

CATO INSTITUTE

POLICY FORUM

LESS HEALTH INSURANCE AND BETTER HEALTH CARE
TWO-TIERED HEALTH BENEFITS MODELS

Friday, November 2, 2001

Moderator:

Tom Miller, Director of Health Policy Studies,
Cato Institute

Featuring:

Helen Darling, Washington Business Group on Health;
Kenneth J. Linde, Destiny Health Insurance Company;
and Lawrence H. Mirel,
Commissioner of Insurance and Securities Regulation,
District of Columbia

The Cato Institute
F.A. Hayek Auditorium
Washington, D.C.

P R O C E E D I N G S

MR. MILLER: Good afternoon, and welcome to the Cato Institute. We are talking about two-tiered health benefits today -- an evolution, rather than a revolution, in the way in which health care is delivered to consumers. We have the perspectives of a regulator, a representative from a health insurance company, and someone from a large employer's organization, trying to respond to what consumers want and what they need.

Again, as I said, the change in health care, given the long history, suggests it is a matter of evolution rather than revolution. And after the demise of the Clinton health plan in 1994, private employers generally resorted to various forms of conventional managed-care practices, which for a while held down costs but seem to have run into more problems lately in managing both access to care and containing costs and maintaining quality. They seemed to hit an unyielding wall of soaring costs, expanded liability risks, political opposition, and consumer discontent.

Now, currently, a number of powerful factors, even without political action, seems to be moving health insurance away from third-party decisionmaking by employers, insurers, and the government, and more to consumer-driven alternatives. And some of those factors are that health insurance premiums are

rising again at annual, double-digit percentage rates; the managed-care backlash, which we are not hearing that much about this fall but will be back soon; weakened third-party constraints on health care spending; Congress remains still ready to add some expanded liability costs for bad medical outcomes to the health benefits bills that employers pay; and we are seeing looser labor markets and business belt tightening that is inevitably going to result in less comprehensive insurance coverage and greater cost sharing by employees. And on the positive side, the wider availability of information-technology tools and e-commerce intermediaries should be decentralizing health care decisionmaking.

You know that something different is going on in the health care marketplace when you picked up a copy of The Washington Post last August and read an article by the D.C. Insurance Commissioner, saying that something is wrong with our insurance system, and he is not calling for a national health insurance. Lawrence Mirel talked about the current system for paying the cost of health care as being seriously flawed, and he has suggested that we need to deal with two different tiers of health care needs that must cover those needs with two separate tiers of payment. We want to understand what is going on here -- when The Washington Post and the D.C. Insurance Commissioner -- it seems there is something wrong with this picture.

Lawrence Mirel is Commissioner of the District of Columbia Department of Insurance and Securities Regulation. He was appointed by Mayor Williams to that post in July of 1999. His responsibilities include directing the agency to enforce all the laws of the District of Columbia relating to the conduct of the insurance and securities business in the jurisdiction. And his long background in the legal community involved representing a number of insurance companies, both in individual practice and with several firms. His law degree is from Columbia University, and an MBA from Overland College. And today we are going to hear what exactly should be different about our health insurance system.

Commissioner Mirel.

LAWRENCE H. MIREL,
COMMISSIONER OF INSURANCE AND SECURITIES REGULATION
DISTRICT OF COLUMBIA

MR. MIREL: I am not sure why you are so surprised that somebody in the District government would have anything interesting to say. We are in a new era in the District of Columbia and a new era in our government, which I am very pleased and proud to be part of.

I knew before I became Insurance Commissioner that our health insurance system was not working well. I do not think I am unique in that. I think people generally understand that it does not work well. But I was not prepared for the level of anger and the number of complaints that I got and that I get as Insurance Commissioner from every part of the system. People who are insured under the present system are confused about what kind of coverage they have. They get angry when things they think are covered are not covered. They have a lot of trouble trying to figure out the system -- how do you file claims, where do you file claims. I am Insurance Commissioner, and I am a lawyer, and I cannot figure it out. Luckily, my wife is better at that, as she is at figuring out the VCR.

Then talk to providers, talk to doctors and hospitals, and they are furious. They are very angry at the notion that someone who, first of all, is less qualified than they are, and secondly, has not seen the patient, second guesses their professional judgment about treatment; or worse, does not pay them when they have actually provided the services on the ground that the services were somehow not necessary. They thought they were necessary; that is why they provided them. So they are angry about that.

In addition, the insurers are unhappy. That was a surprise to me. The insurers are unhappy because they have

developed the system to try to control costs. And that system means managed care, it means eliminating certain things, it means cutting back on services. And every time they do that, people complain to their legislature -- local or national, mostly local -- and mandates get passed. And mandates drive insurance companies crazy because that is not how they price; they price on the basis of what is covered. And if a mandate is passed and they have to cover something they did not intend to cover, then they are going to lose money. So they do not like the system either.

I thought a lot about why the system is not working -- what is wrong with it -- and I really came up with two major features that make it not work well. The first is that a lot of things that we insure under our health insurance system are not insurable. I remember from my law school course many years ago on insurance law that an insurable event is something that, first of all, is not likely to happen; it is rare. Secondly, it is a major event. And thirdly, it is something that the person who is insured does not want to have happen. That is what makes it an insurable event.

Well, part of the health insurance system fits that definition. It is the part that deals with injury and illness. Nobody expects to get a serious disease, and serious diseases are relatively rare. Nobody expects to be injured in an accident,

and accidents are relatively rare. When they happen, they are devastating. They cost a lot of money, beyond what people ordinarily have hanging around the house. They are, in short, insurable events.

But routine health care is certainly not an insurable event. That is, when you go to the doctor either because you want a physical exam, or because you want to get a flu shot, or because you want to have some kind of test to keep yourself healthy, it is, first of all, not unexpected. Secondly, it is by choice; you decide you want to go. Thirdly, the cost is not a devastating cost; it is not a big deal. And that part of the health care system, in my view, is simply not insurable. And one of the major problems we have with our current system is that we are trying to use the insurance system for something that it was not intended to handle and handles it badly.

It handles it badly because the whole expertise of insurance companies is to limit the amount of claims that are paid. Underwriting is the key to the insurance industry. You try to figure out what the risk of loss is, and then you try to lower that risk -- paying fewer claims. There is nothing wrong with that, and sometimes it works very well. I will give you one example.

A worker's compensation insurer, for example, wants very much to make sure that fewer claims are filed. So the

insurer will spend a lot of time and energy trying to make the work place safer for the employees. And that is a good result. You want that. And they will do it for the noblest of reasons -- fewer work place injuries means they make more profit. That is how the system should work.

Well, then you try to apply that to the kinds of routine health care that people go out to get, and it makes no sense at all. They do not want to pay for a doctor's visit because that is not insurable. You picked it. You did not have to go. They do not want to pay for flu shots because that is something you chose to do, you want to do; it is not insurable. So they try to limit the amount of claims paid by a very rigid system of managed care designed to hold down the number of claims.

Well, to me that is crazy. You want people to go to the doctor, you want them to get the flu shots, you want them to do the things that they should do to maintain their health. And you should not do that through insurance. In addition to the fact that that is the wrong paradigm, it is also very expensive. Because in order to determine whether a particular claim is a valid one or not, there is a great deal of paperwork involved. That may be all right if you have an \$8,000 bill for a hospital stay, but to apply the same thing to an \$80 charge for a doctor's visit is crazy, because it costs the insurer as much

administrative time and expense to process the \$80 claim as it does the \$8,000 claim. That is the first thing wrong with the health insurance system, is that it is not health insurance -- at least a big part of it is not.

The second problem with it, I believe, is that the coverage is a contract. People think if you have health insurance you are covered for anything that happens to you. Well, that is not true. You are covered for what the health contract says you are covered for, no more and no less.

Well, who negotiates that contract? It is negotiated between the insurance company and the employer. The employer wants to be able to offer a reasonable health insurance plan, because if he is interviewing an employee, the employee is sure to ask -- a prospective employee -- do you have health insurance? And the employer wants to be able to say, yes, we have a fine plan. And that is as usually as far as it goes. The employee does not ask, well, what does it cover exactly and what doesn't it cover? The employee usually finds out what is covered and what is not covered when the claim is made. Then he finds out that it is not covered, and he is angry.

What are the motivations of the people who enter into this contract? The employer wants to hold down costs. All employers want to hold down costs. So he wants to provide an insurance plan because he feels he has to, to be attractive to

the kinds of employees he wants to attract, but he does not want to pay too much money for it. Insurance companies are very competitive, one with the other, and they know this, so they keep trying to provide lower-cost products, or at least hold the increases down.

Well, there are really only two ways to reduce costs, two major ways, to reduce costs in an insurance plan. One is to provide less coverage. It is too expensive; all right, we will drop dental, we will drop visual, we will drop the family. We will cover the employee, but we will not cover the family. So you provide less coverage. The other way is you pay the providers the less. You will reimburse the doctors less than they want, you will pay the hospitals less than they want, and you will reduce the costs that way. And that is in fact what has been happening and what causes all the anger and distress that I talked about before.

But it is important to notice that the people affected by this contract are not there when the deal is made. The providers are not part of that deal and the employees are not part of that deal. And yet, they are the ones most affected by it. And to me that is another serious problem with the system.

Well, are there solutions? And that is what we are here to talk about today. If I could wave a magic wand, I would prohibit the sale of a product labeled "health insurance" with

less than a \$4,000-a-year deductible. That is not to say that there should not be plans for covering health care costs under \$4,000, but it should not be insurance. It should not be treated as insurance; it should not be underwritten as insurance.

There are two pieces to the health care puzzle. One is covering serious illness and injury; the other is maintaining good health. They are different systems, and they need to be treated differently. You can insure against a catastrophic event, such as a major illness or accident. You cannot insure for routine health care. It is just not insurable. So I would separate them out by drawing a horizontal line -- this is the two-tiered concept that we have been talking about -- and say that you cannot sell as an insurance product something that is not insurable.

There are already powerful incentives in favor of going with such a system, not the least of which is the Medical Savings Account Program that Congress enacted some years ago. Now, at present, it applies only to small employers and self-employed. But the concept is that you can pay for that part below the 4,000 or 2,000, or whatever the cutoff is, with untaxed money. That is, you can put money aside that you have earned, not pay taxes on it, put it in a medical savings plan, and use it to pay your routine health care costs. That is a powerful incentive. But I

think there are other incentives, as well, for such a system that have not been as much talked about.

One is that it is a real pain for an employer to have to negotiate a new health care contract every year. That means the employer has to go out and find a company. Usually, the employer does not have to find one; they will find the employer. The employer has to negotiate with several different companies to figure out which one offers the best combination of coverages, which one is likely to be most attractive to his employees, and then sign a contract, which is for a year. And next year he has to do the same thing all over again. Some employers, if they are large enough, will punt and will offer what is called a cafeteria plan, and let the employees pick which on of these plans they want.

But if in fact you had a two-tiered system, then for the lower tier -- the routine health expenses -- the employee makes his own choice and the employer has nothing to say about it at all. This is money that is put into the pocket of the employee, and the employee can spend that money for whatever he wants to. So if one employee has a lot of dental problems, he can spend it for dental stuff. If somebody else wants to go into mental health therapy, he can do that. It is not the choice of the employer as to what is covered or not; it is the choice of the employee. And I think that is pretty important.

I also think it is important for another reason and attractive for another reason. And that is, that it puts the patient and the doctor back in touch with each other. That may not be true when you go to the hospital -- you may be unconscious when you get there -- so we are not talking about the high-level thing. But when you go into your doctor and you want an examination or a shot of some kind, you pick the doctor you want. The employer does not get to pick for you, or the health plan does not get to pick for you. And you talk to the doctor about what is necessary and what it should cost, and then you make your decision.

I have been thinking about this for a long time, I have to tell you. I was at a law school a few years. I went into private practice of law, and I hung up a shingle and went out by myself. I was not a part of any group, so I did not have health insurance. The D.C. Bar offered a high-deductible, catastrophic health plan, which I took. Then it was a \$2,000 deductible. That would be about a \$4,000 deductible now. And it covered pretty much everything above that. And it was dirt cheap. I think it cost something like \$140 a year for me and my family. I was a lot younger then, but still it was a good deal. And I paid the rest out of my pocket.

Now, the first time I went to my doctor after that -- a doctor I had been going to for some years who I am very fond of

and is a first-rate doctor -- the receptionist wanted to know what insurance I have, who was going to pay for this visit. And I said, "I don't have any. I'm going to pay for the visit. I'm going to pay you cash."

"Well, then you can't see the doctor," is what she said. "We want to see your insurance card." I said, "I don't have an insurance card." We wrestled with this a little bit, and I asked her to go get the doctor. She got him, and he came in, and I explained to him. And he said, "Fine, of course I'll see you. And, of course, I'm happy to take cash."

I do not remember why I was there to see him. He said, "Let's take a look at this. We could give you this test, but you don't need this test." I said, "Wait a minute. If this is part of the standard work-up for this -- and I said I'd pay you out of my pocket -- why don't you give me the test?" "Well," he said, "I can tell looking at you, you don't have that problem." And I was thinking, boy, if I had been insured, he would have done that test.

Now, whose benefit is that? Not mine. I didn't want the test. I did not want to get pricked or cut or whatever they do for that. But he would have done it. You can be sure he would have done it, because the insurance would have paid for it.

So putting the patient back together with the doctor is an important part of this. Paying by cash, or by check, or by

card after the visit -- where the doctor just tells you, here's what it is and you pay him, and he does not have to file any papers, and he does not have to justify what he did, and he does not have to get the prior approval of some primary health care provider, and he does not have to worry about somebody later on telling him that it was not necessary and therefore he is not going to get paid -- is a tremendous savings. It is a savings in cost, it is a savings in aggravation, and in the long run I think it improves the system. So I think that this make sense.

Now, when I wrote the article, I knew of only one company that offered such a product. Since I wrote it, I have heard from many companies, including Ken's, and I find that there are many products like this out on the market today that do exactly the kind of thing that I talked about in my article.

Now, are they all universally popular? No. I can tell you who likes them and who does not like them. The providers love this kind of approach. And they can't wait, for obvious reasons. The insurance companies do not mind it. They like it. They will figure out a way to make money on it. I think employers will like it. Unions have objected to it, and probably will continue to object to it. And they do it for a variety of reasons, some of which I think may have a point, some of which I do not quite understand.

One thing they say is that this is a system designed for young and healthy people. It is a way to help them save money tax-free, like a 401(k). They will, therefore, leave the regular insurance system, leaving behind just the older and sicker people who will have to pay more for their premiums. I do not think that is a necessary result, but I understand the concern. Ken has answers to that, which he will tell you about later.

They are also concerned I think that employers will use it as an excuse to cut back on benefits that they provide to employees. Maybe they will and maybe they won't, I don't know. But they are cutting back anyway. And many employers are just not providing insurance anymore, especially smaller employers. So this has to be a better system than that. Even if you have a small employer who provides only the catastrophic plan, the backup plan, and let's his employees pay the rest, that is better than now, where they are not providing anything.

Public health advocates have raised some concerns, suggesting that, if people have to pay out of their own money, even if it is in a separate account, and they can only use it for medical expenses, they will not go to the doctor as often. I don't buy that. Nobody wants to go to the doctor. You go to the doctor because you have to, not because you want to. And the fact that you have to pay it out of a particular plan or another

I do not think makes a huge difference. And, of course, people who run the managed-care system will object because it means they will be out of a job, which I think is a good idea.

But, in any event, that is the long and the short of my argument. I had an occasion to actually try it out. My 30-year-old son was working on a farm in West Virginia and had no insurance. And I went to the one company I knew that offered this, a company called Golden Rule, and I asked them what they had available. Here is the plan they proposed.

The first \$5,000 is paid entirely by you. And they meant me, not my son, because they knew who was going to pay it. The next \$5,000 is paid 80 percent by the insurance company and 20 percent by the insured. And above \$10,000, it is all paid by the company. That was the deal. The price they quoted my son -- 30 years old, West Virginia -- was \$71 a quarter. \$71 a quarter, that is cheap for that kind of insurance.

Now, I think there are huge savings to be made by such a division of insurance. And those savings, in my view, should be put in the pockets of the employees for them to spend as they want. I think it is possible to do that, to give employees greater control over what they spend their money on, to save time and aggravation for everybody else in the system, and still save the employer some money. I think it is possible. And I think

when you hear Ken explain his plan, you will see that it is already here. Thank you very much.

(Applause.)

MR. MILLER: Thank you, Commissioner. I do want to repeat, the gentleman you just heard speak is the Commissioner of Insurance in the District of Columbia. That is correct.

Now, we are going to find out what is happening in the marketplace. Because you can identify the need, the problems, but we need entrepreneurs to step out there and then put a product in front of the public, and succeed in addressing this in a more effective way. Well, one of those gentlemen is Ken Linde, who is President and Chief Executive Officer of Destiny Health. Destiny Health is a privately-held insurance company. It has created a number of innovative health care solutions. It has a consumer-driven strategy which was modeled first from what its parent company, Discovery Holdings, is engaged in -- it's a global and publicly-traded multi-line insurance company based in Johannesburg, South Africa.

Destiny is based nearby, in Bethesda, Maryland. Its operations are primarily in the Chicago, Illinois area. And it offers flexible plan options that return control of health care purchasing to the consumer for routine and preventive services, yet still providing comprehensive insurance protection.

Ken's background is he previously was the founder, President, and Chief Executive Officer of Principal Health Care, Incorporated. That was a managed-care company that owned and operated over 20 HMO's, PPO's, mental health networks, and other managed-care health operations. And he was previously the Vice President of the Eastern Division of the Travelers Health Network, formerly known as Whitaker Health Services. Before then, he was the director of Federal Qualification for the Office of HMO's in the U.S. Department of Health and Human Services. And before Travelers, he was a Senior Health Policy Analyst for the Boston University Health Policy Institute. He spent over five years with the New Jersey State Department of Health as Director of Alternative Delivery Systems. So Ken Linde has left the church of managed care, and he is now preaching a consumer-driven alternative.

Ken.

KENNETH J. LINDE,

DESTINY HEALTH INSURANCE COMPANY

MR. LINDE: A typical managed-care executive of the past -- I couldn't hold a job.

(Laughter.)

MR. LINDE: By the way, the definition of an entrepreneur is a guy that jumps out of an airplane without a parachute and bag of silk worms over his back and hopes they're overachievers. I will not get into that airplane without a parachute, so I am not perhaps that much of an entrepreneur.

Commissioner Mirel, when he wrote this article, all my staff came running to me and asked, did you see this article? This really describes much of what our company is all about. And it really does. And you have heard many of the concepts -- which I will give you a general overview of -- except we have one different concept. We give much more comprehensive benefits for the insured product; we do not have a high-deductible health plan. So we do all the things that the Commissioner talked about, and we give more comprehensive benefits, which, to the union type groups and others, is much more palatable.

If you picture a triangle -- I'll give you this from a brochure -- and if you assume everything on a triangle that we think of it as a triangle of health care needs -- basically, on the bottom of that triangle are day-to-day expenses that are high-frequent, low-cost procedures -- doctor office visits, lab, x-ray, et cetera -- and at the top of that triangle are more costly, infrequent procedures, such as hospitalization, outpatient surgery, transplants, et cetera.

Now, somewhere along that triangle you have to separate, if you will, that two-tiered philosophy, which is what our product does. It separates what is controllable, health care expenses -- the bottom of that triangle, the day-to-day expenses -- with uncontrollable health expenses, which is the top of that triangle. And that line gets drawn, and we create two products integrated together in our company.

So at the top of that triangle -- hospitalization and surgery, chronic illness medication -- things that are beyond a patient's control -- if you have diabetes and you are taking insulin, if your doctor tells you, you are going in the hospital -- those are beyond a patient's control, so we fully insure for those events. We insure them from dollar one, potentially up to \$1,000 deductible. We do not have high deductibles at the \$3,000 or \$5,000 level. Why? Because, philosophically, we believe that deductibles do not change the behavior of the consumer. If you are going to have those uncontrollable events, a high deductible is not going to change your behavior. So all it is, is cost-shifting into the health care system. So that requires an insurable event.

For my employees we have zero-dollar coverage. It starts from dollar one. We have added up to a \$1,000 deductible, \$250, \$500, because the employers in the marketplace are

demanding it. But we do not philosophically believe in those deductibles from an insurable-event point of view.

On the day-to-day expenses we have what we call a personal medical fund. And that is the patient's money. So if you take a premium that, say, is \$5,000 a year -- and just for discussions here we'll say \$3,000 of it goes to the insured portion I just described, and let's assume \$2,400, or say \$200 a month, \$2,400 goes into the personal medical fund -- that \$2,400 is the patient's money, the consumer's money. It always stays the consumer's money. It is an after-tax fund because it does not meet all the aspects of a qualified MSA, which tends to be a high-deductible, tax-efficient program. It is the consumer's money, and it always stay the consumer's money. It rolls over from year to year if you do not spend it. It can be used to reduce your next year's premium or it can be used as a savings vehicle.

This product -- and that is a very quick overview of the product -- conceptually, clearly works. First of all, there is a million members-plus in this product in my parent company in South Africa. They are about a 9- to 10-year-old company that has developed this concept. Why? Because the private health care system in South Africa happens to be almost identical to the U.S., which was a surprise to me when I first looked at that. In 1992, zero percent of their population was in this type of

product. Discovery Health, my parent company, introduced it there in 1993. And today, 51 percent of the private market is in this type of product. It has revolutionized the system, and it will, I believe, do the same thing here as it starts picking up more momentum.

So what we have is a product that gives very comprehensive care when you need it, but value for the healthy. And if you do not give value for the healthy, you do not keep the healthy in your pool. And so many of the uninsured people in this population are making over \$50,000 and do not see any value in buying health insurance. An example is I paid car insurance for an ungodly number of years, and wouldn't it be nice if State Farm sent me a check for \$1,000, saying, "Great, you haven't had any accidents. I'd like to give you something back." It would be a smart move because they made a lot more than that off me over these many years. But they do not. So what we are doing is giving something back.

Now, the question of whether an employee spends it because it is their money -- many studies have been done in my parent company which shows that does not exist. I just went to my doctor today. It comes out of my personal medical fund. And when the doctor says you need some drugs, I said, "That comes out of my personal fund." What did he say? "I'll give you samples." So it changes the behavior. As you said, the physician-patient

relationship changes, where he starts thinking about how to deal with his patient rather than how to bill the insurance company.

I ran one of these national HMO companies. I have been there. I spent 25 years in the HMO business building the system. The problem is everybody thinks health care cost \$10, and it does not. And if all the answer to health care is we are going to have a \$40 co-payment for a \$42 office visit, then we are in serious trouble. Because as we cost-shift, the out-of-pocket expenses to employees is going up at a higher rate than the general health care inflation. And health care inflation is going up at three to five times the rate of general inflation. So, obviously, we are in serious trouble if we do not cover people with the right incentives.

Clearly, what we have learned, both from the South Africa system and here, is that if you give people comprehensive coverage when they need it, and if you involve them and give them value for their money, they will spend the money when they need to. But what they do not need, they get to use it or keep it. And that "use it or keep it" mind set versus the "use it or lose it" mind set is a powerful change in behavior. The consumers try to find out how much a doctor visit costs. That is a credible concept, isn't it? And they try to figure out how much a cholesterol test costs. And when you get the cholesterol test, is it worth the extra \$70 to get the rest of the blood test. Do

you really need it or are you just doing it because you are paying a \$10 co-pay? Behavior changes. Your relationship with your physician changes.

The industry has about eight companies that are kind of developing this product, along with Humana and United and others, Aetna, that are introducing variations of the product. But nobody has a product that is exactly like ours, where the consumer always holds the money. Most of the other products are for the self-insured marketplace, where the employer holds the money, and it does not stay with the consumers when they leave the employer. And by doing that they get to pre-tax dollars. Ours is the only one that really keeps it the consumer's money. It always stays the consumer's money. And I can assure you, it has a significant impact on the consumer's behavior.

How to accelerate this was one of the questions I was asked. How do we accelerate this type of concept? Well, clearly, the tax laws in this country are probably the biggest issue to accelerate it. As I told you, our fund is after tax. That is the only way you can roll it over and keep it; unless you are pre-taxed, you use it or lose it. There is some legislation trying to go through Congress to try to get FSA's to roll over. That is a step in the right direction.

The last time Section 125 -- which is the cafeteria laws of the IRS Code -- and Section 105 were changed was in the

early 1980's, and before that, the 1950's. So what that tells you is the IRS does not really like opening up the Tax Code and talking about it. There are some companies that may test that Code; we do not like playing on the edge. So in my meetings with the IRS and others, I want to just say it is generally not pre-tax dollars if you carry it over. And if you do that, then it is potentially an illegal product, so we do not do that.

So, clearly, capital is an issue for these types of products. What happened in HMO's in the early seventies, we did have some Federal funding from the Federal Government, but after that a lot of the capital came from private industry, and eventually kind of became part of other insurance operations. And I worked for the Principal Finance Group, which was one of those.

Distribution, credibility -- I have a huge company behind me, but it's in South Africa. A big parent of theirs is called the First Rand Bank, a great, huge bank. But it is in South Africa; it is not the Bank of America. So credibility becomes an issue. So how do we kind of evolve the smaller company into the bigger company and get the credibility? Through a lot of hard work and through a lot of capital.

So we have actual experience in our company. That is very important. In South Africa, year after year, for every year, their increases are 25 percent below their competition with

this product. So far, our increases in the first year of renewals are small numbers. We have about 3,500 employees signed up in the Chicago area. We are a life/accident approved insurance company in Illinois. We are starting in that market and then expanding. We are enrolling 500 to 1,000 new fully insured members a month.

We are not just going after the large self-insured market like many others. We are not a venture capital company. We are an expansion of a very large, successful company. And our renewals so far are in the 4 to 7 percent a year range. And if you assume our groups are mostly in the small-group market, most of those are getting 20 to 40 percent increases. So it is a huge consumer change in behavior.

Now, again, these are small numbers, so they don't mean anything, but the 25 percent of a million members means something. Those million members in my parent company are -- in the entire U.S., in the MSA's, there are about 220,000 members -- so the marketplace there is well ahead of the U.S. marketplace in this type of product.

Clearly, small-group reform issues -- and the guaranteed issue in Maryland and New Jersey and Florida and other types of States -- and some States, I think Connecticut and New Jersey, outlaw high-deductible health plans -- there are a whole bunch of laws that have to be looked at in order to promote more

competition in health care. Each State is different. That is a separate issue, because it is so hard to get approved in every State under different regulations.

The whole concept of controllable health care expenses and uncontrollable expenses works. It works even in a system that the Commissioner described. You have to separate people, but you have to educate people. You have to give them information. So we give a lot of information to our consumers. We educate them. We do patient advocacy. We also do what I will call Nordstrom service in our company. We pay claims in four days. We answer a phone call from a member with one to two rings, by a human being. We do underwriting turnaround in 24 to 48 hours -- unheard of in the insurance industry. But that is what we think is going to be the future of our company. Those kind of companies that excel, that stand out, that do dazzling type things to customers versus just paying claims and having confrontations. And as an old HMO guy, it is really nice to go out with a group of friends that do not accuse me of killing one of their relatives. So it is really much better when I talk to them about the consumer-driven initiative.

So our future? The future is there are going to be more consumer products. They are coming. They are coming with companies like ourselves. They are coming with venture capital type of companies. They are coming with the existing marketplace

adding them to their portfolio. I think that is a problem, because as a person that used to have those continuum of products, administering it is hard.

We have a passion for the product that I have described to you. We firmly believe in it. We do not want to sell HMO's and PPO's and this product. We want to sell this product and do it really well. If you have it as one of a multitude of products, you do not build your computer systems around it, you do not build your service around it, and your salespeople sell what's hot. And the answer to the adverse selections is we insure all these groups and take the entire group as a full replacement. So there is no adverse selection. We take the entire group.

In South Africa there are a huge amount of unions that are in this product, and they love it. Again, the use or keep it mind-set works.

So that is a little bit about who we are. It is a little different. It is exciting. It involves the consumer. We do all kinds of things through our EOB's. When a patient, for instance, goes into a doctor's office, the doctor's office bills Destiny Health. The card says \$0 co-payment on it. And, by the way, this fund can be used for dental, medical, alternative medicine, whatever it is that you want to spend it on. It is

your money. You get to spend it on what you think is right, not what the insurance company tells you is right.

So the bill comes to us. And we use Private Health Care Systems in Illinois as a discounted PPO network. If the bill is for \$100, the Private Health Care discounts \$80. Let's assume you have \$1,000 in your personal medical fund. We pay the \$80. We send an EOB back to the member saying, the bill was \$100. We paid \$80 under your contract with Private Health Care Systems. You now have \$920 left in your fund. We start educating people on the cost of their health care. We do many other aspects of educating them, as well.

You cannot put consumers in charge without educating them, and taking care of them, and guiding them through the system. We do huge amounts of information on our Web site and on materials that does that. So it is different, it is exciting, it is coming. Hopefully, you can see the passion we have for it. Thanks.

(Applause.)

MR. MILLER: Thank you, Ken.

Our next speaker is Helen Darling. Helen is the President of the Washington Business Group on Health. This is an organization first founded in 1974. And it is the only national nonprofit organization exclusively devoted to providing practical solutions and innovative policies to its large employer members'

most important health care problems. The Washington Business Group on Health members are typically Fortune 500 companies and large public sector employers who provide health coverage for more than 39 million U.S. workers, retirees, and their families.

Helen, before taking over as President of the Washington Business Group on Health in September, had previously, for three years, served as Senior Consultant, Group Benefits and Health Costs, for Watson, Wyatt & Company, a very well-known global consulting firm that, among other things, provides services in employee benefits and human resources. And prior to working for Watson Wyatt, she directed the purchasing of health benefits and disability for employees and retirees at Xerox Corporation. Prior to her time at Xerox, she was an advisor to Senator David Durenberger, who at that time was the ranking Republican on the Health Subcommittee on the Senate Finance Committee.

I guess we have outlawed HMO's this afternoon, but employers have made a pretty big investment in it. So the question is, how will they adjust to the new options on the table? Will they? And how might they go about doing that?

Helen Darling.

HELEN DARLING,

WASHINGTON BUSINESS GROUP ON HEALTH

MS. DARLING: I was really worried that you were going to go back like you did with Ken, all the way back in my life, and you all would figure I have been around a long time, which I have.

I am glad to be here. Actually, I am often in the position of being a contrarian or somebody who brings a dose of cold reality to something. And I have to say that I really, fundamentally, do not disagree with anything that has been said so far. I think the challenge is sort of how to get from here to there. And I think everybody agrees that the system is flawed. But as we know in politics, certainly in this town, having agreement on all the problems does not mean there is agreement on the solutions.

You can go back and say, well, why didn't we solve some of these things long ago? And the answer is, because everybody's ideas about how to solve them are radically different, and there's everything in between. But we actually all pretty much agree on the problems. And I think we actually, probably pretty much agree on the solutions. It is more a question of can you make it happen in the United States of America today or anytime before we are in our phased retirement programs.

I have to say, my six years of running the programs at Xerox were really enlightening in many ways. But one of them is

I learned that people do not really do what we all -- who are sort of conceptualizers and policy people -- think they will do. And, in fact, one of the things that I always thought was so ironic, is that the people often who were most, shall we say, careful with the tiniest amounts of money -- like how much you got paid for a tooth scaling -- were sometimes people with lots of money and very high salaries. So there is something that happens to people when they get in the world of insurance and coverage that is not totally predictable, and, frankly, in some instances is not terribly attractive, or, frankly, even rational in their interest.

I remember, for instance, when I first went to Xerox, we had an indemnity plan. We had lots of HMO's. We did not have sort of first-dollar coverage in the indemnity plan. And things like mammograms and routine screenings and those things were not covered. They were actually all covered in the managed-care plans, which were all HMO's. But I remember having some person, who, frankly, made quite a lot of money, coming and complaining about how we did not pay for them. And you would have loved what I said, because I said exactly what you said.

I said: You will have these every year, depending on your age and everything, and you know they are going to come. And a screening mammogram cost \$55. I can take your \$55 either in foregone wages or actual dollars. I can then load on another

\$7 or \$10 of admin costs, or maybe even higher because it's such a dinky little claim, and it's not electronic. Then I can ship it back to you in the form of a benefit. Or you can just pay for it, and we will keep the cost down in the indemnity program, which, by the way, were already outrageous.

And much to my utter amazement, the person looked at me and said, "Well, it should be covered. It should be a benefit. I'm very unhappy." And in our culture at Xerox, if you said things are unacceptable -- and they say it in this authoritarian way -- and they said "And your not providing it is unacceptable to me" -- and that was a very important learning experience. And it happened over and over.

So, how do we get from here there? How do we take somebody who is highly intelligent, in this instance, well-educated, has surely grasped the picture, and yet somehow couldn't get over this idea that they wanted somebody else to pay for it? And they had to have had enough economics to understand the concept of foregone wages. Anyway, realistically, it is tougher than it sounds.

There is also the sense for people, other than the ones who really take the time to do it -- and it drives us all nuts, but it is reality -- and that is if somebody else does not pay for it we are not going to somehow get it, or we should not get it. These mandates drive our business group crazy, and we are

opposed to mandates, and they make us mad because most of our companies have incredibly rich benefits. In fact, most people would say they are far too rich. But because they are rich that is sort of taken as the base. And then it is sort of, oh, by the way, the fact that you provide work-family benefits, you provide child care, you are the greatest place in the world for women to work, blah, blah, blah, and oh, by the way, now we are going to mandate all mental health benefits, and we are going to require, basically, unlimited access to a mental health system that does have its own financial incentives for making certain that you come back for a long time. So if that is fully paid by somebody else -- I mean, we are going to blow the lid off some of these things.

So how do we get from here to there, and how do we transition to something? Well, first, as I have tried to indicate, we cannot design systems that assume people will make the right decisions. That may mean that you give people choices. It may mean that you provide something like Destiny, which I think is terrific and might theoretically be great for everybody, but realistically lots of people will not choose it. So if you are a large employer and you want to give that option as part of the packages you give them, then that is great. But you are going to find other people sort of floating to these other -- we

would say -- much less wise decisions, but they will make them in spite of us.

You also have to understand that there will be some people who, frankly, are not willing or interested to think about these things, or shop, or do anything. My favorite example of that is I was quite proud when I went off to Xerox, that we were the managed competition program and we wanted maximum opportunity for choice and maximum information. We were the first to put out quality report cards. In fact, we developed HEDIS for the purpose of having uniform, standardized data for health plans so that we could give it to consumers and to our employees.

By the way, every market had competition, and we tried to give them different types. We wanted a really good group staff model HMO, the best in the region, and then to have a loose IPA model HMO in a market so people had choices, maybe two or three. We didn't put any limits on it. And I remember one man calling me up. And I was particularly proud because it was the first year we put out all this information. We had these gorgeous materials, all these side-by-side comparisons. We basically had the computer go in and by your zip code you got every detail. And I was so happy. And I got this call from a man. And he said, "This is the worst year ever." And I said, "Sir?" And he said, "I'm going to stop opening these packages. This is a lot of work for us to have to look at this. You just

tell us what to do. Or if you give us a choice, just tell us you're giving us a choice. And then I won't even open the package, and I'll stay where I am."

By the way, I might add, this was a highly intelligent person. This is somebody that I knew. I was stunned. I then got more. And in fact, subsequently, there has been consumer research that in fact documents that consumers like choice, no question about that. They really react negatively to too much choice. So you have to kind of balance those things.

And many will not take the time. And, frankly, I think today, given the stress that everybody is operating under, it is just one more thing. As somebody who just moved down here and had to set up another household and get another DSL line, get a whole bunch of new phones, learn all those numbers, get all these security cards that I have, and get my car, if somebody said to me I had to make a choice on something else that I did not have to do, I would say, no, not this year. Next year maybe, but forget it, I am not going to do it. So people won't necessarily do it.

Then, finally, I think the biggest problem I see in all of these -- and, unfortunately, it works against the things that are near and dear to my heart -- is that we do not have the data to make a lot of the decisions. For example, we would all love

to know what the best hospitals are for different procedures. Who would not want to know that?

I know that is valuable. I know I want to know the infection rate in a hospital. I know I want to know how many CABJ's this particular hospital did last year and is planning to do this year. I want all of that information. I am in the business. I have been in the business. I co-chair the HEDIS Committee. I have done that for six years. I used to be on the U.S. National Vital Statistics Advisory Board. I mean, there is nothing to do with statistics and epidemiology that I have not been involved in one way or another. I cannot get that information. And if you all know how to get it, please tell me. Because, I promise you, it would be out there in a nanosecond.

So some of the things that you need to know to make the only decisions that matter are not available. And even where they are available, they are not accessible. For example, the Joint Commission has reports on sentinel events. These are alerts about bad things that have happened to good people in hospitals. Now, can you get your hands on that yet? No. Do you even know it exists?

How many people know about those reports?

This is probably the most sort of health-policy group that you could find of, quintessentially, people in this business. And yet one of the most important things you would

want to know about every hospital in this country you do not know about and you cannot get your hands on it.

So somehow we have to have mediating organizations. Ideally, PHCS, the networks, the health plans, the organizations that George represents would have that information and make it available so that people could, in fact, make wise decisions, whether it is with their personal account money or their other accounts.

I would also just add a couple other challenges to making these things work. The biggest one is communication. We do have a nation of people entitled, expecting this to all be done by somebody else, and most large employers do it. Most large employers who do it learned long ago -- as I did, and was humbled in the process -- that it is really hard to communicate something that is complicated. And it is all complicated enough to start with. And the reaction, most employers, they care about controlling cost, but they also care about employees' satisfaction.

I cannot tell you how many times I heard, "Helen, make the problem go away." And by the way, I used to hear that in the Senate, too. There are a lot of similarities to these places. "Make the problem go away." If you have that happen to you enough, you are not going to be out there doing things that create problems and create noise that then you have to solve.

Because it is not like there is somebody else out there solving it for you. So you want something that you can communicate.

The second thing is, we have this problem of risk adjustment by people and by geography, and by type of plan. Nobody wants a system that -- to overstate it -- rewards the lucky and punishes the unlucky. I used to have people who made comments to me, because they were paying the indemnity part -- which, by the way, is nothing compared to what the program costs, but they still complained -- and they would say, like this, always hands on the hips -- "Well, I haven't gotten a dime out of this program in years, Helen." And I would say, hopefully, diplomatically, that they're really lucky. That we had people who cost \$100,000 to a million dollars because they were unlucky. And if you haven't -- just like fire insurance or auto insurance -- if you haven't used it, that is good news.

Now, that is a hard thing to understand. But if you have multiple sclerosis, if you have cystic fibrosis, if you have a child with a major disability -- very common, if you are large enough, you will have all of those things -- then whatever you do, there is so much you do not control, and there are so many expenses you have. So when you sit down and say, is every employee in Xerox Corporation going to get a \$6,000 average annual payment? That is great. I did not spend a dime. I actually had to give my money back in 125 because I was not

spending any money -- knock on wood; there but for the grace of God go I -- but there were plenty other people who were spending \$20,000-\$30,000 of their own people on top of what Xerox was paying because of all the other things. So they were the unlucky ones, and I was the lucky ones.

So somehow, when we figure out how to price these things and do them, we have to do it in a way -- we do not want to reward the system for bringing you back all the time, except unless you need them. So somehow we have to do that.

I would say, in addition, we do have the problem of geography. Anybody who has looked at some of the Winberg studies of small area variations, a look around the country, I can tell you, I would have loved a premium nationwide that was equal to Rochester, New York's and Southern California. If I had had that, my health care costs at Xerox would have been 40 percent lower -- a 40-percent difference between Southern California and Rochester and many other places in the country. And our highest premium in the country was, of all places, Oklahoma City, Oklahoma. Why? Because the doctors control everything in Oklahoma City.

So how are you going to do that? You have people you are moving all around the country. You are going to say, if you are unlucky enough to live in Boston, or the Washington, D.C. area, or Connecticut, you are not going to get that kind of

money, but if you live in these other areas. So it is sort of how do you adjust for that. Because if you have a \$1,000 personal account, my personal account is not going to last very long in Connecticut. Somebody else's personal account in Rochester, New York is going to last twice as long. So I am not saying these things cannot be solved -- these are technical issues and should be solved -- but they have to be.

And finally, I would just like to make one plug. Washington Business Group on Health is going to make one of its highest priorities the straightening out of this silliness about the way health accounts are done in this country. The idea that people's own money, which they put aside some time during the year -- but if they for one reason were lucky enough not to need it, whereas next year they may be unlucky enough to need twice as much as they had, that they cannot hold on to that and roll it over so when they are unlucky they have the money and they are not wasting it when they are lucky, makes no sense.

The fact that the IRS has been whatever they are -- I will not characterize them -- to not look at it for a long time should just make us all mad, and say there is absolutely no excuse for not solving this problem. It is easy. It is people's money. We are not doing anything -- we are giving billions of dollars away to all sorts of things right now -- to let the

American people hold on to their own money; it is something that the President ought to do tomorrow.

I would just say, all the other parts of it -- the 401(h)'s, the 105's, the 106, all of those should all be wrapped into what we are calling an expanded 401(h) account, which is portable, if you change jobs, you can take it with you; that is flexible, it can be used for any sort of legitimate health care expense; and if you are lucky enough not to need it until you retire, you can pay for retiree medical, which you will no longer have if you are a certain age in this country. And if you do not even need it for that, you can buy yourself some long-term care insurance. Because if you are all that healthy, you are going to live a very long time. And then you may need at the end of life some long-term care. Thank you.

(Applause.)

MR. MILLER: Before we go to questions, Ken Linde has a couple of follow-up comments.

MR. LINDE: Just some comments on what Helen said, because she was right-on on most of these issues.

First of all, in South Africa there is no Medicare program, and they are pre-tax dollars because they do allow it to carryover there, because it is a lesser regulatory environment there. So it becomes a real savings vehicle for people that reach retirement or reach a Medicare-type age. So it is kind of

like a Christmas club plan for retirement. It is exactly what we are going to need for either the lessening of Medicare benefits or whatever.

The other thing that I want to make clear, which I did not because of time -- and there are a whole bunch of other things to our benefits I did not clarify for you -- if you run out of money in your personal medical fund in our company, then there is a safety net that catches you into a traditional 80/20-type insurance company. And that is set at a certain actuarial threshold.

So, as an example, if you put the \$2,400 into your personal medical fund as a family, and the family threshold -- think of it as a deductible above the personal medical fund -- is \$3,000, then there is a \$600 possible out-of-pocket gap for the member who pays out of pocket, and then they go into a 80/20 insurance policy. Because the consumer decides how much they want to put in their fund on their own, not the employer -- they decide on their own; it is their money -- if you fund it at \$3,000, there is no gap. So you control your own experience, your own premium. And why not fund it at a higher amount because it is your money and you are getting interest on your money, as well?

So we do have a protection, a safety net, that catches people. If you run out of money in your personal medical fund,

you do not lose it. And we also loan you the first full year's premium of that PMF in the first month. So if you have a lot of expenses in your first month, you get to use all that money right up front.

MR. MILLER: Thanks, Ken.

Helen, you said, "Make the problem go away." We have a lot extra challenges, but at least maybe we are focusing on a few of the big problems going away while we deal with the lesser ones.

We would be happy to take any of your questions. If you would wait for a microphone to come around and identify yourself, and at least disguise your commentary in the form of a question.

MS. SODERGREN: Hi. My name is Katherine Sodergren. I am from McLean, Virginia and very interested in this subject.

One of the arguments I hear against the personal savings account all the time is that people would buy other things with the money; they would not use it for medical. Well, as far as I am concerned, they are doing this today. There are many young people that have good jobs, that can afford insurance, but instead of buying health insurance, they buy the latest hi-fi equipment or the latest something else, and then expect the government and other people to pay for their medical expenses. How do you answer that when people say, well, they would not use

this money if it was theirs for medical; they would do something else with it, and then they would need medical care?

MR. LINDE: Under the qualified MSA legislation, or under the FSA-type legislation, or under any of the consumer-driven companies that out there -- all eight of them, the ones that have personal funds -- they are only allowed to use their funds for medical expenses. We allow it for alternative medicine or dental in our company, or medical, but they cannot buy stereos. They must be under the same type of rules under the FSA-type regulations.

MR. MILLER: Another questions right back there.

MR. GREENE: John Greene from the National Association of Health Underwriters.

The Washington Post also ran an article in the Health Section this week about physicians who are pulling out of all managed care and basically returning to fee-for-service. And the predictable response is that the costs are higher. How would you deal with the continuity of care issues if you find that doctor A has a lower price on X, and doctor B has a lower price on Y, and how do you then measure quality? And where do we have the time to go look for who has the best price on X, Y and Z?

MR. MILLER: Commissioner?

MR. MIREL: I don't know why we think that health care is so different from anything else. We have these kinds of

choices to make all the time about everything we do in our lives. I was interested in what Helen said about people who had plenty of money who complained to her about having to spend it for health care, and it resonated with me. Not long ago, I had in the same week a screening colonoscopy and a 50,000-mile check up on my car. It turned out they both cost the same amount. They were both \$1,200. I paid the auto mechanic the \$1,200 without thinking twice about it, but it sure did kill me to pay \$1,200 to the doctor who did the screening colonoscopy because it was not covered by insurance plan.

Now, why do we think that when it comes to health insurance -- the most important thing, really, that we have to deal with -- that we should have any less responsibility than we do when it comes to taking care of our car? And yet people do not gripe about that. There is no insurance for your car's health. And you can imagine what a problem it would be if there were.

MR. MILLER: Helen?

MS. DARLING: Well, I would just say I think this is the problem of the evolution of the market. Because those of us who have been around a while know that there were times when people said the American people would never wear seat belts. And there have been times when people have said the American people would not give up smoking, and things like that.

If there were enough people who were in fact doing the shopping for their own out of their personal health account or however it's done -- and it is always pre-taxed, which means you are allowed to keep your own money, I might add -- you in fact will have physicians being able and willing to say what something cost. And they will probably even begin to have signs, like if you go in a place for your hair now, there is a little discrete sign that tells you that whatever you are going to have done is very expensive. You will begin to have that information. So it will not be that hard to get, and it will not be that difficult to shop. And maybe people will decide, well, I don't think it's worth it, and make different choices. But that will also facilitate the market.

And I would just make one other point about that. One thing I was very struck by and learned, too, was in the early days when managed care came in, there were physicians who said, my patients -- my 1,200 or 1,500 panel of patients -- they are loyal, et cetera, et cetera, they are not going to move around. And it was very interesting. It was just a stunning, stunning change that occurred all over the country, especially in metropolitan areas. Very tiny differences in payment were happening. For example, for family coverage, \$20 more a month would get you one plan versus another. And your doctor you loved, near and dear to your heart, was in the other plan, but

people moved on that \$20. Now, I think that is unbelievable. And I think the physician community were stunned at how little money it took for people to change their own behavior. And many times they did not even complain about it.

MR. LINDE: If you go for 20 minutes on the telephone as I did for hours in South Africa with people that have been in a system for nine years, or even less, you will hear incredible discussions about what is the cost of going to this facility versus that facility. Even in our system in Illinois you get it to some degree, but we are still small enough where it is not as much. When you give consumers control over their own health care dollars, they will start asking questions, and they will start being interested in what things cost, and the differences, and trying to research what is going on. It has a dramatic effect on consumer behavior.

MR. MILLER: Brian?

MR. MCMANIS: Brian McManis with Golden Rule Insurance Company. I appreciate the business.

(Laughter.)

MR. MCMANIS: A specific question for the Commissioner. What has been the reaction among your colleagues in the other States, because they tend to be fairly adverse to anything consumer friendly?

MR. MIREL: I do not know the answer to that yet because I have not tried them out. A couple of commissioners have told me that they read the article. And they said, "Gee, you really do think outside the box." I could not tell whether that was a compliment or a criticism. But they were certainly interested in the idea. The ones that come to mind are the Maryland Commissioner and the Pennsylvania Commissioner, both of whom were intrigued with the idea.

But even within my own government I am not sure how I am doing yet. I am here today speaking on my own behalf -- I should have made that clear in the beginning -- and not on behalf of the Williams administration, not because the Williams administration is against it, but because they cannot figure it out yet. I am going to try and see if I can interest them in it. I think it is something that would work for our own employees in the government.

But it is an uphill battle because, as Ken said, people are used to paying \$10 for a visit to the doctor. They think that is what it cost. And they are going to resist, frankly, the notion that they have to figure out what to pay and who to pay it to.

MR. MILLER: Commissioner, in terms of the policy tools at your disposal, what possible things could you do at the D.C. government level that might open up more of these opportunities?

MR. MIREL: Well, like any government, it offers a variety of health plans to its employees. And one of the things that I would like to try to see is if we could get one or more of these plans as alternatives, to be chosen by people who would like to choose them.

I testified two weeks ago before the House Committee on Civil Service. And they were worried about why the Federal plan is getting to be so expensive. And I said the same thing: Why don't you offer that as an alternative in the cafeteria of the Federal health plan?

It is like everything else; it has to be sold. Americans do not buy; they are sold things, and it is a major undertaking. But what we have going for it is that the present system is failing. It is falling apart as we speak. People are pulling out of it, and people are going to start looking for alternatives.

MR. MILLER: Another question?

MR. MOSKOWITZ: Dan Moskowitz. I am a freelance writer.

Since both of these variations in the plan has some sort of stop-loss protection, it seems to me that despite all this rhetoric about you are not getting in the business of saying yes or no, doesn't there have to be some sort of vetting of what people are spending this money on? Sure, not hi-fi's, but how

about massage therapy? How about hypnotists? How about Tarot card readers? I mean, there has to be something in which you say, no, this is not legitimate health care. And if there has to be something, doesn't that mean you have to look at every single bill?

MR. MIREL: Ken will have a different view on this than I do. But under the Medical Savings Account law, what you do is you claim it on your income tax as a health expense. And the IRS can disallow it if it is not a health expense as IRS defines a health expense. Now, their definition of health expense is very broad. It would include massage therapy, for example, if it was for medical reasons. It would include alternative medicine. It would not include a hi-fi. So there is that check on it. But it is also your money, and if you spend it for something, and then you need it for health care, you are not going to have it until you reach the stop-loss.

MR. MILLER: Helen?

MS. DARLING: I think a lot of these, what I call sort of junk problems, will go away when everything is electronic. For example, you can go to Uzbekistan now, probably, and put your ATM card in, and get cash. And they may even ask you which language. So the idea that you could not have a smart-card technology that, for example, just like sometimes you go to a store like Staples, and you cannot see the price and what they do

is they swipe it and they tell you the price. Well, they could tell you immediately if it is allowable on a pre-tax or they can actually charge it to different accounts. We are already there in technology. So a lot of the things that some of us have, over the years, worried about could be solved tomorrow.

I might add, I would more than happily give up all the extra fringe things that the IRS lets you pay for in return for letting the American people keep their own Section 125 money. And I cannot imagine that it is probably not kind of a wash item in a CBO scoring sense if they had to score it.

MR. MILLER: Another question? Bill Erikson.

MR. ERIKSON: Bill Erikson, with the Cato Institute.

Actually, I have two questions, Tom, one for Ken Linde, and then one for the Commissioner. Ken, did I understand you to say that your renewal rate on your product was 4 to 7 percent? And if that is correct, isn't that rather a poor testimony for the consumer acceptance of the product?

MR. LINDE: Well, actually, our first renewals came in August, and there was very few cases sold in August or September and October of 2000, so those are small numbers. But, clearly, the marketplace back in August of 2000 was probably around 5 to 6 percent increases. Today it is 13 percent for large groups and as much as 40-plus percent for the small groups. Most of these groups are small groups, 2 to 50 lives, that are generally

getting somewhere between 20 to 40 percent increases in the marketplace. So in those groups that are enrolling the small numbers that they are, they are much lower than the traditional marketplace.

MR. ERIKSON: When you said renewal rate, I assumed you meant the annual renewal of the policy itself.

MR. LINDE: The employer's increase in cost from year to year. We had a broker meeting two days ago of a launch of our new products. We had 500 brokers that attended two days ago. There is a huge market acceptance of this product in the Illinois market, where we are concentrating on it.

MR. ERIKSON: Well, I would like to take a look at your product on behalf of the Cato Institute.

Do you hold any hope at all of the MSA's being a viable component of the two-tier solution without Congress amending it to make it universally available to people with more than 50 employees?

MR. MIREL: Yes, I have a lot of hope. But I do not know why you limit it to Congress not amending the law. I think Congress is very likely to amend the law. I think at the time the MSA law was passed, it was loaded down with restrictions and amendments by people who were holding out for a universal health plan and wanted to make this not work. I think if it were less restricted, it would work a lot better. I know there are bills

now before the Congress that would untie some of these restrictions, and I certainly would support them.

Whether it would happen without those amendments -- it has not happened without those amendments in any meaningful way -- but I think if those minor changes in the law were made, people would use it much more effectively. Under the MSA plan it does roll over. Unlike the FSA, the MSA does roll over. And if you do not spend it this year, it is yours for next year. And if you do not spend it, when you get to be 65, you can spend it for anything.

MR. MILLER: Question?

MS. HUNTER: Hi, Angie Hunter with the Council for Affordable Health Insurance.

I have a couple of comments I am going to throw out for the panel just to get your reaction. One of them is on consumer information -- how much does this provider cost or this service cost, et cetera. And in advocacy on that particular issue, the arguments that you frequently hear is, well, it is hard to know what something cost, because there is this negotiated price with this person and that negotiated price with the other person. And what is wrong with the shelf cost of what the item would be? You run into that. We do not really have a cost; it depends on who is purchasing it and the agreements.

And one other thing on incentives for people to go towards a more consumer-choice type of product. I remember one of the larger employers that I worked for, in an effort to get their employees to move into a more managed-care type of health care product, what they did is they said, you have these three or four choices. But if you chose the more restrictive in health insurance selection, the more they paid on the premium. Why couldn't employers do something similar for MSA's or what Ken's company is doing?

MR. LINDE: On the latter one, I think they are. First of all, there is a difference between the larger self-insured market and the smaller insured market. We concentrate in the under-500 insured market in Illinois. Under the qualified MSA, one of the many restrictions says that an employer and an employee cannot both contribute to the MSA fund; it has to be either/or. In our program, the employer or the employee can contribute, either/or or both. Oftentimes, the employer may fund the insured part of the benefit and the employee funds the personal medical fund, or the employer could pay 100 percent, or anything in between. So this allows for a lot of flexibility for the employer to do just that.

And most larger employers, when they have slice-type, dual-choice business, and moving toward more of a defined contribution model everyday, do set the contribution at a certain

level, and anything above that for other plans would be out-of-pocket.

MS. DARLING: Yes, I would certainly support that. A lot of large employers have what we call benchmark pricing -- is the terminology. And it is usually a more efficient plan. And sometimes, for example, Verizon -- and I know Xerox when I was there -- and a number of other companies use sort of a mixture of quality indicators and cost. So you could be the low-cost provider in the market and not be the benchmark, because another plan met quality standards. Most large employers do some really interesting things, which is one of the reasons they like to be left alone. Because they're able to do some really creative, interesting things to try to drive the system in the directions that make sense in terms of quality and efficiency.

On the point about the costs, I do not know. This is one of the reasons problems have not been solved in this country. There is an awful lot of noise in our system in answers to things like that. You can be assured that somebody knows what the cost is, because they are going to make a claim. Therefore, to say to the person that is asking this, "Oh, well, we can't know" -- well, you damn well know. All you have to know the person's group number, which you have to know. They will not even let you come into the doctor's office without it. And swipe it, or pick

up the phone and call, and say, for Group GHI, blah, blah, blah, what do we get reimbursed for this procedure?

And yes, they might have 5,000 codes, but it is all computerized if they have 5,000 codes. And they can give you that answer in a nanosecond. So these things are frequently used to keep us from making progress in important areas like this one, but they are not correct.

MR. LINDE: There are some companies working on this. My competitor, if you will -- I don't really consider them a competitor, though -- a consumer-driven plan, it is called Health Market, has developed what is called episodes of care, that does give the fees. The problem is that it gives the fees at the time of service. So the kind of a joke is, you are on the operating table just about to get the knife and you say, "Just a minute, what does it cost? I'd like to negotiate this." So it may be a time of getting there, but there are a lot of companies working on these type of products, like episodes of care, and they will come. But it is hard to get those prices in the market.

MR. MILLER: One final question. John again.

MR. GREENE: [Off microphone.]

MR. MIREL: No.

MR. GREENE: [Off microphone.]

MR. MIREL: Let me answer both parts of your question. The first part is that there is a difference between the

deductible for an individual and a family, but it is not very much. If the individual deductible is \$3,500, then typically the family deductible is \$4,000 or something. It is not big.

When it comes to the affordability, it is amazing to me what people can afford if they want to buy it. They seem to have no trouble paying for health care for their pets. And that is expensive. They buy a car when they want to or a TV when they want to. Somehow they do not like to spend money on health care if it is their money.

I think, as somebody said, once you have put the lollipop in their mouth it is hard to get it out. People have gotten used to not paying for health care. And yet they will find the money for something else. Especially since with most of these plans the amount of money is in your account almost before you know it. And Ken's plan, and other plans as well, can give it to you on day one. If you are going to have a stop-loss of \$3,000 and you are going to get \$500 a month put into your medical savings account, it does not take very long to make up the \$3,000. Then it is there if you have not spent it.

So I think that it is possible to do, but I also think that it is important that we realize that people spend money for what they want to spend money for. That is why my belief is that insurance ought to be for insurable things. We pay to fix the porch on the back of the house. It may cost a couple of thousand

dollars, and we will find a way to do that. The insurance is for when the house burns down. That is what it is for, when there is no way to do it. I mean, the insurance ought to be for something that you cannot reasonably cover yourself.

MR. LINDE: The Commissioner is absolutely in my opinion, as well. Our product, you are allowed to put zero to \$4,500 into your personal medical fund. So let's assume you put zero, then it is a catastrophic health plan. It works the same way as kind of a high-deductible health plan. We do not promote that, again, because we think that consumer behavior and health care costs are controlled by getting consumers involved, and having them have their own savings account, and getting information. But it can work that way for some employers that do not want to pay as much money as that.

MR. MILLER: I would like to thank all of our speakers on today's panel. And although we will not have any lollipops to put in your mouth upstairs, we will adjourn to a health-enhancing lunch. Thank you very much.

(Applause.)

(Whereupon, the Cato Institute Policy Forum concluded.)