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HSC's 13th Annual Wall Street Comes to Washington Conference
Session 1
Center for Studying Health System Change
July 9, 2008

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PAUL GINSBURG, PHD: —I want to welcome you to the 13th Annual Wall Street Comes to Washington Conference and the purpose of this conference is very specific. It is to give the Washington health policy community better insights into market developments that are relevant to health policy and we are going to discuss market developments and their implications for people's health care, which is the core activity of HSC Center for Studying Health System Change.

I see this as an opportunity to tap a different source of information, equity and bond analysts, on this topic. As you know, the equity analysts advise investors about which publicly traded companies will do well and which ones will not and bond analysts advise in the likelihood of debt repayment.

The really good analysts, like the ones on our panels today, develop a thorough understanding of the markets that the companies they follow operate in and they also follow public policy, which often has important implications for these companies.

Some of the analysts work for brokerage companies and advise the clients of those firms. Some work for institutional investors such as mutual funds or hedge funds and one of the analysts on our panel works for mutual fund that invests in bonds issued by not-for-profit hospitals. This adds to our

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panel a window on an industry dominated by organizations that do not come into the equity markets.

This is an opportunity for the equity and bond analysts to take a break from their day jobs of assessing the outlook for profitability or solvency of the companies and bring their understanding of market forces to bear on the questions that those involved in health policy have on their minds.

We also include, on each panel, a Washington-based health policy analyst and these people have made valuable contributions to these sessions by better tying the market developments into health policy issues.

Our format this morning is like what we have done in the past, that it will be a roundtable discussion of a series of questions that I have shared with the panelists in advance and we are going to have a panel, the people you see here, that is the panel on health care costs and premium trends and various issues connected with health insurance and the second panel is on delivery system issues from the perspective of providers of care such as hospitals, physicians, and the pharmaceutical industry.

There will be an opportunity for audience questions and answers after each. There are question cards in your packet. Please fill them out and give them to an HSC staff member or you can go to the microphones and ask your question and we

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would really like to have some of each at this meeting if we can.

Please note that the analysts are often not permitted to answer questions about the outlook for specific companies. That is not what this meeting is about. We care about the impact that policy makers care about, which is the impact on consumers, the budget, etc.

I want to thank the Robert Wood Johnson Foundation that funds this conference and is the largest funder of HSC and thank the people at Kaisernetwork.org for web casting the conference and the web cast will be available after noon at kaisernetwork.org. HSC will post the transcripts of this conference on its website by early next week and before you leave the conference; we would appreciate it if you would fill out our evaluation form. It is the yellow paper in the packet. I hope it is yellow this year, and leave it on the registration.

I want to briefly introduce the panelists. The panelists comprise mostly people who have been here before at this conference and for those that come frequently, you are familiar with them. Those that have been here before are Christine Arnold formerly of Morgan Stanley; Matt Borsch of Goldman Sachs; Josh Raskin and Adam Finestein of Lehman Brothers; Geoffrey Harris of the Cerimon Fund, and Bob Berenson

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and Bob Laszewski who comments as policy analyst rather than as bond analyst. One thing I want to mention about Bob Berenson is that Bob has participated in HSC site visit work on a number of projects including the broad community tracking study and some of what he will bring is the perspective from that. New to the panel is Kevin Ponton of Dreyfus Corporation.

So, I would like to begin the discussion with an issue that is very much on the radar screen not this week but otherwise the question of health care reform. The first questions are I would like to ask about insurance industry leaders and how are they positioning their company for the possibility that some type of health care reform could be enacted next year and is there more than one scenario that they see including a scenario when some say nothing is going to happen. We are going to ignore it. Who would like to start? Yes, Matt?

MATTHEW BORSCH, CFA: Sure. I will take just a quick crack at that. I think just to spotlight one company that has made efforts in a couple of different directions perhaps not while they have not expressed this as openly as preparing for health reform, I think it, in some ways is, which is Aetna and their purchase about a year ago of Schaller Anderson and the Medicaid infrastructure that, that acquisition brought to Aetna

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and I think that prepares them for the potential of reform in one direction.

Then the other would be that the focus on the individually purchased health insurance - direct health insurance purchase market, which historically, Aetna was not as focused on. They have been much, much more focused on that over the last couple of years. So in that sense, those are both immediate growth opportunities but they are also hedging their bets in the sense that one direction reform could take would be certainly greatly expanded public sector coverage programs for not only the Medicaid eligible but the low and even moderate income uninsured and then in the other direction, the individual purchase market, which would be more in line with some of the pro-market health reform initiatives and of course, it is possible that health reform could extend enrollment on both of those fronts.

PAUL GINSBURG, PHD: Christine.

CHRISTINE ARNOLD: I agree with what Matthew said. I would just add that it is not just Aetna that has kind of discovered the individual market. Cigna, for the first time, has gone into the individual market. We have seen unprecedented growth in new markets by Coventry and Humana on the individual segment side. I think the expectation is that barriers to entry in the individual market will decline. You have got guaranteed

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issue enrollment brokers is diminished, the concept is if you are in a lot of different markets then when that growth happens, you are in the best position to take advantage of it. Humana is developing networks especially for their private fee-for-service segment with the expectation that deeming [misspelled?] could go away and funding for private fee-for-service is vulnerable and it is a big topic this week as the Senate takes up their bills.

PAUL GINSBURG, PHD: We will go into that next.

CHRISTINE ARNOLD: And both Aetna and United have acquired Medicaid companies. So, we are seeing shoring up of Medicaid with the expectation that will grow and I would simply point out that the companies are saying that they think it is going to be very hard to do anything more than incremental because of the budget situation, because of Iraq and the economy but with a single party potential control, I think if you look at the MMA, there is definitely precedent for something more sweeping then the companies anticipate or are positioning.

The one thing I would add is that Kaiser is looking at retroactive recision as a potentially big issue and they are offering that anyone they have rescinded in the last couple of years can come back on the roles as they expect the issue of, I

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think, retroactive recision the individual market to be taken up at a state level and it could bubble up to a federal level.

PAUL GINSBURG, PHD: Yes, Josh?

JOSHUA RASKIN, CFA: Yes. I would just add, I guess, sort of taking a step back and thinking about broader health care reform. I think everyone sort of alluded to without sort of stating obviously that there is a focus on the uninsured. I think that is going to be the big topic going forward. That is not new news to these companies.

So, the big question becomes how do you prepare for that and I do not think there is an answer. You have got two presidential candidates with different ideas, I think, of how to ultimately get there and from a health plan's perspective, you can introduce more individual products and different price points at the lower end and things like that but at the end of the day, I think that the biggest efforts have been hiring lobbyists and just trying to help with the actual formation of that legislation as opposed to any real preparation work at this point.

MALE SPEAKER: I would just add to that, that obviously the debate between Obama and McCain, Democrats and Republicans, is whether you build on existing employer-based systems, Medicare and Medicaid, which Obama favors, McCain wanting to redo the system on an individual platform. I agree with

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everybody here that companies are sort of covering their bets and expanding what they are doing in individual health insurance. The big exception to that is what Christine just mentioned in the recision controversy. You probably saw in the news yesterday WellPoint settled an $11 million suit that hospitals in California over the people who are rescinded. It boggles my mind that the industry would be playing those games out in California at a time when the Republican nominee for president wants to build on an individual platform. I would have to think most of the people that run these insurance companies are Republicans and they are not doing the Republican nominee a big service by fighting these battles in California the way they are.

For those of you who know me, you know that I run a health insurance company and when I came up through the ranks, we did not rescind policies for the things that they are rescinding them for. So, that adds to my confusion as to why they do not get it straight.

The second thing that I would say, I think that is important, is that leaders in the health insurance industry are firmly behind expansion through the employer-based system. While there are some cover your bets things going on in terms of building individual capability, there is no question that the leadership in the health insurance industry wants to see an

expansion through the employer-based system and some people have even said that publicly. The CEO of Aetna testifying before Congress came out and said that flat out. So, there is a discomfort in moving in the individual direction.

PAUL GINSBURG, PHD: And that is a good segue way to talking about the individual market. That is with an either Obama plan or a McCain plan, to different degrees, there will be increased emphasis on the individual market because that is where a lot of the people who are uninsured but are in the income ranges that tax credits or subsidies might be used are enough to get their coverage. The question is from your understanding of how the individual market works, what will the federal government have to do in legislation as far as structuring, regulation, etc. of that individual market to get it to deliver what society would be looking for. If we are going to be spending a lot of government money, we want people to get good health insurance and efficiently through it. So, who would like to start? Yes, Christine?

CHRISTINE ARNOLD: Individual markets complicate it because you have got the broker in between kind of the managed care company and the individual. I think the key is to entice healthy people into the pool and we have got some now Clinton had suggested and individual mandate, which neither Obama nor McCain supports but I think there is a precedent for going

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half-way in terms of not really implementing an individual mandate and the question is well how would you really enforce that? Would you send people to, I do not know, Guantanamo if they did not actually sign up for coverage and so it gets really kind of tricky in terms of making sure it actually happens.

So, if you look at the PDP, I think we have got some precedent here. There was a penalty for seniors who did not get into a PDP plan within six months, right. So, maybe if we enact this legislation and the folks choose not to get into the health plans and they are going to be subject to medical underwriting in three months, six months, or there is going to be an incremental penalty or they are going to be stuck in a different plan with less choice of doctors and hospitals but some form of enticement to get healthy people into the risk who I think is critical because insurance is all about spreading risk and if we have guaranteed issue without enticing healthy people into the risk pool then all we have got is people waiting until they have had the car wreck then calling Geico and getting the car insurance to cover it, which is not going to work from a structural perspective.

We need subsidies for the sick and we need serious discussion about a minimal affordable benefit. So, what protects people against catastrophic costs but also entices

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them to have the right behaviors and change their consumption of health insurance coverage and then we need to get around some of these, I think, some of the state mandates. So, then we need to change what has traditionally been regulated by the states in terms of minimum benefits versus the federal government.

Are we going to cover say infertility the way that New Jersey does? Is that going to be part of what is required to be covered in a minimum benefit package? Are we going to take all of the mental health circumstances that California covers? We have to make some tough choices.

PAUL GINSBURG, PHD: Thanks. Bob?

ROBERT BERENSON: I would suggest, I think your question was, what does the federal government need to do to make the individual market work. The federal government actually has some pretty good experience there. It is called the Part D drug benefit. It is community rated. It is voluntary. The age range starts at 65. There are people in it who are 95 years old. The people in the population are fairly sick and high utilizers and it is a system that has worked surprisingly well. I have been surprised at how well it works.

So, we can devise a community rated voluntary, not mandated, plan for lots of people who have lots of pre-existing conditions and we have seen it work before and I think that is

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the model. I am very surprised that Senator McCain, who has proposed the individual solution, has been so reticent to embrace what I think are pretty much traditional insurance principles. Senator McCain says we ought to de-regulate the market.

If you are sick, you would not be guaranteed coverage other than perhaps in a state-based risk pool so that the industry takes the healthy people and puts the sicker people in a state-based risk pool. I think they point to Minnesota as an example of one that works pretty well. If you look carefully at Minnesota, Minnesota is 50-percent subsidized by the government based upon assessments made through the back door to insurance companies. An individual platform can work really well as it has in Part D and you can do guarantee issue as we have done in Part D in a voluntary system and you can figure out how to take care of the sick people coming through—, through a reinsurance scheme that assesses the entire block.

So, it is very possible. It can work. It can work well. Distribution is a big issue. Overhead costs are a big issue. Overhead costs in the group market average 12-percent, overhead and profit. In the individual market, they average almost 30-percent. Now Part D, they average about ten-percent because we have gotten involved with sending people a catalogue and

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marketing in that way. So, we can come up with some pretty efficient ways to do it.

So, we can create an efficient individual market and I do not think it is saleable to the American people. I do not think you tell the American people to give up their employer-based health insurance without giving them some insurance as to how they make that transition.

The one thing that has worked for Joe and Mary Middle America in the American health care system is the employer-based system. It may cost the employer a lot of money, may be unsustainable but it is the one thing that everybody appreciates. How many people in here would give up your employer-based health insurance? You are not going to do it. You are not going to take that leap unless you are confident you are going to be able to do that somewhat seamlessly. So, it can be done and Part D is an example of it.

PAUL GINSBURG, PHD: Okay. Good. Josh?

JOSHUA RASKIN, CFA: I would just say one thing. To me, I sort of think about Part D and huge success and obviously, high satisfaction levels but the key to Part D, in my opinion, was the government was the backstop. They provided massive potential subsidies for losses to risk corridors and provide a catastrophic insurance. So what is going to happen, I think, in a scenario like that is you end up footing the bill at the

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government level and I do not know, , maybe they find some funding, maybe there is an idea to sort of spend in that direction but ultimately, whether it is ten years or only five years or who knows, 20 years, you are back at the drawing table because spending in this environment or whatever and how you sort of roll that out is going to be sort of out of control.

I think ultimately the way to attack the individual market is the cost. I think the one thing everyone talks about is improving access and rolling out new products and new programs and I do not think there is a traumatic loss. I mean everyone in the country, there are ways to get insurance. I mean I am sure there are certain pockets, right, if you got pre-existing conditions and things like that. I mean there was that article in the, I think it was the Times Journal [misspelled?], I forget, this morning that was talking about the high risk pools but at the end of the day, it is not an affordable product. So, I think there has got to be some way to bring down the cost of the product before we can really address the access.

PAUL GINSBURG, PHD: Good. Let me move on to the issue of this week, which is Medicare Advantage and on the second panel, we will get into the other side of the issue of physician payments. I would like to start off about private

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fee-for-service plans and ask the panelists;, do they have the potential to bring value to Medicare and its enrollees. Matt?

MATTHEW BORSCH, CFA: Sure. I will take a stab at that. I think the truth is the jury is still out on this. There are a couple of things that can be done even without defined provider networks, some voluntary disease management outreach and some targeted high-cost case management, whether those things at the end of the day, yield demonstrable savings, has yet to be determined.

Humana, one of the largest firms in the private fee-for-service market, would argue that it is yielding value at the same time that company is moving towards the eventuality of private fee-for-service likely going away. It may be that we will not have the full answer to the question until after the product is gone.

PAUL GINSBURG, PHD: Is there a private fee-for-service business left if there is no deeming?

MALE SPEAKER: I would say I mean private fee-for-service, as we know it, no. I mean clearly without deeming, you have to build networks and, I think as most of you know, the problem that you run into is in rural and semi-rural areas where you have a scarcity of providers and plans do not have network leverage to yield unit pricing that is comparable or even close to Medicare.

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I would say though that some of the larger plans were probably better positioned on this front given that they already have commercial relationships and I believe in the legislation that did not get through that was recently proposed. There were exceptions for areas, rural areas, so you would continue to have those types of plans in areas where networks were perhaps the most difficult to develop.

PAUL GINSBURG, PHD: Bob?

ROBERT: Well the problem with private fee-for-service is two levels I think. First of all, private fee-for-service was never intended to be a permanent product. It was intended to be a transitional product. As I think most people in this room know, the '97 Balanced Budget Act really kind of screwed up the private Medicare markets, pushed seniors out of it, pushed insurance companies out of it.

So, in 2003 to get insurance companies and seniors interested in the product again to sort of prime the pump, private fee-for-service was created with some generous subsidies, if you will, so that insurance companies would go into markets where there were not provider networks, have the incentive to build a block of business that could then be later converted to two networks and provide the incentives for seniors who may have been skeptical to come into the programs.

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Once you got a ton of lives in a particular market, you would then go to the next phase, which is to build the network because, I think, anyone who believes that managed care can be more efficient than Medicare would have to believe that it is managed care that will do it not a fee-for-service product. There is no traction.

It starts with the fact that Medicare has an expense ratio of around three-percent. I realize that is controversial in some places because people feel that there are unallocated costs someplace else but for the sake of comparing what Medicare charges itself versus what the insurance company can charge, they are operating at about a three-percent expense ratio. In the private market, you are operating at a ten to 15-percent expense and profit margin.

So on day one, the private insurance company starts out more than ten points in the hole. So, you have got to make up that ten points in being able to manage care. Well, if you have no networks, which is the case for private fee-for-service, how do you make up the ten-point margin? So, it is a non-starter. It was always intended to be a transitional product.

What the Bacchus [misspelled?] Bill does is it says that by 2011, people have to have networks and really, I think, that is a pretty reasonable thing for the Democrats to be expecting. They are not cutting the rates. They are simply

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saying, gee whiz guys, you have been doing this since 2004 now. You get to 2011, seven years later, maybe we can kind of take the training wheels off.

So, I mean that is what the proposal is about and no, private fee-for-service is not sustainable because it was never intended to be a sustainable product.

PAUL GINSBURG, PHD: Yeah, following up and Christine, is there a way that policy changes can actually force changes in private fee-for-service to make it viable long-term?

CHRISTINE ARNOLD: Well I mean I think the key issue here is that according to [inaudible], we are paying 19-percent more per senior that is enrolled in a private fee-for-service plan relative to what we would have paid if they stayed in regular Medicare fee-for-service. So, I think the issue here is, is it fair that we are depleting the Medicare trust fund by overpaying for this small portion of seniors, presumably are getting better benefits and potentially overpaying the managed care companies.

So, I think the question is do we want to support private plans or not and if I were a policy maker, here are the things I would consider. Let us make this a product since we are paying more than for fee-for-service Medicare that is only available to those seniors that need the enhanced benefits and

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then lets regulate to make sure those enhanced benefits happen. So, here is how I would think about it.

This could be a product that would only be offered to low income seniors and right now, CMS does not audit the [inaudible]. So, there is no guarantee that the incremental 19-percent in payments is actually resulting in incremental benefits to seniors. So, I give CMS audit responsibility to ensure that, that 19-percent or some portion of that 19-percent is going to these low-income seniors in the form of enhanced benefits because they are vulnerable seniors who cannot afford many of the co-pays and the deductibles associated with fee-for-service Medicare.

I would require that these plans offer Part D. Right now, these plans do not have to offer drug coverage and by not offering drug coverage, that could be risk skimming the healthiest seniors. What you want is an integrated package so that managed care could truly work. So, require that it be an integrated package and then permit some medical management.

According to the managed care companies, going from an unmanaged product to a managed product can produce up to ten-percent savings. So, if you can harvest that ten-percent savings, you can get some of that 19-percent back without harming patient coverage. So, allow incentives to doctors and hospitals to notify the managed care company when someone has

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been admitted. Coordinated care, pre-cert, prior auth, none of that is happening right now because the doctors and hospitals are not required to tell the health plan that a member is in the hospital. So, how could the health plan manage the care if they do not know that you are getting care?

So, I would implement some managed care provisions and allow pre-cert and prior auth. That is what I would do.

PAUL GINSBURG, PHD: Okay. I would like to turn the discussion to the rest of Medicare Advantage, the coordinate care plans, the HMOs and the PPOs and ask the analysts about how are these plans evolving and maybe one way of crystallizing it is are they going in the same direction that commercial plans are going or are they, because they are different, are they heading out into distinct direction or not heading anywhere? Matt?

MATTHEW BORSCH, CFA: Just quickly on that, the one key difference obviously is that the Medicare Advantage product is at the individual retail level and so in that sense, Medicare Advantage plans do not have the burden that employer-based plans increasingly have and I say increasingly because employers, more and more, are contracting with fewer and fewer carriers and in many cases, a single carrier and so they have to select a plan that has very broad networks that meets the

needs of a geographic and otherwise diverse workforce and that is not the case with Medicare Advantage.

In fact, with the coordinated care plans, you can design something that is much closer to the original concept of the HMO model or even a staff model plan that can work for a segment of the population that you are targeting.

PAUL GINSBURG, PHD: Okay. Josh?

JOSHUA RASKIN, CFA: I would just add that one of the things about sort of the core of the HMO, I think that same medpac report that Christine was alluding to suggested that the HMOs were spending about 95 cents on the dollar to provide the same level of benefits as Medicare. So, clearly there is an opportunity to use private plans to save for the government. So, I think there is long-term viability in Medicare Advantage roughly speaking. I would agree with the previous comments of private fee-for-service is not the answer.

In terms of product design, I think you are seeing actually a migration towards techniques used in the commercial populations. The drug benefit, which is now all of almost three years old, looks a lot like the three-tier co-pays in our structure that we have seen in the commercial population for the last decade or so.

We were just looking at some data that was talking about co-pay differentials and you are even seeing in terms of

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the bids, we have not seen the '09 stuff but the '08s versus the '07s, same exact trends keeping that first tier of generic co-pay very low, no changes there and then increasing the spreads between the second and the third tier.

So, I actually think you are seeing the techniques that were useful in the commercial population being translated to the Medicare population. At the end of the day, they are all designed for cost savings, which sort of helps everyone involved.

PAUL GINSBURG, PHD: I remember a few years ago when Part D was developed a lot was said about the potential for integration of the Medicare Advantage benefits and the Part D benefit. In your sense, was that just a buzzword or are plans actually really taking advantage of the fact that they are providing both drug coverage and medical services?

MALE SPEAKER: I think that the biggest problem is the product design. So if you think about it, if you are a health plan, you have got different sort of reimbursement and lost potentials in Medicare Advantage, sort of the MA product versus a PDP product and sort of that bridge with MADP. So, there are areas where you may, from a total medical cost, it may be more efficient to provide a certain pharmaceutical spending in terms of preventive medicine where, under the MADP plan, that may not be the most economical for the plan.

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So, I think the integration of pharmacy and medical data is certainly a reasonable way to better manage health care costs and improve quality. I am just not sure the product design necessarily facilitates that at this point.

MALE SPEAKER: Paul, again, I think it is important to remember the reason we did this in the first place, that conservatives believe that the way you bring Medicare under control is using the private market to do it. Now, obviously [inaudible] have a different view.

I actually think George Bush had it right in 2000 when he ran for president because when he called for in 2000 and running for president in Medicare was to create a system where private plans would competitively bid and you would set the reimbursement rates based upon competition in the market. When the 2003 Medicare Modernization Act was passed, instead of that, while we had that provision in there, it has been long ago lost in place of the system that is currently being taken advantage of where CMS sets the rates based upon what they think they pay for standard Medicare and that is done county by county.

So, what we have got is a system right now where the way you make money in Medicare, private Medicare, is figuring out which markets you get the best reimbursement in taking advantage of that. That is the biggest reason why we have had

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such incredible growth in private fee-for-service is because you get by far the best reimbursements in private fee-for-service particularly in certain counties.

So, what we have got is a market place chasing a system, trying to figure out how to gain the system instead of a market place trying to figure out how to manage care more effectively. That is a bit of a supplication because in many of the mainstream Medicare Advantage plans, health plans are trying to do a better job of managing care and bringing costs down but not enough of that is going on in the market. That is why private fee-for-service is, by far, the fastest growing part of the system.

As long as we have a policy here in Washington that we send out to the health plans that says go figure out which counties you can make the most money in, we are not going to be chasing the right objective. Which is managing the cost of care much more effectively and efficiently.

PAUL GINSBURG, PHD: Actually, this kind of reminds me of something that I was never taught in economics programs but I think it comes up at these meetings often is that there are easy ways to make money and hard ways to make money and people will not get to the hard ways to make money until they have exhausted the easy ways.

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MALE SPEAKER: That is right and they are making it pretty easy with 17-percent overpayments.

PAUL GINSBURG, PHD: That is right. Christine?

CHRISTINE ARNOLD: One issue that you did not necessarily ask about but that I have been thinking about a little bit is that the PDP program has, as Bob talked about, done really well and been really successful for seniors but I think we have a looming policy challenge, which is that 40-percent of PDP members are in United and Humana and both are struggling with the challenge of the dual eligibles.

So, the risk quarters contracted both companies are, I mean Humana is losing a lot of money on their PDP and United is not doing much better. If you look at the structure of the plan designs both United and Humana cover the majority of the top ten drugs taken by seniors whereas the companies who, I think, are making a lot of money do not have those branded drugs on formulary.

So, the issue with the dual eligibles the maximum you can charge them is a five-dollar co-pay because they are poor and they are old and they do not have the resources. So, the only way to keep that senior from getting that branded drug is to take it off the formulary and say no. The challenge we are going to have is either United and Humana are going to do the right thing for their business, which is to take these drugs

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off the formulary, in which case all these seniors in nursing homes are not going to have access, nightmare to the nursing home or they are not going to do the right thing and we are all going to be pretty irritated for another year but this will only go on for a certain period of time. So, I think it is time to revisit the way we are treating the duals in the PDP program and a little tweaking of that benefit might be in order. I do not know how my friends on the panel feel about that but—

PAUL GINSBURG, PHD: Yes. Actually, let me ask a follow on or maybe a statement. It seems to me that as far as dealing with the issue of risk selection, that PDP program has the very toughest job imaginable because what is to enrollees no more than they are likely spending on drugs for the coming year and the fact that they were enrolled as individuals.

So in a sense, we could have the most sophisticated risk adjustments and market rules about who you have to enroll and we still could have a selection spiral. I do not know if any of the panelists have thoughts on that.

MALE SPEAKER: We may be in the beginning of one. I have always been dubious about PDP in terms of some of the issues in the market and we do seem to be seeing a tightening of margin. I have always believed that isolation could be a big issue with the seniors. It did not show up in the first and second year.

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So, I am clear that it is showing up in the third year but I actually, the first year the seniors were intimidated by Part D and everything about it and now they are not so intimidated any longer. They go into the catalogue, they find the drugs that they need and they find the insurance that gives them the best coverage and they take it.

So, I actually think that the senior market is getting smarter about it and it could be a problem down the road. That is why it is so much better to have the Part D drug benefit integrated into a larger Medicare program rather than sitting out there all by itself. I think that we are going to have to get to the point where it is integrated into a larger Medicare program or we are going to have this sort of cherry picking going on, on behalf of the consumer.

PAUL GINSBURG, PHD: Okay. Let me go to the next question, which is commercial insurance. I want to begin by, for those that do follow the stock market, I am sure you have noticed that insurance stocks have experienced very large price declines year-to-dates and I am sure that these analysts have been interpreting what that means for their clients but I want to raise the question, is there anything in what has happened in the insurance industry and the stock declines and the reasons behind them that are relevant to a policy audience in a sense that as far as the future of the insurance market. Matt?

MATTHEW BORSCH, CFA: Let me take a crack at that. I think that we see the multiple facets to what has negatively impacted in companies this year but two things I would point to you as major causal factors.

First and foremost, we can get into this a little bit in the next question, the health insurance underwriting cycle and I am not sure that, that dynamic has really any particular lessons for policy makers other than to be aware of that in terms of forecasting where health spending is going.

Secondly, though is what is going on in the employer market place and I think that there is clearly a big problem because normally if we just backtrack for a minute, in economic expansions, you normally see an expansion of employer coverage and you certainly saw that in a pretty pronounced way in the late 1990s.

Then of course, as expected, we saw some pretty sharp erosion employer coverage in the sort of mini-recession of 2001 but the economic expansion that we have been through until recently has been contrary to the trends you expect, employer coverage has been eroding during that expansion and now it appears and we see this in some of the pressure felt in managed care companies that the erosion of employer coverage is really in an accelerating phase and the danger here for the industry

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is the political support for the employer-based system may be eroding more rapidly than is commonly assumed.

PAUL GINSBURG, PHD: Okay. Anyone else? Josh?

JOSHUA RASKIN, CFA: Yes. I mean I think it is [inaudible] to Matt's point is that when you see difficult times like this for the health insurance industry and it corresponds with an election year, you start thinking about well if you are McCain, we have got to dismantle the idea of the tax subsidy for employers and change the whole system, etc. My belief is just the markets are self-correcting. If the health plans have been doing something, acting in ways that were not sustainable, that will correct itself.

So, I am not sure there is a ton to pull. I mean the problem is the uninsured has been a big issue and it has been rapidly growing in the last several years. So, I just think it is one of these environments where we are going to talk a lot about it. I am just not sure that this is, I do not think we are necessarily going to get policy action. I am not necessarily sure we even need policy action at this point.

CHRISTINE ARNOLD: The one thing I would point out is that the sector is not in the position of strength from a capital access and balance sheet perspective. Therefore, policy changes that destabilize or dramatically reduce the profitability of the industry creates a real risk that we see

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reverberation, i.e., liquidity issues. These companies levered up to buy stock at higher prices and they are not hugely levered but they are more levered than I have seen them in two decades and they are getting to the point where they are saying look, we cannot borrow anymore. We are at risk of losing our debt rating.

So, steps to reduce profitability in multiple business lines all the same time could really to stabilize these companies and if some of these companies have issues go away, the repercussions to doctors and hospitals are not instant [misspelled?].

MALE SPEAKER: I do not think you can ignore, from a policy perspective, what is going on. For those of you who do not follow the stock market on a daily basis, as of July 1, the S&P 500 Index was down 19-percent. Universal American, one of the largest disproportionate players in the Medicare Advantage and Part D business was down 62-percent, United Health down 57-percent; Humana, down 55-percent. This is over their 12-month highs. So, Humana down 55-percent over its 12-month high. Coventry down 53-percent; WellPoint down 48-percent. Cigna stock price down 38-percent and Aetna down only 34-percent.

When the day is done, the value of a company is a function of what the market place believes its value is to deliver its product in the market place. If the company is

doing a good job of delivering the value of its product, its stock price will reflect that. If a company is doing a poor job of delivering the value that the customer expects it to have. It will have a high price.

What business are these people in? They are in the business of delivering cost effective and quality health care. What does the market place do about the value of the product they are delivering today? It is interesting when you look back at Medicare Advantage and Part D, two-thirds of these companies have lower stock prices than the day they went into the Medicare Advantage business. Every one of them has a lower stock price than the day they launched the Part D business.

Shareholders, interestingly, have not benefited whatsoever from the privatization of Medicare and you can say well but they are going through an earnings cycle and I guess they are going to talk about the earnings cycle in a few minutes. Well that is part of the business and what you have is a lack of confidence in the part of investors that these people can deliver value. There is a policy implication to that.

PAUL GINSBURG, PHD: Matt.

MATTHEW BORSCH, CFA: Just quickly because I know we are going to get into the topic of secular trend in the industry that, Bob, I actually disagree with your viewpoint there because I think what the market is reacting to really reflects

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the financial cyclical trend in the industry, which I do not pretend to completely understand nor do I think the market completely understands it but what the market is reacting to is very specifically the prospect that the earnings of these companies are declining not growing where we went through a period where earnings growth was astounding in this industry, 30-percent or more a year for the years between 2000 and 2005 and the market has always been pretty short-sided about that type of thing but the market is looking at declining earnings now and the market is worried about the Medicare side, which in some ways, is still working but there are some problems where there are storm clouds on the horizon in terms of reimbursement.

PAUL GINSBURG, PHD: Do you have a buy rating in any of these?

MATTHEW BORSCH, CFA: Well, let us go through them. I can [inaudible].

PAUL GINSBURG, PHD: I do not think we are going to get into that but let me actually ask the next question is, do you think that these hard times for insurers will result in new business models arising or even entering into the industry by someone who is doing it a different way.

I guess if we think about the last downturn, which was just about ten years ago, that was sort of the tail end of sort

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of the HMO era and where sort of the middle of the PPO era. So, it was more of a product design change, etc. but at the end of the day, these companies are still in the business of delivering health insurance to employer groups and individuals and government entities in any way, shape, or form.

So, unless there is a large change from a regulatory standpoint about how the design of the tax code is around health benefits. I cannot imagine that these companies are going to reorganize, decide to get out of commercial group insurance and go just individually. I cannot imagine you would see anything like that.

PAUL GINSBURG, PHD: Christine?

CHRISTINE ARNOLD: I think there is real evidence that the consolidation of the industry has actually been value destructive. That has been the card this industry has been playing for the last couple of years, right. So, United and Humana [inaudible] a whole bunch of companies. I do not know what their cost plans are. I do not know what to price. I cannot process a claim, yadda-yadda-yadda. It is in the papers.

So, that and consumer directed health care have been the thing we have been talking about for what, the last five years and nothing positive has come from those trends and I think we have actually reached the trend of diminishing marginal returns on both of them.

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I think we shifted so much cost to the consumer that they are delaying deferring and now we are seeing a spike in catastrophic care because people are train wrecking. That is consumer directed health care.

We have talked about the issues with consolidations. So, I think the market place is really ripe for a disruptive health plan. So, think about what is happening in the market place. The hospitals are only collecting 50-percent of co-pays and deductibles, half, that is it. So, no wonder the hospitals are raising price to managed care companies, which is spiking the medical trend because they are not collecting co-pays and deductibles. Well, what if a new [inaudible] were to come in and say here is your benefit card and you have to have personal credit to cover your out-of-pocket maximum and it is linked to this?

Now, Aetna and Cigna are trying to have a card and link it to Visa but Visa and Amex were like oh no. We do not want to take any of the medical risks because you could file for Chapter 11, bankruptcy, da-da-da as an individual and all that gets wiped out and they did not want the risk. So, you have to put it on the consumer. That is one example of kind of a disruptive health plan.

Employers are really irritated with the whole disease management thing. So, if you talk to Mercer Powers, Hewitt, all

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those guys, they will say look, people get sick. They die or get better. It is aversion to the mean. How do we know disease management is actually producing anything positive? What they really want is an at-risk health plan.

So, some new health plan that takes risks and says I am limited in what I can do with Arissa with my beneficiary right? So, if I say you have got to get your body mass index to X, okay. So, we ask you to participate in a program but if it does not work and you do not do the things you are supposed to, there is no penalty under Arissa.

So, we need, according to employers, is kind of a health plan on steroids with respect to how they treat doctors in hospitals. So, let us pay the docs and the doctor groups double if they actually produce positive results in terms of health and let us pay them half if they do not and let us take the people, once they have been diagnosed, out of the mainstream health plans, which employers believe are not doing anything very interesting for people. About 80-percent of costs driven by 20-percent of people who are sick, let us pull them into a separate health plan.

These are things that employers want and from my perspective, from a policy perspective, the industry needs a little bit of adult supervision here. They need to be forced to share data so that we can actually identify who the best

doctors and hospitals are because if Aetna is saying this is a great doctor and United is saying it is not then we erode consumer confidence that we do not have any idea who a good doctor is. So, I think the time is ripe and I am hopeful that we will see some movement.

PAUL GINSBURG, PHD: Yes. Okay. Let me get into the core of the cost trends, premium trends, underwriting cycle and basically ask is there change in the cost trends and what is your spin on the underwriting cycle? Josh you have not had a chance to start yet.

JOSHUA RASKIN, CFA: Sure. Thank you. So yes, I mean just looking at the cost trend, it has been a real sort of interesting year observing the public traded companies because there really has not been, maybe Conventry, there really has not been anyone that has come out and said there has been this massive uptake in the commercial medical cost trend. Everyone thinks it is, I do not know whether it is seven and a half or eight-percent, somewhere in that range, and the data behind it if you look at hospital admissions or certainly pharmacy data, and some of the other Medicare data that you can pull, it is just not visible that increase in cost trend.

So, if you think about what we are seeing this year versus what the companies are sort of reporting from earnings, there is a little bit of a disconnect there but I think until

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we see evidence in the market, I think it is hard to say that there is a definitive uptrend in medical costs here.

PAUL GINSBURG, PHD: Yes, Matt?

MATTHEW BORSCH, CFA: Well, I would generally agree with Josh. I guess I would just interject one point here on the cost side, which is on the one hand, you can look at pharma scripts and hospital volumes and it is definitely true that the volumes are certainly do not appear to be rising and accelerating right in the number of areas. They look more sluggish if anything but what may be impacting the managed care companies to some degree on the margin and perhaps more so this year is there is this sort of form of adverse selection when you think about how much the consumer and small employer is squeezed in this environment.

One theory is that those who, and this has clearly been going on to some extent for a while, those who need coverage are very tenacious and holding on to it and obtaining it and the healthier younger people in this economic environment, perhaps, are more likely to decline even heavily subsidized employer-based coverage.

You have got the fact that more people are disrupted from their jobs and higher take-up of COBRA and COBRA is sort of the ultimate form of adverse selection if you will and even some anecdotal information in the industry that there has been

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some adverse selection towards the lower benefit products and in the middle market employer groups, a shift to employer self-insuring, which tend to be the healthier groups on the margin.

So, you have got this segmentation of the community risk pool. What used to once be a community risk pool has increasingly becoming one where risk is concentrated and I think that is impacting trend as experienced by some of the managed care companies.

CHRISTINE ARNOLD: I am seeing evidence of medical trend uptake and it became more definitive for me after first quarter. I also cover the hospital sector and we do a survey every quarter of hospitals and over 50-percent of hospitals said that they were getting commercial pricing increases that were accelerating in excess of 200 basis points entering 2008. The problem that we have is that hospitals got price increases and that the pricing power of the hospitals has somehow increased.

Now, we got the same survey result of the hospitals asking the question different ways in January versus May and what baffles me, what I do not understand is that hospital pricing was negotiated. So, the managed care company and the hospital were at the table kind of like we are and how the managed care company could leave the table not realizing he had

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just negotiated a price increase is one of those great mysteries.

PAUL GINSBURG, PHD: What makes you think they are not aware that they maybe had no choice but to agree to a price increase?

CHRISTINE ARNOLD: But you call them now and they say there has been no price increase. So, then you look at the price per adjusted admit at the hospitals and you are like wow. There was a flu first quarter, which is low acuity, which should bring down price per adjusted admit yet it was through the roof and the survey results twice asking the question different ways of different hospital CEOs and CFOs suggest the same thing.

So, another data source that I use is talking to the reinsurers and I am seeing, with the reinsurers, a spike in catastrophic claims. I do not know whether it is a train wreck, i.e. you had a $5,000 deductible. You delayed and deferred so instead of getting diagnosed stage I, you were diagnosed stage IV of whatever disease state. That is a possibility. It could be the adverse selection that Matt is talking about. People who are insured are just generally sicker. It could be the fact that the hospitals are getting price increases so we are bumping more claims into that catastrophic coverage area. So for example, coverage we said a 50 to 150 category of

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catastrophic claims, which is your first [inaudible], which could be just a bump up of a hospital pricing.

So, the reinsurers are saying they are seeing an increase in obesity-related claims, which is producing single birth NICUs as the borderline diabetic mom. It is full blown gestational diabetic and also an increase in dialysis-related claims, also they attributed to some obesity issues.

With the whole Christopher Reeve thing, out-of-pocket maximums have increased. It used to be a million dollar lifetime max. Now, we are seeing two to five million lifetime maxes, which is increase in catastrophic claims as well. So, I think medical trend is accelerating and those are the reasons I think it is.

PAUL GINSBURG, PHD: On the medical trend situation, I would agree with you that we are starting to see an uptake in medical trend. One of the interesting things out there, we talk about stock prices and we can talk about insurance company pricing behavior but one of the observations that I am making is that we are in fact seeing a lot more big claims and we are in fact seeing people sicker and there is no answer for why that is going on. You have got some pretty good theories about it that I think are intriguing.

CHRISTINE ARNOLD: But I made them up.

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PAUL GINSBURG, PHD: Well I know you did but they were good. They are pretty good and—

CHRISTINE ARNOLD: I should not have admitted that, yes.

MALE SPEAKER: Yes. The point is what troubles me a bit is there is no answer for what is going on out there. There is no really good explanation for what is going on out there but we are seeing a sicker American people particularly at the top and particularly when it comes to these big claims.

Now that aside, trend is ticking up a slight amount. One of the big questions people ask out there is, is there an underwriting cycle? No, there is not an underwriting cycle. The last time we had an underwriting cycle in this business was probably in the late 1980s. What we are having is a medical care trend cycle where we go through periods where the payers and the providers are sort of in and out of equilibrium.

In 1999, we got costs down to like zero-percent trend and we got the patient rights rebellion, probably should have called it the provider rates rebellion. We got push back. The lid came off. Costs went from 1999, zero-percent trend to 2003, 13-percent trend. We reached a kind of equilibrium between the doctors, the hospitals, and the insurance companies starting in 2003 and trend began to decelerate and it decelerated to a low of about seven-percent in 2007.

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That trend deceleration had bottomed and with the trend deceleration, it was really easy to make money in this business as trend is coming down. When it bottom in 2007, it could only go one place. It was either kind of going to bounce around there or start going up and what we have seen now are indications that it may be ticking up a little bit.

Two things tend to drive medical cost trend in the insurance business. One is higher inflation and the other is cost shifting from doctors and hospitals to insurance companies when the government, Medicare, and Medicaid underpays.

Looking through the rearview mirror the last few years, we have not had inflation and we have not had cost shifting because really Medicare and Medicaid have been paying about as well as they have ever paid. Whatever the providers tell you out there, Medicare and Medicaid have been about as good as it has been. Alright, now going forward, obviously we are going to start seeing some significant inflation. Going forward, I do not have to tell anybody in this room doctors and hospital and others are under a lot of pressure for cost cutting by Medicare and Medicaid and we are going to start to see that trend really increase.

So, this industry had, from 2003 until now, one heck of a nice tail wind but now the industry is starting to face a real head wind and it is going to be a very, very difficult

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period for the next three or four years as providers now need to get money and they are going to get it from the payers and the payers are always a little bit behind in getting those things priced through and that is going to hurt the margins.

That is at a time when Medicare, private Medicare sales, have slowed down. The low hanging fruit is gone and what they are being reimbursed for those things are tightening up. So, we have the trend windfall and we had this wonderful private Medicare market thing the last five years. Those two things start to be negatives going forward and you have got a head wind.

PAUL GINSBURG, PHD: Matt?

MATTHEW BORSCH, CFA: I just want to comment on the pricing side and I do agree with the points that Bob has made in the cost trend side is definitely an important factor in impacting the earnings and fundamentals for the health insurance but the pricing side is important too and I do think there is still an underwriting cycle, if you want to call it that, in this industry and so be cognizant of the fact that in the early years of this decade coming off of the last downturn in the industry, you had a situation where most health insurance plans were pretty squeezed. Their capital levels were depleted from the last downturn. Their profitability was severely depressed or negative in many cases and the end result

of that is the pricing discipline, as it is called in the industry, was very hard coming into the early years in this decade.

In fact, what you saw was the health insurance industry had an accelerating cost trend but was actually pricing above that accelerating cost trend and expanding margins again in the early years of this decade into about 2003 when the not-for-profit plans got to a point where they had a little bit of a problem of an embarrassment of riches relative to their not-for-profit status and things started to turn and now you have a market where at least until recently, pricing has been very aggressive in margins and then coming down.

PAUL GINSBURG, PHD: Thanks. Next question is about benefit design. Have any of you have data on whether buy-downs, benefit buy-downs are slowing, which I think last year Christine reported and is there any movement towards some of the more innovative benefit designs such as value-based benefits or is that something that is more in talk of conferences rather than reality?

CHRISTINE ARNOLD: As data suggests, we do a broker survey every year, that for the first time in three years, benefit design changes are decelerating. So, we are seeing 50 basis points less in cost shifting to the consumer.

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Therefore, if the trend remains stable and say you have ten-percent trend both years and last year you shifted five-percent to the consumer and this year you are shifting only four and a half-percent, the trend realized by managed care company would rise, right? So, that is a headwind. I agree with Matt that we also have a pricing problem because the broker survey suggests that pricing before buy-downs is decelerating by 100 basis points.

So, I think we have an acceleration in medical trend for the reasons we talked about earlier. We have got pricing coming down because the industry hoped or expected or whatever the trend would come down and it did not. So, pricing is coming down before benefit changes and we maxed out benefit design changes according to both brokers offering to small employers and large employers. So, the only place we can continue to shift costs to the consumer but we have not is unionized accounts where there is obvious impediments.

PAUL GINSBURG, PHD: Good.

MALE SPEAKER: I guess my only question is just what is the economic impact there, right. If you are a large employer group and you are in summer or fall of 2007, things seem to be okay still at that point. So, we do a mid-year survey as well. The data we show that we saw as well was that '08 was a lower level of buy-down versus 2007. As we are looking at 2009 and we

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are getting into the sort of renewal cycle, as large corporations across America are struggling, we may feel like we have saturated that point of no return in terms of how much the employer can take but when the employee can take but when the employer is struggling, I think it will be interesting to see, I would not rule out the idea that we see further, additional buy-downs in '09 versus what we are seeing in '08.

PAUL GINSBURG, PHD: How would you say this is linked to the developments in the economy over the next year?

MALE SPEAKER: Unfortunately, you have got to make health care decisions way in advance of what happens in the economy. I mean if you are a large, large employer in the United States, you are deciding on your benefits for 2009 today. So, you are making a guess as to what is going to be happening in the end of 2009 and the summer of 2008.

So, if we were to see an economic recovery that was somehow quick and rapid in 2009, I do not think that would be indicated in the decisions made by benefit managers. I think that is probably not reflected until 2010.

PAUL GINSBURG, PHD: Good. Next thing I want to get into is health promotion and wellness and certainly HSC has been publishing that how this sharp increase in interest by employers and programs to promote wellness, etc. I wanted to ask the panel, is this just a fad that is going to pass or is

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this something real and do they have powerful tools that are just a matter of deciding to use them?

MALE SPEAKER: Yes. I mean I will jump in there. We cover a couple of disease management companies in our coverage universe. What is interesting is we do a little bit of work on this. It looks as though the application for new wellness programs is actually slowed and I think it has been a recent phenomenon, I think the last three months or so. I am not sure exactly what is doing it. The economy certainly could have something.

I think the idea of implementing a new additional cost for an employer group even if it is preventive and it has got a good ROI, etc., it is still an impediment in the short-term just the economy but it is interesting. You have CMS, there is Medicare health support pilot programs that they rolled out, which were just failure after failure after failure there and CMS basically just put their foot down and said we are not going to throw good money after bad.

So, I think there was a little bit of a tarnishing from a reputational standpoint and I do not know how many decades it has been but that wrestling between am I really getting a return on my investment? It is very hard to measure and it is very difficult to determine whether or not there has been success in that. So, it could just be temporary, again

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economically drive or something like that but we have actually seen a slowdown in interest in the wellness programs.

CHRISTINE ARNOLD: I agree that the disease management thing is slowing down and when you talk to employers and you talk to employer groups, the new, new, new, new thing is the kind of the medical home. So, it is the concept that this disease management company over here that is doing cardiovascular and this one over here is doing diabetes, well hello, she is diabetic and has a cardiovascular problem. So, there is a cause-effect thing.

The whole fragmented disease management thing does not work and none of us want to get a call from our health plan telling us how to make ourselves feel better because like that is something you can really trust right?

So, the sense is that I think the managed care companies risk losing the function of managing care in which I do not know what we are going to call them but we will talk about that next year.

The doctors are the place where we think that care should be managed. So, I think we need to overhaul the doctor's office and these medical homes are all about changing the profile of the doctor's office. Instead of Matilda running around the front desk while you wait for half an hour with a paper files that you can sit there for ten minutes and have the

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doctor look in your mouth and ears and eyes and take your blood pressure as if you just swallowed a golf ball, I mean those days are probably over.

So, I think what we are going to have is new specialists in the doctor's office who can really help to coordinate care and medical home is all about that. We got rid of the big group practices with multi-specialties when the physician practice management model fell apart but now I think we are trying to implement more coordinated care at the point of the physician and there is probably a place for a whole new specialty in the medical field, take it out of the disease management companies, the fragmented disease management companies, take it out of the managed care companies and put it in the purview [misspelled?] of the doctor. I mean there are some doctor practices that do really well at this and there are many that do not.

PAUL GINSBURG, PHD: Are insurers in a position to somehow get this to happen?

CHRISTINE ARNOLD: Well I mean I think that is why we need this adult supervision from the policy makers that we have been talking about right. I mean someone has to come in and figure out, okay, what are the best practices? What should we be doing for the person that has diabetes and cardiovascular da-da-da-da, non-compliant and he or she is gaining weight and

smoking and da-da-da-da, fine. How do we treat this person? What is the protocol and then which doctor groups and hospital groups do best at implementing that and then steer them?

So, the health plan on steroids, we are paying the group double for doing the right thing and half for screwing up and all their people winding up in the hospital, that is an opportunity for a managed care company to do something interesting but I talked to the managed care companies and they are like oh Christine, you want us to recontract with all of our hospitals and doctors? Yes, yes I want you to recontract with your doctors and hospitals or someone else is going to do it.

So, in the absence of managed care companies doing this and I have been talking to venture capital firms and private equity firms about hey here is an opportunity, the big companies just, their heads are not there. They are not there.

PAUL GINSBURG, PHD: Yes. Actually the reason I asked that is some interviewing we were doing about high performance networks and when we would talk to medical groups, they would tell us about this fragmented system that Aetna says I am great and Cigna says I am not—

CHRISTINE ARNOLD: That is absurd.

PAUL GINSBURG, PHD: —And in a—

CHRISTINE ARNOLD: You are either great or you are not.

PAUL GINSBURG, PHD: —So, in a sense, it almost means that except in some states where there is a very dominant Blue Cross/Blue Shield plan, it kind of looks to Medicare as best positions if an insurer is going to do anything to do this but then Medicare plods along. It is going to do demonstrations for a few years and—

CHRISTINE ARNOLD: Study it—

PAUL GINSBURG, PHD: Study it, yes.

MALE SPEAKER: Well, I think the policy implication here is that as the managed care industry and physicians and disease management companies take a step forward in trying to manage the cost of care and improve quality, the American people have been taking two steps back.

You have seen any number of studies recently about how the health of Americans is declining. The most recent one was the Harvard University Washington study that found that 20-percent of women seen now a decline in their life expectancy and obesity, diabetes, and smoking is right at the top of it. You have heard that the youngest generation risks being the first generation whose health is going to be worse than the prior generation.

So, the fundamental problem here is you can take a step forward in the market or government or anywhere else in terms

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of quality care and the American people take two steps back on you and health declines.

I think to your point, I was at a Blue Cross conference composed of sales managers a few weeks ago, three weeks ago, and one of the questions I kept asking was about this insurance underwriting cycle and if, in fact, we are seeing underpricing and the answer was no. I mean the pricing environment has been the same. It has been pretty static. You have always got somebody undercutting you and underbidding you and but people are not behaving any differently from a competitive standpoint than they ever have before but what they were complaining about is the Blue Cross sales executive would say to you but you know what is really different about it now is I have got, one guy said I have got like 20 alligators picking at me constantly. Where we have the whole package before, now I have got a disease management company trying to take the disease management piece away. I have got a PBM trying to take the PBM piece away.

So, what is happening out there is that we are getting more fragmentation in the market. To your point and rather than having one organization kind of controlling the whole thing, we are getting a lot of different organizations, a lot of different specialists and when you get the specialists pulling the pieces away, whether it is wellness, PBM, disease

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management, whatever it is, you lose the integration and when you lose the integration, you lose the ability to deal with these things.

So, we are probably going a little bit backward but the American people are peddling backward faster than anybody.

CHRISTINE ARNOLD: Yes but part of that is an Arissa problem. I mean it is a discrimination if you charge the person more for premiums if they, you know what I mean? So—

MALE SPEAKER: Sure, yes.

CHRISTINE ARNOLD: Your hands are tied from a benefit perspective. What you should be doing is non-compliant people should have benefits taken away. You cannot do it. So, policy implication, change Arissa.

MALE SPEAKER: The policy implication is that we have got to hit this obesity epidemic, etc., head on and stop ignoring this huge elephant in the room. It is creating more problems for us than anything we are doing in the market place.

CHRISTINE ARNOLD: No cars outside kids [misspelled?].

MALE SPEAKER: Yes. [Laughter]

PAUL GINSBURG, PHD: Josh or Matt, do you have any comments on this? Okay. We have got about five more minutes of questions so it would be a good time for those that have questions to ask from the audience that want to do it by card rather than by microphone. So, write them out and ask them to,

guess if everyone passed them to the center aisle, it would be easier for the staff to pick up.

I have got a few possibilities. One is I want to ask about consumer-driven health care. What is happening in that sphere? What are its prospects? Is that evolving into something that is going to be with us for the future? Is it tiring? Josh?

JOSHUA RASKIN, CFA: Yes. I mean I guess, I do not know, I think about the search for the Holy Grail every couple of, every decade or so is when we hit a tough economic period, recessionary period and that corresponds with an inflating health premium period. So, I think of these as sort of those intolerable periods of history where the employer groups are seeing declines in their revenues and net income and yet, they are being asked to pay an accelerating amount for their health care benefits. So, we think of whether it was the HMOs first or what have you, we need something new. So, I think that was what the idea that really generated this idea that hey, let us get something new, consumer health plans.

The uptake has been, I think, steady but relatively slow still. We are still at maybe three to four-percent market share in the United States. I think it is an attractive product ultimately because in either funding arrangement, you are still saving money. You are still paying less. I do not think the health plans necessarily have a huge incentive to promote these

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from a financial standpoint other than the ability to retain their membership or attract new members to plans.

So, it has been a little bit slower. I think there are certainly some benefits to it. I love the idea of more transparency into quality and even into cost. I think that is useful as well but I think it is going to continue to sort of chug along a little bit slower than expected.

PAUL GINSBURG, PHD: Matt?

MATTHEW BORSCH, CFA: Just I would say that we went out and met with a number of large national employers late last year and I was a bit surprised just how skeptical universally those employers were about the consumer-driven health plan products, I guess with one exception but at the other end of the scale in the individual and small employer market, you see these products and whether it is a consumer-directed health plan or not, they are really high deductible, lower benefit products. They are just being adopted out of desperation as the only alternative to having no coverage at all.

CHRISTINE ARNOLD: We have seen a stalling out of the products in the small and individual market, which means it is not expanding the health insurance market where we are seeing the growth as in large group, which means it is just, it is eroding benefits for people who already have coverage and exacerbating the collection problem that the hospitals are

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having, which is resulting in the hospitals raising pricing because now they cannot, so it is raising costs overall ironically but this vehicle that we are supposed to reduce the number of uninsured and lower costs is ironically raising hospital pricing and raising costs for everyone and not reducing the number of uninsured, which is interesting.

PAUL GINSBURG, PHD: Good. I would like to just ask before we begin questions whether any of the panelists have something they would like to add, question I did not ask or some final thought about a discussion. It does not look like it, okay. Now, I invite questions from the audience and actually let me start, when people are coming up with this one with health care reform looming, that is what I asked, let me not do that one. [Laughter] That was our first question. Maybe someone came in late. Okay. This is for Christine. Why are hospitals only collecting 50-percent of co-pays and deductibles? Are people not able to pay? Are hospitals not aggressively going after them? Is it a structural change in benefits? Higher co-pays and deductibles and do you see a similar situation for Medicare patients?

CHRISTINE ARNOLD: Okay. So, for Medicare patients, there are provisions in the hospital panelists next panel will probably could give you some information on this too but for Medicare, there are provisions where you can go back to

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Medicare and get patient cost sharing if you have not been able to collect it. So, it is less of an issue for the Medicare population.

In terms of collections for doctors and hospitals, the average co-pays and deductibles are in the $1,500 to $2,00 range for the individual and small group market and people just do not have $1,500 to $2,000 lying around. The out-of-pocket maxes can go up to $5,000. So, you go to a hospital. The hospital is in network. The doctor is in network. The anesthesiologist was not. What are you going to do, undergo surgery while awake? No [laughter], right?

So, you wind up with these hidden, I mean I actually went through this. you wind up with these hidden costs and now you are out of network so now it is more than the $2,000, which was your co-pay or deductible because now you are in the out of network territory and there is a whole new out-of-pocket max, which can go to five or $10,000. So, two years ago, community was saying that they were collecting 70-percent of co-pays and deductibles as were most of the other publicly traded hospitals. Now, they are saying they are collecting 50--percent and it is simply a function of co-pays and deductibles rising faster than incomes.

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PAUL GINSBURG, PHD: Good. Here is another question because no one wants to use the microphone but there we got someone. Sir? Could you identify yourself?

HARVEY FERNBACK: Yes. I am Harvey Fernback [misspelled?]. I am with Physicians for National Health Program. We believe in single payer national health HR600 [inaudible]. Obviously, we believe in the [inaudible] approach to health insurance and replacing with government-financed care. I was pleasant to, but my question is I was pleasantly surprised to see a quote from Wilbur Ross who is an industrialist out of New York who came out for single payer and the question is why are employers not seeing the benefits of going for single payer, which would level the playing field between GM and Toyota in America. If you have a laying off, a part time worker, I mean employees would come to their employer with health insurance right there. What is the reluctance to do that very obvious thing?

PAUL GINSBURG, PHD: Okay. Sure.

MALE SPEAKER: The best answer I can give you a two-part answer. The first part is the reason most employers are in favor of single payer is the people who run these companies are Republicans and they do not think that way but what is really, but I think your question opens up a really interesting avenue here and that is there is this debate going on again. McCain,

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Obama, it is in the Wyden-Bennett Bill about moving away from the employer-based system to a market-based system.

So, I think an even better question is why are employers not embracing this notion of moving away from the employer-based system that Wyden-Bennett and McCain this opportunity that they are giving them for the reasons you just asked.

What I have been really surprised at, over the last couple of months, is the way the employer community continues to really want to embrace employer-based health insurance and I say that as being surprised by it. Employers continue to believe that it is really important to compete in the work place as part of the wage and benefits package even though health care in trends, that ten-percent and wages trend at three-percent but in talking to advocates for Wyden-Bennett, for example, they continue to get a lot of opposition on the, or at least nothing much more in the lukewarm response from the employer community and it is surprising but it is there.

CHRISTINE ARNOLD: Well a couple observations, one, no one looks at Medicare and says what a progressive, I mean what a progressive program that is doing great disease management, really coordinating care and we just got drug benefit, what two year ago?

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So, I think part of it is that people look at Medicare and if we are not able to say this is something we all want to be in then how can we embrace it as something that everyone should have, number one, and number two, these are business men. So, they do not want the government making cars. They do not want the government doing their business. So, I think they have kind of aligned with the business people that are walking in that are running the hospitals and used to be in the physician practice management business and they are running the managed care companies.

PAUL GINSBURG, PHD: Yes. Well, do I not go to the next question. Amy?

AMY TAYLOR: Yes. I am Amy Taylor, HRQ. This is a question for Christine Arnold. You said that it would be good if the insurers kept better records so we really knew who the good doctors were, something—

CHRISTINE ARNOLD: I am not sure they should keep better records. I think they should share the data.

AMY TAYLOR: Okay. They should share the data.

CHRISTINE ARNOLD: So, there is a huge battle because you have got WellPoint, United, and some of the other big ones.

AMY TAYLOR: See but here is a question and it is from my experience and those of my friends. There are not really that many good doctors out there and particularly [laughter]

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okay, particularly among internists, primary care doctors, gynecologists, either they do not take insurance or their practice is full. How do you handle this in the, the not taking insurance obviously, if people pay doctors who say talk to you more that might—

CHRISTINE ARNOLD: See, that is what my health plan on steroids is supposed to do. It is supposed to pay those doctors double like really stretch the limits of what you are going to pay the best and the worst. So guess what, his practice might not be quite so full if he is going to get paid double, right, for—

AMY TAYLOR: Who is going to pay the double, the insurance company or the patient?

CHRISTINE ARNOLD: There is 40-percent cost savings, right place, right time to be had. So, there is a lot of room here to stretch the limits and care-focused purchasing, which is an effort, I was involved in at Mercer, as it stonewalled [misspelled?] a little bit because we are having a hard time getting really good data in and the health plans will not share the data. So, that is the first impediment but once you get beyond that, you can profile the doctors and hospitals.

The goal is to cut out the bottom ten or 20-percent and what you are going to do is you are going to start some, move the worst to better and then and so you are also going to

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improve physician practices and the whole medical home concept is about NCQA and some of these other organizations having specific criteria that you need in order to improve your practice. So, it is about initially carrots and sticks, double and half the pay, which will improve the availability of physicians at the high end and also will move the ones at the low end to the high end.

AMY TAYLOR: Okay. So, you are talking really long-term, as soon as you [misspelled?] do this from—

CHRISTINE ARNOLD: This cannot happen overnight. I mean we need the data to really determine, we need to agree on what the best practices are first of all. That needs to be done by medical societies and we have got that. We have already got the medical societies that came together on the medical home. We have got NCQA with the criteria. So, we have started there.

Now, we need to identify which doctors and hospitals are doing it and which ones are not and that is where we cannot have everyone hording their data because if you have got someone who does pretty complex cases or is say operating on cancer patients, he may do what, five operations a week. Someone with 20-percent market share only sees one of them.

AMY TAYLOR: So no, you need risk adjustment for anything.

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CHRISTINE ARNOLD: Yes, risk adjustment and you need, yes and you need pooling of the data. I think the government policy role initially is to force the pooling of the data and start by opening the Medicare database.

AMY TAYLOR: Thank you.

PAUL GINSBURG, PHD: There is a question here about special needs plans, which we did not get into when we were talking about Medicare Advantage. Do you see them playing an increasing role in coming years and for those and the special needs plans are the coordinated care plans that are focusing on particularly high-risk populations.

MALE SPEAKER: Yes. I mean I would just jump in and say two things on that point. The company that has really led the way with the special needs and special interest plans has been United Health. They have got literally ten times as many as the next plan or maybe eight times as many as the next closest plan in terms of total membership and for them; it has been a very difficult population this year. They are seeing all sorts of adverse selection issues. So, the plans that have done well with some special needs plans in terms of costs, etc. are ones that are rolling out, I mean special needs plans that are not really special needs almost, I mean they are just general Medicare HMO plans where they are getting higher reimbursement and you have actually seen some congressional efforts already

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to focus on that Medicare and the new regs. They suggested that I think you needed to have a minimum of 90-percent of your snip [misspelled?] membership actually being special needs—

So, I think it is an interesting concept, I think with risk adjustment that, that can work out but the plans that seem to be doing it right like a United really targeting the sickest patients are getting hurt economically so you are going to see a reduction in their membership next year whereas those that are sort of looking for a special need being, yes, elderly I mean or something crazy like that. It just seems like that is where they are making money. That is going to slow down. CMS is already on top of that I think.

PAUL GINSBURG, PHD: Matt? Okay. Let me see, to what extent, you see international trends in the use of evidence-based medicine in influencing clinical practice, pricing, and payments for health care in the United States?

CHRISTINE ARNOLD: I do not get out much so I do not know. [Laughter]

PAUL GINSBURG, PHD: Okay. Maybe we are not going to answer it. Here is, duals and PDPs. Do you have any sense of how CMS' risk adjustors for low-income subsidy enrollees in Part D are working? It seems curious that some insurers seem to argue that they are losing money on, I guess that is duals and enrollees, and might even be bidding strategically to unload

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these enrollees while other insurers seem to be glad to have 75-percent of their PDP enrollments in, and I guess dual enrollees. Bob, did you want to answer that?

ROBERT BERENSON, MD: I just have the same observation. I do not really have an answer. On my blog earlier this year, I have posted on this that the two biggest players in PDP, Humana and United were unloading and the smaller guys with less data were uploading. So, I think it probably says something. It probably has to do with market sophistication not anything else.

CHRISTINE ARNOLD: I think it is formularies. So, if you look at the top kind of ten drugs taken by seniors, you have got United and Humana saying yes to those drugs and the most they can charge a dual for it is five bucks and you have companies like Well Care Health Net and Coventry who seem to be doing okay saying no, it is not covered. You want the drug? No.

So, I think it is a function of formulary management and I think the policy issue that we are going to run into is either the big companies, United and Humana with all these duals and 40--percent of the PDP members are going to do what they need to do for their business, which is cut the formularies and create a potential issue with these nursing homes with these frail, elderly seniors or they are not and we are going to continue to have this issue of them losing money.

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So, for example, Celebrex, Lipitor, Prevacid, Toporol, and Zelatan [misspelled?], I am pronouncing [inaudible] wrong. I am not a pharmaceutical person, Zolatan, none of those are covered by WellCare and they are all covered by Humana and United. So duh, of course United and Humana have a problem.

MALE SPEAKER: But I think that data is really good Christine because what it does point to a policy issue and that is you cannot control drug costs if you cannot control formulary and one of the problems on the Hill, and the Democrats, early last year, tried to pass a bill that would allow Medicare to negotiate drug prices but they gutted it. It never passed but it was gutted if it would have been passed because you could not play with the formulary. You had to get offered everything.

So, the short answer to all of this is if you want to control drug costs, as they do in Europe, you have got to be able to limit what is on the formulary.

CHRISTINE ARNOLD: Right and I think the risk, maybe we think about a risk adjustor just for the duals because the risk adjustor had reimbursed companies for 80-percent of costs above expectation once they got two and a half-percent beyond what they bid. This year, the risk adjustor went to, you only get half coverage once you have gone five-percent and five-percent is your margin.

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So, part of the problem is that you saw stratification of the formularies, which stratified the sick seniors at a time when the training wheels were coming off the risk quarters.

PAUL GINSBURG, PHD: Good. I think we have time for just one more question. Sir?

BOB ROSENBLATT: Bob Rosenblatt, freelance writer. Christine mentioned there is a real problem of noncompliance by patients with what they should be doing and Bob talked about American people peddling rapidly towards obesity. How far are you prepared to go to be tough with patients? For example, should insurance companies say you are obese? I am giving you a free gym membership and I am giving you consultation with a nutritionist. A year from now, if you have not lost 25 pounds, your co-pays and deductibles will go up significantly. Should insurance companies do that?

CHRISTINE ARNOLD: Well they cannot now. It is a violation of Arissa and the ADA. Well they will not do it. Employers will not do it. Go to the Mercer employer form. So, what they do is they say we will give you dollars to enroll in a program and we will give you, I got 50 bucks to take the mail thing where I lied.

PAUL GINSBURG, PHD: Yes. Christine, I think you just [laughter] you just hit on it and employers will not do it. Employers will not do it and—

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CHRISTINE ARNOLD: Which is why you have to, this is why disease management and managed care from managed care companies is not working. They are getting my fictitious mail [inaudible] thing in. So, that is why it has to come from the doctor's office. The doctor's office knows what I weigh. He knows what my cholesterol is but we need to take all of this from the realm of the patient and the disease management company and the managed care company up to the doctor.

MALE SPEAKER: I think it is also a place where conservatives have a good argument for moving the system to one of individual responsibility and individual accountability because until there is that direct responsibility, we are not going to be there.

There is also the overarching issue, I think, of confronting obesity head on in this country, which no one wants to do, not just the employer, the way we confronted smoking over the last 30 years and I do not mean that by having send them out to the loading dock. I mean that by confronting it head on and by talking about it, dealing with it, saying it is a really stupid thing to do to yourself, which we are very reluctant to do. Half of it, I think, is fully [inaudible].

PAUL GINSBURG, PHD: Good. It is time for break. I want to thank the panel for an enormous job [applause] and we will restart with our second panel at 10:45.

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