of plans is important as long as the doctor you've been going to is in the plan that you select.

Now the second dimension of choice has to do with the desire of patients to be able to see a specialist if they feel they need one. If they think that they need a cardiologist, they don't want the general practitioner to tell them that they don't need to see a cardiologist.

Then, of course, the third would be a choice among various health plans, and the best read that I can get is that people are very concerned that they have the

choice of physician and hospital. If they have confidence in somebody that they've been seeing for 10 years, they don't want to have that ruptured if they can avoid it.

CHRIS O'FLINN: I think the employment-based health system has been dealt some body blows over the last decade. The high cost of health insurance has hurt the solidarity and cohesion in a company-sponsored health plan, where basically the younger people pay for the older people. That equation just doesn't work when a younger employee hired around age 25 is paying 3 percent of pay for health insurance. They probably face a 50 percent probability of zero recovery in 10 years of plan participation. Introduce downsizing, and now the younger employees have to think about the extent of their life within this pool that preaches solidarity and is asking them to subsidize the older and probably higher-paid people.

Choice is an opportunity for adverse selection, and that was brought home to the employer-sponsored health plans in spades by the HMO act. This law created a wonderful opportunity for the low-paid younger workers to get lower cost coverage and thereby also, incidentally, suck out a good part of the profit that went into the plan to subsidize the cost of the older people who were still in the indemnity arrangements.

Couple that with the data showing how HMOs have an uncanny ability to turn in better-than-average performance, apparently because they get better-than-average risks. Somehow there is a selection favoring HMOs.

So what happens when all of that profit that formerly went within the group, the solid group, cross-fertilizing, goes out now to one of the choices? It raises the cost of the more expensive choices. It makes it really difficult even for a large employer to run an operation that looks equitable.

STAN JONES: I wonder if it wouldn't be more honest, instead of talking about choice versus quality or choice versus price or choice versus no choice, as though it's a

black-and-white thing, to talk about how much choice and what are you willing to pay for it. In these multiple choice systems you can choose to go with the panel. People have different reactions. Some are never going to do that, but why not allow it for those who want it?

In many markets, the newcomer plan (or the new plan among many employer offerings), especially if it requires you to change something such as doctors or insurance forms, will get favorable risk selection. HMOs came in like a wave in the 1980s, and they were usually the new plan. Anybody who's using care and is used to the way the forms are filled out and the way the financing works, doesn't change plans. The people who change plans most quickly are the ones at the bottom of that claims distribution chart who often don't even know a doctor. They haven't seen a doctor in a couple of years, and they don't have much of a relationship. They react to price and they'll go into the new plan.

The work I've done with employer groups shows that HMOs frequently did get good risk selection. But, they very often also produced efficiencies in care that we can't explain by risk selection. It's hard to draw a line, but the evidence suggests that well-run HMOs really can lower cost as well as sometimes getting favorable risk selection.

CHRIS O'FLINN: Are lowering cost and achieving efficiency the same thing? Dan Leach talked about hospitals becoming more efficient. I can negotiate with Dan and say, "Dan, we'd like your services, but you have to come down 20 percent," and I've lowered the cost. I haven't necessarily made Dan more efficient. Are you saying that HMOs have lowered costs or are you saying they have achieved greater efficiency, or both?

STAN JONES: There are so many models and so many different HMOs. For example, the California Kaiser HMO owns its hospitals and operates 95 percent occupancy level, because it only builds the beds that its subscribers need. It is dealing with a closed universe. Also, it only hires as many physicians as it needs for its

population. It has very little excess capacity that it's paying for. So there are efficiencies.

Other HMOs operate in different ways. Some of them achieve lower premiums through discounts, and it is uncertain whether it's a real efficiency or a case where charges are being shifted to somebody else. However, I think the consensus among researchers on HMOs is that the tightly run ones can save money through efficiency. Some may also be getting good risk selection.

DAN LEACH: Another comment relates to the practical side of choice. Is the level of sophistication present for individuals to make some of the choices that we are devotedly trying to protect? And I'll cite a quick example.

A very common illness, and potentially very serious one, but one that's easily treated, is hyperthyroidism. There's been a lot of press on hyperthyroidism. An employee was in a plan that had both in-network and out-of-network benefits. Because of a longstanding relationship of trust with a physician the employee decided to go out of network in spite of a high deductible.

The physician treated the hyperthyroid problem with a 10-year-old procedure using medication known as PTU, which does work but it tends to also poison the liver and sometimes can cause leukemia. The employee then went to several specialists, including two neurologists, and one neurologist determined that the problem was hyperthyroidism. A primary care doctor ought to be able to determine this, but, in fact, didn't.

This same employee went to another physician who was in-network. That physician said this is a piece of cake, that will cost a few hundred dollars. The employee was sent to a radiologist and was given radioactive iodine.

After this experience, the employee had probably become a more sophisticated purchaser. The employee was me. I'm as close to medicine as a hospital administrator can be. But, as an individual, I don't know hyperthyroidism from anything else, unless I go through the experience.

We need to look beneath the surface of some of the things like individual choice that we want to protect but that may not work.

RON HOVIS: Since 1987, we implemented a point-of-service managed care network, a point-of-service mental health network, and a mail order and retail pharmacy programs, as well as revised our HMO contribution policy.

We have over 4,000 employees who live outside of the locations where we have networks who have elected to receive their care in network locations, and they make that as an annual decision. For those employees in the network arrangement, about 90 percent of the medical claim dollars in the network locations are paid to network providers.

Whenever we have done surveys of employees using network services, we have received about 90 percent favorable responses. There was some discussion earlier about choice. Most of our employees have HMO alternatives available to them, and we are at the point now where fewer than 10 percent of them elect to be in those HMO options.

Also, we are increasingly an urban-concentrated company. At times in the past a much larger percentage of our employees was in rural locations. That is becoming less and less true. Both of these factors affect our response to changes in the health care delivery system.

I think there is a notion among the population, whether it's employees or in general, that there's a strong desire to choose the doctor you want to go to. Willingness to spend money to have that choice is different. We provide choice through the point-of-service plan. At any point someone could say, "Enough of this. I'm going to see this particular specialist."

LEN NICHOLS: I certainly appreciate the veracity of your example, but I think it's important that we not jump to the conclusion that because only 10 percent of the money is going out of the network that that implies somehow the value of the choice is reflected in that

10 percent. You're going to go out of network if you think you've got a problem that isn't being adequately addressed. It speaks to the quality of your network that so few are going outside it.

The product with the option to go out is a much different product than the one that says you cannot. There's clearly a willingness to pay for the option, even though it may not be utilized.

RON HOVIS: That's the reason that we have the design that we have. We didn't want to foreclose the option. The availability of it, with an appropriate price tag, is a legitimate approach.

BILL LINK: We were an insurer. It was logical to have a point-of-service plan because we used to have an indemnity business, and we have the whole infrastructure in place to handle that type of plan. It's very difficult for an entity that has been an HMO and not been an insurer to now offer a point-of-service plan. They have to incur a tremendous cost to put an infrastructure in place to allow that option. I would hope that no legislation would say that an HMO couldn't offer a lock-in plan. I think you can offer an HMO without a point-of-service option a lot more cheaply, and some individuals are willing to buy that. The individuals who are willing to buy that ought to be able to reap the cost advantages that go with it.

DENNY DENNIS: Cost can be controlled by allowing the consumer/patient to govern health care and health care financing decisions to a far greater extent than is now possible. Consumer choice means movement toward a more market-oriented system. Or, costs can be controlled by appointing some "knowledgeable person" to replace the patient/consumer. This knowledgeable person makes health care and health care financing choices on the consumer's behalf. There isn't much in the middle, including whether that knowledgeable person is a bureaucrat in Washington or Hartford. In fact, the policy middle ground today is the status quo.

BILL LINK: Individual employees and their dependents are also playing an increasing role in the purchasing decision. Where employees have a choice among competing plans, they represent the second sale. The plan they choose tends to be governed by the employee contribution amount, by the perceived value of the benefit plans, by the image and reputation of the health plan and its providers, and sometimes by whether their current provider participates in the plan.

Marketplace

JOHN GENTLEMAN: There are millions and millions of employees covered by

multiemployer plans who work for small employers. In the construction industry, as an example, you have on average employers who employ fewer than 10 employees, and that's very important to the previous discussions. The same can be said in the transportation industry, in the food industry, and others.

I have yet to hear anything about rationing, and I know that's a very frightening word to everybody, but I think it needs to be discussed. Also, malpractice. If it costs \$100,000 for a surgeon to open his or her door because of malpractice insurance, maybe that has to be taken into consideration.

DAN LEACH: You can manage price through competitive bidding and not do a thing about cost. Cost is something that a provider will have to manage or shift. In the marketplace today price competition is actually stimulating more cost shifting without necessarily helping the total cost problem.

DWIGHT BARTLETT: Any voluntary insurance mechanism, whether it is privately or publicly sponsored, involves a degree of socialization of cost. The question is

how much of that socialization of cost will the marketplace tolerate? Clearly, New York, with its pure community rating, has pushed the socialization of cost to the point where the marketplace simply will not tolerate it.

LARRY ATKINS: Small groups and individuals have the problems of risk and risk pooling. Large groups naturally solve those problems. So there is not a societal need to pool everyone. We need to pool in those areas where natural pooling of risk does not occur.

JOHN ROTHER: The challenge is how to finance the system when those people best able to pay are allowed to opt out. If higher income and healthy individuals can always leave risk pools, we will always have problems.

CURT MIKKELSEN: Bill, what's your vision as to the role for the small to medium-sized insurers who simply don't have the deep pocket that Prudential and its large competitors have? As a practical matter, do they have much of a future? And, if so, what might that be?

BILL LINK: I think this is a local business. I don't think just because you're a national company you can win everywhere. For example, Prudential left Detroit and Minneapolis because we thought we couldn't add value or compete in those locations.

It's important to have a certain market share in order to be successful in this business. On the other hand, I do think competition is very important, and I wouldn't like to see oligopolies or monopolies because I think by having competitors we improve. When Cigna or U.S. Health Care or Kaiser finds a better way to do something, we are challenged to find an even better way to do something. We try to monitor what they do.

People have said, "What's going to happen at the turn of the century? Are there just going to be five giant health care companies?" I don't think there's any chance of that. In a particular market, for example, a Jacksonville or Orlando, you might just have a half dozen health

plans competing, but you'll have a different half dozen in Memphis and a different half dozen in Phoenix. I'll bet if you put all of them together, you'll have several hundred health plans.

What I tell my friends at small or medium insurers is they can do this, too. They just can't do it everywhere. They could have 10 percent to 15 percent of a market. If they're going to try to do it with a quarter of a percent market share in 50 places, it's not going to work. If they concentrate their activities, they can get very good results.

MARK PAULY: What does it take to enter a market and what do you leave behind if you leave a market?

BILL LINK: It's almost prohibitive to enter Minneapolis right now. I think that's a concern we should think about in all this: how not to have just one or two players in a location. I think that isn't what's best for the country long term.

It happened in Minneapolis. We had independent practice associations (IPA) networks. So we didn't have bricks and mortar. We didn't have many members. Our main concern was trying to find a reputable company to which we could transition our existing membership in order to cut down on that disruption, but we didn't leave a whole lot on the table when we left. We just entered Raleigh-Durham. We're entering with an exclusive group practice HMO delivery system. Initially, we're going to build three 15,000 square foot buildings, each having six to eight primary care physicians and nurses and an administrative staff. The investment is whatever it takes to either lease or put up those buildings and buy the equipment, hire the people before you have members. If you are already in a market with insurance and are then going to start a group model, you can more quickly transition your existing members and not have quite as much startup cost.

DWIGHT BARTLETT: You entered the Baltimore market by buying an existing HMO. Does it take a smaller investment to enter the market that way?

BILL LINK: It takes a bigger investment to enter the market that way than doing something de novo, and that's why that was the only one we've ever done that way.

We tried that because we wanted to see how to do it. We tried something else in Chicago. In Chicago we had an HMO that was about the seventh or eighth largest plan in the city. Rush Presbyterian St. Luke's Medical Center also had a plan that was about the seventh or eighth largest. Neither of them was terrifically successful.

We looked at doing what we did in Minneapolis, that is, leaving, but Chicago is a very important market to a lot of our customers. We combined the two plans to create what's now the second largest plan in Chicago. We'll have to see if, in fact, we can work together as partners from a financial standpoint. If we can, that might be a model that we would use in other places.

DAN LEACH: Given the local nature of the health care markets, do you find corporate needs and the needs of the local level at times in direct conflict?

BILL LINK: We haven't yet experienced that. More of the conflicts that we have are the national clients who want some degree of consistency when they have people in all 33 of our markets. The local Prudential health managers, say, "I know what's best in my community and how we can really solve the problems and work on things." Sometimes conflict occurs because we don't then do things exactly like a cookie cutter in every place across the country. The concern is how to bring the right balance between the consistency the employee benefits managers are demanding and the local marketplace decisions that need to be made to react quickly.

CHRIS O'FLINN: Dan, I think a lot of the business community is optimistic as you are that a combination of overcapacity in the medical care area and capitation will lead to much greater efficiency. I wonder if you would comment on a little numbers game. I believe the con-

tracts the Prudential has for Medicare pay about 95 percent of the cost of a Medicare patient in a given area as the capitated rate. Hospital providers get paid by Medicare currently at about 88 percent of their true cost. Along comes Bill and he pays 95 percent of 88 percent, which is something like 84 percent, and he makes a profit. Do you make a profit, too?

DAN LEACH: Yes, we do. Slack in the system causes us to seek Medicare risk products. The primary care physicians understood that education is a very important component of making Medicare risk products work. When we sign up a Medicare risk product, we communicate one on one with every member. We bring them in for an assessment and we screen them into three categories: individuals who have imminent health problems, individuals who need ongoing management of problems, and healthy individuals. The healthy people come back for an annual physical. That alone can produce tremendous savings by proactive management of the patient's health.

Another example goes to the emergency department. A 95-year-old patient comes into the emergency department and complains of being dizzy and disoriented. Historically, the first thing an emergency doctor might do is send him or her for an MRI. Well, if you're a 95 year old, chances are you might be a little dizzy and disoriented for reasons other than serious medical problems.

With Medicare, by establishing these clinical path programs and standards of care, you have a tremendous impact on improving the quality and decreasing the utilization and the cost. So even with everybody taking their cut on the Medicare product, yes, there's profit in there. Is there a lot? Absolutely not, because we're moving into an environment of marginal pricing.

CHRIS O'FLINN: I've heard the same thing from other hospital CEOs. Is your experience inconsistent with the position that managed competition does not lower the cost of medical care?

DAN LEACH: For me, it's back to the issue of incentives, risks, and accountability. And if you align risk with reward and accountability, then you'll produce savings in the system because behavior will change. Managed competition in itself I don't believe is going to produce any savings. Some of the managed competition as described I think would add more bureaucracy and cost than savings, but I wholeheartedly believe in the concept of producing savings through competition.

Many insurers and managed care companies compete with hospital systems for the loyalty of physicians, particularly primary care physicians. These companies establish direct contractual relationships with physicians who in turn use hospitals as vendors of in-patient services. Although this is an old contracting model, it is being used much more effectively today as a means of further leveraging down the cost of hospital services. In fact, with the exception of Medicare plans, hospitals are becoming less important as a factor that people consider in selecting a health plan.

The leverage exerted on providers in a price-driven environment can be a positive force over the short term in changing the health care delivery system. Providers will be forced to lower their cost structure, redesign systems and structure, decrease their capacity, and improve their quality if they are to remain viable. Providers will also be forced to innovate and rethink modalities of care.

Hospitals are evolving in several directions. Some hospital systems are attempting to become super-vendors of in-patient services by capturing large blocks of covered lives. Other hospitals are redesigning services and resizing to become small ambulatory service providers. As in other markets, hospitals will also form mergers to consolidate services and downsize noncompetitive units. Still others are forming new ambulatory service joint ventures with other hospitals to consolidate services to achieve efficiency and economies of scale. In this last approach, participating hospitals will downsize or close as the ambulatory service entity grows.

BILL LINK: Prudential is moving away from the vertical integration structure and toward horizontal integration. This model includes physicians, hospitals, and all diagnostics and support services, with capitation and utilization review to help control utilization and data going back into the center to help assure quality. These systems are designed to facilitate communication and provide comprehensive care for the consumer, unlike the situation in a vertical structure, where various parts of the system aren't structured as delivery units around medical needs.

DENNY DENNIS: The decline or even elimination of employment-based health benefits implies neither that American health care will improve nor that American health care will deteriorate. It does imply that American health care will be different.

BILL LINK: The buyer is no longer just the employer's central corporate office. Buying decisions are increasingly made at the local level. Consultants also play a major role in these decisions, as well as in shaping a client's expectations of managed care. At times, unions can play a very active role in the selection process.

Granting providers waivers from antitrust laws would give them immunity from the marketplace. They would not have to play by the same market or regulatory rules, such as having to live up to the same solvency requirements as health plans.

How will health care plans compete in this environment? The key will be to have a strong local presence in the plan's market areas. Plans will need to grow internally through existing and new market segments (Medicare, Medicaid, CHAMPUS, purchasing alliances, workers' compensation) or through acquisition. Plans that are unable to achieve significant local market share but that are achieving acceptable returns may be satisfactory in the short term but vulnerable in the long term.

State Reform

LARRY ATKINS: About 45 states have done some kind of small market or

individual insurance reform, and I guess about another 20 have done some kind of community rating or modified community rating already, all of it applied to, obviously, the non-ERISA market. Do your members generally look at that as favorable or not favorable?

DENNY DENNIS: It varies depending on the state. For example, we're finding that a number of our members are taking advantage of the California plan. There was a 6 percent to 10 percent decrease in premium rates, and we now have approximately 80,000 employees covered under that plan.

On the other hand, there hasn't been any great outpouring of support, i.e., usage in some states. In Florida, about 3,000 firms have taken advantage of the plan. It's only been in effect about three months, so it's getting off the ground. But acceptance has come haltingly, though our Florida people are optimistic.

At the same time, we're looking at a decline in the number of employers who are offering employment-based health insurance because costs are still going up. That's the driver. That's the key, cost.

DAVID HELMS: We're seeing a lot of activity at the state level to design policies to encourage community-oriented smaller networks. Minnesota's community-integrated service network is the most visible example of that, but a lot of the states that are trying to promote some variation of integrated health plans do not want to create a situation where the rural providers or smaller urban providers don't have a chance to build networks.

Although, the risks for the states when they establish these plans is that they have to have much

lower solvency and capitalization requirements or nothing will happen. The states will have to stand behind more of these plans.

JOHN DUNLOP: In regard to health insurance the National Education Association's (NEA) environment is extremely diverse. The public sector follows what happens in the private sector. If there are changes in the private sector, they leak into the public sector.

NEA is very comfortable with state level reform. While many see the problems as technical, for NEA most of the problems are political. Employee choice at all levels is a very important concept for us to deal with, and it has significant political ramifications for us. Remember, the essence of a union's strength is in its own internal cohesion and solidarity. We must maintain that solidarity.

The second problem we have is in the rising cost of Medicaid. That's probably our strategical problem because elementary and secondary and higher education compete with Medicaid for public dollars. Getting control of health care costs becomes a high priority for us, and the Medicaid arena is very critical.

A third area that's a problem for us will be in how we configure risk pools. I am intrigued with the idea of aggregating small groups. We've tried that in a number of states, but, again, a technical problem for you becomes a political problem for us.

DEAN ROSEN: The real challenge is asking what the states need and what changes need to be made. The information issue was one that we thought we could solve pretty simply. The taxation problems are a little bit more difficult. There is going to be a continual drain from Medicaid and continual price pressure. States will want to have more people in pools and will want more revenue. Taxing self-insured plans is a much more convenient way to tax and get more revenue while hiding the cost in the plans, as opposed to outright individual taxation.

DENNY DENNIS: The likelihood is that the states, like the federal government, will devote most of their effort to debate. The most frequent activity will probably focus on “any willing provider.” Here we begin to see the unavoidable conflict between choice and cost inherent when consumers are the designated spender and someone else is the designated payer. Moreover, any willing provider is the best evidence to date that the left and right are both correct in their assessments of the impact of the decline in provider choice.

ERISA

RON HOVIS:
We are concerned about the potential loss of federal uniformity

under ERISA for multistate employers, and that obviously would come about in the form of permission for state-by-state experimentation. Our concern is simply that we have employees and retirees in every state, and a loss of uniformity would affect our ability to have consistent employee relations across all the state boundaries.

In connection with a number of the preemption-type proposals, there seemed to be opportunities for new taxation, opportunities to increase our cost of plan administration, and potentially in our cost of claims. All of these cost increases are a source of concern because they could negatively affect all of our stakeholders: our customers, our employees, and our owners.

DAVID HELMS: A number of states want access to limited ERISA exemptions, to get standardized information about the self-insured plans. The data are needed to provide a systematic way of understanding what health care coverage and costs are for all firms, including self-funded firms. The states would also like to get at the revenue potential of a premium tax. In addition, they would like some limited exemption where the state has

imposed an employer mandate.

Most of our states are not islands like Hawaii and do have to be in the business of competing for employment. I think it is harder politically for a state to do a mandate when it borders a state(s) that does not impose this requirement.

I think we could learn a lot in this country if we had allowed or encouraged a state to continue with its mandate. Massachusetts and Oregon have enacted legislation two or three times, but have delayed the deadline of their mandate. I can tell you states with employer mandates are nervous, and their biggest concern isn't ERISA—it is holding the consensus together for this fundamental change.

LARRY ATKINS: I think a lot of what the states have articulated is the fundamental problem they have with the Supreme Court decision in 1985 in *Massachusetts v. Met Life* to create a distinction between self-insured and insured plans. The self-insured definition has always meant self-administered. So that from the state perspective, to the extent that they try to regulate that insured world, that world just shrinks.

Part of the exercise here is to come to some kind of a resolution about where state responsibility begins and ends and where plans should be reasonably accountable to the federal government. Some of this can be decided on an issue-by-issue basis, particularly in relationship to things like the states' concern to get information.

The Graham-Hatfield bill,² for example, would have granted waivers for premium taxes in one state, for information systems in Minnesota, and for community rating in other states. ERISA preemption waivers would really take down the entire structure of federal regulation and oversight that has been there for large plans. I think to take it in little pieces with ERISA preemption waivers is probably the most dangerous way to go.

² S.2452 was introduced by Sens. Bob Graham (D-FL) and Mark Hatfield (R-OR) Sept. 22, 1993 to grant states specific waivers to remove federal obstacles to existing state laws. The bill died with the end of the 103rd Congress.

DEAN ROSEN: I think a lot of people on the Hill view ERISA as a proxy for markets because it allows a great deal of flexibility for private entities to experiment and deliver health care. They're increasingly starting to view state government experiments as a proxy for governmental control of markets.

FRED HUNT: The ERISA multistate issue was not just for large employers. Keep in mind about 80 percent of all U.S. employers had multistate personnel responsibility, including my small office, which has employees in three jurisdictions: New York, Washington, and Illinois. It's probably closer to 95 percent when you take into account things like the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You may be in Texas, and all of a sudden one person becomes widowed and moves to Alaska. You're now an Alaska plan because most state laws are written in the context of any citizen of the state.

DWIGHT BARTLETT: My bias for state regulation is going to come out here, but a lot of the comments are premised on the notion that the federal government, in fact, regulates ERISA plans. It clearly does not. For example, the Department of Labor has something like 30 employees to deal with all the claims-related complaints of all the self-insured plans covering tens of millions of people. Hundreds of complaints come into my office every day. People who can't get resolution of their complaint against their employer. I can't even refer them to a federal agency to get resolution of it because I know the federal government doesn't do the job.

HOWARD FLUHR: I don't know what the right measure is, but I don't think the measure of whether they're operating effectively is the number of staff in the Labor Department.

I think it's an interesting quirk of history that we have 50 states and, therefore, 50 systems, because

that goes back to the fact that we had 13 colonies. If we were starting a new country today, it seems very unlikely that we would say the first thing we'll do is have 50 different state insurance systems.

BILL LINK: But complying with more than 1,000 state laws doesn't come without a price. It creates pressures within the health care delivery system. Health plans, in an effort to comply with regulations, must put pressure on providers to live up to quality standards, to help the organization meet tough accreditation standards set by the National Committee for Quality Assurance, and to help meet the information demands of the Health Plan Employer Data and Information Set (HEDIS).³ There is also a rigorous utilization management process to help with treatment outcomes, which places demands on providers, and tough contract negotiations to provide for a lean and responsive health care management organization. All of these things serve to improve the quality of care customers receive, but they also stretch the system. Providers begin to rebel against the pressure of the regulatory arena, and to do so they move to the legislative arena.

Any willing provider legislation is a perfect example. Any willing provider mandates, promoted by some provider and consumer groups, limit a health plan's ability to contract with whomever it deems appropriate. Twenty-four states have some sort of any willing provider law on the books. Without a national health reform law, these laws will likely expand, becoming more onerous in states that already have them, breaking new ground in others, and costing consumers more money.

³ *The Health Plan Employer Data and Information Set is a private-sector initiative designed for use by large purchasers in judging the comparative value of competing health care plans.*

Policy Forum Attendees

Moderators

Paul Fronstin EBRI
Dallas Salisbury EBRI

Speakers

Bill Custer EBRI
Denny Dennis National Federation of Independent Business
John Dunlop National Education Association
Ron Hovis SBC Communications Inc.
Stan Jones Consultant
Dan Leach Lutheran Medical Center
Bill Link Prudential Insurance Company of America
Alan Nelson American Society of Internal Medicine
Louise Novotny Communications Workers of America

Discussants

Larry Atkins Winthrop Stimson Putnam & Roberts/
The Corporate Health Care Coalition
David Helms The Alpha Center
Diana Jost Group Health Association of America
Len Nichols Office of Management and Budget
Dean Rosen Office of Senator Dave Durenburger
John Rother American Association of Retired Persons
Syl Schieber The Wyatt Company/ Business Council
on National Health Policy
Paul Van De Water Congressional Budget Office

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Carson Beadle William M. Mercer Co., Inc.
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Arnold & Porter
Special Committee on Aging
The Segal Company
Society of Professional Benefit Administrators
AZ Affordable Healthcare Foundation
National Education Association
National Rural Electric Cooperative Association
MetLife Insurance Company
Office of Senator Bill Bradley
BellSouth Corporation
Congressional Research Service
NYNEX Corporation
Salomon Brothers, Inc.
American Compensation Association
The Wyatt Company
Chemical Bank
University of Maryland
Morgan Guaranty Trust Company
Massachusetts Mutual Life Insurance Company
General Motors
State Street Bank & Trust
Mobil Oil Corporation
Leonard Davis Institute for Health Economics
Coopers & Lybrand
Merrill Lynch & Co., Inc.
The Principal Financial Group
IBM
The Commonwealth Fund
Capital Guardian Trust Company
Kwasha Lipton
APPWP
MetLife Insurance Company
U.S. Department of Health and Human Services
Senate Labor Health Subcommittee
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