CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Defining "Defined Contributions": New Directions for Employer-Sponsored Health Insurance Coverage?

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Introduction, Opening Remarks

DR. GINSBURG: I'd like to welcome you to HSC's third and final conference of the year entitled "Defining Defined Contributions." In this meeting we're attempting to get a better sense of whether defined contributions represents a future direction for employer-sponsored health benefits. We see this meeting of interest to benefits managers, to unions, to health plans, and to public policymakers.

Whatever changes are made will reverberate through the health care system and affect the consumers that it serves.

In June, at our annual "Wall Street Comes to Washington Meeting," I asked the analysts about what they had been reading in the trade press, and they characterized defined contributions as a key emerging trend and helped us make the decision to have this meeting. And in our site visits, we've been asking benefits consultants about this and have been told that it's very much on the minds of employers, but that few concrete steps have been taken or even planned at this point.

In today's program we're going to better define the various approaches that come under this category "defined contributions." We're going to examine in-depth their feasibility, and we're going to discuss the implications for consumers and for policy.

Let me provide an update on the center. We're currently collecting the third round of data from the Community Tracking Study. As you know, the Community Tracking Study involves biennial surveys of households, employers, and physicians in 60 communities across the United States, as well as site visits to 12 of these communities. The CTS is focused on identifying major changes in the nation's health system and analyzing the effects of such changes on individuals.

In February, we began releasing trend information from the first two rounds of the surveys and will be releasing many more such studies in the coming months. Next month, reports that chronicle changes from the intensive study sites will be released.

To keep on top of these studies, I'd like to suggest that you register on our web site to receive e-mail alerts about these topics as they come out.

Let me close by saying that this year is the fifth anniversary of HSC, and I want to take a moment to thank the Robert Wood Johnson Foundation for their continued support of HSC and also to acknowledge the contributions of Mathematica Policy Research, which whom we are affiliated.

Let me introduce the speakers. Our first speaker is Sally Trude, and she will be followed by two separate panels. Sally Trude is a senior researcher at HSC who previously worked at MedPAC and Rand, and she's the lead author of the defined contributions Issue Brief which we are releasing today and which is in all of your packets.

Sally will start us off by presenting a framework that characterizes the various defined contribution approaches and which will help organize our discussions throughout the day.

The first panel consists of three Internet entrepreneurs with distinct products that seek in various ways to support a movement to defined contributions. The panelists include Ray Herschman, who is CEO and founder of HealthSync, and previously held numerous senior positions at University Hospitals Health System of Cleveland and its QualChoice health plan; Dr. Lee Newcomer, who is executive vice president and chief medical officer of Vivius and held numerous senior positions at United HealthCare; and, finally, Steve Wiggins, who is chairman and CEO of HealthMarket, and who was previously the founder and CEO of Oxford Health Plans.

Jon Christianson from the University of Minnesota will moderate this panel. John is a widely published economist who has worked extensively with HSC on its site visits going back to round one.

The second panel includes an employer, a union representative, two health benefits consultants who have large employer clients, and Sally Trude.

In the order in which they are sitting--I hope they are sitting, right?--Larry Atkins is the founder and president of Health Policy Analysts, where he advises Fortunate 100 companies, among other clients; David Blitzstein is the director of the Negotiated Benefits Department at the United Food and Commercial Workers International Union; Helen Darling is a senior consultant at Watson Wyatt & Company, where she assists purchasers with their health care and group benefits decisions; and Pam Krol is director of Health Programs and Benefits Administration for Lucent Technologies, where she is responsible for health care policy, strategy, administration, and performance management.

Looking at the agenda, we'll begin with Sally Trude giving a 15-minute overview of defined contributions, and this will be followed by the Internet panel. Each of these participants will provide a short description of their product and how it relates to defined contributions. Then Jon Christianson will ask follow-up questions. Then we will have questions from the floor. Then we'll take a break, and the second panel I will moderate. This will be no presentations but just discussion, and then we'll have a second opportunity for questions and answers from the audience after this panel discussion.

Let me turn it over to Sally Trude.

Overview of Defined Contributions

DR. TRUDE: Thank you.

Let's see, do we have the lights?

Defined contributions have become the latest rage in employer-sponsored insurance. Is this the beginning of a new revolution in health insurance, or does it merely reflect employers' frustrations with the current system? Hopefully by the end of this conference, we'll have a better sense of which.

For my part, I'd like to clarify some of the uses of the term "defined contributions," discuss the trade-offs between the approaches, and conclude with a look at the potential policy implications of a widespread move to defined contributions.

What I also hope to show is that for a discussion of defined contributions, the definitions matter. They especially matter for understanding the trade-offs and the policy implications.

The framework I will lay out for you today should also provide a useful context for the panelist discussion that follows.

The Jackson Hole Group first popularized defined contributions in the 1970s with their concept of managed competition. They felt that health insurance would be improved if consumers would bear more of the cost burden.

First, purchasers were expected to pay a fixed dollar amount toward premiums, ideally the cost of the lowest-priced plan; second, purchasers are expected to offer a range of plan choices and information to help the consumers make their decisions; third, employees were expected to pay any extra costs if they chose a higher-price plan.

This whole package requires substantial administration and oversight on the part of purchasers and, hence, the name managed competition.

Today we see that some of the structure of managed competition has become part of the health insurance landscape, although the inroads of fixed contributions has not been as extensive. There's only 8 percent of employees who have a choice of plan with the fixed-dollar contribution. Employers limited to offering a single health plan are sort of the main reason for that.

And so the employers that offer a choice of plans do see substantial administrative burden. As I mentioned, they have to choose among the competing plans, assess the plan performance, and convey all of this to their employees. Yet for all this, employers find themselves faced with the managed care backlash and potential liability.

So now, in counterpoint to managed competition, defined contributions for pensions have recently been suggested as an alternative model for health benefits.

Similar to retirement benefits, the employer contributes a dollar amount toward health benefits and shifts the risk and responsibility for those dollars to the employee. For employers, this could substantially reduce their administrative burden, expand choice, empower consumers and avoid the backlash, and make their costs more predictable.

But there are drawbacks to defined contributions for health benefits that don't apply to pensions.

Currently, employers pool risk and all employees within that pool pay the same amount for coverage, despite differences in likely use. Without this, older and sicker workers may be unable to obtain or afford health insurance.

In addition, under current arrangements, employers and health plans limit the range of choices to avoid adverse selection. A defined contribution approach may not be able to expand choice for these same reasons.

Furthermore, many workers look to their employers to negotiate with plans on their behalf, for example, in negotiating with plans on their behalf on issues of price and coverage. This advocacy role could be lost under a defined contribution approach.

The benefits and consequences of moving to defined contributions will depend on the approach taken, however. I've already discussed the fixed-dollar contribution approach. More recently, there's

been a proposal, what we call a cash transfer, which involves paying the workers higher wages in lieu of health insurance. If the worker chooses, they can buy health insurance on the individual market, or they can use the cash for other purchases. This approach, however, would lose the current tax advantages.

Another approach would be to issue vouchers to ensure that the money is used for health benefits and, therefore, you can preserve the tax advantages.

As you can see from this slide, the voucher and cash options promise to reduce the employer's administrative burden and also expand choice. Now, as designed, the fixed-contribution approach was also supposed to expand choice, and there has been an expansion of choice, but not because of the widespread adoption of fixed contributions.

The extent to which vouchers and cash transfers might expand choice will depend on what's available on the individual market.

As mentioned earlier, vouchers and cash approaches leave more responsibility to the employee, but then they lose the value of the purchaser clout and the risk pool.

Risk selection is common among all three scenarios, although under the fixed-contribution approach it's typically handled by the health benefit manager, by the management of the benefits and plan offerings.

In the future, though, emerging Internet ventures may affect employers' health insurance strategies and whether or not they move to defined contribution. There's been an explosion in this area of new Internet ventures offering a vast array of options for employers. I have broken it into basically three groups:

First, there are ventures that provide some technological improvements that reduce administrative costs but basically operate under the current system.

Second, there are some ventures that would require employers to go to fixed contributions or a defined contribution approach. And even within this group, there is a wide variety of options which you are going to see today.

The third group supports those purchasing health insurance in the individual market. The California Health Care Foundation recently published a report contrasting three web sites that offer these services, and this approach may radically change the role of brokers in some of the local markets.

Today's panel are all representative of the second group I mentioned: Internet entrepreneurs that should facility employer's move to defined contributions. With the help of both panels today, I hope we can resolve whether defined contribution approached are the wave of the future and what role the Internet might play in all of this.

In closing, I'd like to note some of the policy implications a movement to defined contributions could make, although what the implications are is ultimately going to depend on the approaches that employers take. And one impact could be on the number of uninsured persons.

If employers used defined contribution approaches to target low-wage workers, we could reduce the number of uninsured, for instance, by offering one plan at no cost, and that would make it affordable for the low-wage workers who typically don't take up insurance due to cost.

On the other hand, substantial reliance on the individual market without reforms to that market could potentially increase the number of uninsured. EBRI estimates that workers in large companies would pay about 32 percent more on average if they had to buy their premiums on the individual market. And older workers would be faced with much higher premiums than would younger workers,

who might not bother to even buy the insurance. And that way you could see that there might be more uninsured as a result of that.

Finally, defined contributions can also have implications for patient protections. Currently, employers play an important role resolving customer service issues and disputes over coverage. Some employers also play an important role in patient safety, quality improvement, and insuring accountability. So if employers move to defined contributions to avoid the managed care backlash and employees lose their employers as an advocate, there may be a call for government to play a stronger role in patient protection and regulation to take up the role that employers have left behind.

DR. GINSBURG: Thank you, Sally.

Panel One: Internet Approaches

We'll turn to Jon Christianson, who will moderate the first panel.

DR.CHRISTIANSON: I think we'll go right into the presentations of the panel members, and, Ray, why don't you start?

MR. HERSCHMAN: Sure. Good morning. I appreciate the time today.

I want to cover five key points: first, HealthSync, what we are. HealthSync is an employer-sponsored electronic marketplace or exchange where employees become consumers and purchase their coverage based on what's most important to them as an individual. And there are some key words in there. Employer-sponsored, this is clearly a key criteria in meeting with employers. They are not looking to cut and run. Any notion of that is a showstopper, and this is clearly an area which provides a basis for which this system works.

Two is that consumer-driven is an imperative. The way employers make decisions is based on averages, and it's very different from how you as an individual would select your own coverage. And so you need to have that transfer of decision making from an employer to the employee.

Point two. You need some rules. To have an exchange, to have a marketplace, there are rules that have to address two key areas. The first is from the buyer perspective, the buyers being employers and their employees. From the buyer perspective, no individual underwriting. There has to be maintaining of the social contract of insurance, pooling of risk. Employers will not migrate to defined contribution if there's any risk that any of their employees would get priced out of the market. We've developed a rule system that addresses that area.

From the seller side, you need rules to protect the interest of the sellers, the sellers being carriers and the provider networks. If the sellers do not have assurance that the premiums they receive correspond with the relative risk of individuals that end up buying them in the marketplace, you don't have a marketplace. These are tough areas to address, and what we've done is we've addressed these in a very complex but rational basis using actuaries and computer systems to be able to maintain the pooling of risk on the one hand and the distribution of premiums addressing adverse selection risk on the other hand.

If you have no rules, you don't have a marketplace. If the rules are too lax, if there is not enough structure that brings down the perceived risk of entering the marketplace to at least where it is today, you won't have a marketplace. And if the rules are too rigid, you won't have a marketplace either.

The rules have to be dynamic, and the rules have to be progressive, and they have to utilize technology and they have to utilize information. The key of the rules is to improve market efficiency. We can talk more about rules as we go on.

The third point is process. For an employer to even think about moving towards this idea, there has to be a process whereby a very complex decision right now, purchasing health care coverage, is brought down to the level where the average employee--below-average employee can make that decision. It's critical. This is very complicated. It doesn't have to be complicated. I think one of the outcomes of a consumer-driven health marketplace would be radical simplification. I'm sure the carriers would welcome it. The consumers would welcome it. You won't see those changes unless it does become a consumer marketplace.

We've created a process by which there's the Internet, there's customer support, a contact center; there's also humans that will sit down with employees and walk them through the buy process. It doesn't mean that we will tell anybody what to buy, what's better, what's worse, but the process is critical.

What we've done is we've looked at other software applications that have taken things very complicated and have simplified them down to the level where an 8th grader could do it. I think we're aiming for 4th grade level. Right now we're at 8th grade level.

The easiest example is Turbo Tax. If we all did taxes in this room ourselves the old-fashioned way with the books, we'd all come up with a different answer. Thirty-eight million Americans use Turbo Tax. Why? They've created a process, a structured syntax, and it shows you where you're at in the process. You could go back and make changes, and you get a result. We followed that same methodology to provide some structure to purchasing health coverage at an individual level.

Decision support and strategic partners. This change will not happen if our company, these companies here don't leverage the talents of other organizations that have core competencies in benefits administration, benefits consulting, payroll deduction, all the different technological aspects of bringing about a marketplace. That is a must-have, and we've gone about this in a very strategic way, not only from the employer transfer side but also from a consumer side, decision support.

There are a number of companies--some of them exist now, some of the organizations, NCQA, Quality Compass--there's a number of organizations out there that exist, there's a number of new ones that are developing very rich information for informed consumers, which makes an efficient marketplace. We're going about bringing that information to the table so that people can make that decision.

And, lastly, the marketplace has to be objective and neutral. To have a marketplace, there can be no real or perceived bias. And so for our organization, the key is to make sure that we do not take money from insurance companies in investment, we don't tell anybody what they should buy and create bias, but to create a neutral utility, if you will, that creates the marketplace.

The way it works is an employer would establish what their contribution strategy is. This is an employer's decision. This is how it works today. At one tier everybody gets the same amount of money; two tier, single plus family; three tier, single, single plus spouse/family. That's up to the employer what their strategy is.

The consumer then goes to the marketplace. They go to the Internet or Intranet. They go to the contact center. They sit down with somebody. And they take from the broad marketplace and they query the marketplace what's most important to them as an individual. Is it Dr. Jones in University Hospital? Is it price? Is it brand? My mom bought Blue Cross, I buy Blue Cross. Is it network? It's all up to the individual. Is it benefits? Do they want a new type of benefit that allows them to be more in control of the claims detail process? That's up to the individual.

The individual puts these attributes in, and from the broad choice in the marketplace, we developed a query engine that brings back to you, the individual, what meets your selection criteria. And you can pare that down, you can broaden, and you make a buy decision. If you buy something that costs more than what your employer is funding, there's a payroll deduction.

All of the money from the employer, all of the defined contributions from the employer plus all the payroll deductions from the employees, if they opt to pay more out of their pocket, are pooled in an employer plan account. This is critical. It keeps the pooling of risk in place. So the social contract of insurance is maintained. Young subsidize old; healthy, sick; large contract size, small contract size. All the elements of insurance are still maintained in this pooled account. It's an employer-controlled account.

Also, because of this pooled account, you keep the tax treatment for the individual's contribution. Our company then picks up that money and distributes that money out to the carriers based on who selected them. This is where the risk adjusting occurs.

What we've done is we've created a series of variables. It's the exact same variables that carriers use right now when they develop a quote for an employer group.

In large employers, for example--and this is what we're talking, large and medium size employers. There's a number of reasons for that. When a carrier competes for some of that business, it's called slice business. And what happens is they get experience, demographics, industry code, a number of other variables, and they go in the back room--this used to be my job--and you guess at what distribution of that population you're going to get. And then you wait six weeks and you sweat. Okay? If you're the underwriter, this is serious sweating.

Then, if you miss, what you get from the marketplace--if you get older, if you get bigger contracts, you lose. What we have done is we've turned the elements that the actuaries use right now in rating, we turn them into variables so that when you as a consumer go out to shop, you see a group rate, a group rate that's specific to the employer group you come from.

There's a number of reasons why. One is there's no free lunches. If you have asbestos workers and architects, they can't enter the marketplace and all of a sudden have a community rate. You won't have a marketplace.

DR.CHRISTIANSON: Ray, we're going to have to ask you to finish up in another minutes or so.

MR. HERSCHMAN: Sure.

DR.CHRISTIANSON: And in the process of doing that, can you let us--you know, give us some information on how many people actually use your marketplace and why carriers would want to participate in it.

MR. HERSCHMAN: Okay. The carriers are interested in participating because they are protected from adverse selection risk. And there's no other model right now out there that does this.

Two is we have had pilot planning meetings--we are not up and running yet--in both Atlanta and the Cleveland area with large numbers. On Thursday, last Thursday, we had 19 Fortune 500 companies sitting as a group so that none of them players are going out there by themselves exposed, so we could get up a marketplace. You get the critical mass. You get the group protection. And it makes for easier going on moving to this change.

DR.CHRISTIANSON: And what's your time target then?

MR. HERSCHMAN: We will be up and running in February of next year, and we will have real revenues and open enrollment July 1st of next year.

DR.CHRISTIANSON: Do you have any quick summary statements before Lee takes over?

MR. HERSCHMAN: Quick summary. Just an example so this goes in your head because this is important. The young 25-year-old male and the 55-year-old male go with the marketplace. They both pick HMO 101. They both see a price of $150. Their employer has given them $120. They both agree to have a $30 payroll deduction. It goes into the pot. There's $300 in the pot. A hundred dollars follows the young guy, $200 follows the old guy. Okay? So that idea, that notion of how the distribution works so that the carriers are protected is critical.

Thank you very much.

DR.CHRISTIANSON: Thank you. I don't know whether I like the reference to the old guy, but other than that--

[Laughter.]

DR.CHRISTIANSON: Lee, why don't you go ahead?

MR. NEWCOMER: You just confirmed what my son's been saying about my age for some time.

We were just called about 20 minutes ago Internet entrepreneurs, and I was struck by that because I've never considered myself that. And I think as you listen to these three discussions today, the Internet is basically just a tool. What we really are is marketplace entrepreneurs. You just heard about our marketplace for health plans. Steve's company is actually titled HealthMarket. Let me read you our mission statement.

It says: We are creating an open health care market driven by personal values and choices. So this discussion today is not about the Internet. This discussion is about how do we take health care purchasing and bring to it all the positives of a true marketplace.

And one of the consequences of that from my physician perspective is you will also begin to put the physician and the patient back together again in a true physician-patient relationship without a third party in the middle. But this time there is far more accountability for both the patient and the physician.

So you're taking, again, the positives of a physician-patient relationship, getting rid of all the things that used to get in the way of it, but making sure that both parties are accountable to each other, and that's what a marketplace can do much more powerfully than millions of rules that you and I might write together.

Let me tell you briefly how Vivius works and see if we can't demonstrate how we are creating that true open health care marketplace.

We also start with a voucher form of a defined contribution, so money is seeded into a health spending account by the employer, and it's the employer who decides how that money--what kind of scheme they will have for funding the employee's account.

Once the employee has that money in their health care spending account, it is dedicated only to health care. It can be used for other purposes. And it can already be done in the existing cafeteria plan laws that exist today.

The employee has two jobs with that money. The first is to select 22 different health plans, basically health care providers, ranging from a personal care physician--primary care, as we know them--to an orthopod, an OB/GYN, to a hospital, to an outpatient surgery facility, and a pharmacy. There are 22 selections they will make that become their personal set of providers.

Those providers will be able to cover about 90 percent of any health care problems that patient would run into. For the other 10 percent, the employee is required to buy a mandatory indemnity

insurance policy, good old-fashioned 80/20 coverage, and that indemnity policy applies only to those 10 percent of items that the 22 choices they made before can't take care of. For example, you don't choose a pediatric cardiologist. If you need one, the wrap-around insurance policy covers that.

What my company does right now is provides the marketplace for the employee to make those choices. Think of us as a supermarket with 22 different aisles in it. There's an aisle for internal medicine. There's an aisle for orthopedics. There's an aisle for dermatology. There's an aisle for hospitals.

And right now we're stocking the shelves of those aisles with the various providers as we're going out in the marketplace. We're saying to them, before you put your box on that shelf, the first thing we want you to do is put a label on it. Tell us all the information that we should put on that label that a consumer would be interested in reading about your practice. Some of it's very obvious: What are your office hours and where is your office? But it can also get as sophisticated as tell me about all the performance data in your practice. If you do surgery, what are your complication rates? How many cases did you do last year? It can be HEDIS data. It can be anything that the physician believes is relevant to their patient.

And just as an aside, they won't put HEDIS data there because it's not relevant to most of their patients.

The second thing they post on that label is their price. Just like every other product on a supermarket shelf, it has a price. This price is a retainer. The physician is saying for X amount of dollars every month, if you have a problem that requires my specialty, I'll take care of you.

Now, a lot of people in the old world would call that capitation, and it is. But there are some very important differences between this form of capitation and what you saw in the Californias and Floridas of the world.

First of all, it is the physician setting the price, not the health plan. The health plan said here's our budget, go make it work. The physician is saying I know I need this much money to deliver proper care, that's what I'll charge. It's the consumer who decides whether or not that's a fair price.

Second is we're not pooling the physician with anyone else. In all the large capitation schemes that have failed, you saw physicians get pooled with people they didn't know, people they didn't work with, people they had no business relationship with, and they couldn't control it. Here the only thing they're putting at risk is their time and their effort. That's what they're pricing.

The third thing that they put on the label before their box goes on the supermarket shelf is a list of recommendations. If I were shopping with you, who would I tell you to pick in the other 21 aisles? We are stocking the shelves currently in Kansas City, Minneapolis, and Denver. We have about 2,000 physicians actively enrolled so far in the communities of Kansas City and Minneapolis.

Now the consumer walks into our supermarket with their voucher in hand. They look at the 22 aisles, and the first thing they say is there's no way I can do this. And they're right. I can't do it either. I don't know a urologist in Minneapolis, and I don't want to know a urologist in Minneapolis.

So we give them a little help. We have them start with a personal doctor. It can be anybody. It just has to be somebody they know and they trust. So they type in that physician's name, and what they get is a shopping list provided by that physician. I would type in Sam Carlson. He's an internist who's taken care of me for ten years. When I need a specialist, I call Sam and say, Who should I see? I would type in Sam's name, and I would get on the next screen a list of those 22 aisles with Sam's suggestion about who to buy.

At that point I have a couple choices. I can just walk down the aisles and take them all, everybody that Sam recommended, and I'm done. I can also go shopping. I can come to the orthopedics aisle and say, well, Sam recommended Jay Albright, I don't know him, I assume he's good because Sam recommended him. But, you know, I had a great experience with some guy named Greg Strathey three years ago. He took care of a sprained ankle. I liked him a lot. He was thorough. He explained things. I got right in. He was always on time.

I could go down the aisle and look for Greg Strathey, do that on the Internet. I would find out that Greg Strathey is there. He costs, by the way, $2 a month more than Jay Albright. And now as a consumer I get to make a choice. Did I think he was that good? If I did, I'll pay that $2 very willingly. If I didn't think he was quite that good, I may go back to Albright and save some money. It's up to me to use my values to determine who I want to take care of me.

When I'm done with those 22 choices, I know exactly each month what I'll have to pay to those doctors to have coverage, and I'll have first-dollar coverage, basically a copayment, whenever I go see those physicians, hospitals, or pharmacies.

Now, when you think about that, there are several things that we've done different from a policy standpoint in the marketplace. For the first time ever--and you'll here this also, I think, with Steve's presentation--is the physicians and hospitals that do a better job can actually ask for a higher price in the marketplace. You can't do that today under current health plan laws. If I'm a physician, I'm an oncologist and I take care of a patient superbly, I send a bill into the health plan. If I take care of that patient very mediocrely, I still send a bill, and the health plan would pay me exactly the same amount of money regardless of how well I did it.

The marketplace turns that around. If you're delivering superb customer service, if the technical quality of your care is superb and you can show it, you can legitimately ask for a better price and people will pay it. They do it in every other marketplace we have today. I pay a ridiculous amount of money for a shaving system that has three blades because it works better. I pay a fairly low amount of money for an automobile because I don't care about particular amenities and qualities of those. So I don't have a Lexus. I drive a Chevy truck.

Those are choices that I get to make in the marketplace, but I don't get to make when it comes to health care. We changed that around with this system.

The second thing we do is we put the physician and the patient back together again and take out the third party. There is no medical management in our system. The physician doesn't have to ask for permission to take care of anybody because they have incentives that are correctly aligned. Their incentive is to clearly take care of their patient well or their patient will leave them in the marketplace and go to someone else. But because they are putting out a retainer fee, they have the incentive to be efficient about how they take care of that patient. Doctors under this system are a lot more likely to call their patients and talk to them over the phone than have them come into the office.

The third thing that we do is bring back accountability. Each party now is accountable to the other in a way that's direct. This is a direct contracting model. And I would argue that that purchasing clout is far more powerful than anything an employer can put together, because a physician pays the most attention not to General X but to their patient. And when their patient's coming in saying you just did a 25 percent price increase on me last year, I can't afford it, I've got to go find somebody else because they would do just as good a job, that will have far more impact on how that physician prices than whatever they might hear from a health plan or General X Corporation.

DR.CHRISTIANSON: Lee, can I--

MR. NEWCOMER: We're done.

DR.CHRISTIANSON: Okay. I have a couple of real quick questions for you, then. How do you make money out of this?

MR. NEWCOMER: We make money by taking a percentage of the money that gets transferred from the employee to the employer every month. It looks a lot like a credit card transaction. So we go into the employee's account, draw off the funds that he has promised to pay as a retainer, take 4 percent of that and send it off the physician.

DR.CHRISTIANSON: And the second question is: You've noted that you have stocked the shelves with physicians in Kansas City and Minneapolis. How many people do you have that are actually using Vivius now, or what's your target date for--

MR. NEWCOMER: Our target date for opening to the public is first quarter 2001, so today's there no employees enrolled at all. We're still in the process of stocking the shelves and making sure that we have enough people on all those shelves to be attractive.

DR.CHRISTIANSON: And third is more conceptual. I admire your attempt to substitute the word "retainer" for "capitation," and if you pull it off, it's brilliant.

[Laughter.]

MR. NEWCOMER: Okay.

DR.CHRISTIANSON: But what happens with the individual physician? How do you get enough patients signed up with an individual physician so that that physician feels comfortable with pooling of risk.

MR. NEWCOMER: As we began with an employee count of zero, the physician is, in fact, joining us in this venture, because it's quite possible that in the first year they may have to do a procedure, and you know what? They're going to do that procedure for $100, maybe $200.

The key is, obviously, to have lots of patients so you can begin to do the good old-fashioned pooling and the actuarial disbursement of risk. But today, if you talk to any physician and asked him how many cases last year were denied by Medicare or by the HMOs in their community, almost all of them will pull off a stack of at least two dozen cases for which they received no payment. And most of them are quite willing to take that adventure and take that risk with us as we begin to grow.

DR.CHRISTIANSON: Okay. Thank you.

MR. NEWCOMER: Thank you.

DR.CHRISTIANSON: Steve?

MR. WIGGINS: Ten minutes starting now. Lee, have you noticed how many middle-aged guys like you and I are driving trucks?

[Laughter.]

MR. WIGGINS: Is there something going on?

I'm going to talk about a completely different concept here. Hold on to your seats because it's not an easy one to understand, and that's probably our biggest challenge. We are creating at HealthMarket a business that is truly an alternative to all of the existing managed care models. It's a completely different paradigm for managing risk. It's a completely different paradigm for organizing, financing, purchasing health care, and in the process, we're bringing both price and quality transparency to the market. And I will get into some of those briefly, very briefly.

We are absolutely not dependent upon defined contribution in this business. We're just creating a new product that will sit out there on the shelf, to use Lee's wonderful metaphor of the grocery store. We will simply try to take up some of the shelf space which is occupied right now by what is essentially three different product designs. There's indemnity, various permutations of that; there's HMO, permutations of that; and there's PPO, or point of service. And many of you in the room know, years ago, when I introduced the first point of service plan and we came up with that phrase, it was copying a Minnesota experiment that had been done by Blue Cross of Minnesota and reported in Health Affairs.

And since that time, there's really been no product on the shelf. And so what we're trying to do is not try to catch the wind of defined contribution, but we're trying to create an alternative product, whether employers move to define contribution or not. If they do, it's going to be a heavy wind at our backs, and certainly we will have the sails up for it. But it is not really a defined contribution play, although most of these conferences I do sit on panels that are defined contribution health plan panels, and we're stuck in this definition of ourselves whether we like it or not.

I'm also not creating a health plan. I think that distinguishes quite a bit from I think Lee is creating a new type of health plan, and it'll be exciting to see if people do want to make that advance selection of their network. I'm creating an operating system that allows any health plan to offer this new type of product I'm about to confuse you with. I'm creating an, essentially--we're trying to be the "Intel inside" insurers that enable them to administer and execute on a new family of insurance products that address all of these issues of risk spreading, all of the things that Tootie or Trudy? Sally Trude, sorry.

[Laughter.]

MR. WIGGINS: I have three Tooties in my life and one Trudy.

So let me take you through the product quickly. First of all, it depends upon self-direction of the health care dollar. We essentially give the individual subscriber total control of the insurance dollar to spend as they see fit. It's a little bit radical, but it can be done with controls. It actually is an actuarial model that is more successful than managed care. And 1/1/2001, when we launch this in the first 11 states--it'll be in all 50 states by the end of 2001 with insurance partners that we've already set up and that we'll write it on their paper--it'll generally hit price points, on average, that are about 15 to 20 percent below managed care.

How do we do it? I'll explain the three levels of coverage that we have.

The lowest level are those things that are routine care. For 82 percent of you, you consume $500 to $800 or less, depending on your market, of health care services. We don't do anything to manage those resources. I ran a Fortune 300 HMO that I built from scratch, and I learned that that model has profound problems. I also built a big physician practice management company that took lots of capitated risks and have contended with all of the dilemmas of capitation, both as it relates to restrictions on choice and as it relates to the bad outcomes financially for the providers. So for that low end, routine care, all it is is an old-fashioned insurance policy that says, "This is how much we pay for each service, go wherever you want, and you can access all of our networks." And we've contracted with every single network we can find in our first five launch markets, where we're going deep with provider recruitment people in the markets. And we've signed up two big national PPOs that you can access their prices.

And, by the way, you can go onto our Internet site today, and for the first time in health care you can actually see what it'll cost in your town to go to your doctor at our deal. You can log on right now and see that. That's price transparency for the first time in health care. It's never happened. It's a

little bit controversial. It's a lot controversial because health and law are the last bastions of secret pricing. And so it's going to be a while before it's completely accepted by all providers that their prices get put on the Internet. But you don't need to be on the Internet.

You can also call up and say, "I've got $100 for this office visit in my allowance, in my plan, for my routine services. Can you tell me what doctors I could go to in my Zip Code that would fall under that. Or you might want to log onto our site and do a qualitative examination of the providers. We have wonderful information, and it's getting better every day. We have a release coming out every month right now of the website. And you can see exactly what it costs and what their background is. And we're headed towards volume data, outcomes data. We're relying on a lot of other firms to help us with that.

Now, let's move up the risk ladder to the 17 percent of you that have acute and chronic conditions for which you seek health care every year. You, 17 percent, consume 65 percent of the medical dollar. And it's those of you that are in that 17 percent that have the widest variance in spending, often without good reason. And that's where managed care comes in. We developed medical management, precertification, all of the utilization review programs, referral programs. All of that was developed to control generally that 17 percent of people that experiences wide variance in their cost outcomes.

What we've done there is worked with the best people in the country, in the field of episode definition. And we create an episode allowance around getting a hip replacement or having a baby. So you, in our program, you would log on. We would send you an e-mail, as soon as we get an alerting claim that indicates you are pregnant, and we would send an immediate e-mail back to you indicating you have $21,000 or whatever the allowance is in your market to spend.

You can either call us and an ombudsman will manage you, if you will. You can opt into managed care, and we'll take care of making sure that you have no exposure. Or you can spend the money as you see fit, log onto our site. We're getting bids from providers for those episodes. We're going to hospitals and saying, "Will you give us a package price?" Physician groups are doing it, disease management companies are giving us these bids, and we're creating a unit of purchase out there, a product, if you will, which is an episode. It is an episode of care that instead of buying a service that an ala carte service, you're buying the solution, you're buying total labor and delivery or you're buying a hip replacement, you're buying the total package from a provider. You are not forced to make any decisions about selection of provider until you need them, and you are motivated to do that selection.

Finally, at the very top end, the catastrophic care--those are the neonates, the traumas and the transplants--you are covered 100 percent because nobody can be expected to work with an allowance there. And we do have old-fashioned case management there. You can opt out of case management, if you'd like, but then you opt into an allowance. But we don't advise that for anyone in those situations.

We're very hopeful that people like HealthSync, and Sagio [ph] and E. Bennix [ph] and all of these companies are successful. To every one of them, we're going to make our services available on their exchanges because this idea of an online purchasing cooperative really drives people to the individual purchase decision. And I don't expect that the product that I've created here is going to be for all of you. It's probably only for either the most savvy health care consumer out there or the most Internet savvy, sort of information-seeking person. We call them self-directed health plans. We borrowed the phrase from self-directed IRAs. And in the product, you can pretty much self direct as much or as little as you'd like. And that's my ten minutes of time up here.

DR.CHRISTIANSON: How many people do you expect eventually to use your product?

MR. WIGGINS: Well, right now we have thousands every day just logging onto the site to see prices of health care providers, and then can bind our price online. You don't even have to be an enrolled subscriber. We're providing that to people that don't have insurance right now. If you do not have insurance and you need to seek health care, you can get about a 40-percent discount by coming to our site. And we deliver to you the purchasing power of an HMO.

The networks are a little nervous about it. Some of the health plans are nervous about posting their fees online. But we have three health plans that are teeing up to offer our products, one in 2001. We have a partnership with Zurich Financial Group. They're offering it on their license in 50 states. In the event we can't get local health plans to offer it, it'll be available everywhere as an option.

We expect that it'll be most attractive to large employers where some employees join. We think it'll also be very attractive in the individual market, where it's more price sensitive and people are already making more of the individual purchase decisions. And we expect that over time it will become increasingly attractive in smaller employers that are a little bit more Internet savvy or information savvy.

DR.CHRISTIANSON: Thank you.

What we're going to do now is I'm going to ask a couple of questions of the panel as a whole, and then Paul will field questions from the audience and direct them to the panel members.

So let me just start out by asking everybody on the panel here to--I'm going to sort of turn around Sally's observations earlier. She was talking about some of the public policy issues that might be raised by defined contribution approaches. I'd like to turn that around and ask the panel members if there are particular regulatory kinds of issues that exist right now that are important and significant to them in developing their products.

Let's start with Ray.

MR. HERSCHMAN: Not any specific issue. I think that in meeting with a number of folks in the legislative process, I think what we've heard most is that they don't want to develop code that will actually ruin this momentum. I think our business, different from these businesses, because they are very different, provide a framework where you can bring in under an uninsured if there was going to be some type of government subsidy voucher, payroll deduction. Where would you go with that? You need a marketplace.

So the issue is how do you not have legislation ruin it as opposed to what's in place right now. And I think in discussing this in more depth, it's clear that if the government is going to step in to provide some relief, some graduated way to provide coverage for an un- and underinsured, that it's going to be through payroll deductions of some sort initially. There's no other way that you would be able to have that happen at an individual level through your annual tax filing or something like this.

So I think the key is is that there's communication. I think aside from that, the government really has started to talk about how do you aggregate small groups. There are some actuarial and underwriting issues and a lot of state regulatory issues around a small group that have to be addressed at a federal level. This is going to really work its way down to a small employer.

MR. NEWCOMER: I would ask for two things. The first is, in all of our programs, if a consumer decides to save a little money, they should be allowed to carry that over to the following year tax free. We'd love to have that provision. Because it doesn't matter what program you are talking about, unfortunately today, if a consumer saves some money and it's in a cafeteria plan, it goes back to the employer at the end of the year. It's use it or lose it.

So what are the incentives? Spend it on something. That's why we all have new eyeglasses in December. That's why we all get shinier teeth in December. And to be able to carry that over to save that money for a rainy day, when I finally do become one of those 17 percent, I may want to use that money then. That would clearly help in all of our existing laws.

I think the second thing I would ask for is a little bit of diligence in the FTC area. My kids have braces on. I priced 18 different orthodontists in the Minneapolis-St. Paul area and got exactly the same price from all 18. Where's the marketplace? And why doesn't the FTC or someone else get a little interested when every single provider in the community has exactly the same price? I think we need to look at that within the health care arena that exists today. I think the opportunity for it exists even more with products like Steve just described or I did, where the prices are very obvious, very public. If they all come to the same site, it makes you wonder about what's going on.

DR.CHRISTIANSON: Lee, that's interesting. In the tracking study, one of the things that we've noticed over the last two rounds is a lot of mergers of single specialty groups. And I think your model really depends on competition among physicians to hold prices down. And if there aren't competing groups in these communities, it's a little hard to see how that's going to work for the consumer in the long run.

MR. NEWCOMER: That's one of the risks.

DR.CHRISTIANSON: One of the articles about Vivius on the Internet that I read quoted an insurance commissioner from Kansas talking about how they couldn't decide whether to regulate you as an insurer or not. What's your position on that?

MR. NEWCOMER: Well, the wraparound is clearly an insurance. And that we have no problem with. The other 90 percent, the physicians in hospitals who are taking their own small individual piece of risk, we would argue that is a business risk and not an insurable entity. And today as we've been in front of both Minnesota, Missouri, Kansas and Colorado, no one has decided that this product is a regulatable entity from the provider's standpoint today. Now, that could change. We understand that. But they've all seen the model, and at least the first pass has said it's not a regulatable entity.

DR.CHRISTIANSON: Steve?

MR. WIGGINS: Well, I served with that insurance commissioner on Clinton's Commission for Patient Protection, and she'll regulate you for sure.

[Laughter.]

MR. WIGGINS: She'll come up with a strategy, I have no doubt. Nancy is a regulator at heart.

There's really no restrictions on our product in current law. It exists very nicely within all existing insurance laws and regs. The problem is not many people understand it. Our biggest challenge is really at the consumer side and on the provider side. On the consumer side, making sure consumers are comfortable with self-directed health care concepts, and it won't be for all at first. My guess is it takes some time to get into the marketplace.

And on the provider side, there are 82 episodes for that 17 percent of the people. We have defined 82 episodes. Each episode has modifiers for complications and risk that raise the reimbursement based on what comes in. It's the most sophisticated data analytic undertaking I am aware has ever happened in organizing health care around episodes. And when we get out there and begin communicating it, a lot of people want to go into that detail, and you lose them. And so the big problem there is just the risk adjustment to raise the allowance a lot of people get lost with.

DR.CHRISTIANSON: Second maybe question for the panel before we turn it over to the audience, one of the things that clearly happened with Internet companies, and I know you don't want to be called Internet entrepreneurs, but--was, you know, you've got Amazon.com and then you've got BarnesandNoble.com. One of the things that I wonder about with this is what's the response of the existing managed care industry? Maybe that's more relevant for Lee's product than some others.

The health insurance industry, in general, has been I think pretty successful politically, in terms of influencing legislation. Where do you see the existing industry, in terms of how it's going to respond to the development of these new products? And I guess, in your case, Ray, the issue is why would a carrier want to participate in your market?

MR. HERSCHMAN: Carriers will participate if there is an at least equal, if not better, probability of making money. That drives the market. I think the key is that if you look at carriers, CIGNA, look at a national carrier, they really don't have depth in that many markets. They have single-digit market share in most markets and then high penetration in a handful of other markets. So there's an opportunity for them to compete for volume at a direct individual level that does not exist now. I could use examples. Pittsburgh is a key area where CIGNA has zero market share. This is an opportunity for them to go at the market directly, without the intermediaries that kind of control the marketplace.

The other aspect is, if this becomes the standard convention, then they could keep their customer for a longer period of time. When you change employers, you are just changing who is funding your coverage. You actually address another issue, which is portability. The price might change because the employer you are with has different risk factors, but otherwise the carrier can now keep their customer for the first time for a long time. The churn is incredible. It's about one-sixth every year, is the churn rate in a population--big population of coverage.

Where is the ROI on disease management? Where is the investment in the managed care part of managed care? Well, there isn't really that deep investment. Why? Because you make that investment now, and your customer is gone. So there's a huge opportunity, from a carrier's perspective, because that is where the money-marketing opportunity is, managing care over a long term. It's viewed as a short term.

So I think the carriers are saying: At least, I want control over the products I sell. I want control over the price that's presented. They say that. But I need the protections of the adverse selection risk. If those needs are met, we'll play ball.

DR.CHRISTIANSON: Good. Lee?

MR. NEWCOMER: I would simply say that I, too, would want to be in a HealthSync, Sagio, whatever. Because that's just another way, a good distribution arm.

I think the major insurers right now are watching us as a curiosity. We are too small, not well established enough to be considered a serious threat. And that's just fine with me. We'll see if we can prove the concept and then compete in the open marketplace against them.

I don't think, and let me make this very clear, the insurers are not going away. If you've read that kind of hype in the news, then it really wasn't worth the paper or the electrons it was printed on. There's clearly a large demand to stay in the mainstream, and that's going to stay there. What we're working with are the early adopters, the early innovators who are looking for something different, who are highly dissatisfied with the current system, and there are plenty of those people. And if we can offer them a solution that they like, they'll spread the news for us. But that isn't going to happen tomorrow. It's going to happen over a longer period of time.

MR. HERSCHMAN: I want to make one quick point. I think our model is pretty different from Sagio and E. Bennix because we do risk adjust, we do not dictate the product that the carrier sells. And there's a huge difference there. I think it's a subtlety, unless you really look at it from a carrier perspective, and then the carrier says that is a big difference.

DR.CHRISTIANSON: But those are your two main competitors.

MR. HERSCHMAN: Those are similar. You know, we've talked about migrating to dealing with risk adjusting, but they haven't yet. So they definitely--they validate what we're doing, which is a good thing, but they're not doing it the same way.

MR. WIGGINS: Well, given that we're actually selling our product through the carriers, at first they looked more at me as, oh, God, he's back.

[Laughter.]

MR. WIGGINS: And so they were a little worried because we really handed it to quite a few insurers as we grew Oxford. And the game plan now is to--there's been really no innovation in the insurance markets in the last ten years. Think of, we introduced an alternative medicine program now nine years ago, and I can't think of another major innovation that's happened in the insurance product arena. And so we're just trying to bring really a new insurance product, but also, as you get older, you just don't have the energy to create a new health plan again. So you say, well, why don't this time let's just be the operating system for other people to do it.

And also our product will be so much more attractive if it's on, let's say, Lifeguard in California or Coventry in Pennsylvania, if it's on their license because they've got really good discounts with providers that individuals will get access to so that they spend their allowance with all of the purchasing power that Sally alluded might be lost in defined contribution. You really need to hold that. You need to deliver the purchasing power of those big payers to that individual. And we've done that with PPOs and existing networks.

But, for instance, in most markets the dominant carrier has price points on their provider contracts that are generally 7 to 15 percent below the price points of most other payers in that market. So you want that payer to offer this product because it's going to be most attractive to the individual.

Question & Answer Session

DR.CHRISTIANSON: Paul, do you want to field questions from the audience now?

DR. GINSBURG: Sure. Actually, if you could start walking up to the microphones. While you're getting ready for questions, I have an observation, and I want to run it by the panel.

It seems as though all three of the ideas put forward from the marketplace entrepreneurs could work with the fixed contribution model, and that in some cases they could also work with voucher models, and yours is very much around the fixed contribution. And I just want to ask the panel is that correct?

MR. HERSCHMAN: Yes.

MR. NEWCOMER: Yes.

DR. GINSBURG: Okay. I'd like you to state your name and affiliation before your question. Why don't you begin, sir, and then we'll go there and then there.

MR. ZWILLICK [ph]: My name is Todd Zwillick. I'm with Reuters.

The impact on the individual insurance market has been mentioned by almost everyone now. In Congress, there are initial moves to decrease the number of uninsured by offering refundable tax credits.

Part of the criticism of this is that if you give someone, an individual, a $1,000 tax credit, which is the proposal that's being thrown around in a lot of committees, that they'll be able to purchase their plan. That plan will have $3,000 in premiums and about $6,000 in deductibles.

I'm curious, from each of the three panelists, to hear about what your business, what your plan could do for an individual purchasing individual insurance with a $1,000 refundable tax credit that they're going to use to try to purchase insurance which they do not have right now. What could you do for these people?

MR. HERSCHMAN: Well, I think that if the amount is $1,000, you'll get at least some coverage versus zero. So I think it's at least a more efficient use of the thousand dollars than the way it works right now. I think beyond that you have to step back and say either the government is going to mandate some minimum benefit design--we're not going to do that, okay. That is outside of our role. I think that's much too intrusive for our business.

I think the other is is that if there is a product that lets somebody get more value for their thousand dollars, then that product will come about, and it'll be available in the marketplace. So I would say that at least it's a move in the right direction. How the thousand dollar number is coming about, that's what I would challenge more. What does the government think they're going to get for a thousand dollars? Because that's exactly what you'll get.

So I think it's the right move. It's how it's deployed and how does that voucher get realized? Is it through payroll deduction? On a practical, applied basis, how does that work?

MR. NEWCOMER: For $1,000, you can't get insurance coverage. What you get, you could got to a product like Steve's and try and find a better price for your $1,000. The people who get income tax credits, by the way, have a whole lot of things to buy that they're barely making it in the first place like shelter and food, in addition to health care. So I'm not a big proponent that a $1,000 tax credit is really going to move dealing with the uninsured.

DR. GINSBURG: Actually, before you go on, I was sitting in a meeting last week of some group that's coming up with new tax credit ideas. And I think the thinking is not that anyone thinks $1,000 will buy insurance, but that with the poor covered by Medicaid and for children, as CHIP, there's a notion that there's a population that perhaps is just $1,000 subsidy away from buying insurance, that they have some of their own money that they're willing to pay. So, in a sense, we shouldn't dismiss it because obviously you can't get anything for a $1,000.

MR. HERSCHMAN: So I think if it could be married up with some employer contribution, you'd have more money as well. So it's not only what somebody is willing to take out of their paycheck. But if the employer is saying, hey, this is a better benefit, at least I am able to provide some access to coverage.

MR. WIGGINS: I think you're talking about the individual market. There's no employer involved. I think--

MR. HERSCHMAN: Seventy-five percent of uninsured work.

MR. WIGGINS: Right. What he's talking about here though is the proposals right now are that you'd get $1,000 tax credit if you're an individual purchaser of health insurance because your employer did not provide it.

First of all, that's a wonderful policy initiative. I don't care what party you back, you should back that. It's fair, it's the right thing to do for the individuals that lack insurance, and it will just stimulate

more coverage, less uncovered care. It does not, however, have any impact on affordability of health insurance. So there would still be a marketplace out there that competes on price.

What some of us are trying to do is create insurance products that are very powerful products that cost a lot less. We have a $100 health plan that's a very comprehensive family health plan. But you probably don't have enough in your allowances, if you're in that 17 percent of the people that has allowance limits, you probably can't get your health care service in midtown Manhattan. You can get it if you commute to less costly areas. There's wide variance in cost levels for health care across the U.S. and nobody knows that. Nobody knows that you can go to the Mayo Clinic for one-third the price that you can go to Columbian Presbyterian in New York unless you paid for it. And it makes you want to make sure everybody knows that, hey, you know what, the Mayo Clinic is a great deal for health care, and it's probably the best health care in the country.

DR. GINSBURG: Actually, there was another part of your question. One was $1,000, and that's what everyone has focused on. But the other one was the individual markets. And I was wondering if any of you, and you don't all have to speak, have any views about the status of the individual market now and how well it would work for someone of modest means for whom the $1,000 tax credit made the difference, that they would consider getting health insurance.

MR. WIGGINS: The individual market right now is shrinking. It's a problem. It's a little bit like the reinsurance markets right now are going away. There's a crisis right now in the financing of health care in America that's gone unnoticed. And that's the shrinking capacity of insurance underwriting capacity out there. It's hitting the health plans first. It's hitting the self-funded employers with premium hikes that are going through the roof. And it's hitting the individual market.

So there's already a shrinking universe of payers, insurers, that will write in that market. So we first need to address that. We need to make it a more attractive environment. I think you do that at the state level with state laws that govern underwriting of individual policies. And right now there's a patchwork quilt in the United States where it's the Wild West if you write products.

In some states you have pre-ex, you have all kinds of special conditions you can exclude forever. And even now HIPAA has created even further dysfunction in that you can buy short-term policies in the 6- to 36-month variety that allow permanent pre-ex.

And so the marketplaces need I think what HealthSync is doing, they need rules that are standard.

MR. NEWCOMER: Steve, isn't that the problem, though, is that in the individual market it's very, very hard to underwrite risk? Because as you get the risk factors in, you either have unaffordable insurance or you only are able to insure those people that are healthy and running marathons. Until we solve that problem, the individual market needs a lot more than just a $1,000 tax credit.

MR. HERSCHMAN: And I think that that can be addressed the same way issues with small employers would be addressed. If there's some aggregation or affiliation or the equivalent of a credit union, but for health care, where you could aggregate, there has to be risk adjusting within that pool, but there is a way you could think about creating pooling so you could address that issue. But I don't think that's going to happen without the government.

DR. GINSBURG: Sure. Thank you.

Next question?

MR. SCANDLEN: I'm Greg Scandlen with the National Center for Policy Analysis.

Actually, that discussion ties into my question. I would argue that because employer-based coverage has a 40-percent subsidy on average, anyone who can possibly get employer-based coverage will do so, leaving only those people in the individual market that are too sick to work, who can't keep a job, who are in very high-risk occupations where their employers don't provide coverage, that sort of thing.

And I would argue that that's contributing to the problems in the individual market more than the lack of regulation because there's no lack of regulation.

[Laughter.]

MR. SCANDLEN: But Ray raised a question of portability, and this is a connection, I think that's really critical in defined contribution. And, in fact, to the extent we're using a pension--defined contribution pension programs as a model for this, that is characterized by individual ownership. And I'm afraid that HIPAA--actually, Ray used it--you didn't think there were many regulatory obstacles towards that. I'm afraid HIPAA, which is ironically called the Health Insurance Portability and Accountability Act, prohibits portability.

MR. HERSCHMAN: Yes. Well, I'm, unfortunately, too familiar with HIPAA. The intent was good, the execution was brutal for employers and carriers. So I think until the financing mechanism changes, you will not see portability.

MR. SCANDLEN: Well, I think without portability, without individual ownership, all you have is managed competition.

MS. CAPPS: My name is Katherine Capps with Health2 Resources. I've got ten questions, but I think I can summarize it with one question, I hope.

With all of the products and services that your companies offer, who do you see as the primary customer? And I'm not referring to the end user, I'm referring to the primary customer. This is a two-part question. If each panelist would answer that.

And the second part of the question is, how will your products and services, as you are proposing the rollout of them, increase accountability for consumers and not diminish accountability for consumers?

DR. GINSBURG: Who would like to start?

MR. HERSCHMAN: I keep starting, so I thought we'd flip it to the other side.

MR. WIGGINS: You're flipping it to me, okay.

Well, first of all, on the second question I think that obviously when you give people the right to control the insurance dollar, you are moving quite a bit of opportunity for them to have responsibility over to the patient. And our customer is clearly the patient. We believe that all of these moves by employers, whether it's to define contribution or if you've been selling health plans for 18 years, employers are already using some type of limit on what they pay. There's already a defined contribution model out there that shifts quite a bit of cost to the individual employee.

And we're trying to--and so when you run a health plan, you have a two-tier sale. First, you have to sell to the employer, but your main sale, particularly in the large-case market, is to the individual. What Ray is doing, and others, is maybe bringing that direct-to-consumer decision making down into smaller employers, which is my hope that Ray is successful in that model.

What Hillary couldn't do, Ray is doing by creating purchasing cooperatives that any employer or any individual can opt into. Generally, right now it's sold through employers, but there should be no reason his model doesn't lend itself to the individual market or anyone. So our customer is the individual.

And with the whole idea of an episode allowance, you have as much or as little responsibility and control as you want. You can punt out of it if you just say I don't want to pay attention. I like the managed care model where somebody tells me what to do. Fine, we'll tell you what to do.

DR. GINSBURG: Lee, do you want to go next?

MR. NEWCOMER: I think our customer, we maintain, is still the provider community. That's where our financing comes from. Yet the problem with that answer, of course, is if there are no employees with pools to draw off of, what business is there? So you still have to think of the actual consumer employee also as a customer of ours.

For accountability, I think the physician and hospital accountability is quite clear in our model. But the consumer also is quite accountable. I call it skin in the game without road rash. They have first dollar coverage for care, basically, a deductible, and they can access care. But every year they have to deal with a budget just like you do at your house. We know our income is going to be "X." What are we going to spend it on? And every year when the defined contribution is established, that employee has to think responsibly about how they will spend their money or how much money of their own personal dollars they want to bring into that fund so that they can purchase the kinds of physicians and hospitals they wanted.

So the accountability for them is to be pretty smart purchasers of their relationships.

MR. HERSCHMAN: I think, from a pragmatic standpoint, our customers right now are employers and carriers. Those are the decision makers right now. We want providers, we want consumers. That doesn't happen unless the two primary constituents, employers/carriers, say this is a better model. So that's the first.

I think on the second point of the consumer, I think that consumerism, the mind-set of consumerism is going to be over time. I don't think people are going to just jump in and say, and this is not in any way a criticism because I would buy this plan, but picking 22 different specialists and with the 1,900 other things you've got going on all day I don't think is--that's a quantum jump. I think similar to 401(k), initially, people put their money in low risk. Information became available, people got more comfortable, and it's driving a lot of how people make their decisions about their pensions.

If you would have asked me when I was an altruistic 24-year-old, would it be more likely that employers would allow their employees to manage their pensions or their health care, I would have thought for sure health care, and it hasn't happened that way.

So I think that people will be able to make those decisions. A lot of them they make already. It's just that the data-intensive decision making I think is going to be over time.

MR. NEWCOMER: Ray, I've got to respond to 22. It was my worry, took, when I first joined the company, until the focus groups, when the employees came in and said, you know, the first thing the employers are going to say is that we aren't smart enough to make these 22 choices. And they all got it. The guy from Midas Muffler got it in about 22 minutes.

MR. HERSCHMAN: I agree with that for some consumers, not all of them are going to--some want Kaiser still. They're comfortable with it.

MR. NEWCOMER: Oh, sure. That I'll agree, yeah.

MR. HERSCHMAN: So I think you need both. You can't have just one.

MR. NEWCOMER: I agree.

DR. GINSBURG: Yes, sir?

MR. GROSSMAN: Jerry Grossman from the Kennedy School, Harvard.

MR. WIGGINS: And Squam Lake, yes.

[Laughter.]

MR. GROSSMAN: I just want to comment on the question about the $1,000. Massachusetts, which is, of course, renowned for the highest costs in the country, does also now, or until yesterday, had a diminished uninsured. They now can't agree whether or not we had a 3.5-percent decline from 10 to 6 and something. Nevertheless, you had CHIP, you add a million people in Medicaid. And if you were to have we just started something called the Health Insurance Partnership, in which if you show up as a small business with a 1040 that says you don't have the money to pay for insurance, they've set some limits, they'll give you a 50-percent voucher to give to your employees. And if your employee then shows up with his or her 1040 and shows they can't afford it, they get a graded personal payment as low as $50 a month for their family. It just started now, but it sort of picks up the gray space of the employed people who work in companies who can't afford it.

Using size is a terrible thing. We have a four-person office. We give health insurance. We shouldn't be eligible for a government subsidy. So you need to have means-tested companies and means-tested employees. Some people don't like that. And then we have buying cooperatives, the chamber of commerce, and all of those things.

So you can put together a package that would allow everybody in the bottom third, I think, to play in any of your arenas. So I think there has to be a clarity that there is a strategy to get as close as we could to universal access for people at prices they can afford. But the more you guys present options, the closer we're going to get. Massachusetts can't ever get there. We're going to have the highest cost system in the world until you die and he dies because I'm dying faster.

MR. WIGGINS: Is it easier, by the way, to have four employees than 10,000 like you used to have?

MR. GROSSMAN: Oh, much, because I took them from the 10,000. I took the best four.

MR. WIGGINS: You had your pick, didn't you.

DR. GINSBURG: He took the four healthiest people.

MR. WIGGINS: By the way, everybody missed you this year in the Cosumpi [ph] Open.

DR. GINSBURG: Sir?

MR. WOLFF: Bruce Wolf, Hogan and Hartson.

I applaud enormously the object of moving toward a marketplace and giving the consumer an enormous amount of choice. It's clear, though, that in some of these models an essential element of choice, particularly in yours, Lee, I think has choice made in advance of the onset of the episode or, Steve, in yours at the onset of the episode, but not during it.

And I wonder, in two respects, what are you doing about feeding into the loop not just price and not just kind of objective quality measures, but people's experience with the providers, the choices they're making; and, two, when people are in the middle of an episode, having chosen a package provider, Steven, yours, or, Lee, having chosen a provider, how do you move out? I mean, what do you do about the denial of care, the skimping of care, the feeling that you're not being well served in those models?

MR. WIGGINS: In our case, you can opt out whenever you want. The payments go out pretty much on a fee-for-service basis to the providers in a care team. If that care team has given a fixed price, the payments still go out on a fee-for-service basis to them until they hit a max. So you could be a third of the way through a $50,000 allowance, and you would still have $35,000 left that you would

take if you didn't like--you're going to know right away. And generally speaking, the large-dollar consumption in an episode, you've made the decision and it's over. It's the hospitalization and it's the surgery, if it's a procedure intervention.

So you do pick. It's very different. In an episode, you're quite a ways along before you have to make any decisions. You've already had the diagnostic work done, and you're deciding to have a treatment. You may be a man with prostate cancer, and you've decided to have high-dose seed implantation. And you're going to go shop and pick and decide who you go to. And once the implants are there, they are there. You are not likely to make big switches.

MR. NEWCOMER: I hope you aren't, anyway. It's tough to take them out.

MR. WIGGINS: Yes. Yes.

MR. NEWCOMER: Remember that not only do we allow the consumer to look at some data, but the way they got to most of their choices was through somebody they trusted already. What we're doing is really just automating a process that happens every day. I call Sam Carlson to find out who to go see for my seeds if I needed them, and I still use that same mechanism in ours. So we think we're going to emulate pretty carefully a system that already works relatively well.

Now, when there is a conflict, and I don't like the guy that I was sent to, you have two choices in our system; one, you can change your providers. There is a waiting period determined by the other provider you are going to. That's to prevent them from getting adverse selection; or you can use your wraparound insurance policy. So you can use that just like you did with point of service in a health plan to select another provider. You'll have to pay a little more money out of your pocket, but you can do it immediately without any other approvals.

DR. GINSBURG: Before I go to the next question, I want to say I think we've got two people here, and I've got a question. I think that will exhaust our question time for this session.

So, yes, sir?

MR. WALKER: Greg Walker, American Cancer Society.

In these models, what would be in place, what would drive prevention and early detection to prevent or to mitigate catastrophic illnesses down the road and not increase that 17 percent of people who are receiving care for catastrophic illnesses?

MR. HERSCHMAN: Several things. One is that if the carrier is going to want to keep their customer. So it's always less expensive to keep your customer than to get a new customer. They will be directly involved in that process. I think the provider, because in an individual purchasing their coverage, most often, if you ask individuals, will first select on provider. There is a relationship there.

I think the third is, and this is where we're going, is that we are migrating from kind of global aggregate actuarial variables for risk adjusting to population-based diagnosis risk adjusting, which is to say if a carrier and their provider network, they have a partnership, not an adversarial relationship, the way it is now, and they can prove better outcome for cancer, and they go and market that, they will get a corresponding higher premium based on getting more cancer people. And that will be what drives the real innovation in health care. So I think that there is movement.

If you are able to prove you have a better result, then you will attract those that are already sick. If you are able to proactively mitigate risk, therefore, keeping your population healthy over a longer period of time, people will stay with that carrier.

And therefore you will incent the carriers and the providers to actually work, for the first time, as a team. Because there's data that's aggregated at the carrier level that the providers don't have,

there's competencies that the providers have that the carriers don't have. And right now it's kind of adversarial by design. The point is that right now the way it is, if Dr. Jones cancels a carrier, they lose their patient. In the future world, they could keep their patient because that patient will be able to change what carrier they have based on who does the best job.

So I think that it's kind of a broad answer. You have a very specific question.

MR. WALKER: So the assumption is that the provider will inform the patient what they need and not look down the road and say, there's more money to be made--

MR. HERSCHMAN: I'll use myself. For example, I'm on Lipitor. Thirty-seven years old, and I have incredibly high cholesterol, genetic. There's nothing in my diet or whatever. Right now, the carrier is looking at me as a loss leader. They're for sure losing money on me being on Lipitor. Because the reason why I'm on Lipitor now is so that when I'm 55, I don't have a heart attack. The carrier is looking at that as a negative right now. If they know that they could keep me, earn my value, and I stay there, they'll get their return on investment. So it changes the dynamic.

MR. NEWCOMER: In our model, it's consumer marketplace again. You would pick physicians who took prevention seriously, if that as an important value to you. If a physician that you chose as a primary care, you walked in and said, "Well, I've got risk factors for heart disease, and my cholesterol is a little high," and the guy says, "Fine. You don't need to do anything," if you're a consumer-savvy person, you'd say, "Hey, this guy isn't interested in prevention. I'll go to someone who is and change."

Now, having said that, the other incentive that occurs in our plan is to look carefully at whether prevention really works. Let's take the Lipitor example again. His chances of having a heart attack are reduced by one out of 1,000. Now, in the study, that is a 50-percent reduction. So I can say to this patient two things. I can say I can really lower your chance of having a heart attack by half, boy that sounds pretty good, or you have a two in a 1,000 chance of having a heart attack. I'm going to take it down to a one in a 1,000.

And you know what, when you present it that way, the vast majority of patients say, "Forget it. I'm not taking Lipitor for the rest of my life for that kind of reduction."

So what happens in our model is the incentive becomes to be realistic about prevention, to talk to patients in a way that doesn't say the easy thing, oh, I'll reduce your chance by 50 percent. Here, take this pill. But say let's talk about this. We have a pill that we can take. Here's the consequences of that pill for you. They're pretty mild, except for expense, and here's what you're really going to gain from that. And prevention is overblown. I think I'm the only physician. Are you a physician? I didn't look.

MR. HERSCHMAN: No.

MR. NEWCOMER: I'm the only physician on this panel with a whole bunch, two years of master's work in preventive services. And quite frankly, prevention is seriously oversold in this country right now.

So the things that would really make a difference, seat belt and cigarettes, we choose to ignore, and we spend more time thinking about things like Lipitor. That's where the incentives are.

MR. HERSCHMAN: Well, I was an informed consumer. I also had a large number of my family die of heart disease. So I was an informed consumer. I'm just saying that the incentive to focus on where you can minimize and give that option is--there's no economic reason to do that right now.

MR. WIGGINS: Ray, I'm not a physician, but I think I can lower your risk even more than the drug. I think you should get out of starting a company.

[Laughter.]

DR. GINSBURG: Next question.

FLOOR QUESTION: Two quick questions. Steve Ferenti (ph) from the University of Minnesota. First of all, are any of the pending or proposed medical privacy laws going to affect any of your business models as well as the HIPAA implementation rules? And the second question is: Are the connectivity companies that are showing up in the health care space going to help assist, have no effect on your business models?

MR. WIGGINS: Well, first of all, on the privacy issue, yes, there are a number. We might want to convene another panel for the privacy dialogue. We spent two years on the Clinton patient protection bill, a lot of it on the issue of privacy, and unfortunately, the practical reality of what's getting implemented is making it more difficult to move information around, movements that might benefit patients. And so there's a lot of protections and there's a lot more expense now associated with privacy.

MR. NEWCOMER: We don't have a privacy consideration because we don't get any medical data. There are no claims. The only thing that we have is the name of the physician you've chosen. So we think there's very little in the way of privacy issues.

I've forgotten your second question.

FLOOR QUESTION: Connectivity companies help you on--

MR. NEWCOMER: Again, irrelevant for us because claims data and transactions don't occur.

MR. HERSCHMAN: Data is less important from our perspective. I think actually the privacy issues actually act as a catalyst a little bit. I think employers are starting to say, well, why do I have this information on my employees at such an intimate detail level. That's an exposure area. In fact, I want to get the heck out of that area. It's not my core competency.

So there are some positive and negative that's coming out of the regulatory side.

FLOOR QUESTION: The risk adjustment stuff you talked about earlier that you would hope to use, what data is going to fuel that model?

MR. HERSCHMAN: That would be diagnosis based--population based, diagnosis based. That will leverage some standardization from HIPAA on data. That goes into effect in another 19, 20 months. I think that how you design systems and where that scoring of relative risk, where that happens, is a key aspect. And if you compile the HIPAA security standards on your system, then I think you address part of those issues.

DR. GINSBURG: I have a question I want to address to the panelists in different ways. I've been sitting here thinking a lot about risk selection, and I think each of you have different exposure to risk selection.

I guess in your case, Ray, you're exposed to attracting employers that know that they have fairly high-risk workforces. And in the other cases, basically there's the notion that the sickest people want to go to the best providers for their care and whether the best providers wind up saying, well, we can't handle this, we have to--we're on a death spiral. We have to keep raising our rates because we attract the sickest patients.

Any comments on those risks?

MR. HERSCHMAN: Sure. The reality is that this is as or more attractive to employers in the technology industry who have empowered workers. They're younger. They want choice. They're narcissistic by default, and employers, for everything else in their business, have shifted more

responsibility, more process, more decisionmaking onto their employee. And so there's something that needs to be trued up. You can run the business, you can improve the business, you can have ownership of the process of the business, but you can't pick your health care. So I think it's more of a philosophy than are my health care costs high.

DR. GINSBURG: I just meant what about Joe's Welding Shop that has a bunch of people that haven't taken Lipitor and--

MR. HERSCHMAN: Okay. There is a part of the process--and this is why we're dealing with large- and medium-size groups until somebody deals with the small group from the regulatory side--where the carriers still apply their own experience factor for that group. Okay? There's all the normal variables of rating, plus an experience factor. So the higher the risk, the higher price their employees will see out in the marketplace, based on the group.

DR. GINSBURG: Okay. Any comments from Steve or Lee?

MR. NEWCOMER: I would just mention that we have actually--the price that's posted by the provider is factored up by the underwriting carriers for the group. So if we sign up a small group of 15 employees and their risk is 1.3 average, when they go into our system, they will see every provider's bid up by 1.3 in order to help provide the providers with some protection against that increased risk that they would be seeing in that pool.

MR. WIGGINS: In our case, we're not sure yet. We've had the top three actuarial firms in the country, two on behalf of carriers, one, M&R, that's our permanent--that's on retainer with us permanently, they even disagree. Some believe that episode allowances will attract people that have had a lot of bad experiences in managed care and that we will attract sicker people that are higher risk.

My experience in new products in the health insurance arena is that it's a lot like any early adopter model. Early adopters tend to be younger, healthier people, and so I think we'll probably get a little bit of both, is my guess. But it doesn't matter in the end because--it matters in the first few years, but in the HMO movement years ago--I'm sure, Lee, you remember--everybody thought, well, you HMOs are going to get all the good risks. And then once you got past about 15 percent of an employee population, you began to distributions that were more normal.

I know Mathematica, you know, sponsored this, but the Mathematic study of the Medicare program, which I think is maybe one of the most flawed studies and led to some of the worst policy decisions in the history of health care, but it essentially said that the HMOs were getting better risks in the Medicare risk program when we had hard data, many health plans had hard data that would show that, in fact, if you used DRG case mix as a surrogate index, or if you used symmetry-based groupers as another index of risk mix, that, in fact, we were certainly getting far sicker than average Medicare patients enrolling in our health plan.

And so I don't think you can make any gross generalizations. It's probably going to vary by employer. It's going to vary maybe even by region. But in the early days, we expect to figure that out. But it's a guess to get started.

DR. GINSBURG: Okay. Well, this is a difficult area, but I'll conclude that neither of you feel that that's your Achilles heel, that if you don't succeed it's not going to be because you've attracted higher risks but because of other reasons.

Good. It's time for us to take a break. The panels will be switching for the second half of the meeting, and I just want to mention the panelists will be available after the meeting to answer your

questions informally. And I see those orange pieces of paper around, and I want to ask you to start thinking about filling out your evaluation because we make heavy use of those.

Thank you.

[Break.]

Panel Two: Employer and Union Responses

DR. GINSBURG: We're about to begin the second panel. If you could take your seats, please?

As soon as the panelists are seated, I'll ask them their first question.

Okay. The first question--that's good. We've got all the panelists except, Sally, you should come up. Oh, you're going to be there? Okay.

The first question I'd like to ask is: Is there anything that you've heard from the first panel discussion that would make employers or unions more likely to embrace defined contribution approaches? Do you want to begin, Helen?

MS. DARLING: Well, actually, I was going to say it's a tough one because I'm--I think there is a lot about defined contribution, but I'm not sure that some of what we heard would be the stimulant to thinking, other than the fact that you have a lot of bright people who are turning their energy to developing solutions that are facilitated or partially enabled by technology, which can be very powerful and will make everything much more possible and attractive, and certainly a defined contribution approach in its several versions may make it easier to--or make it more likely that consumers or employees and employers are likely to look to these solutions.

But there is a big gap, I think, between what we heard--never mind that none of them are even operational yet, but a gap between what we heard and what many of us would hope would be the kind of ideal set of solutions.

DR. GINSBURG: Okay. That's a good--Larry?

DR. ATKINS: Well, I'd like to add to that and just say that I do think that the two things that employers would see valuable in what we've heard this morning that would contribute to either an effort internally to develop more consumer choice and individual decisionmaking within their existing health plan or might contribute to maybe some progression toward more of a defined contribution model, I think the capacity to have some degree of information on providers and provider performance. I'm not sure how much is really going to be there. I think that's probably one of the most difficult things to get information on. And it's one thing to say that providers are going to put their information out there. It's another thing to say that you're going to have some kind of information that's useful and comparable among providers for making decisions.

But moving in that direction is going to be a very important part of it, and I think the other piece that's going to be very important is the risk pooling, external risk pooling and risk adjustment. I think that the HealthSync model is an intriguing model because it takes the employer's pool, maintains it intact, essentially, pulls it outside the employer, and then creates a risk adjustment mechanism as individuals then move into plans.

I think employers are somewhat skeptical about how sophisticated risk adjustment really is and how successful this risk adjustment is going to really work. But it'll be interesting to see how that gets set

up and runs, and it will be, I think, attractive to employers if, in fact, there's a chance for risk adjustment to work effectively.

DR. GINSBURG: Yes?

MR. BLITZSTEIN: I would like to make a comment about the definition and the terminology that we're using, and I'm not sure how controversial this will be, but this defined benefit/ defined contribution dichotomy in the health care area I'm not sure is a true breakout of what's taking place.

I would argue that we already have a defined contribution model, that if you look at federal law, health insurance is treated differently than pension plans. There are not vesting rights within ERISA in terms of health insurance, with a few exceptions as it relates to certain retiree benefit--retiree health benefit arrangements that have been either codified by litigation or have just sort of been written into contract.

So I would submit that we essentially already have a defined contribution system with in some cases short-term entitlements. For example, in the collective bargaining environment, we negotiate--in my union, we negotiate a defined contribution or a fixed contribution that might have an inflation escalator in it to cover increases in cost. And those contracts and that entitlement to the benefit is a short-term entitlement. It might last three to five years, and at the end of three to five years, everything's up for grabs.

DR. GINSBURG: Actually, you've focused on one aspect of defined contributions, which is the amount of--committing the amount of money; whereas, a lot of the discussion is about choice of plan. And this might be a good way to get into the next question. I'd like to ask each of you if you can answer: What is it that--to the degree that employers or unions find this idea broadly attractive, what is it that's the main attraction that your place would want to investigate?

MS. KROL: Well, I'll take a two-part because I didn't get to the respond to the first question. I'm encouraged that the panelists were grappling with the risk pool issue because that's a significant concern for us. And, clearly, at Lucent we very much embrace the use of technology as a solution for our future health care delivery system.

[Laughter.]

MS. KROL: Hopefully that will improve our stock price.

But, as well, I think one thing I was encouraged by the panelists is that there was some recognition of--of--advocate--

DR. GINSBURG: Yeah, ombudsman function.

MS. KROL: I can't say that word. --function, and I think that is an important role because a primary aspect of my job is really helping people navigate through this system and it is very complex, and I don't think that could be mitigated.

What we do like about a defined contribution approach is trying to bring consumers to be more involved in the medical decision process and giving people more choice. I think one of the panelists did indicate that benefits are vanilla or they're average. They are. They're designed for the average employee based on what the company can afford, and they're really not designed to be customized to individual needs. And I think that would be a true advantage under a defined contribution system.

DR. GINSBURG: Okay. Helen?

MS. DARLING: I think, as Pam hit on it, the choice we know is extremely important, and we know from the center's data how little choice most employees in the country have, except really a handful of the jumbo employers. It also allows you to have those things you value, and benefit managers

know that. They really would like to have happy employees, especially right now. I mean, I think the most important thing on everybody's mind from the CEO down is recruitment and retention of talent. That is the biggest problem, and that's what they pay attention to. So anything that makes them happy is going to be appealing.

I think, second, there's certainly the feeling among benefit managers it's extremely important for employees to have a financial stake in their decisions. I don't want to take issue with my fellow panelists, but I think there's still a lot of defined benefit, at least belief out there, and a fair number of employers still do it. Maybe they don't do it happily, but they do it. And they would really like to be able to give the employees some financial stake in their decisions.

I think also the belief that--and I think a lot of especially the employers like Pam and others who really lead the quality movement, that to be able to drive the system from every perspective you can, whether it's consumer getting quality information or having provider information on line and making choices, is extremely important.

Then the one final thing--and I think this morning's panelists really made the point--the more we open up the system, the more we allow this kind of choice, we will see new models of delivery, a recent article in Harvard Business Review talking about disruptive technology, for those of you who are familiar with it, this is a disruptive technology that could radically change our system. And I think most of us feel that that would probably be a very good thing.

DR. GINSBURG: David?

MR. BLITZSTEIN: Again, I think there's some broader social policy issues here that are taking place, and they are taking place in a period of economic--unprecedented economic growth and prosperity. And it's a paradigm shift that we've been seeing in this country for over 20 years, and it's a movement away from the social contract between employers and their employees.

If you look at sort of a libertarian approach to defined contribution, it promotes choice almost at all costs. It promotes a shifting of obligations, and I guess the problem that exists out there in terms of broader social policy is what does that mean in terms of doing something about uninsured people, about the cost of insurance. Do the products that we really saw or talked about this morning, are they going to bring down the cost of insurance today? Are they going to expand coverage? And I think those are very tough issues.

I think the other thing that we're seeing is that there's sort of a desperation out there. There's a desperation because we have not fixed the health care problem in this country, that the employers who are represented in this room and the unions that are represented in this room known that medical trend, medical costs are coming back with a vengeance, and that the low-lying fruit has already been picked in terms of savings, and now we're looking for something that's going to protect us for maybe another five or six years. And, therefore, we're seeing this proliferation of new ideas and products.

This doesn't mean they're all bad. In fact, just to make a quick comment on some of the products I saw this morning, I think, again, from the technological standpoint, there are tremendous potentials here in terms of price and quality transparency issues and being able to avail group plans with more information to make them better and stronger purchasers of health care. That's where I see the potential.

DR. GINSBURG: Larry?

DR. ATKINS: Well, it's hard to come up with some new ideas after all of that from this wonderful panel, but I want to echo a few things.

I think one is that what's happened here is that in the movement from traditional indemnity plans to kind of a plan environment, a health plan environment where people selected managed care plans, that has driven the need for some degree of choice. And it's also driven the need to move the employer back out of the equation a little bit. The employer, when they were providing indemnity, they were essentially paying the claims and people went out and had their relationships with their physicians. But as people enroll in plans, it becomes more difficult, in an employer environment, to continue to have kind of one plan or a few plans that people enroll in, and then as people move around have to change plans. So that has driven, I think, the movement to some extent, and also employers, as they've moved to have plan choices around the country, have increasingly gone to off-the-shelf products that are available, which means that the role that the employer has played in structuring and administering the plan is changing. The employers are increasingly outsourcing functions. They're increasingly looking for ways to have these activities that they perform become generalizable, have them done by organizations like NCQA, as opposed to having to do them individually. And there is not as much value to having a differentiated product anymore.

This is, I think, driving whether--you know, no matter what else happens, I think there's a long-term trend that's going on to more of a defined contribution concept where the employees will have their plan relationship and that will be disconnected to some extent from the employer.

Then I think, obviously, the upturn in cost recently is a very significant factor. I think a lot of employers feel like we've explored what can be done with managed care to control costs. We're kind of throwing up our hands on utilization review. There's got to be another model out here somewhere, but who knows what it is. But as we move into this uncertain environment with costs, and I think the particular concern with rising drug costs, it's increasingly important that the employees play a much stronger role and feel much more the cost pressure themselves. That's the only way they'll ever get support for being able to manage any of this.

I think the employers see themselves now in the middle and are looking for ways to move themselves back out of the middle, and I think that's a major portion as well.

DR. GINSBURG: There are two things that I didn't hear from the panel. One of the things is the managed care backlash, whether employees' attitudes towards the managed care plans that are being offered by the employers is having a role in this. And the other is future liability. Are those things just political words or do employers really worry about that?

DR. ATKINS: I think in terms of the loss of utilization review, I think both of those are driving that. And I think what's happened is that if you--particularly liability, but I think the concern that people are now going to deal with utilization review issues in courts is a major concern. Whether the employer's at risk or whether the plan's at risk is really insignificant. And a lot of plans have responded basically by saying they're going to be the kinder, friendlier plan, which is a very nice thing to be, but that leaves the employer kind of holding the cost for this kind of friendlier environment. So I think it's a very significant concern.

MS. KROL: I'll address the backlash. We actually took a comprehensive look at our managed care plans that we actually inherited from AT&T, and we looked at not just customer satisfaction and utilization and those indicators. We also looked at indicators of productivity. And when we looked at some of those measures, we were finding people were spending a significant amount of time--and it always seemed between 9:00 a.m. and 5:00 p.m.--working on issues around the health delivery system. And when we compared that to a PPO product, a managed PPO product we introduced versus some

of our standard managed care plans, people were spending significant amounts of time, like over 20--I think we had about 18 percent of people spending over 20 hours a year on issues around managed care.

And I think some of it is just a backlash around procedures and common sense--lack of common-sense approaches where, for instance, you may be able to get a better price for lab and X-ray at a centralized facility, but then the employee's out of work for half a day because they can't get the comprehensive services in the doctor's office.

So I think they're being very driven by cost dimensions and not looking at cost and productivity and satisfaction dimensions, that we find that there was--there is some loss in our productivity, some other cost of doing business beyond just the annual premiums.

So I think that's how we've addressed some of the backlash of moving to information-based point PPO product, and then, clearly, as a self-insured employer, if we become engaged in litigation, then that would certainly be a stumbling block for us and have us seriously look at our role as providing health benefits.

DR. GINSBURG: Yes, Helen?

MS. DARLING: Yes, I think generally my experience was a little more positive with managed care, and I think it does vary by part of the country. What we saw in places like Rochester, New York, that had had the programs for years and years and they basically covered the whole community, we had the highest satisfaction--in fact, in national studies the highest satisfaction in the country was in Rochester, New York. But we also had places like Texas where everything was wrong and the doctors spent all their time complaining bitterly to our patients about the plan that their lousy company had put them in.

So we had everything in the world--I do--I believe it was you all's research at the center that said basically it doesn't matter what you think about your managed care, it's whether you think you're in managed care, what you think about your care. And basically even people who were not in managed care didn't like it, and those who were in it didn't like it, and the connections were really more, you know, sort of the newspapers and, you know, the "managed care company killed my baby" sorts of stories in the New York papers.

So I think definitely that--in fact, I had employees at Xerox when the managed care horror stories first started who called me up and said: I love what we've got. What am I missing? Is this affecting everybody else?

So I think just sort of the publicity around it is a problem, but the nice thing about all these options is if people have the options and they're willing to pay more--and I think it actually will be pretty clear pretty quickly that a lot of people won't be willing to pay more for these systems they think they want, as long as somebody else is paying.

In terms of liability, that sort of cuts both ways. For the most part, it's true that if employers were able or if you had the sort of perfect defined contribution through technology, employers had absolutely nothing to do with it, theoretically the Congress might in its wisdom leave employers alone. It's not clear that it necessarily would happen. And I guess the second thing I would say is that as an employer and as a benefit manager, it seems to me that you've got to keep your employees happy. Even if somebody else is doing it to them and they made the choice, I can assure you there are lots of companies that do a lot in the 401(k) area, especially when some of the plans they offer--and they may

offer 50 or 60. If two or three of those just plummet for some reason, depending on how profitable the company is and how paternalistic they are, they go in there and they do something about it.

So they do not necessarily get out of playing a role just because of a defined contribution approach.

DR. GINSBURG: Let me go to the next question about the fixed contribution approach versus the cash-out or voucher approach. We talked mostly, I think, about the fixed contribution approach. I'd like to hear your views about what's the potential of the second one.

Do you want to start, Larry?

DR. ATKINS: Okay. Well, I mean, I think cash-out is highly unlikely for quite some time to come because there are huge technical questions about how do you do the cash-out and equity questions that come up depending on whether you're going to cash everybody out equally or you're going to try to do some adjustment for risk. Do you try to make it possible for everybody to have enough money to go and purchase insurance? Which is very different from just simply cashing everybody out equally. And those are very complicated questions.

In addition, there are some tax consequences to that which I'm not sure we're ready for yet. It's not just a matter of the loss of the exclusion, but also the employer has a higher Social Security tax contribution as a result, as does the employee. So trying to top up out of that gets pretty expensive. So I think those are questions that are very difficult to resolve. I think it's--the voucher idea, I think, leaves the employer in place to do the risk adjustment. That also gets a little hairy because it makes the employer a risk adjuster. They have to incorporate the technology that will make it all work. And I think it also gets into some privacy issues, which is--you know, is the employer going to--should the employer know enough about your health condition to be able to do adequate risk adjustment in a voucher, or should it go somewhere else?

That's why I think if you look at HealthSync it's kind of interesting because if somebody really creates an outsourcing capability that can handle risk adjustment, it may solve a number of problems for employers.

MR. BLITZSTEIN: The cash-out voucher approach is part of this school of individual responsibility that has grown in social policy in the country, and it can have some very negative impact on the rest of the marketplace. And one issue that has not been discussed up until now is the potential for cost shifting to other employers. And this is sort of the silent cost that many employers are factoring into their premiums today. I've seen estimates of anywhere between 20 and 30 percent of the premium is what you're paying for other employers who are either underinsuring or not insuring their people at all.

DR. GINSBURG: So cost shifting, you mean what shows up in hospital rates that, in short, people pay because of their uncompensated care obligations?

MR. BLITZSTEIN: Yes.

DR. GINSBURG: Okay. So you're talking about cost shifting from uninsured employers rather than from an employer that has chosen a different plan.

MR. BLITZSTEIN: Or it could also have an effect where you don't have adequate insurance.

DR. GINSBURG: Okay.

Yes, Helen?

MS. DARLING: Well, the cost of administration for anything that's individual has got to be--unfortunately, that won't come off as a trade-off for something else, probably.

Premium collection, I mean, anybody who's worked on COBRA and HIPAA and things like that can tell you that once you don't have somebody in the workplace, you know, even getting a right address for them sometimes, never mind all the other things. So just the cost of running that program will be huge.

The tax issues, obviously, we talked about for the cash. The technical equity issues, as somebody who tried to move a benefit allowance to a common benefit allowance out of equity and live to show the scars, it is nothing like telling the American people or the American worker about internal equity to see not very good behavior come out.

For example, somebody mentioned Boston. You know, we have people in Boston, you have people in California, are you really going to in the same company let people know that you're giving a $11,000, $15,000 benefit in Boston, and the poor folks down in Greenville, Mississippi, get about a $3,000 benefit? And how are you going to compensate for that? So you have the geographical difference.

You also have the individuals, families, domestic partners. How is that going to be done?

And the minute you start putting it in a single, whether it's a voucher or cash, then you absolutely confront those issues, and I would not want to have to be the one on the other end of the e-mail or the phone when that happens.

Then, finally, I guess I'd say in terms of cash-out, this is where I become very--I don't know if it's liberal or conservative, but--maybe it's both. But my experience, if you look at the uninsured data and you look at the number of people, even with good incomes--I believe, again, from you all's data--who don't buy their children medical care, who don't even buy themselves medical care when it's not even a money issue, and the idea of turning it over to people many of whom will not make a wise choice if given the choice. And you might want to give them a plan choice. You might want to give them all sorts of incentives. I'm not saying we should be micromanaging the world. But to assume that people will take the money and do the wise thing is a risk I personally--just personal opinion--would not want to take.

DR. GINSBURG: Pam?

MS. KROL: Helen has hit on all of the--being responsible for operations, all those issues that we can't grapple with as a large company in terms of equity and the geographic regions, the age-sex variations, all of those issues, I don't see a short-term solution.

I think the solution we'd like to have is the ability as a large employer to have medical savings accounts. I think portability is important, and the ability to have people have money earmarked like a 401(k) plan for medical expenses and then to have options within that kind of account, and then to be able to take it with them.

In 1999, Lucent introduced a cash balance account for our management employees, and with that people have access only to retiree medical.

And there's no mechanism for people to say they cannot save enough money for retiree medical under the 401(k) plan, even though we did put some seed money. It's not at all practical with the cost of care. So we definitely need some mechanisms, tax-free vehicles, for people to be able to save for insurance.

DR. GINSBURG: To what extent would a medical savings account plan raise some of the issues that Helen was just describing, as far as equity among different regions and groups within the firm?

MS. KROL: Well, I don't know if it's going to solve those. But we'd like to take more of a total compensation look. And just like we don't seem to have to get into the equity issues with retirement. I mean, you can purchase or have an annuity or a spousal annuity, there seems to be different mechanisms that we don't really--that seem to be adequately addressed in retirement savings that we don't seem--it seems a more visceral response with health care. But at least I think it gives the--it starts to give that sense of consumerism ownership that you have money invested in these kinds of accounts and that then that will be a way for products, a funding mechanism for products to be developed to meet different consumer demands.

DR. GINSBURG: The next question is about the stumbling blocks for the various approaches to define contribution. Now, probably the last question was really about the stumbling blocks for the cash-out voucher. So why don't we focus on more the fixed contribution approaches.

And perhaps we should start with Pam, since we seem to be alternating orders.

MS. KROL: I guess we have the same stumbling blocks, in terms of an employer defining the amount of dollars. But we are moving, again, as a high-tech company, into a total rewards concept. And people are getting compensated more through stock options and other variable benefits that they need to be able to have those opportunities. Just like at Lucent, when you do get an award based on performance or you have stock options, you have the ability to earmark some of that money into your 401(k) account. So, again, trying, as an employer, think of a total rewards package and be able to allow you to earmark bonuses and stock options to reinvest that money into a medical savings account would be an advantage.

DR. GINSBURG: I was talking about stumbling blocks.

MS. KROL: Stumbling blocks.

DR. GINSBURG: Actually, let me come back--

MS. KROL: We talked about the stumbling blocks.

DR. GINSBURG: Sure. Helen, stumbling blocks for the fixed contribution approach?

MS. DARLING: I think a big one is the importance of keeping employees happy right now, although, in theory, they might like it better if they understood it. Change makes people very nervous. And when you're in the recruitment retention situation you are right now, you don't want anything that gets people excited about anything. And if you're not going to spend more money, they're not going to see it necessarily as a positive.

Group purchasing is less expensive. So individual purchasing will cost a lot more. And I think that's a problem.

Again, my experience, and my experience now as a consultant working with a lot of other large companies, is our collective experiences, most employees don't want a lot--they want choice, but they don't want to do a lot of work. There's a difference between having six plans with a range of co-payments and things that are pretty simple. Most of them stay right where they are almost always anyway. A lot of people don't even open their packets or if it's online, they don't even go online. They just hit something that says I want what I had last year. Leave me alone and don't ask me any questions.

I think a stumbling block, another one is the tax issues, but I think this business of not being able to carry it over. People could psychologically feel, whether it's an MSA or any other approach, that if you don't spend, you still get it. We know from the Medicare world how much people kind of overinsure and overprotect themselves. So if they could hold onto that money and have it, I think that psychologically they would feel a lot better.

The other thing is we always talk about the percentage of people who have most of the costs. Well, it's not the same ones every year. There is a core number. It's true that 15 percent is 80 percent or whatever the formula is that everybody uses. But the fact of the matter is a significant number of those people, that's one year. They might go three years without something, and they know that. I mean, I think most employees know that, and that gets to be important.

The technical and pricing issues, we've already talked about that. That is still a major stumbling block.

And in the final one, and I'm just really gratified to hear all about the data and the performance measures and those kinds of things, but as a practical matter, we don't yet have those systems in place to the level of sophistication that everyone would need and like to have it really work. And maybe that's only two to three years away if everybody works very hard. But if it's not in place, and we put in the choices without the information, people will get discouraged.

DR. GINSBURG: To what extent will putting in more choices stimulate the industry of getting the data? Well, I guess they'll both influence each other.

MS. DARLING: Yes. Actually, my life experience would suggest that two things will happen. It is true we would get a lot more data, and thank God for the Internet and what's happening. But it's also true that what happens is, as people get exposed, they get into a panic, and they shut down systems. And I think some of the patient protection stuff--I mean, health services research and biomedical research could get shut down if some of the rules that are now coming out stay in the form they're in.

So as things begin to happen, there will be vested interests, not all good ones to be sure, who will try to put a stop to it. So it's really a two-edged sword.

DR. GINSBURG: Sure.

Any others? David?

MR. BLITZSTEIN: I would just add one point. Many of the models that were discussed this morning, obviously the presenters had very little time to talk about business plans that probably took 12 or 18 months to put together. And that's always part of the unfairness of making that type of presentation. However, I think we heard a common theme in all of those presentations, which is my program is based on the very sophisticated actuarial model. And as we know, sophisticated actuarial models have often crashed, and we've seen many of these models fall apart in the managed care side, in terms of pricing and capitation, especially over the last five years.

And I could tell you, as a plan sponsor and my union sponsors 85 multi-employer plans around the country with the employers that we have contracts with, that it is an incredible, incredibly difficult task to put networks back together for workers where you've had managed care products under contract and all of a sudden the next day they no longer exist. The chaos that that creates with the provider community is phenomenal. And it points to some of the tremendous financial weaknesses and solvency issues that currently exist in the health care system today at the private-sector level.

DR. GINSBURG: Larry?

DR. ATKINS: Well, let me be clear on what I think I'm addressing here, which is we're talking about essentially a fixed contribution that stays within the context of an employer plan. So nobody is walking out of the plan. But it's a fixed contribution, much like the managed competition model. And presumably there's a much greater degree of choice here not only of health plans, but as we talked in

some of the models this morning, of actually being able to empower consumers to take dollars or a fixed amount of dollars and go into the system as individual consumers picking providers.

So that the major stumbling blocks I think there are going to be the lack of the underlying technology that is going to be necessary to make all of that work. And really what we're talking about is both what Helen talked about, in terms of information, enough information for consumers to be able to make informed choices, and the fact that we really don't have, in this country today, provider information that gives you very much of a differentiation between providers at all. And we have a long way to go in getting providers to report information that could be used to do that.

But I think more significantly is this question of risk. Because even though you have the employer pool intact, as you go into a consumer choice model, you are putting into motion individuals in a way we've never seen before in the system--individuals going to providers with amounts of money and providers taking very small portions of risk. So we've been through a period of ten or whatever years of watching the effort to shift risk out through capitation and other methods to not only health plans, but providers. And we've watched that fail pretty substantially, pretty remarkably, in some places. And we do not have at this point sophisticated risk adjustment technology. We don't have the information we'd need to do sophisticated risk adjustment.

So there needs to be a series of intermediaries who can grow up and become experienced in being able to manage this. I think it's wishful thinking to think that you can have consumers go online, pick a health provider, give them an amount of money and that that's all going to work well and that there is not going to be a substantial amount of risk selection in there that people just have no way of anticipating, but they'll find out when they wake up one morning and realize that they don't have the revenues to cover their expenses.

So I think those are probably the most significant hurdles at this point.

DR. GINSBURG: You've probably covered some of this. But if you could focus on employees, both as to whether there are certain types of employees that would particularly value this or particularly feel harmed by it. And perhaps you could also touch on the issue of adjudication of employee issues. Is it going to be more difficult for the large employers to do what they have done historically of adjudicating employee issues in this context of a defined contribution?

As we switch order, do you want to start?

DR. ATKINS: I'll try that one. Let me start with adjudicating. Because I think the issue is what is the employer left to be responsible for in this? I mean, right now the employers select health plans. They have a fairly substantial obligation, I think, to help in the adjudication of issues that come up with regard to claim for benefits. Because they design the benefit plans, they often have a lot to say about what gets paid for and what doesn't get paid for. And so they are in the middle of it.

I think as you move to defined contribution, I think that the whole concept, and particularly with more of a consumer choice model, increasingly, the concept is to get the employer back out of being in the middle of it and let the employees make the decisions and therefore have to be more responsible themselves for adjudicating what happens. And I think in that case probably what we're talking about is more of an ombudsman model, more of an independent way for people to have some of these issues taken care of.

I don't think--I agree with Helen--I don't think the employer is going to back out of it entirely. But certainly the nature of what they're adjudicating will change fairly substantially.

And what was the first part of it?

DR. GINSBURG: The first one was about who gains, who loses among employees, as far as who is this going to be very attractive to and who's at risk for coming out behind?

DR. ATKINS: Well, there really certainly are a lot of employees who are kind of chafing at the bit to get out there and be much more involved. And you can just see, in terms of what people are doing in terms of more health information on the Internet and how people are moving into physician's offices much better equipped to understand their diseases and stuff.

I think giving people information that we'll have a lot of employees who want to take advantage of that. There will always be about 50 percent of the employees who don't and need to be protected in some kind of a residual model. But I think it will be attractive to a large number of employees.

DR. GINSBURG: David?

MR. BLITZSTEIN: In terms of the effect on employees, it would be interesting to ask employees exactly what they are interested in having provided for them. And if you look at some of the EBRI surveys, there is still a very strong attachment, according to those surveys, that I think are performed annually, to the employer-based system. I don't think a majority of people are looking to take over the administration of their own health insurance, at least if that's what you read into the survey information.

I would agree with Larry. I think one of the tremendous potentials here for plan sponsors is to move more and more into the area of education and providing health information to employees so they can make good decisions and they can make educated decisions about when to see a provider, which provider to see. And, again, I think it's worth repeating, the potential of some of these Internet products, in my opinion, is really in that area of sharing huge amounts of micro-type information, outcomes analysis, quality analysis on individual providers.

In terms of adjudication, I think the whole purpose of the extreme of defined contribution that some people are advocating is really to get out of that business, is to outsource any type of dispute because businesses don't like to deal with disputes.

Where I come from, where my union sponsors multi-employer funds, we have jointly trusteed funds where labor and management are responsible for administering the funds. And we have dispute resolution processes in place that seem to work very well and avoid litigation to a great degree. I think they would be undermined by an individual responsibility type system.

DR. GINSBURG: Helen?

MS. DARLING: I think, in terms of employees' level of satisfaction, there is no question most employees really don't have much choice, if any choice. So the further we go down the road to choice for them, however it's done, there's going to be higher satisfaction. And if there's information for them to make those choices, all the better.

Within a cafeteria plan, if employees are allowed to use money that they don't use for health care for other benefits, then that could be a plus for those who don't use all of those benefits. And that's actually fairly important to employees.

Now, in addition, if there's proper risk adjustment and there's real protection, the group I worry the most about are the people with serious medical conditions or children with major disabilities. So whatever the system, if it's designed to make certain that those cases are always taken care of, then some of these more subtle things at the front end, whether you go back to the doctor six times in one year instead of four times in one year, those kinds of things that'll be fine. But, unfortunately, some of the

systems we have in place don't do that kind of protection. And I think that that's important and needs to be considered.

Clearly, if the system is opened up for more people, then employees in the aggregate are going to be better off. And if new models are coming forward, even if they are not desirable to every person, and as several of the panelists talked about, this isn't necessarily going to be for everybody. But we have a huge country. I guess we are, what, 276 million people. Ten million people in the United States is not a lot of people, but that's a big service.

So if you can provide, again, with the proper risk adjustment so people who are seriously ill are not harmed in any way and those who have more flexibility are given more choices and have the ability to control the payment in a different way, and go wherever they want, and pay the difference if they don't, then that's going to be something that's very appealing to employees I think everyplace.

MS. KROL: We are kind of unique for a high-tech company. We have 120,000 retirees that we inherited from AT&T, and while we spin all the companies off, we keep all the retirees. So, pretty soon, I think Lucent will become the largest retiree employee of the high-tech world.

We have 50,000 union employees and 40,000 active, and all of our major growth is in companies who are buying in Silicon Valley. So I feel incredibly challenged in addressing any kind of one product that is going to meet the demands of those groups of people.

I think the one thing they all value is they do understand the power of a group purchasing model. So they do understand as a company, we can leverage price and quality on their behalf. I think they do value that.

The other attribute that they value is really the information we can provide them, and I think we have a long way to go on that.

Where I did not answer as a stumbling block, it is clear that we do not have a clearinghouse of uniform information that somehow is validated to be accurate, and that that kind of information would be of help to consumers and moving into a co-insurance PPO plan design, the biggest issue I have is that people want to know discount off of fee-for-service. Well, discount off of what, and what is the price? I cannot share that with them. So I am interested in looking at the health market site to see about costs being provided because we have not been able to do that. So consumers are ready to look at cost and quality information, and it does need to become a standard part of the program.

Another role, again, is this advocacy, that if things are broken that they expect Lucent will take their issues and represent them and leverage our size, even though I have to admit we are becoming pretty marginalized as employers in this marketplace where hospitals now go directly to the newspapers to terminate contracts with vendors. Probably a good part of my day now is dealing with hospital network disruption and doctor disruption. So those roles are things that our employees value, and I think that those can be really set up in a defined contribution or through an information model.

DR. GINSBURG: We are getting a little short on time. So let me just give a final question to the panel before going to the audience.

If we fielded an employer survey in, say, 2003 or 2004, had a bunch of questions about changes since 2000 in employer-sponsored plans, I was wondering what type of responses do you think we might get. I guess that was an indirect way of asking for your predictions for the future of what is going to happen over the next 2 or 3 years.

It looks like Helen is ready.

MS. DARLING: Well, you mean what are the employers going to do? Is that the question, or what is the prediction on the increase?

DR. GINSBURG: What is going to change as far as employer-sponsored coverage?

MS. DARLING: Well, in the short term, not much, and my reason, again, the single most important fact is the war for talent in this country right now. It is affecting every market, every employer, except a few that are about to go under. They are the only ones who are not worried about recruitment. Most are not going under because of the economy.

I would say as long as we have this dearth of new workforce entrants in the 20-year-olds, until the millenials--if you all are not familiar with that term yet, the millenials are the kids who are right now between 12 and 22. I guess you are no longer a kid at 22. But that generation is the largest since the baby-boomers. When that crowd begins to really hit the workforce, some of this problem is going to go away. Demography is ruling on this one.

So I think in the short term, employers are going to do anything they can to make employees happy. Fast-food restaurants, companies that have never provided health benefits are beginning to provide them now. I do not have a single client that is willing to even uptick a tiny bit, a copayment, except on prescription drugs, but on office visits, no, they are eating more of the contribution. It is roughly 80/20 nationwide, and this last 3 years with the increases, none of the successful companies that I know or work with have passed on even the 20 percent of the increase. So it is actually that the proportion has gone down slightly because of the economy and because of the war for talents.

So I think in the short term, we will not see much change. They will continue to eat the increases. There will be small changes in copays, and I think we will begin to see some pressure more on things like formularies out of desperation, even though they are not going to like that, but they feel that they can kind of get that in without a great uproar, but all of the sort of main plans will stay untouched, I would say, until the millenials join the workforce.

DR. GINSBURG: Larry?

DR. ATKINS: I would just add to that. I think there is a lot, though, right now of strategic planning going on where people are investigating alternative models and thinking about how to get more skin in the game for employees and very worried about long-term cost. I think there is a feeling that this is not just a little uptick right now in health care costs, but the beginning of a long-term trend, and the feeling is that we have lost some of the tools that we had that probably worked for a while and we do not have new tools in hand to manage this cost.

I think there are people who are anticipating that this is going to become an issue in senior management in about 3 or 4 years when they are going to have to be prepared with some kind of a strategy to get out of this, but I see it starting and then maybe taking place over a very long period of time in the transitional piece.

DR. GINSBURG: So it sounds like we could have a phenomenon of we do not see much as long as labor markets are tight, but there is a lot of thinking going on, and that once labor markets are not so tight, we see change that is maybe more rapid than we are used to.

I guess the question is, at that point, when the labor markets have loosened, I would ask for your prediction on what types of changes would we likely see from employers.

Pam?

MS. KROL: I will echo. We certainly are looking at strategies, and in 3 to 5 years, actually, we have increased our copays, but we are not a normal employer. We inherited the AT&T model of

free health care and nominal copay. So we are not still close to what most people pay for health care, but we have made a commitment to push communications through the Internet.

Obviously, as a technology company, we have a website with the Mayo Health Clinic. So we have more and more pushed communications on your condition, going to the workforce, on-site fitness centers, a lot of that kind of more tangible show of health promotion. Probably, we will kind of cut back on some of the defined benefits on health care only because a lot of our younger employers, they do not value a lot of these benefits as much as they want stock options. We are really in this dichotomy. I mean, there we have in telecommunications about a 20-percent turnover. So we have a turnover issue, and we have a workforce that is highly motivated by stock price, and why offer very expensive health benefits which Lucent has because of our cohort when our population that we are trying to attract to Lucent do not value those as much.

So, again, we will probably have different strategies for the different groups. Retirees are actually on a cap. So they are on a defined contribution already, and we are starting to pass the cost onto retirees. The unions, we negotiate benefits. So there are tradeoffs there. For our management people, really in probably 3 to 5 years, we will probably see more of a cutback in some of the dollars, but more flexibility for people, again, this total rewards to use their money from the company to purchase benefits of value to them.

DR. GINSBURG: David?

MR. BLITZSTEIN: I have a couple of comments just to support. Helen has made several interesting statements about the tight labor markets and the impact on health insurance.

I do not know if any of you saw this, but this ran in the New York Times on October 1. A company by the name of Gardsmark took out a two-paged advertisement touting the fact--and this is a company that has 15,000 employees, so it is not a mom-and-pop operation--touting the fact that they provide 100-percent-paid health care for their employees. I don't recall what an ad like this costs. I used to know these things 10 years ago, but this has to be--

DR. GINSBURG: $110,000.

MR. BLITZSTEIN: Yes, easily. It was also in the Wall Street.

It is sort of fascinating to see that type of statement, social statement, if you want to call it.

So I guess insurance is important to employers and employees. My prediction is a pretty ugly one for the period beyond 2003. I could tell you that the 1.4 million members of my union based on polling that we do across the country feel that their health insurance benefits next to their wages have most important economic value. I think they understand that without it, they are basically running bare and naked in terms of the life of their family and themselves.

When we went through a period in the '80s where this became contentious, there was a lot of social conflict. There were quite a few strikes in this country over the issue of health care, and not only do I foresee that beyond 2003, I think at some point when the uninsured numbers start popping up at the normal rate that they have been, you are going to see Congress back into the fray. They will surely approach it differently than they did in '93 and '94, but they will be involved, to the better or to the worse.

DR. GINSBURG: Helen, did you have one more thing?

MS. DARLING: Yes, just to add a point about the possible changes.

I do work with some dot-coms, and interestingly, there are only two things that are required, the dot-coms require, and that is 401(k), especially since everybody doesn't qualify for stock options, and

"medical." Medical usually means as a practical matter a PPO, and it is essentially defined contribution, but it is at close to a 100-percent level. So they are setting the stage now for the future, and more employers are either moving to or offering a PPO which, of course, built in has a little bit less coverage and doesn't usually have as rich benefits to start with and they are less expensive.

Most important from an employer point of view, what an employer pays per month for a PPO access fee is somewhere about half of what they would pay for point-of-service. So I see short term and long term a much bigger shift to PPOs because basically the large health plans are pricing themselves out of the market with their point-of-service products. If that does not change, combined with defined contribution, the tendency to let people have a PPO because they prefer it, all of that is going to move. We will begin to look a little bit like the old indemnity world. Then, of course, we could all reinvent the new models together.

DR. GINSBURG: Before I go to the audience, I could not see this panel. So I cannot tell from their expressions whether they are chomping at the bit to say something, but I wanted to give any of them, if they would like, an opportunity to react to what they have heard from this panel.

MR. NEWCOMER: The only thing that I would say, the entire discussion centered around employers and their employees. There has been no discussion whatsoever about changing the incentive of the key vendor; that is, the providers of care.

All of the models or all of the objections you talked about up there about maintaining the status quo, tweaking it here and there, still leave the provider essentially unaccountable for what they do. I think as long as we continue that, we better be willing to pay the bill because nothing is going to change.

You have to think about systems changes that get down to the individual provider level to create incentives for them to do the right thing.

Final Questions and Comments from the Audience

DR. GINSBURG: Do you want to come to the microphone?

FLOOR QUESTION: I am writing this up for the Health System Center.

Helen Darling, you mentioned, and a couple of the panelists this morning mentioned, what a good idea it would be if people could carry over their unused health benefits. In the next breath, you mentioned your concern for families with chronic children. Isn't it the money that went into the system that wasn't tapped for health care needs that really subsidizes now those chronic and serious health needs?

MS. DARLING: As far as I am concerned, as long as everybody is protected for the higher cost and more extensive, we are really talking about like in the medical savings account model where everybody has a certain amount of money for visiting the doctor and doing things like that, the sort of very low end.

If, for example, you are a lower user, then, yes, I think letting them carry it over, that is different from letting them have it at all, but if they have it at all, which we have in the current model, then it makes no sense to not let it be carried over.

He is right. Every year in December, I buy seven new contact lens because I never use up my money. That soret of stuff is silly.

DR. ATKINS: Can I comment briefly?

DR. GINSBURG: Sure.

DR. ATKINS: I think it was one of the groups this morning talked about having the episodic allowance, and in a system in which chronic disease gets taken care of with some kind of a capitated model where it is based on a diagnosed condition and you kick into then that kind of managed care, in that environment, in that context--and then, of course, you have to deal with risk adjustment--the medical savings account makes great sense as a way to handle the front end of the cost up to some dollar level. That is one way of dealing with it.

The other thing is that I think some people view the medical savings account as more of a lifetime accumulation approach, which is that by retaining it over some period of time, you build up a fair amount that then becomes available to you when you hit a period in your life when you are more likely to have higher medical costs.

I do not know if we have the capacity in this country to go to a lifetime model or not, but I think that is some of the thinking.

DR. GINSBURG: Good. We have a few questioners. We will start with Greg.

MR. SCANDLEN: Greg Scandlen with NCPA.

I have just a couple of quick points. On the tight labor market issue, you all seem to assume that this will be perceived as a take-away benefits rather than an enhancement. I would suggest for a lot of the community, that is not the case, particularly for mid-sized employers, employees who may be in an HMO they do not like. With the current disgruntlement, widespread disgruntlement with managed care, a lot of people may see this as a huge enhancement of their benefits program, not a take-away.

The other thing, just generally in the discussion, Helen alluded to this, and I appreciate that, but there is too much talk about employers like this, employers like that, workers can do this, workers cannot do that. That is kind of like Washington government program thinking where whatever you do has to apply to everybody.

In this case, we are talking about a market. The majority of employers may not like this. Eighty percent of employers may not like this, but that leaves 20 percent, which is a hell of a business for some companies. That is not to be dismissed.

MS. DARLING: Absolutely.

DR. GINSBURG: Alan?

MR. WILDE: Alan Wilde with The Urban Institute.

I have a question about sort of the value of choice which is a theme here. We just had an issue in health affairs talking about Medicare competitive bidding demonstration falling apart because of the gap between the theoretical value of rules of competition and the practical reality that in markets some people actually lose.

It seems to me that if we are thinking about defined contribution as more than just outsourcing the administrative tasks of a benefits office, but really moving to a defined contribution, and we know that people are very, very price-sensitive, it seems like a likely outcome here is a large majority of middle-wage workers moving into low-cost plans and entrepreneurs being willing to offer on a defined contribution model some low-cost plans.

I am trying to imagine the politics of that and why they are any different from what we have just been through. Employers, for price reasons, moved their employees into managed plans and the employees bristled at the restrictions on those plans.

Now, employees empowered, I suppose, presumably will make identical decisions and feel just as frustrated as they did when it was their employers. It seems to me, there is a lot of power to be

harnessed in the market, but I am worried about the political endpoint being the same as the one we just went through. How is it that by calling this choice, we really think that in the end, the employees will be more satisfied?

DR. ATKINS: For one thing, I am not sure we are ever going to be able to get away from the fact that the employees or the patients are going to become increasingly frustrated with the costs that they are going to have to bear in a much more expensive system.

I think the idea of choice is the employees or patients, whatever, have to take more responsibility for the consequences of their own actions in wanting health care because I think the employers started out by trying to create a system in which they would have decisions made for them. They would get things that people felt were medically necessary, and they wouldn't get things that people felt weren't medically necessary. The difficulty with that is it makes somebody else responsible for the decision.

So I think people are exploring ways to get employees to be more involved in that decision themselves, and I think the feeling is that if you begin to see what the impact of what choice is on cost, hopefully you become more of a partner than an opponent in terms of managing health care cost, but who knows?

MR. HERSCHMAN: Can I make one point. I think this is important. We keep hearing cost, cost, cost. It is value. The issue is value.

Cable TV costs more, but we buy it because it has value, okay? If people want easier cell phones, they will go for 7 cents a minute. They understand it, but it might cost more. I think you have to think of it broader than just cost, and when you get to things at an individual level--I will go to a narrow network insurance product, not one that my employer would ever pick, because that is imposing it on people, but if it meets my criteria and the price is right, I am willing to do that. It is a good value.

So I think you have got to get out of the cost mantra and think about value, and once you start thinking about value, then you will see that markets work.

MR. NEWCOMER: Well, I just want to add to that. In our focus groups, we found out that about two-thirds of the people there wanted to spend more to get providers they thought had value, and they couldn't get to them because their health plan wouldn't sign them up. They were more expensive.

I think the questioner's assumption is not necessarily proven in the marketplace.

DR. GINSBURG: Helen?

MS. KROL: I would like to address that. We have point-of-service plans, and you have a $200 deductible and 80-percent coverage to go out of network on a plan that only costs $10 a month to participate, and 90 percent of the utilization is in network. I spend all of my time lately dealing with Pennsylvania because hospitals are dropping out of that network. When I tell people for $200, you can go out of network, they say, "You expect me to pay that?" So there is the marketplace and your shelf, you know, the grocery store concept. It is based on the premise that consumers have information, and the information is validated by organization, Food and Drug Administration, Agriculture Department. There is information on that box. So you know what you are buying.

Unfortunately, in this marketplace, there is no information on cost that is readily available to consumers, and there is even poorer information on quality. People just make decisions based on reputation of the hospital that they want to go without any information on the outcomes of those procedures.

So I love Regina Hertzlinger's book, and we move to a market-driven system, but in 2 years at Lucent, I have not been able to put cost data up. I have not been able to put reasonable quality data up. So, I mean, we would love to be in a market, but a market has to provide those attributes.

DR. GINSBURG: Larry and then Helen.

DR. ATKINS: I would just say there is a great danger that in the absence of really good information on providers that does distinguish on the basis of quality and outcomes that the higher price that a provider charges will be seen as a proxy for higher quality. So people will just buy more expensive providers because, gee, they must be better, and I think there is a danger of that if we do not get good information.

DR. GINSBURG: Helen?

MS. DARLING: I think there is also always the danger of judging the future on the past, although that is sort of the only thing we have, but most people will put into model types that they do not like and they did not have choice. So a lot of the frustration is that they sort of think that there is "managed care," and that is kind of in their minds that sort of everything that they don't like.

So what we do not know--well, maybe some of us do know because we have offered multiple options--how different it would be if you had the wide range and you did, indeed, have at least more information than we have got now and you pay a difference.

My experience is very similar to Pam's. I was always astonished at how little money it took for even wildly well-paid people to nitpick about reimbursement, and I never understood why they cared. It was less than you would pay in a taxi to go to National Airport, and these were people with lots of money. So there is something about the mentality or people coming in and saying why don't we pay for something. I say, "We could take your money in a premium. We could pass it through, add 25-percent administrative cost, and send it back to you as 80-percent reimbursement. Would you really rather do that, or why not just pay for it yourself out of your flexible spending account?," and they would have the same look of horror, "You mean to get my mammogram, I might have to pay for it?," even though it is their lives.

So I think we have to be realistic, and people probably will never be happy with all the solutions. I guess the one point Larry made and others have made, which I think is really important, the worse news is still ahead. The kinds of increases we have had in the last 4 years are terrible, basically, especially this last year, depending on whose numbers you look at, 9 to 13 percent in one year alone.

Everything about what we have got in the system today would suggest that that is going to continue to explode. There is nothing. Nobody is managing care out there anymore. They are not even watching the store anymore. They are certainly not doing case management. We audit these places. So we know that.

So what we have had for the last couple of years, we will have many times over, and I think if there is a level of unhappiness, we got it in the next 2 years and it is going to be brutal.

DR. GINSBURG: Thank you.

That would be a good time to close the meeting, but I would like one last question, though.

MS. VARNEY: I have been standing here a long time.

DR. GINSBURG: I know. I want to hear the question.

MS. VARNEY: I am Stacy Varney, and I am with Choicelinx. My question is with regard to consumers having access to more medical information now than ever before. Do you see any kind of a shift or a trend toward employees wanting more options around alternative care that may not be

covered under a traditional health plan, and if so, do your current plans provide for that? Would you have any plans to offer those options in the future?

DR. GINSBURG: Or, actually, if I could modify, whether defined contribution would make a difference in offering alternative care.

MS. VARNEY: Exactly.

MS. KROL: At Lucent, we do offer acupuncture and chiropractors care, and we have looked at alternative medicine networks. We are waiting for them to be more fully developed in terms of credentialling and breadth of providers because, in certain geographic areas, we do not have very good coverage, but with that model, again, having information to be able to discriminate when you are depressed, should I be taking St. John's Wort and what is the cost of that versus a therapy appointment versus a massage. So, again, we would like to see more alternative medicine treatments available to consumers because they do value it, I believe. They spend a lot of money on it outside of the plan.

I guess that is why I have been also struggling with a lot of this competition model. I think we have worked a lot on trying to provide integrated models around health and welfare and alternative medicine, the psycho-social support with illness. As we look at some of these models, we are really looking at competition on price with providers and value, and I get a little nervous that we are kind of fragmenting the care, mind-body care concept around some of these talks. I am still struggling with how to package products that would be more comprehensive versus purchasing just a gall bladder operation or cardiac care without purchasing the rehabilitative services and other services involved.

DR. GINSBURG: Any others? Steve.

MR. WIGGINS: I just would like to make one comment on alternative medicine and some of the options that will exist. When you actually move to episode-based payment, which we did at Oxford for 30 episodes--we have 80 now in this new program--we got lots of providers moving into it. We had tens of thousands of patients going through them. We had more money for alternative medicine, and people in an episode-based allowance system can make that tradeoff. They can say, "I would rather spend maybe one day less in the hospital out of a 7-day stay. I would rather use those incremental resources for acupuncture." It might be something as esoteric as chi gung or some other type of alternative therapy that could be used when you have control of the resources.

It is too bad that we really didn't get a chance to go into this model deeper because so many of these issues are so easily addressed with more explanation.

DR. GINSBURG: Thank you.

I appreciate your staying longer. I think we had some great discussion. I want to thank all of the panelists, Sally Trude, Jon Christianson for his moderating. Please fill out the evaluations before we go. We need them.

I want to thank you, the audience, for providing such provocative questions, and The Robert Wood Johnson Foundation for its support of this meeting.

Thank you.

[Whereupon, at 12:10 p.m., the conference concluded.]