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WILL NEW IRS TAX RULES PUT HEALTH CARE CONSUMERS IN THE DRIVER'S SEAT?

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The Cato Institute

F.A. Hayek Auditorium

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P R O C E E D I N G S

MR. MILLER: Good afternoon, everyone. Welcome to the Cato Institute. I'm Tom Miller, Director of Health Policy Studies.

Today we are going to examine the implications of recent tax guidance from the Internal Revenue Service regarding health reimbursement accounts for the future of consumer-directed health care. This appears to be a rare case of good news from the IRS. I haven't checked to see whether or not hell has frozen over, but this should at least perhaps crack the ice in terms of employers getting interested in turning over more of the health care dollar to their employees, or perhaps light the fuse toward consumer-directed care.

The tax opinion that was issued by the IRS on June 26th is expected to encourage employers nationwide to adopt a type of different health care coverage which gives consumers greater control over their health care expenditures. The IRS clarified that employees could carry over from year to year the funds that were left over in their company plans that provided these tax-free health savings accounts without any further tax consequences in later years. Those plans allow employees to

choose their health care services and pay for them out of individual accounts that are funded by the employers.

Now, there are some interesting features on this. Unlike medical savings accounts, which we've also worked on for a good bit at Cato Institute, these type of accounts would be available to employers of all sizes, without the eligibility restrictions provided by the MSA legislation. Other features of the IRS ruling indicated that although the funds cannot be rolled over when an employee changes companies, the employer could set up a plan so that the employee who leaves could still have access to those funds in several different ways, including for COBRA continuation coverage. Also, retirees might be able to have access to these unused reimbursements.

So we have clearer guidance from the IRS, some positive developments among a number of startup companies that have moved into this field, and the possibility is that a number of companies will look more closely at this new alternative in health care in the balance of the year.

Now, skeptics will say that consumer-driven health care has its limitations. It may not save overall health spending at the end of the long run, that consumers won't have enough information to make their own health care choices, and there may be problems with risk selection among different choices.

Today we are going to examine these issues and the overall issue of consumer-driven health care with a panel of top experts and leaders in this evolving field of health care policy. Our first speaker will be Congressman Jim DeMint. Congressman DeMint was first elected to represent South Carolina's 4th District in November 1998. He currently serves on the House Education and Workforce Committee, the Transportation and Infrastructure Committee, and the Small Business Committee, where he is Chairman of the Subcommittee on Workforce Empowerment in Government Programs. He is most notably a citizen legislator, who has self-limited his terms in office to six years.

Representative DeMint earned his bachelor of science at the University of Tennessee and his MBA from Clemson University. In 1983, he started his own company, the DeMint Group, which advised businesses, schools, colleges, hospitals, and other institutions on how to be much more competitive and productive. Now he's in a hurry. He just has over two years left in the House to do the same thing for government programs and, more importantly private health insurance markets, that have been hampered and distorted by many public policies.

Congressman DeMint has been recognized as the key leader in the House of Representatives on consumer-directed health care issues, and he has worked closely with the Treasury Department in encouraging the IRS to issue its new guidance for

health reimbursement accounts. Today he is going to sketch out a broader vision of consumer-directed health care, and suggest further items on the reform agenda ahead.

Congressman Jim DeMint.

JIM DEMINT,

U.S. REPRESENTATIVE FROM SOUTH CAROLINA

CONGRESSMAN DEMINT: I appreciate everyone being here and Cato sponsoring this event. This is a huge issue in America. And what I would like to do, just for a few minutes, is look at it in a broader context than just this particular ruling or even broader than health care in general.

It is a good time for me to do this. I have been re-inspired about what I am up here for. I have been reading the book about John Adams. And if you haven't read that -- I'm only a couple of hundred pages into it -- the passion that our Founders pursued their goal of freedom and liberty for citizens is just so encouraging. And now, every time I feel sorry for myself when I get delayed at the airport for an hour and it takes me three hours to get home, I have to remember these folks who spent weeks on horseback going to Philadelphia to write our Declaration of Independence.

One of the things that Adams talked a lot about, along with our Founders, was the foundation of our freedom resting on citizens, with two major characteristics -- virtue and a spirit of independence. And today we might translate that into character and personal responsibility as key to making freedom work in our society. And it still works.

It is interesting, whenever we have a problem, that folks tend to point to freedom in our system being the problem, when in fact it really goes back to character and responsibility. Folks are looking at Enron and WorldCom and saying we need to regulate and over-regulate and pass new laws and try to central-manage our free enterprise economy. But we must, as Americans, continue to defend the concept of freedom, because it is so important to us individually in everything that we live for and we believe in as individuals. Because choices and responsibility are really what are at the essence of American life, and they should always be there.

That is the essence of freedom. It is what gives meaning and purpose to individuals. The ability to go out and make your own decisions about things that affect you and your family is really central to what we are as Americans. But millions of people making individual decisions is also what makes our system work. It is what makes free enterprise work. It's what makes our political system work. And we have to maintain,

at the bottom of everything we do, individuals making decisions for themselves. That is what makes our society more prosperous and creates more choices and opportunities.

The system is really too dynamic to centrally regulate or to centrally manage. That is what a lot of folks here have not understood yet. The whole system of our economy, of prices and consumers making choices and cost/benefit analysis, and competition taking place, new products being developed, this is something you cannot centrally manage. It has to be dynamic and free to operate in order for it to work.

Folks will say that some things are just too complex to allow to happen in a free system, that they have to be centrally managed. Years ago we thought that about computers, that individuals would never be able to buy and use computers themselves. But with new technology and the market moving to people, creating better information, now you can have a 10-year-old buy a computer more powerful than the experts used 20 years ago. It is because it's a consumer market.

You see the same thing in a part of health care today. And you can just carve out this one piece of health care called LASIK surgery, and see how consumerism and consumer-driven markets really work. When the LASIK technology was first developed, it was very expensive, it was only done in a few places around the world, but it was something that was not

covered by insurance or Medicare. It was a consumer market. Very quickly this technology has moved to meet the consumer. The prices have come down. The quality has gone up. Convenience has increased. Now it is offered in different settings. But it is important to recognize that this would have never happened if it was a third-party payor system. And I will talk a little bit more about that in a minute.

We have experimented with trying to operate major institutions in this country outside of the free enterprise system. We have done it in education and, out of compassion, have made education free. But by taking the price out of the equation, we have eliminated many choices. We have lowered the quality and we have increased the cost of delivering it. And you cannot look at education without seeing that when you pull freedom out of it and try to centrally manage it, it is too dynamic to do well, and education has really suffered.

Unfortunately we have done that to health care in America over the last 30 or 40 years. Health care is a vital service to everyone personally in this country. And it is central to many people's lives, particularly as we get older or you have any kind of catastrophic event. It is very important to us as individuals. But it is also a large part of the American economy. Directly and indirectly, it is about 20 percent of the

American economy, if you look at all that is involved with health care.

We are the point now with health care in America where it is going to go one of two ways, because the system is on the verge of collapsing. We are not in a position to keep it where it is today. We have fixed prices. We have set up a tax code, in effect, where individuals are disadvantaged trying to buy health insurance. We have employers paying for it. We have a third party making decisions about what kind of care will be provided and what will be paid for and what is paid for.

When the consumer goes to access health care, they don't know what it costs, they don't care what it costs. The providers of that service don't know what it costs or care what it costs. Even insurance companies, while they pay for it, they write the checks, they don't really care what it costs because that is passed along to the employer. So we have a system almost with no accountability built into it, and the whole concept of freedom and free enterprise has been extracted from health care.

We have a system now where the process of continuous quality improvement does not work. I have been in many hospitals where they tell me they have a better protocol, that is better for patients, that is cheaper to deliver, but they cannot get paid if they do it that way. And a lot of it is around prevention, where they can keep people out of the hospital by

treating congestive heart failure on a regular basis, but they don't get paid unless the person has an attack and comes in. And that is when it costs $100,000-$200,000 to treat them.

That same thing that we see, on a big scale, is happening everywhere in health care, where we are not continuing to improve because it sometimes takes two or three years to get a new methodology or new protocol or new technology approved for payment. And while we see other industries in this continuous quality improvement mode all the time, where things are changing, they're trying to get a leg up on the competition or open a new market, that is not happening in health care. We are not letting our free system work in health care today.

The result, I think most importantly, is poor health. It is not just a financial issue. We have set it up where the individual is not only not responsible for their health care, but they are not responsible for their health. Health in America is declining. Obesity is going up. We have taken the personal decisionmaking out of health and health care. And this is hurting people. So don't start with the financial side. Start with what we are doing to the health of Americans.

The third-party payor system is hurting health in America. It is causing higher costs and lower quality, and we need to change it.

There are several options. A lot of folks now believe that it is time to move health care towards a single-payor system, to totally central-manage it, like we have done with education. We already see the results of fixed prices and fewer physicians going into the practice, some turning down Medicare. The system is on the verge of being over-regulated and on the verge of collapse.

I think our only chance of saving health care, and a large portion of freedom in this country, is to move towards a free enterprise system, a consumer-directed system, that we know works in just about every other product category. No one is going to convince me that health care is too complex to be directed by consumers. Because the information will come if consumers are given the decisionmaking. We cannot stay where we are.

An ideal system would be, if you just think with me a minute, if individuals had their own health care savings and most of their health care they purchased themselves when they went to the doctor or the hospital. And doctors and hospitals respond to that by publishing their prices, whether they be on the Internet or they do what we call global pricing in a hospital. If you go and you have to get your gallbladder out, it is no longer come in, we will charge you whatever we need to and we'll send the bill to your insurance company. The hospitals would be competing

to say, okay, this is going to cost you $1,500, and the next one may give you a different price. And they would have to publish information about quality.

I am not suggesting this would create a perfect system, but it would create a much higher-quality, lower-cost system if you had millions and millions of consumers out shopping with their dollars and asking questions and, in the process, becoming more healthy because the incentives are all on the save side of health care. Again, the ideal system would have people buying most of their health care themselves with health care savings. They would have what businesses call stop-loss, or reinsurance, at a certain level, where you are insured for catastrophic events. But health insurance companies would not be paying for every time you went to the doctors, as they are doing today.

We have a bill like that, that would create a modified medical savings account. Employers could put money in it pretax. Individuals could put money in it pretax. You could even use those same type of accounts that Medicaid could fund or Medicare could fund, so that most of the health care is purchased by people, whether they be poor or retired or employed, out of a health savings account that can be contributed to from the private sector as well as the public sector. And the same fund could be used to purchase insurance, whether it be from your

employer, association health plans, or just individual policies on the open market.

Realistically, let's talk about how we can get there. Because politically, we are not going to go from where we are to that type of system. We have a rare opportunity, as has already been mentioned today, that the Treasury Department, through the IRS, has opened a door wide to make this happen, to allow employers to actually give money to their employees to go buy their own health care. This is a start.

It is not an account that the individual would own and could take from employer to employer, but what it does is it opens the door to consumer-directed health care. It would give individuals money to be shopping for health care. It would begin to develop the health care provider side of this. When they know they have to do business with the patient, they are going to start providing better and better information, more pricing, be more competitive, advertise more, and we would create more of a consumer market there.

There is another component of this that we hope we can push through Congress. The HRA that the Treasury Department has approved, the health reimbursement arrangement, or account, allows employers to make money available to the employee to shop for their own health care. That money can accumulate and grow if that individual does not spend it. So there is an incentive not

to spend it. But there is also a better deal for the employee -- they don't have to go to a $250 or $500 deductible before they get some help paying for their health care.

The other side of that is we have to get the individual involved with financing part of their health care. They already have to pay part of their premium through their employer, but flexible spending accounts are something that employers have been using for a number of years. Unfortunately, just like employer money, the individual has a "use it or lose it" rule on flexible spending accounts. If they don't use all they put in it by the end of the year, they lose it.

We have a bill in Congress, that the President supports -- it already has bipartisan support in Congress -- that would just allow folks who put money in flexible spending accounts to roll over up to $500. With this system, we could have individuals putting pretax money into an account. We could have employers putting pretax money in the account. This gives the individual more flexibility as far as what they buy with health care.

Because right now there is a lot of talk of mandated coverage for everything from eyeglasses to dentistry to mental health to all kinds of problems that folks, different interest groups, want us to mandate as a government that all insurance companies cover all of these things. Instead of taking that

road, if individuals are able to have $1,500-$2,000 a year, where they are paying for their own health care, whether it's an insulin pump, mental health treatment, or whatever type of problem they have, they have the flexibility to use the money where they need it rather than mandating that all insurance companies cover the first dollar for those. That is one way to get the cost of health care down.

If we do this with the HRA's -- employer money, the FSA's, employee money -- we are setting the stage for consumer-directed health care business at the same time we are setting the stage for more advanced medical savings accounts, or what we are calling sometimes health savings accounts, that individuals actually own and can take from employer to employer, take into retirement, can be subsidized by Medicaid or Medicare. They will be an individually owned account. But in order to get to the ideal, we have to start with where we are today.

The point of this meeting today is to recognize the significance of what has been done by the administration with setting up HRA's, clarifying that this money can roll over tax-free, and this is going to open the door for a consumer market.

What we have to do is really three things. We have to have innovative product development. And we have some folks on the stage today who will talk about how to use this new ruling to

develop new products that help employers and employees. We have to push the flexible spending accounts through Congress, to allow employees, for money for their part of the premiums or other things that are not covered by insurance, to have pretax access to dollars for their shopping. And then we have to get the providers involved.

A weak spot in this whole system is the physicians and hospitals are not set up to do business with patients. We have to get physicians publishing prices. We have to get preferred pricing schedules when someone pays cash. We at least hope that individuals will not go in and pay the top retail dollar at a physician's office when in fact they are the least expensive patient to do business with because they would be paying cash for their services.

So getting providers engaged in this new consumer market is going to be key. And some old taboos that the physicians have had about not advertising, not being competitive, those have to be thrown out the window.

We have a real opportunity. I think this is one of the biggest opportunities for freedom that I have seen since I have been in Congress. We are opening the door to save a large part of our economy to the free enterprise system and actually create something that is better for patients, that is better for health care and better for America.

I am excited about continuing to push this in Congress. I appreciate Cato's highlighting this today, and all the folks on the panel who are here to talk about it and even criticize it so we can make it better. And I appreciate all of you taking an interest it, because it really is an open door that we have to walk through just as soon as we can.

Thank you.

(Applause.)

MR. MILLER: Our next speaker is Doug Kronenberg. Doug is Chief Strategy Officer for Lumenos. Lumenos is based nearby, in Alexandria, Virginia. It's one of the country's leading providers of consumer-driven health care. And it tries to engage consumers in their health care by giving them control of routine health decisions and dollars, along with the tools to make wise and informed decisions.

Doug is the former National Vice President of Marketing for Prudential Health Care. Prior to joining Prudential Health Care in 1996, he also managed the national marketing organization for Humana, Incorporated. Doug spent the first 16 years of his career in a variety of brand management assignments in the packaged goods industry -- now he is packaging health care -- but previously he did that other work for Proctor & Gamble and Hallmark.

Today he is going to outline the various consumer-driven health care product designs that are currently in the marketplace and what they have in common. He will also discuss how these products will fit into overall health management tools that could maximize consumer value, while keeping costs down, throughout the various levels and tiers of health spending and health care utilization.

Doug Kronenberg.

(Applause.)

DOUG KRONENBERG,

LUMENOS

MR. KRONENBERG: Thank you.

I am going to spend just a few minutes talking about really a program that has kind of taken hold within the marketplace that fits into what the Congressman was talking about. There are a number of different programs out there, so I will try and describe them as best I can and not create a Lumenos commercial out of this. But I do want to give you a feel for what it is that is really being adopted in the marketplace today and what is driving that.

What is driving it, as we have talked about, is the consumer. What consumer-driven health care does is finally

engages the consumer in the purchase of health care services. And there is an important distinction here between purchasing the services and purchasing health care programs, which a number of people talk about. What this is all about is really providing the consumer with the means, the financial means, and the health management tools to be able to effectively and efficiently purchase the services themselves.

As the Congressman said, the model that is out there now that seems to be gaining the most acceptance is one that transfers some of the dollars for routine care to the consumer, but at the same time provides them with blanketed coverage above. And I will explain that in a minute. But the one concept that I would like you to leave with today, because it is kind of at the heart of everything that we do and everything that we talk about and everything that is driving this, is that the consumer is at the middle of this.

So when you hear folks talk about concerns around whether or not the consumer, for instance, is sophisticated enough to be able to manage this process or whether or not they are able to be able to determine which doctor they ought to go to or which procedure they ought to have, or navigate through the system, the whole idea that as long as they are not engaged in the process, that whole program is impossible for them to do, because somebody else is making those decisions for them. As

soon as we get them in the middle of that and they are actually purchasing those services, then it becomes a very, very different experience for them.

There are a number of large companies -- this is just a few -- that are taking this on because they see the benefits for their employees. By the way, although cost kind of hits center stage oftentimes when we are talking about this, the benefits go well beyond that. The goal here is to create a better health outcome, not to create a cheaper health outcome. So, again, the whole idea and what the vision there is, and the companies that have looked out into the future see, is the ability to be able to create a health care consumer that can do a better job of working with their doctor to take care of them self.

So there are dozens of companies -- and you will hear about them today, you will see them and read about them in the coming months -- dozens of companies that are going to be implementing this program, not just ours but our competitors, between now and the 1st of the year. And interestingly, what we are finding is that the majority of those companies are going to be offering this program to all of their employees. They are not looking at this anymore as a test program or a pilot program.

The other interesting thing that relates specifically to the IRS ruling last week that we are finding very interesting from an input standpoint so far is that there seems to be a

potential retirement benefit here that is emerging. Employers see the advantages of being able to create these health savings accounts that can then be taken into retirement. And there are a number of questions from employers today coming in around how they might structure these programs to enable that. That is a key move forward, a positive move forward, from this IRS ruling that came out 10 days ago.

So there are a number of companies, literally dozens of them, very sophisticated, who have looked very carefully at health care for their employees, and across the nation, and what it is that this type of program can do for them, that are going to be implementing this over the next six months.

I am going to talk briefly about the design of the program that, again, is being adopted today. And I am not creating a Lumenos commercial here; this model is being used by a number of companies. I think it gives you an idea of how it works. It starts with a health savings account. In this example for instance, this family would put $2,000 into that account. That $2,000 is used to manage your routine care -- the office visits, the immunizations, the annual physicals, whatever it happens to be. The incentive here is that if you don't spend all of that money, at the end of the year you are going to be able to carry it over and begin to create a true health savings account.

There is a bridge in between that -- in this case, let's say $1,000 -- that the employee would be responsible for in the event that they went through that initial $2,000 of health savings. Interestingly though, think about year two. In year two that you have been able to carry over a portion of that, you have now been able to essentially offset that bridge, or your liability, with the savings that you have in your account.

When we explain this to consumers, what we begin to find very, very quickly is that they start thinking about health care in terms of multiple years -- two, three, four, five years. They begin to calculate what their health care needs have been over the previous five years and then begin to think about what those expenses are going to be going forward to determine what it is they think their liability is going to be here. So the important point is that the consumer then begins to think not in terms of 12 months of health care, the way they purchase health care today, but in terms of two, three, four, five years.

So we have the bridge there, and in this case it is $1,000, at which point traditional coverage would kick in. Employers are designing this traditional coverage essentially to match up with what they have today, either in the form of an indemnity plan or a PPO. The important thing here is that when you get to this traditional coverage, you have something that is very familiar to the consumer, so that they understand, in the

event that they do have a serious illness or a series of illnesses that begin to get expensive, that they are going to fall into coverage that is very familiar to them.

So this is the design that is really kind of taking hold today in the marketplace with most of the employers that we and our competitors are selling to. There are slight variations of this that you can see as you go across the spectrum. For instance, there are programs that allow the employee to vary the coinsurance level or to be able to create their own networks. And those are beginning to come along also.

But the key here, and based on the research that we did very early on with a number of employees, is that they need to learn to walk before they run. So what they want to be able to do is get control of the dollars that they can use to manage their routine care -- let me get comfortable with that, let me begin to use the tools that you're going to provide me with, and then we can talk about how I might be able to get more sophisticated and actually begin to kind of create my own networks, for instance, or begin to actually price and look at buying procedures.

What you find when you do that is that the employee gets hungry for information. And so what we want to be able to provide them with is information that allows them to determine what those costs are, not just the cost of an office visit but

the cost of those procedures. The interesting thing here, getting back to the example that the Congressman used on laser eye surgery, is that depending on the need and the desire on the consumer's part, they are going to want more or less of this information. We, along, again, with our competitors, have found that it's important to build in the flexibility to provide as much information as is needed by the consumer to be able to make their decision.

And then we have to wrap all of that around a health care system that can create the positive health outcome that the Congressman talked about. That is, a health care system that allows the employee to be able to get engaged and begin to use some very powerful tools that technology has provided us with today.

So in a health care system, for instance, like this one, where the employee is either seeking information and looking for the ability to be able to get in and quickly get an answer to a question, or seeking care through a provider network that includes a million providers nationally, that they can sort through very quickly, and not just get standard kinds of information but cost information. If I'm going to the doctor, I want to know what that office visit is going to cost me. If I am going to the doctor and you have a discount with that doctor, I would like to know what that discount is so that I can look at

one doctor versus another. I would also like to be able to get quality information.

So they are looking for a Web site, they are looking for tools that can provide them with the flexibility to dive as deeply as they want to go. And then, at the end of the day, they want to be able to talk to a person. Eighty-five percent of the initial contacts that we have at Lumenos are on the phone. People simply want to be able to make that phone call and understand from somebody on the other end how to get an answer to a question.

The important thing is that as we are talking to them, we provide them with the technology means to be able to get the answer to that question the next time that they need it. And what we are finding, as folks do get in and use this, is that indeed that is exactly what happens. As they get comfortable with the tools, as they get comfortable with being able to look for the answers to the question, then they will use the Web site more and more often. And at the end of the day, we are very confident that that is going to lead to the positive health outcomes that the Congressman talked about.

That's the model that essentially is being put into place today. That's the model that is being adopted, again, by a number of very large employers out there, and a lot of medium- or small-sized employers. The key to the IRS ruling is that a major

hurdle has been removed here. There were a number of employers, for instance, that were putting warning statements on materials that were going out, up until a week ago, saying that the tax liability wasn't clear. There were a number of employers that were waiting to make a decision on this. And there were a number of employers that were asking about whether or not separate retirement benefits could be structured out of this plan if indeed their employees were able to save money.

The answers to those questions are all now very clear and, as a result, we have a group of employers that are moving forward and making the kinds of adjustments that this ruling has allowed us to do.

Thank you very much. I think we are going to have questions later, so we will get to them then.

Thank you.

(Applause.)

MR. MILLER: Thank you, Doug.

Our next speaker is Michael Showalter. Michael is Vice President for Policy Development at Definity Health. He is responsible for the design of consumer-driven health benefits, designs that have already earned Definity Health several industry awards, including the 2001 Creative Excellence in Benefits Award from the International Foundation of Employee Benefit Plans, and

the 2001 Health Insurance Association of America Innovators Award.

Definity began just in 2001, less than two years ago, with three client companies, all of which have returned and expanded their Definity programs for this year. Today Definity has more than 30 clients and 40,000 consumer-driven members, including nine members of the Fortune 500.

Michael, I notice one of your clients was Budget Rent a Car. I guess you could make double duty use of today's title if you could sign up Hertz, to put consumers in the driver's seat, but I'm sure you're working on that to get those synergies of cross-marketing.

Michael's previous experience includes health care consulting for employer groups at Marsh & McLennan and Watson Wyatt. Prior to his consulting experience, he worked in the health plan industry in a variety of positions, including underwriting and field support for National Benefit Resources and Prudential Health Care.

Today Michael is going to discuss how health reimbursement account products can help manage costs while ensuring quality health care. And he will also emphasize that the private sector has created this flexible solution to health care problems, and he will suggest that further steps, such as

greater portability and more individual control of health saving dollars, should be considered in the future.

Michael Showalter.

(Applause.)

MICHAEL SHOWALTER,

DEFINITY HEALTH

MR. SHOWALTER: Thanks, Tom.

I apologize for being late. I was sitting on an airport runway for two hours this morning as a thunderstorm blew through Minneapolis. And I was sitting there and I was thinking about last night and the kind of choices I make. Last night I had a tee-ball game that my two daughters were at, and I had to make a choice: Should I fly in a day early, which would assure me getting here on time, or should I actually attend the tee-ball game? And as Americans, basically, we make choices like that every day. And we make choices and we have consequences from those choices.

The one area where our choices are truly limited is in the arena of health care. And as a managed care industry, we have limited the choices we have. Whether that is through benefit design, whether that might be through the information we provide to our consumers, or whether that might be through the

panel size that we provide, we have limited those choices. So the IRS move is significant, in that plans like Definity Health that offer choices to the consumers now have the green light to go ahead and do the kinds of things we are doing in the marketplace.

It is with that in mind that I would really like to thank the Treasury Department for allowing these plans to move forward and allowing the private sector to work hand in hand and have an input into really the policy development that has come out in the last couple of weeks.

For those of you who don't know, Definity Health is actually now in its third plan year of operating consumer-driven plan designs. We have about 60,000 members. As Tom mentioned, 40,000 of them are on the type of plan that you saw Doug just presenting, a consumer-driven health plan.

We have implemented over 30 clients, and have about 20 more visible for 1/1/03. What is significant about that is the industry is poised now so that by 1/1/03 as much as 10 percent of all Fortune 500 companies could be adopting some kind of consumer-driven health care plan. It is a significant move, and the IRS is opening that up to even more explosive growth in the next two to three years.

So, again, the employers are thanking them for opening up the options to control the costs. Employees are thanking them

for bringing greater control. And then, me personally, I would like to thank the Treasury, because I cannot tell you how many hundreds of hours I have spent on the phone and in conferences with attorneys in the last two and a half years trying to explain the legal and regulatory environments that this would be allowable under. And attorneys and critics have spent a lot of time talking about how this won't work legally. And now that this question has been answered from the IRS, I am sure we are going to be talking now, on the critic side, about how the design won't work.

So, instead of talking about the philosophical underpinnings of the design and whether it works or not, from our third year of operating, I will just tell you results. I was reading somewhere about a claim distribution, where if you took the average health care design under a consumer-driven health plan, that something greater than 60 percent of all employees would actually use their personal care accounts in the first year of operation. The fact of the matter is, from what our data shows, over 60 percent -- precisely 60.4 percent -- of employees actually roll over dollars from their PCA.

In addition, when they start to have that control on the financing, they start to seek information. And that is really evidenced by the people that utilize our 24/7 nurse line. We have precisely 46.25 calls per 1,000 members into our nurse

line. Which is basically double the national average of calls that come into a nurse line. And why that is significant is people are now seeking out information in areas that they did not really care about before when they had no connection to the financing and quality of care. So now they are seeking it out.

Seventy-some percent of those calls are symptom-based calls. So people are saying, here is such and such a condition, what are my options, what can I do? They are seeking information. They're getting answers. They are learning how to be new users of the health care system.

I would also like to point out our pharmacy utilization. And I point that out because pharmacy data is extremely credible. It comes through real time. There is a high volume of it, and there is very little scamming of the coding of pharmacy data. We have about .56 scripts per member per month. Which, depending on what national benchmark you look at, you are looking at anywhere between a 23 percent to a 34 percent reduction in pharmacy utilization.

What is significant about that is clearly pharmacy is an area where the consumer can have an impact. They make decisions every day about, should I get a brand drug or a retail drug? Should I go into a setting that allows me to get it face to face or should I send it out to mail-order? So there are

decisions that can be made, and there is an impact that is being made by the consumer as a result of their decisions.

Now, these results, you could say, are skewed because you have some abnormal populations, so I would just like to say that we don't. We actually have a very average population -- actually slightly worse demographically speaking. The average age of our population is 41 years old. Of the people we were offered to, that is slightly older than average. The average age that we were offered to was 39. Fifty-two percent of our members are female. And our average contract size is about 2.6. So the relationship of members to employees is about 2.6. Which basically suggests we have more families, or larger family sizes, than the average health plan in existence today.

On the side of satisfaction, I wanted to let you know that 91 percent of our members rank Definity Health and their health plan experience as they are satisfied or very satisfied, which is extremely significant in the first year of operation of really any health plan. And 97 percent of all of our members re-enroll in Definity Health once they have been in our plan.

I would like to make the clear point that what is interesting about this is that all of this is happening with the first generation of consumer-driven designs. What we have in the marketplace today is just a first step. What you are seeing is we are just starting to tap the power that demand-side economics

can really have on the health care system. And as this evolves, we will start to have a really dramatic shift in the way health care is delivered.

The IRS did a great thing, because now the employer financing isn't tied to this artificial one-year insurance contract; it really lengthens that time horizon out, much like health care does not occur in nice little one-unit chunks. So now the employer dollar can be stretched over that employee's lifetime and even into retirement. Anything that can be done to share that financing, so that the employee can stretch that out, whether that is actual true portability of the FSA, whether that is FSA rollover, anything that allows that shared financing, so that we are not being taxed on our health in the latest years of our life, when we can least afford it, would be very beneficial as we go forward.

When I looked at our development list, I have 264 product evolution ideas on our product development list right now. We are going to be rolling out, in the next year, the next two, three and four generations of consumer-driven health. You had to start here, because it is the closest thing to the marketplace. You can over-engineer health care, and some of our competitors have done that and they are now out of business. So the power of consumerism is we are just tapping the tip of the

iceberg. And we are going to see a dramatic shift in the U.S. health care system in the next five or six years.

Thank you.

(Applause.)

MR. MILLER: Thank you, Michael. Your comments about waiting on the runway made me wonder whether you were having the problem that Congressman DeMint is going to have to take care of in just a minute, which is the possibility of gunplay at 30,000 feet. He has a vote coming up on the House floor to preserve the right of airline pilots to bear arms. It's a small footnote to the Second Amendment.

For that reason, we are going to break format for just a couple of minutes and take a couple of questions for Congressman DeMint before he has to depart. He can take about two questions before he needs to get to a vote on the floor.

Does anyone have any questions for the Congressman?

QUESTION: So far in the last couple of years, we have discussed this in a philosophical sense, I think, for freedom of choice and all of that. That was great. And I feel like this is a graduation. And just like a college graduation, you go from the philosophical to suddenly the logistics. I'm the head of an association of people who run employee benefit plans, so we're kind of nerds for all that kind of stuff, government compliance and all. And I think Mr. Kronenberg had a good quote there on

his screen. He said that whoever holds the money writes the rules. That is why ERISA was written, for instance, as a very tight protection.

I'm wondering where does this animal that has now been created fit? Are these ERISA plans? Do you have trusts? If one of these firms is holding the money for the individuals, is it in the trust? Or does that make them an insurance company because they are on the risk for guaranteed money?

Part of the reason I bring it up, I thought we were all on the same track until recently. And there are a bunch of us who have been working on this. And the e-mail started coming back, and people were saying, oh, no, no, this is not an enforceable thing, it's voluntary, it's no big deal, employers can pay it or not pay it. And this was coming from people who were very involved. So it suddenly sent up an alarm for me, because we haven't been talking about any of the logistics and the legal protections of whose money is this.

So I was wondering, because I know you are on that committee, does ERISA?

CONGRESSMAN DEMINT: I think that probably some of these folks who have been designing the plans could answer that better than me, whether all of these plans will fit under ERISA or some different models. And I think that is what we are going to see over the next few months, is how creativity works in

creating plans for a lot of different types of employers. But I am not sure exactly how this is going to hit the ground with plans and what jurisdiction it is going to be under, whether it's Federal or State. I would assume a lot of companies that do this already have ERISA plans, and this will just be a variation of that.

In fact, instead of one central fund, they create many accounts for employees. But some of you folks in the insurance business may want to answer that.

MR. MILLER: Let's take one other question first, because you have to leave.

Dennis Kelly.

MR. KELLY: I guess I'm looking at it from an overall logistics standpoint. Obviously the next progression of this language would be expansion of MSA's to the larger companies, and that's a logical holding place for money. Do we see any movement in converting the trial program into a real logistical thing? On a side note, the Cato Institute has been in a qualified MSA plan since January 1, 1997. Today they have over 80 employees, and they have not had a rate increase in five years now. So I think there are quite a few employees with money in their bank accounts.

MR. MILLER: We're now at 100 actually.

MR. KELLY: Over 100.

CONGRESSMAN DEMINT: MSA's are so tightly restricted right now that not many companies fit in so they can make it work. I don't think we are going to move real reform of MSA's through Congress until we demonstrate that a consumer-directed market can work. Because one of the criticisms of MSA's is that people can't be responsible for themselves, they can't work with their doctor. And I think we are going to dispel all of that with these new programs that Treasury has approved, and hopefully with FSA's. I hope MSA improvement happens before this has had a chance to work its way out.

The reason I'm so excited about what Treasury has done and the possibility of FSA's is I think it opens the door for a true personal account that is owned and portable, that can grow, that can buy insurance, that can buy health care. That is what we want with MSA's.

So, whether MSA's happen this year or not, what we are doing now is almost a prerequisite to MSA's really working to demonstrate that physicians and patients can do business with each other and that it can be as good or better -- I'm sure a lot better -- than the system that we have set up right now.

I can't answer your question specifically, but I do have legislation myself. We call them health expenditure accounts, to get away from the medical savings account baggage. It basically takes all these other ideas, where an employer can

put money in it, an employee can put money in it pretax, and you can buy health insurance with it or you can buy health care with it, and you can move it from employer to employer. It is basically held in trust outside the employer system, which is where I hope we can get to.

We have a big demonstration project going on now. We are going to show that consumers can go out and buy health care, and that can put downward pressure on price. And it can put incentives on the consumer side to save money and not necessarily order an MRI when they could get a CAT scan that the doctor says does the job. So, it's the first step, as someone has said.

MR. MILLER: With that, we are going to return to our regularly scheduled programming and excuse Congressman DeMint. And we thank him very much for his leadership on this issue.

CONGRESSMAN DEMINT: Thank you.

(Applause.)

MR. MILLER: Our next speaker will be Charlie Klippel. He is Deputy General Counsel of Aetna. Aetna is one of the nation's leading providers of health care and related group benefits. It serves approximately 15 million health care members, 12 million dental members, and 12 million group insurance customers. It also serves more Fortune 1000 customers than any of its competitors. Aetna is also the first national health benefits company to offer a product in this emerging

category of consumer-directed health benefits plans. The Aetna Health Fund was launched in September 2001.

Charlie's responsibilities at Aetna since 1981 have focused alternatively on Aetna's health operations and its international businesses. He assisted in establishing Aetna's first HMO's in the early 1980's, but we won't hold that against you.

(Laughter.)

MR. MILLER: In 1996 he became Senior Vice President and General Counsel of Aetna's International Division. In 2000 he rejoined the Corporate Law Department as Deputy General Counsel. Charlie Klippel is a graduate of Harvard Law School and the Harvard School of Public Health, from which he holds a master's in health policy and management. His remarks today primarily will focus on how HRA's can evolve to address retiree needs for health coverage, long-term care protection, and other benefits that can be coordinated with Medicare.

He also plans to discuss how enhanced health information and indicators of quality and convenience can be integrated into HRA-type benefits, working on both ends of the health spending spectrum, the early discretionary dollars for routine care, along with coverage that handles upper-end chronic and catastrophic illnesses.

Charlie Klippel.

(Applause.)

CHARLES KLIPPEL,

AETNA

MR. KLIPPEL: This is a tough team to bat cleanup on. As I was sitting there, I was thinking the only potential bright spot is I wasn't speaking directly after Congressman DeMint. But apparently I failed even at that.

(Laughter.)

MR. KLIPPEL: I had the absolute opposite experience, I think, coming to this from Michael. Michael said he spent all his time with the lawyers, fending off those questions. I "was" the lawyer fending off all those questions, so I am equally relieved and equally grateful for the very helpful guidance that we've gotten from the IRS on this issue.

I think there were two topics in Tom's introductions. Let me try to get to those. He mentioned that Aetna was the first national insurance company to enter this market, with the Aetna Health Fund product. This graphic shows that product. It's similar to the designs that we have talked about here this morning.

There are many positive attributes. And again, I'm not going to review these because my two predecessors have covered it. Although let me pick one of them out in this list, just because I'm going to talk a little bit about the employer and the employer's position and activities vis-à-vis these plans. And the fourth from the bottom illustrates value of benefits. I think this is kind of a side effect of these programs, but an interesting one, and so a quick side comment. In addition to showing the value of health care services and the cost of health care services to employees, I think these products have had the effect of showing the value of the benefits that employers provide to those employees. I make that comment just as an aside on this slide.

I really want to focus on four issues here. And all of these relate to the larger rubric that Tom introduced, which is where employers are going to take this new-found freedom and where are they likely to drive all of us in this industry in the next few years. I think there may be four places where we will see a lot of development. Certainly more finance and plan options. I think we will see efforts to put more benefits inside this concept, greater integration of benefits that currently live outside, or may live outside, of the HRA structure. Finding solutions for more consumers. And, finally, retirement health, where I'll finish up.

Financing is probably the simplest of these. I think, for the most part, these programs started out in the self-insured markets and at large national customers. You remember the chart full of customers that we saw earlier. They were all big Fortune 500 names, or most of them were, that you recognize. I think what we will see, and we'll see it very shortly, is this concept moving down market, in the sense of reaching middle market and smaller employers, who will find the same way to do that.

That means changing the financing mechanisms underneath these products so that they become fully insured or split-funded, or the traditional ways in which smaller employers have been able to afford the costs of these plans. And we will, for sure, see those developments. In fact, Aetna will have a fully insured product on the market in the very near future.

We will also see further options in terms of the ability of employees to buy up and buy down. I think this is the choice. As people develop accumulations in these HRA accounts, they will want options where they can choose different levels of attachment for their catastrophic plans, for their PPO plans. So, if you have $5,000 in your account, you may be perfectly happy, and it may be a prudent economic decision for you, to buy a plan with a $6,000 deductible, although you probably wouldn't do that the first day.

I think we will certainly see developments in network configurations. Most of these plans today couple the HRA with a PPO-style benefit. I think there is no reason why you won't see that coupled with an HMO or an EPO-style benefit. And we have certainly seen, and Doug alluded to, plans that are even trying more complex structures with consumer-directed networks. I think that is a concept that consumers may have to get their head around a little bit, but we will see efforts to continue to drive toward that direction as well.

Expanding benefits, Michael talked about pharmacy. And I think pharmacy is the natural benefit to extend into this concept, because it is increasingly consumer driven. We all see the drug advertisements and realize that consumers are buying drugs, in part, based on direct-to-consumer sales, and that it makes sense to include prescription drugs inside these plans.

I think we will also see all traditional benefits ultimately incorporated into these plans, because it is a natural extension of the way benefits are provided. Certainly dental I think is very likely to be included in these plans. And for employers that don't offer dental today, this is potentially a way in which they can do so. They can offer a benefit that covers some dental services without offering a full-blown dental plan. Vision is already in most of our plans.

Complementary and alternative medicine, it's an interesting thought. There is an increasing consumer drive in this country to embrace complementary and alternative medicine. It has always been a challenge for the traditional insurance industry because the science isn't there. So, it has been a difficult thing to prove what was effective and what wasn't effective. But it is truly a consumer-based movement. And I wouldn't be at all surprised to see these vehicles as a way to provide some early start into embracing broader complementary and alternative medicine.

These are ones I like to think about adding to this. Long-term care is an interesting option. I think that, increasingly, there is an awareness of the value of long-term care. And this may well be a vehicle to encourage people, particularly people who have some savings in their HRA's, to look at new ways to use that savings to protect their future health care. And long-term care is one way to do that.

Disability I put here just to be provocative. I'm not sure I have the answer for disability. Michael said he had 246 ideas on the drawing board, and one of them may well be disability, but I'll let you ask him that question, rather than me.

Where do employers go with this? I think that it is the case in most employee benefit ideas, new ideas, that they

ultimately expand to become mainstream. And both Michael and Doug talked about this, that this is moving from the era of an experiment or an option to being the standard plan, or at least being a standard plan. And there is a lot of incentive for employers to do that.

Employers want plans that serve all of their employees. They worry that if they have a plan that only serves 5 percent, that that is potentially adversely selecting within their group. I'm not saying they do; I'm saying it is a worry that employers have. They also want to simplify their options. And there is no reason to believe that these plans, that the HRA concept, coupled with the right coverage for more acute care, doesn't work for all their employees. So, the question is, how do you make it work well for those employees?

Finally, from the consumer's perspective, the calculus is easier. "Make it work for me" is the consumer goal. If you think about that, you have to think as an employer here for a second. This is a nominal graph but not unrepresentative of what an employer may see in their own experience. That is, 60 percent of their population accounts for about 5 percent of the medical costs. And as you go across the continuum here -- which isn't quite a continuum but bear with me -- acute care may be 35 percent of their costs. Chronic care may be 25 percent of their costs. Catastrophic, very high-end care, may be as much as 35

percent or more. Again, this is a bit of an arbitrary chart, but not unrepresentative of an employer's population, and not unrepresentative of the general population.

Now, if you think where HRA's are today on an annual basis, or at least the first year, they're probably here. So, from the employer's perspective, that's a two-edged sword. That is, they make 60 percent of their people happy -- maybe more, because I think it is true, as Michael says, that you are seeing enrollment in these plans that is more representative of the whole population -- but, for sure, they make 60 percent of their people happy, but that's only 5 percent of their costs. If you think what people need if they're in these categories, their needs are different.

Certainly, if you're well, the risk transfer, the pooling, the insurance part of your health benefits is a relatively minor thing. The tax benefit is nice. If you are not well, the risk pooling is critical.

Similarly, for routine services, you may be more price sensitive. For catastrophic care, you may well be less price sensitive, in part, because you may not have the access or there may be fewer options of service available to you.

Quality also probably varies, and these are obviously gross generalizations, but bear with me. Primary care services,

it may well be that quality is more subjective: Can I get to my doctor when I want to? How easy is the access?

At the very far end of care, when you get to transplants, quality becomes very objective. That is, we have the data, we know where to go. And I think these differences will in fact influence how employers build these plans going forward, both where they put the attachment points for the HRA and how they design the complementary benefits that go with the HRA. And I think it really relates to what the support mechanisms are.

At this end of the spectrum, information for the consumer is very important. And all of us are working on improving information, getting information into the marketplace. At the far end, it may well be that assistance -- that is, real more hands on sort of assistance -- is helpful.

And quickly, there are some categories here. I know Doug and Michael talked about a lot of these. The information, there is a series of different ways in which you can get information to consumers. The assistance may be in different ways -- institutes of excellence, transplant programs, disease management programs, patient safety, which was not on this list.

So you will see employers work with these plans not only to push this end but to push that end, to try to provide the

best and the most responsive solutions for their employees. And all of us are going to be responding, I think, to that demand.

Finally, on retiree health -- and Doug teed this up in his remarks, and I think it was an astute point and I just want to emphasize it a little bit -- this is an indication of where employers are going with retiree health. It happens to be the cutoff at 500-plus. If this were a chart of 1,000-plus, it would look the same, except the scale would be moved up. And if it was 50-plus, it would be the same, except the scale would be moved down. But the message is the same -- that employers are moving away from defined benefit-style retiree health programs.

And how can these products help? Again, I think Doug teed this up quite well. The carry-forward is hugely valuable. And I think this is one of the places where employers will use the flexibility of carrying forward very quickly. I think they really will focus on these as retirement programs. They will think about vesting. They will think how to do that.

I think you will see very creative solutions. I think you will see employers who say, after 10 years, we may double your contribution to your HRA, or we may triple it after 15 years. So we may start out as a discretionary spending account and, as you get toward retirement, build these accounts so that they become a real retirement savings account.

And I think one of the really neat pieces of this guidance is the notion that the employer can continue to contribute to it after your retirement. So the employers have the capability of putting more money into that account for those retirees. And I think you will see employers take up that solution as well.

Then the challenge to all of us will be to develop the programs that allow those retirees, once they retire or as they near retirement, to convert those benefits for themselves into some combination of defined contribution and defined benefit -- so buy-up options or buyout options -- to give them defined benefit coverage to supplement Medicare or to provide, again, my favorite: long-term care.

Thanks.

(Applause.)

MR. MILLER: Thank you, Charlie.

Our final speaker is Paul Fronstin. He is a Senior Research Associate with the Employee Benefit Research Institute. That is a private nonprofit, nonpartisan organization, committed to original public policy research and education on economic security and employee benefits. Paul is also Director of the Institute's Health Security and Quality Research Program.

He earned his bachelor of science degree in economics from the State University of New York at Binghamton, and his Ph.D. in economics from the University of Miami.

Today Paul is going to discuss whether consumerism can slow the rate of health benefit cost increases, as is outlined in his new paper that's available outside. It may not be all about the money, but Paul believes that the measure of success or failure for consumer-driven health benefits will be its effect on the cost of providing those health benefits and the number of people who can receive them.

Paul Fronstin.

(Applause.)

PAUL FRONSTIN,

EMPLOYEE BENEFIT RESEARCH INSTITUTE

DR. FRONSTIN: After hearing everything we've heard today, I'm ready to sign up for one of these plans. How many people want to join me?

We've got a majority among those in the back.

Tom, I appreciate the opportunity to be here today. I was told, because I was asked to be in the minority, that I would have more time than the other speakers -- because I'm the only one in the minority -- but I'm the only thing standing between

everyone here and lunch. I'm not going to take that much time and I think we should leave some time over for questions.

For those of you who don't know, EBRI is a membership organization. We are supported by dues-paying organizations. Some of those organizations include companies that have jumped on the bandwagon, some that have been mentioned in the slides already -- Aon, Abbot Labs, Pharmacia. Our members also include companies that are probably going to be offering these plans. And our membership also includes everybody else who doesn't offer these plans -- that is, so far. I think we are going to see a huge movement into these plans over time.

It is too bad Congressman DeMint had to leave, because I did have some comments about his flexible spending account proposal. A lot of people look at flexible spending accounts to try and learn something from them in order to understand how people may behave with health reimbursement accounts. What we know so far is that only 19 percent of eligible employees participate in those plans. The average contribution when someone does participate is just over $1,000.

Part of the reason why we see such low participation and conservation on contributions has to do with the fact that there is this annual "use it or lose it" rule, and people are hesitant to put money aside if they think they're going to lose even a dollar. I think that is irrational, because they are not

taking into account the tax break that they get if they do only lose a little bit. So we do have this proposal to let people rollover $500 per year. I think what is going to happen is, if we did allow people to roll over $500 a year, we would see a lot of $500 accounts. Whether or not people use the money differently is to be seen.

I am not sure that people spend irrationally at the end of each year as much as we think they do. We always hear about dental visits at the end of the year. We always hear about people buying extra eyeglasses at the end of the year. Right now vision care only accounts for about 2 percent of what we spend. So if we were to allow rollovers and try to avoid unnecessary eyeglasses and some other unnecessary spending, I don't think it would have much impact.

Health reimbursement accounts -- probably the most important thing to remember is it's not a medical savings account. It's not a flexible spending account. It's a reimbursement account. It's employer money. It's not employee money.

It's interesting what Doug said -- and we were talking about this before the session today -- about how people view this money as their own money. It's surprising to me. And I guess it's encouraging to me. But it is not their money. And I don't know that we should expect employees and their families to treat

the money as if it is their own money. It is employer dollars. And if people viewed the money as their employer's money that their employer is giving them access to, to pay for health care services, they may not behave any differently than if they were facing a $10 co-pay to see the doctor.

I think Doug used the example of $2,000 in an account for a family. If you are looking at a $2,000 account, will that change the way you go see the doctor? You may say, well, I've got this $2,000 available to me; I'm not going to change the way I'm using the health care system. There is really not much incentive to save, because I only have to save enough to accumulate enough funds to meet my deductible. So, some people may view these accounts as first-dollar coverage. They may not. And according to Doug, it looks like they are changing the way they use the health care system because of this money.

I think so far, from the experience to date, it is probably too early to really draw a lot of conclusions about the experience with these plans. There is some evidence that it is having an impact on drug spending. But I don't think we need these accounts to have an impact there. If we really want people to use generics, why not make them free and charge a lot more for brand-name drugs? There is your incentive to use the least costly drug. And it doesn't have to be free. It could be a $5 co-payment, and a $75 co-payment for a brand name.

I think, at first, consumers will find this confusing. Over time, I hope that they will understand these plans. How many people in this audience, if they had to explain how these things work, over lunch in a few minutes, think they would be able to do that?

What do you think we have -- about a third of you. That's pretty good. A couple of weeks ago, I was asked to do the same thing I'm doing now at an after-dinner presentation. And when I asked the crowd, it was probably about a third then too. I assumed it was because people had too much wine to drink during dinner, because this was a group of H.R. people, benefits, and CFO's.

It is very difficult to "get" it in a presentation like this, in such a short period of time. People will need a lot of interaction with the system. As Doug says, there are a lot of phone calls at first. People want to talk to someone about it. It takes a while. There are things people are already confused about. They already don't quite understand how their health plans work right now.

We did a survey last year and found that 33 percent of Americans didn't know what the eligibility age was for Medicare. And I'm assuming most of those people have parents who are probably on Medicare.

COBRA is confusing for a lot of people, and this may make it more confusing, or it may not. In the last six or seven months, given the number of friends I have that have lost their jobs, I've gotten a tremendous number of phone calls from them, asking for advice about COBRA. I have become the neighborhood COBRA expert. It's amazing, even with my friends, that they don't get it. They don't understand what it is, how it can be used, or what they have to pay for it

I was in a meeting last fall, an open enrollment meeting, for a local company, where they were going to talk about changes to their health benefits for this year. And the company spent about 45 minutes talking about justifying why their costs were going to go up, before they finally told people what the cost increases were going to be. And when I saw what the cost increase was, I was surprised they took that much time, because it was only a couple of dollars per month per person, and I thought they were trying to set people up for a really big cost increase and then have them accept what they were given and not be too unhappy about it.

The employer's broker spent an awful lot of time talking about what's going on in the market. And when the broker mentioned the reinsurers not willing to give quotes, or insurance companies not willing to give quotes, to administer this plan, which was self-insured, I looked around, and nobody had a clue

what this person was talking about except for me. And I had to do everything I could not to ask a question, because I didn't want everyone to look at me and wonder who was this guy and how come he knows what they're talking about and we don't.

I did go up to the broker afterwards to ask a question, and the first thing out of her mouth was: Are you in the business? And I'm thinking, well, if you're talking to people about this information, don't you expect them to understand it? And obviously she made the assumption that they wouldn't.

Hopefully, over time, people will get it. And I think they will. They will take the time to understand it. But it is going to be confusing at first. I think that is why, when you look at the take-up numbers among a lot of the employers that are offering these plans, they're relatively low. They're relatively low because people are waiting for someone else to do it, so that they can understand from them how it works and see what their experience has been. Over time, I think this will snowball, just like managed care did. And 10 years from now, for all we know, 90 percent of the population may be in these plans.

Whether or not they save money is to be seen. It depends upon how people view the account. There is one handout that I have. Hopefully everybody picked it up. It shows the distribution of health care expenses. It basically reinforces what we have already heard -- that if you don't focus on the 20

percent of the population that accounts for 80 percent of the spending, you are not going to save much money. Because most of the population does not consume a lot.

What this chart also shows is that 50 percent of the population only accounts for 5 percent of the spending in any given year. And employers are concerned about giving an employee $1,000 every year, for someone who is healthy and does not otherwise need health care services.

These plans do rely on managed care. We have not thrown managed care away. We saw from the last set of slides all the tools that insurers and employers are going to continue to use to not only manage the 20 percent that accounts for the 80 percent of the spending but also provide to the 80 percent so that they don't become part of the 20 percent that accounts for 80 percent of the spending.

Let me end there, and we'll take questions. Thank you.

(Applause.)

MR. MILLER: Thank you, Paul.

Let's go right to questions. Wait for the microphone to come, and also identify yourself.

Right in front, Greg Scanlon.

MR. SCANLON: Paul, I want to use your mind on a couple of points. One, it seems to me that paying cash for a service is one of the least complicated situations that people could have.

I don't think they are going to find that confusing at all. It seems pretty straightforward.

The other thing is this notion about giving healthy people $1,000 a year, when you wouldn't normally do it. I believe that one of the interesting things about this approach is that the accounts are unfunded. They're notational accounts. And so the money isn't actually paid out until there is an expense incurred. So that healthy person may have $1,000 allocated to him, but the employer is not actually paying out $1,000, any more than he would if that $1,000 were fully insured.

That is my comment. I would like to get the vendors to confirm that situation.

DR. FRONSTIN: Let me respond to that. When people buy things with their own money, and they have a price list, they know what they're asking for. I think the difference with health care is you don't always know what you're asking for. You're going in for a consultation, more often than not, to try to figure out what it is you should be doing. And at that point I think the price list will come into play more importantly than it would just to get the consultation. Because that is where the big expenses are going to be, once you figure out what it is you have and how you're going to treat it.

And I think that, once there is a price list, people will behave rationally. They will look at it and take it into

account. But right now, we don't have it, at least in a way that could be useful to most people.

The point about these accounts being unfunded and just being a credit, or whatever it is, it is to be seen how people view it. We will see whether or not they view it as money that is in an account or money that they have access to were they to use the health care system. I think we will see a lot of both -- some people looking at it as their money and having an incentive to save it to meet their deductible and have something else for a rainy day, and others just viewing it as here is this pot of money I could use; even if it's not in an account, it's there. Because of electronic transactions, all I have to do is give this credit card to the provider and it gets deducted from my employer's account.

MR. KRONENBERG: Just to clarify, yes, that may or may not happen. I'm thinking about whether it is more expensive for employers because they are giving the $1,000 to healthy people who would otherwise not be consuming services. My understanding is they are not actually giving the $1,000; they're simply allocating, in effect, a non-cash credit of $1,000.

DR. FRONSTIN: They're allocating it, but if it does induce some demand, they may be spending it sooner than they otherwise would.

MR. KRONENBERG: Greg, I would have said that if it were only the case that these accounts were going to the 5 percent of healthy people, then that risk may be greater. I think the employers really do have an incentive to try to develop these plans so that they cover all their employees. And I think the more that they are inclusive plans, the less that issue of being expensive because of that piece will be an issue. I think it will be just a reordering of benefits for more flexibility for a broader range of employees, or at least I hope so.

MR. SHOWALTER: I guess I wanted to answer that, Greg, to say that in any plan today, for instance, an employer might say you have access to a $1 million lifetime maximum benefit. That does not mean that they are spending $1 million every year for every employee in their health plan. The same is true here. I might say you have access to $1,000.

Now, your employer is giving you access to $1,000. Whether it's the employer's money or the employee's money, you have access to $1,000. What you have as an incentive to changing behavior, however, is the fact that you have real cash outlay pending in the gap between your personal care account and your health coverage. That's item one.

Item two is you also have the opportunity to use it on benefits that are appropriate for you. So, unlike what was suggested, why don't we just have a zero dollar co-pay for

generics and a $75 for brand, the nice thing about the PCA is you use it on the benefits you need, when you need it. It's not designed for some most common user like a defined benefit plan.

And the third thing is, frankly, you can use it over your lifetime; so, for your needs as they vary throughout your lifetime and into retirement. So you're not looking at just a one-year event horizon here with $1,000 and the abuses associated with that.

MR. MILLER: A question over here.

MR. ROSENBLATT: Bob Rosenblatt, Los Angeles Times.

This is the third seminar of this type that I have attended, and I am still trying to get from the high level of intellectual abstraction down to some reality. Employers presumably are interested in this not because you use the word "consumerism" but because it saves money. I would like to know how much -- this is for the vendors -- how much you charge an employer for a single person and a family coverage in this kind of account versus a traditional PPO or HMO, or whatever.

In other words, how much less is it for the employer? Presumably that's the only reason they would be interested in it, not because Cato thinks it's a good thing. So what do you charge for these plans versus what traditional products are going for?

MR. KRONENBERG: The overall costs are comparable to what's out there today. If your question is, at the end of the day, what happens to utilization --

MR. ROSENBLATT: Not utilization. What do you charge the employer per month?

MR. KRONENBERG: Comparable to what you're paying today for regular PPO's. The administrative costs of this are very much in the same ballpark.

Let me get back to your other point, though, around the only reason employers are doing this is to save money. That is what seems to be hitting the headlines, admittedly. But, again, when we have conversations with employers, they are very sincere in their efforts to try and get their consumers involved.

One of the benefits of this is going to be a more efficient health care system. There is no doubt about that. And virtually everybody agrees with that. But, at the same time, to the point that we made earlier, the idea that this is just something that is going to save money is not top of mind for the folks that we are talking to. The idea that getting the consumer involved is going to create a more efficient system and ultimately a better health outcome is really what everybody is interested in here.

The employees will be able to tell us, as they vote and sign up for the plan, whether or not in fact they agree with

that. Based on our early results, they are. It will pan out, and we'll see how all of that works going forward.

But I really want to kind of push back pretty hard on that whole notion that the only reason an employer would do this is to cut costs. They have a lot of ways they can cut costs. They can just drop benefits, if they want to.

MR. ROSENBLATT: But this does not save them money?

MR. KRONENBERG: From an administrative standpoint, no. This is not a cost-savings measure on administrative costs. Our ASO fees are comparable with PPO's that they have in place today.

MR. MILLER: Doug, what about total benefit costs, though?

MR. KRONENBERG: Total benefit costs, of course, the feeling is that an engaged consumer is going to reduce and improve overall efficiencies, reduce utilization, and at the end of the day you will see trend mitigation advantages to this. We will all determine whether or not in fact that is happening as we get the results of large numbers of folks signing up.

MR. SHOWALTER: But to be clear and to piggyback on what Doug is saying, it is not cost shifting. In one year, the actuarial value of your PPO plan might be $4,000 per employee per year. The actuarial value of your consumer-driven plan, on day one that you put it in, will be $4,000 per employee per year. The savings comes over time as your other plan is increasing at

double-digit rates and your other plan is not. So that's where the savings comes in. It's not some kind of cost shifting scam that employers are putting in.

MR. MILLER: Let me just try one other variation on that. We have sometimes seen in the health insurance marketplace what you might call shadow pricing. Which is you have a slightly different product that just gets under what the other products are being sold for and becomes more of a benefit enhancement than cost containment measure. And there is always that tension between the two. What do we see going on in terms of these consumer-driven products in that regard?

MR. SHOWALTER: For our plan specifically, we only offer our plans to self-funded employer groups. So we have no incentive to scam risk or to shadow price. And the employer, since they are maintaining the risk, really has no incentive to underprice themselves for their other benefit plan offerings. So we have not seen any of that "shadow pricing."

Now, Aetna and some of the others coming into the insured market, I'm not sure if we will start to see that or not. But with the self-funded clients we have today, we haven't seen that behavior.

MR. MILLER: Another question. Let's go over here to John.

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

I'm a little concerned about some of the network issues around coordination of care. If I'm working from a price list and I see I can get a better deal outside of this supposed network, is the network a fact or fiction anymore under this new system?

MR. KRONENBERG: Network discounts are a fact. Under the current system, essentially what you're doing is saying to the employee, you decide whether or not you want to take advantage of the discounts that are in place. Our position is that we want to create price transparency, so that regardless of what those discounts are, the employee can see them and decide whether or not they want to take advantage of them.

Going forward, you can ask the question around what's going to happen as doctors become more aware of what prices are being posted on the Web sites that are out there. And we get, for instance, questions from the medical community around whether or not they would be able to post lower prices if an employee or a consumer came in and wanted to pay cash. Our point of view is very simple: Absolutely.

Ideally, what we would like to see this move to is a system where individual docs can post whatever rates they want. So we don't have a strong allegiance, or any allegiance, to

network discounts, with the exception of being able to provide consumers that sign up for the plan as much of a discount as they can get from wherever it comes from.

MR. GREENE: What about the coordination of care issues around I get medicine A from a doctor over here, and then another medicine from another doctor over here, and they don't talk to each other because I'm working from a price list?

MR. KRONENBERG: I'm sorry, could you elaborate just a little bit more on that?

MR. GREENE: I'm a consumer and I'm looking at price lists and I'm only price sensitive. So I may go see multiple doctors based on this price list for care, and I may be getting different advice and prescriptions from these different doctors who are not talking to each other.

MR. KLIPPEL: That's a very insightful and interesting question. I personally believe that coordinated care is a great way to deliver care. Again, let me just give you two quick examples. My mother had breast cancer last year. And she went to a breast cancer center, where all of her care was really tightly coordinated and there was great handoffs from doc to doc as she went across the spectrum of care. I couldn't have been more impressed with the care.

My personal life situation, I couldn't care less about coordinated care. I see a doctor once every three years. I

don't care about coordinated care. So what I'm saying is, as the consumer market evolves and there is true demand and supply, there will be people who value coordinated care and they will seek out those coordinated care settings, and there will be people who don't value it. So let the market evolve if that's a value in the marketplace

MR. SHOWALTER: One of the things that we have in our health management system, for instance, is something called the personal health coach. And I gave you the example of exactly what it is that you're talking about. Not too long ago, the personal health coach was on the phone with a member, who went to the medicine cabinet, pulled out all the medications, and the coach found out that in fact three medications were prescribed by three different doctors. They were all the same medications under different names. That's a perfect example of where coordination of care is absolutely critical and can't get lost in the system and where you need to have the kind of personal touch that I just talked about to be able to manage that. It's critical.

MR. MILLER: In the back, I think I see Grace Marie.

MS. TURNER: Thank you very much. This is Grace Marie Turner.

First, a clarification. I just want to make sure you're reading the IRS rules the same way I am. Congressman

DeMint said one of the problems with health reimbursement arrangements is that they are not portable. And my reading of the IRS regulations is that while that account may stay under the control of the employer, you can continue to have access to it after you leave that employer and even after you retire.

MR. KRONENBERG: That's right. That's why I said that, for retirement benefits, this is a wonderful ruling. The challenge is an administrative problem with younger employees, for instance, who may move to two or three jobs. To maintain these accounts, there is a cost associated with it. So, after they leave the company, that's a real challenge for the employers to try and maintain them.

MR. KLIPPEL: Today we have seven clients that offer this benefit into retirement. Regulations rarely lead the marketplace. They were willing to go out there and offer this benefit, and the regulation affirmed what they were doing. And that's terrific. What we would like to get to ultimately is portability that is not necessarily tied to that employer. So that if I move from job to job or if I'm jobless, or if I'm completely out of the work force, as a working mother for instance, them I am able to maintain that benefit.

MS. TURNER: While this is hugely positive and I'm very excited about this idea, having toiled in the trenches of free market health policy for too many years, I'm always looking for,

"But what if..." and "What's the dark side?" Because there are a lot of people in positions of political power who are not going to like this because it is very oppositional to an idea of a government controlled health care system. And my question is, what do you see as the biggest risk of somebody throwing a monkey wrench or sand in the gears of this new idea just as it's beginning to take hold?

MR. KLIPPEL: This is a new concept. There's no doubt about it. Those of us who have been doing this for the last three years have faced a number of hurdles along the way with getting the adoption rates that we're talking about now. Early on, for instance, in a two-hour discussion with an employer, we would spend an hour and a half defining the product concept that I think everybody in the room basically got after the first five minutes because they've heard about it. So kind of that overall understanding is critical.

I think one of the key hurdles that we have now with the IRS ruling and moving forward with this over the next two or three years is the whole notion around whether or not in fact it can really work. Can putting the consumer in the middle of this whole purchasing decision within health care really have a positive impact on both the health outcome and, at the end of the day, the financial side of this thing? And that's the big question that everybody kind of throws out today.

The skeptics will say no. They skeptics will say that this is a cost shift and it's just a clever way of getting the employee to pick up the cost of health care. The fact is, the reality is, health care costs are going up. Employees, consumers, are going to have to get more involved, regardless of whether or not this kind of a change comes about or not. You simply cannot sit back and expect health care services to come to you the way they have in the past. We just can't do that anymore.

So, change is going to happen. This is one step, we think, in a very positive direction that is going to be appropriate for some percentage of the population and, I personally think, a fairly large percentage. But, at the end of the day, we've got to be able to get over all of these hurdles. I think the key next one, the biggest one, is going to be adoption rate by the employees and being able to get high enough numbers, millions of people, into these plans so that we can really begin to take a look at the power of what this can do for us.

MR. MILLER: We are going to squeeze in just two more questions, because stomachs are rumbling and the cold food upstairs is getting warm.

Carrie Kovar, down here, needs to provide some value to her clients.

MS. KOVAR: Thank you, Tom. I'm Carrie Kovar, with the Legislative Strategies Group.

I wanted to follow up on a question that John asked about coordination of care, and ask about whether or not in your plan models you are actively integrating disease management, and when broadly defined and defined differently by a lot of people, but disease management features and how you're doing that in your plans.

MR. KLIPPEL: I think that there is nothing inconsistent with this design and disease management. I think it is important to see this as a very positive tool to help give employees some additional freedoms, some additional flexibility, in the way they use the benefits. But I think employers are still very conscious of serving all their employees. So, for things like chronic disease, to integrate a disease management program is a very valuable and continues to be a very valuable tool. And I don't think that that will go away any time soon. I don't think this is a switch from A to B. It's an evolution that provides sort of the best of both worlds, one hopes.

MS. KOVAR: How are you doing that, though? Is there a financial incentive?

MR. KLIPPEL: Let me give you an example. Our health management system uses five or six different sources of information to be able to understand where folks are with risk

factors and what needs they have. One of the things, for instance, among the healthy population that everybody kind of wants to discount immediately -- that they never touch the system, they never need it -- we try and get them to do a health risk assessment.

So we're developing with the employers that we're working with marketing plans, including for instance an e-mail campaign that goes out to 5,000 employees within one company that we're working with. We got a 35 percent response to the e-mail campaign, where they went in and essentially filled out mini health risk assessments. At the end of a 12-week period, they essentially had completed a whole risk factor analysis on themselves.

The information that you get out of that is just invaluable as you create these health management systems. And that's the whole idea here, to be able to get folks involved very early on at all risk factors, to be able to help them do everything that's right for them. So that's one example of how a health management system will work. And it goes all the way from that to a very sophisticated risk stratification model that we use, through our health management partner, Future Health, that allows us to identify folks that are at risk, in that top 2 percent, and then proactively go after them very, very quickly to try and help them.

MR. MILLER: We'll take one final question.

Dennis Kelly.

MR. KELLY: I would like to speak to Paul's issue, the idea of employees not understanding the money. As a company that's been promoting these plans for over 10 years and teaching employers how to manage incentives versus managing care, I can tell you that one of the most puzzling questions to an employee that you just gave $2,000 to is, well, where did this money come from? So it's hard to get people involved in the health care equation when they don't even know they're spending their money. So the idea that you give them money kind of really does work and they do think of it as their accounts.

And then to go back to something that Fred Hunt was talking about, in terms of employers stealing this money or taking this money or not putting it in trust and not giving it back to people, employers do that all the time. The reality is employers don't take away vacation days, they don't take away sick days, unless they absolutely have to, and there is a consequence in terms of business operations.

So when an employer starts meddling with these $1,000 and $2,000 inputs, our experience with fully insured plans is that the experience on these plans runs 40 percent below the normal experience. In fact, our biggest struggle in the last four or five years has been convincing insurers that it's

credible experience and they should price the promotion of these plans off of that credible experience. People do avoid unnecessary tests. They do ask their doctors questions.

The last thing, about your 90 percent of the people 10 years from now will be in these kinds of plans, 100 percent of the people today are getting moved into these kinds of plans by shifting co-pays and raising deductibles. And you're forcing them into a situation where they have no tax break. So, in addition to the $100 that you added to their benefit cost, you're adding another $40 of tax. That's real money, and people do see it. So, the more that the industry leaders like yourselves can understand this is real money, not employer money, not employee money, it's real health care dollars, the better we will be able to convince the rest of the industry.

MR. MILLER: I think we will wrap up there. In a moment we will be adjourning upstairs for the type of high-carbohydrate, low-fat lunch that is responsible for the national wave of obesity in our nation -- if you're following the reconsideration recently of the Atkins Diet. If you prefer a more Paleolithic food menu, I suggest good luck hunting for it outside. First, let's thank our speakers for a thorough discussion.

(Applause.)

(Whereupon, the Cato Institute Policy Forum concluded.)