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The Health Care Crisis

Seeking ways to revive an ailing system

NEWSPAPER

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Reform backers hopeful Senate will follow suit

House OKs class-action bill

By MARK A. HOFMANN

WASHINGTON—Advocates of class-action lawsuit reform are growing increasingly confident that a victory in the House of Representatives could help their efforts in the Senate.

The victory came in the House's June 12 253-170 vote in favor of H.R. 1115—the bipartisan Class Action Fairness Act. Although the House had given its approval to a similar bill last year, the measure went nowhere in the Senate.

This year's bill won the support of about twice as many Democratic members of the House than last year's bill, and, with the Senate Judiciary Committee having already approved its own version of class-action reform—S. 274, also called the Class Action Fairness Act—more than two months ago, supporters feel more optimistic that class-action reform will reach the president's desk sometime this year (*BI,* April 14).

"I think we have a better chance now than we've ever had before to move forward in the Senate," said Melissa Shelk, vp-federal affairs for the American Insurance Assn. in Washington.

The House bill, like its Senate counterpart, would allow defendants or plaintiffs to move large multistate class actions filed in state courts to federal court, provided that plaintiffs and defendants were from different states and that the amount at stake was at least $5 million. The House bill had initially set the threshold at $2 million, but the measure was amended on the House floor to bring some of its provisions into line with the Senate bill. In another step to more closely align it with the Senate bill, the bill was also amended to allow federal courts to return some otherwise eligible interstate cases to state court if those cases were to meet a series of criteria that made the cases of a local rather than national character.

Both the House and Senate bills would also

See **CLASS ACTION**/page 35

Medical billing cited as factor in higher costs

By JOANNE WOJCIK

Already-bloated health care costs are being pumped up even further by medical billing codes too inflexible to provide for care administered by nurses or other nonphysician providers, some health care experts believe.

The codes allow, and in some cases force, providers to bill employers and insurers at a higher rate than is warranted for some medical services, they say.

But advocates of the current system of coding assert that it does offer sufficient flexibility and is responsive to changes in health care procedures.

Known as the Health Care Financing Administration's Common Procedure Coding System, CPT codes are widely used by providers, insurers and third-party administrators to track health care procedures and payments. Since the 1970s, they have been largely controlled by the American Medical Assn., which works with physicians of every specialty to determine appropriate definitions for the codes and to establish accurate reimbursement rates for each code.

But even though the AMA updates its

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PHOTO:AP/JOHN FIELD

Maine Gov. John Baldacci signs the state's new universal health care access law in a ceremony outside the governor's mansion.

Maine tries to make universal care work

By JERRY GEISEL

AUGUSTA, Maine—Maine's new universal health care access law could drastically reduce the number of uninsured in the state, but critics contend the program is based upon too many uncertain assumptions.

Last week, Maine Gov. John Baldacci signed into law the plan, designed to ensure coverage for many of the state's 190,000 uninsured. The program, which aims to make it more attractive for small employers and uninsured individuals to buy coverage, also could generate savings for larger companies, backers say.

The law's proponents say that the savings that will result from universal coverage, such as an anticipated huge reduction in the amount of un-

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Special Report:

THE HEALTH CARE CRISIS

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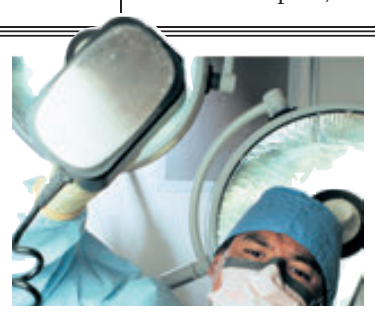

Q&A: HEALTH EXPERTS OFFER INSIGHTS, SUGGESTIONS

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Late News

House panel approves limited FSA rollovers

Health care flexible spending account participants could roll over up to $500 in unused balances to pay for health care expenses incurred in the following plan year, under legislation approved by the House of Representatives Ways and Means Committee. The measure, H.R. 2351, would effectively relax the Internal Revenue Service's so-called "use it or lose it" rule—in effect since the mid-1980s—which requires FSA participants to forfeit account balances that are not used by the end of a plan year.

Health care rate hikes may be slowing: Hewitt

Rate hikes proposed by health maintenance organizations for 2004 are averaging 17.7%, compared with initial rate hikes of 21% that HMOs proposed for 2003, according to Hewitt Associates Inc. As a result of employers modifying plan designs, negotiating with HMOs and changing plans, HMO rates actually increased by 17% this year. The lower proposed rate hikes for 2004 may be a sign that rate increases may finally be starting to moderate, Hewitt said.

PHOTO: REUTERS

GM raising $10 billion to fund pensions

General Motors Corp. announced plans to raise $10 billion through a debt issue to fund its pension liabilities. The automotive manufacturer's pension funds were underfunded by $19.3 billion at the end of 2002. GM also announced plans to raise a further $3 billion to strengthen its financial unit, General Motors Acceptance Corp.

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New York extends, raises hospital bill surcharge

By JERRY GEISEL

ALBANY, N.Y.—A 1996 New York law that already inflates employers' health care costs by hundreds of millions of dollars annually soon will cost employers even more.

The New York Assembly last month overrode Gov. George Pataki's veto of a budget bill that extends for two more years and increases a surcharge on bills incurred in New York hospitals. The measure extends the surcharge through June 30, 2005, and increases the surcharge to 8.85% from 8.18%. The surcharge, added to patient charges, is used to help fund indigent care.

In addition, the legislation increases by about 5% the size of a state pool used to fund, among other things, graduate medical education. The pool is funded by a covered-lives assessment on employers with employees living in New York.

With the size of the pool increasing by about 5%, the amount of the covered-lives assessment should increase by about the same amount. That assessment currently can cost employers—depending on where their employees reside—as little as just over $4 per year per employee to more than $300 per employee. The New York Department of Health determines the exact amount of the assessment each year.

The law—known as the Health Care Reform Act—has generated considerable controversy since it was passed in 1996.

Business groups have argued that it is unfair to make New York employers subsidize the cost of graduate medical education through the covered lives assessment.

They say that money raised by the assessment helps pay the cost of training provided in state teaching hospitals to interns and residents who later may leave the state. The groups also have complained that it isn't fair for employers that are not in areas with teaching hospitals to subsidize the cost of those facilities.

Another complaint over the years has been that surcharges for indigent care are unfair to employers that already pay for health care coverage for their own employees. In a sense, they argue, those employers pay for health care twice—once for their own employees and, through the surcharge, a second time for the uninsured.

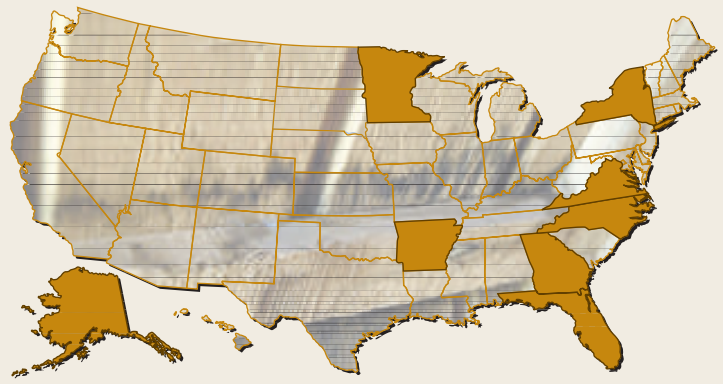
Those arguments, however, have made little impact on legislators, who in early 2000 renewed the law to June 30, 2003, and this month extended it again. The only substantive change legislators made in 2000 was to drop the 8.18% surcharge on laboratory services.

But a spokeswoman for the Albany-based Healthcare Assn. of New York State, which represents providers, described the law as laudable in "supporting public good in health care, such as medical education."

Massachusetts is the only other state that has a surcharge law. That law, though, is simpler than New York's, and the surcharge is much lower. The Massachusetts surcharge, initially set at 3%, currently is 1.85%.

MOLD EXCLUSIONS THE NORM

Only eight states haven't approved exclusions for mold damage



Source: Alliance of American Insurers

Florida officials mull judge's order to OK mold exclusions

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—Florida insurance regulators are weighing whether to begin processing hundreds of filings by insurers to exclude or limit coverage for mold claims, after a judge issued a recommended order that allows such exclusions.

Florida's Office of Insurance Regulation is backlogged with more than 200 filings by personal lines and commercial insurers seeking to limit their exposure to mold claims. Regulators have held off on dealing with the filings until a decision was reached in a dispute with State Farm Florida Insurance Co.

Administrative Law Judge William R. Cave earlier this month issued a recommended order that regulators approve a filing by State Farm that allows the insurer to exclude mold coverage and offer an endorsement that allows policyholders to buy the coverage back.

The Office of Insurance Regulation can ignore the recommended order, which would pave the way for State Farm to seek a decision in a state appeals court, or go along with it and begin clearing the logjam of filings. Regulators also could work with State Farm to reach a middle ground regarding the filing.

"The ball is now in our court," said a spokesman for the Office of Insurance Regulation. "We are reviewing the order and deciding how to respond."

In 2002, Florida regulators rejected mold-related filings submitted by State Farm and Florida Farm Bureau Insurance. Both companies filed appeals to the state's Division of Administrative Hearings. Regulators reached an agreement on mold coverage limitations with Florida Farm Bureau, but the State Farm appeal continued.

Regulators originally rejected State Farm's filing because they thought the insurer was not offering comprehensive coverage as called for in state law, the spokesman said.

"We took the position that it is implied, that it is part of comprehensive coverage," he said of mold coverage.

Florida is one of eight states that has yet to approve mold exclusions in homeowners policies, according to the Alliance of American Insurers. The others are Alaska, Arkansas, Georgia,

See MOLD/page 35

Policyholder attorneys hail court's extensive analysis

Court limits pollution exclusion

By DAVE LENCKUS

WASHINGTON—A District of Columbia Appeals Court ruling that restricts the scope of the absolute pollution exclusion is a dual victory for policyholders, because the court supported its decision with an unusually in-depth analysis of the exclusion, policyholder attorneys say.

Courts in other jurisdictions that are asked to interpret the breadth of the exclusion likely will weigh the District of Columbia court's decision heavily because of the extent of the court's analysis on the exclusion's construction and its drafting and legal history, the attorneys said.

An attorney representing the insurance industry noted, however, that the dissenting judge in the case also issued a lengthy opinion in which he methodically picked apart the majority's reasoning.

In a 2-1 ruling that essentially overturns a federal trial court's decision, the appeals court on June 12 ruled that insurers may not invoke the absolute pollution exclusion to bar coverage for claims that do not involve environmental damage caused by industrial polluters.

Applying the exclusion to any other type of claim fails to consider the insurance industry's original intentions and the language of the exclusion, which incorporates language from federal statutes governing environmental damage, according to the court.

The bodily injury claim at the center of the case was filed by an apartment complex security guard against the site's management company. The guard alleged that she suffered brain damage when she was exposed to carbon monoxide fumes emitted by a malfunctioning furnace at the complex.

The appeals court, which is akin to a state supreme court, issued its ruling in response to a request for assistance from the U.S. Court of Appeals for the District of Columbia Circuit. The case has been pending on appeal in the federal appellate court, which is bound to issue a ruling based on District of Columbia case law. But, with no guiding precedent on the issue from District of Columbia courts, the federal appellate court asked the District of

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Inside Business Insurance

Online

- The **Datebook** calendar lists upcoming industry seminars and meetings and allows you to add info on your own event.
- Searchable **directories** of all the listings of industry vendors found in *BI*'s Market Sourcebook.
- New **Opinion Poll** for readers: How effective would a single-payer national health insurance system be in controlling health care costs?

Departments

REPORTING ON CORPORATE RISK AND EMPLOYEE BENEFIT MANAGEMENT NEWS.

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House expected to pass Medicare Rx bill

By JERRY GEISEL

WASHINGTON—Legislation to add a prescription drug benefit to the Medicare program continues to move briskly through Congress, with the House Ways and Means Committee approving a measure last week after just one day of debate.

However, unlike the largely bipartisan approval of a Medicare prescription drug bill by the Senate Finance Committee earlier this month, the House Ways and Means panel cleared the bill on a 25-15 vote after hours of partisan bickering.

Rep. Pete Stark, D-Calif., described the Republican-supported bill as a "rotten deal for seniors" with "skimpy" benefits.

But Rep. Jim McCrey, R-La., said retirees would recognize "a good deal when they see it."

Despite the often-heated debate, the bill is likely to be approved by the full House later this week or early next week, while action by the full Senate is expected next week. Differences between the House and Senate bills then would have to be worked out by a conference committee.

The measure approved by the Ways and Means Committee would create a new Part D Medicare prescription drug benefit. Participation in the program, which would start in 2006, would be voluntary, with beneficiaries paying monthly premiums of about $35. Generally, the benefits would be offered by insurers, health maintenance organizations, preferred provider organizations and prescription drug benefit managers that would contract with Medicare.

The prescription benefit would kick in after a $250 deductible had been met. Beneficiaries would pay 20% of expenses from $251 through $2,000, and the program would cover all expenses after an out-of-pocket limit of $3,500.

Employers would be eligible for certain federal subsidies if they retained prescription drug plans with benefits at least equal to those provided by Part D.

Even with those subsidies, the committee estimates that 32% of Medicare beneficiaries that have employer-provided prescription drug coverage would lose that coverage. That's because their employers would terminate retiree health care plans due to the creation of the new Medicare benefit.

PHOTO: AP/DENNIS COOK

House legislation that would add prescription drug benefit to the Medicare program encountered opposition from some Democrats, including Reps. Nancy Pelosi, D-Calif., and John Dingell, D-Mich.

PHOTO: ZUMA

Former WorldCom CEO Bernard J. Ebbers can be sued by 401(k) plan participants for breach of fiduciary duty, a judge ruled.

U.S. judge clears way for WorldCom lawsuit

401(k) members charge execs breached duty

By DOUGLAS McLEOD

NEW YORK—A federal judge is allowing WorldCom Inc. 401(k) plan participants to proceed with a class-action lawsuit charging that the company's former chief executive officer, its former benefits director and the plan's trustee breached their duties by failing to halt disastrous investments in WorldCom stock.

U.S. District Judge Denise Cote ruled last week that former WorldCom CEO Bernard Ebbers, former Employee Benefits Director Dona Miller and plan trustee Merrill Lynch Trust Co. of America were all plan fiduciaries and, therefore, are subject to various breach of duty claims.

The plaintiffs charge, among other things, that Mr. Ebbers and Ms. Miller allowed WorldCom employees to continue investing in the company's stock while providing participants with "materially false" information about the soundness of the stock as an investment.

While Merrill Lynch argued that it only followed WorldCom directions in buying company stock for plan participants, Judge Cote found that federal law prohibits it from following instructions when it knows or should know that the actions violate fiduciary duties to plan beneficiaries.

In the same ruling, Judge Cote dismissed claims against 16 WorldCom directors, officers and employees, as well as claims against WorldCom auditor Arthur Andersen L.L.P. The individual defendants did not qualify as plan fiduciaries under the Employee Retirement Income Security Act, while claims against Andersen are barred by the Securities Litigation Uniform Standards Act of 1998, the judge found.

WorldCom filed for Chapter 11 bankruptcy reorganization in July 2002 after disclosing that it had improperly reported billions of dollars of operating costs as capital expenditures and had overstated its earnings by $3.3 billion between 1999 and 2002.

Terrorism Risk Assessment and Insurance Coverage Seminar

Crisis plan key to terror safety

By MARK A. HOFMANN

WASHINGTON—A corporation's role in confronting terrorism is similar to that of the government, according to a prominent security consultant.

"The ultimate objective is to protect lives," said James A. Francis, senior vp-security services group for New York-based Kroll Inc. Mr. Francis made his comments as the keynote speaker at the Terrorism Risk Assessment and Insurance Coverage Seminar presented in Washington by the New York-based Strategic Research Institute earlier this month.

"Crisis planning is the key to everything," said Mr. Francis.

For example, no high-rise building has ever been constructed for total evacuation, he said. Instead, they have been constructed to meet the demands of local fire codes. That means that employers must have plans for "tiered" evacuations, to move people out in the most efficient manner.

In addition, "evacuations without cause are also inherently dangerous," he said. He cited the example of people in an office building making for the exits when they saw workers in a nearby building leaving the structure. But the people in the nearby building weren't fleeing a threat; rather, they were gathering for a group photo on the building's steps, he said.

By having thorough planning and training in place, corporations are better prepared to make the kind of ad hoc decisions that may have to be made in an emergency, said Mr. Francis.

Immediately following his keynote address, Mr. Francis participated in a discussion analyzing the terrorism insurance market. Many of the concerns cited by Mr. Francis re-emerged in that discussion.

Joseph L. LaFleur, senior vp-crisis consulting for Marsh Inc. in Baltimore, said that only about half of the Fortune 1000 companies have been looking to update their crisis management plans since Sept. 11, 2001. "We don't think that's a good situation," he said.

Corporate concern about crisis management appears to have

See TERROR/page 30

Changes seek to curb rising health costs

Whirlpool boosts retiree copay

By ALLISON REYNOLDS

BENTON HARBOR, Mich.—Whirlpool Corp. is redesigning its retiree health care program to sharply limit its exposure to rising costs, while ensuring that retirees continue to have coverage.

The new plan, which strongly resembles a pioneering program IBM Corp. launched in 1999 (*BI*, May 24, 1999), reflects the growing trend of companies to rein in their once open-ended retiree plan obligations by putting finite limits on corporate contributions to the plans.

Under its plan, Benton Harbor, Mich.-based Whirlpool will require employees retiring after Dec. 31 to pay for 20% of their health care insurance costs. The company will set up a notional retiree health care savings account for each U.S.-paid employee to cover the remaining 80%. A fixed amount, $2000, will be credited to every employee's account for each year of continuous service beginning at age 40, said a Whirlpool spokesman.

"Current basic programs were relatively low (in coverage) and out of date. The coverage wasn't contemporary enough, and the cost was too much for the company," he said.

The contribution amount is subject to annual adjustments for inflation, and interest will be credited to accounts upon retirement, the spokesman said.

Current retirees can choose to stay in the current program, which requires no contribution but has a lifetime limit based on years of service, with a maximum of $100,000.

This fall, current retirees will also have a one-time choice to either stick with that plan or opt for one of the two new plans. The first plan is an 80/20 contribution managed care plan, which will increase their lifetime coverage to $1 million. The second plan, which provides less protection but also costs less, is a 70/30 plan, will up their coverage to $500,000. The spokesman noted that choosing to go with either of the new plans does not restart the clock; amounts already spent will be subtracted from the new limits.

There is also an annual limit on out-of-pocket expenses for current retirees, he said.

According to a study released last September by benefit consulting

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Products & Services

Self-funded health plan book has new edition

BROOKFIELD, Wis.—The International Foundation of Employee Benefit Plans has released the fifth edition of Self-Funding of Health Care Benefits.

The book is a guide for benefits professionals, administrators, attorneys and others who work with self-funded plans. It was written by Carlton Harker, whose 50 years of experience includes work as a consultant, risk manager, actuary and founder of a third-party administrator.

A companion Web site to the book provides sample plan documents and booklets, hundreds of related links and other features. New to the fifth edition are legislative updates on measures affecting self-funded plans, information on HIPAA administration, current tax information, an increased focus on risk management and a chapter devoted to new technology.

Copies of the 643-page book cost $125 for IFEB members and $160 for nonmembers. It can be ordered from the IFEB's Publications Dept. at P.O. Box 68-9953, Milwaukee, WI 53268-9953 or by calling 888-334-3327, option four. Orders can be completed by fax at 262-786-8780 and by email at *books@ifebp.org*.

Fortis Benefits provides basic coverage package

KANSAS CITY, Mo.—Fortis Benefits Insurance Co. is offering a new voluntary employee benefits product that provides basic, affordable coverage.

Simple Benefits Solution combines life insurance, accidental death and disability insurance and is designed for employers who have not offered the coverages but want a single package that's easy to administer and not difficult for employees to understand.

The package includes life insurance with a $25,000 benefit amount, $75,000 for accidental death and dismemberment and disability coverage with a benefit amount of 60% of pre-disability pay up to a maximum of $1,000 per month.

More information is available from Kansas City, Mo.-based Fortis Benefits at 816-474-2345.

Arch Insurance offers environmental cover

NEW YORK—Arch Insurance Group is providing environmental liability insurance and risk management services designed for contractors, consultants, property owners and managers.

The Arch Environmental Insurance Program offers limits of up to $25 million and provides strategies for managing the risk. Among the services the program provides are contract reviews, risk management workshops and newsletters on environmental topics.

The New York-based insurer will write the coverage on a primary or excess basis. It may not be available in all states.

More information is available from Rich Zarandona, senior vp and director at Arch, at 973-206-8025.

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Paul Winston

The Brigands of Madison County

In the high-stakes contest over frivolous litigation, a plaintiffs attorney has raised the ante.

Earlier this month, a law firm that holds the dubious honor of filing the most class-action lawsuits last year in Madison County, Ill., subpoenaed four advocates of tort reform in a class-action suit against Ford Motor Co. for allegedly using bad paint on its cars.

Never mind that the four critics have nothing to do with Ford, automotive paint or anything to do with the case at all.

Brad Lakin, the plaintiffs attorney who issued the subpoenas, contends their persistent criticism of the legal climate in Madison County (they have, after all, labeled it a "judicial hellhole") could prejudice his clients before a jury. He wants the four made a part of the case, which would in effect silence their public comments on matters regarding the court.


Paul Winston

The four men—Tom Donohue, president of the U.S. Chamber of Commerce; Sherman Joyce, president of the American Tort Reform Assn.; Ed Murnane, president of the Illinois Civil Justice League; and Doug Whitley, president of the Illinois Chamber of Commerce—contend the subpoenas are a lame scare tactic that will not silence them.

If anything, they say, the subpoenas prove their point.

According to ATRA, Madison County has seen a 1,850% increase in class-action lawsuit filings between 1998 and 2001. Does it make sense to anyone that this single county, population 260,000, really has suffered this much harm at the hands of outsiders? If litigiousness were a virus, Madison County would be labeled a hot zone and would be quarantined.

But instead, this special form of pestilence continues to spread.

There were 77 class-action suits filed in Madison County Circuit Court in 2002, of which 38 were brought by the Lakin Law Firm, according to the National Law Journal. So far in 2003, the firm appears on pace to break that mark, having filed 24 class actions, the National Law Journal reports.

To illustrate how warped Madison County residents' sense of legal entitlement is, I can imagine how they might respond to a small trauma that my family recently experienced in our town:

My 10-year-old daughter, Ellen, broke her arm at school the other day. Her radius broke above the wrist when she tripped over a depression in the playground that was obscured by overgrown grass and weeds. At the time, she was running after a boy who had swiped her Nancy Drew book during recess.

When my wife called me at work with the news, naturally I was:

Chicago: Concerned for my daughter's well-being and wondering what hospital I should meet them at.

Madison County: Eager to get off the phone and contact the Lakin Law Firm. At first blush, the targets of our wrath would be the school district, its teachers, groundskeepers and nurse; the chemical company that made the impotent herbicide that allowed weeds to mask such a hazard; the shoe company (please let her be wearing her Nikes); and, of course, the boy thief and his derelict parents.

Ellen had an X-ray and we were told by an orthopedic specialist that given the degree of the break, it would be advisable to have it reset in the hospital, under general anesthesia, rather than audibly and painfully reset in his office. This prognosis left me:

Chicago: Relieved that it would be a simple procedure and that she would not be in any pain when the doctor reset her bones.

Madison County: Wondering whether there would be some grounds to also sue the doctor and his hospital for mentioning the barbaric option of resetting the bone without pain relief in our presence, causing us much anxiety and mental anguish.

The procedure took place in the hospital a day later and was over quickly and with no ill effects.

Chicago: Thank goodness!

Madison County: Damn! There goes pain and suffering.

Ellen now has to wear a cast for at least six weeks. This makes me:

Chicago: Regret that her summer vacation activities, such as visiting the local swimming pool, will be diminished because of the cast on her arm.

Madison County: Increase the amount of damages we'll seek, since it means her chances at becoming a concert pianist will suffer an irreplaceable setback as piano lessons are interrupted. The jury never needs to know how much she hates these lessons.

Now that the medical trauma is over, I can:

Chicago: Sign her cast.

Madison County: Sign my name on the dotted line and start shopping for a bass boat.

Editor Paul Winston can be reached at pwinston@crain.com.

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Editorial

Consider ways to cure health care

BY ANY MEASURE, the nation's health care delivery system is in urgent need of reform.

Cost increases, which have been averaging 12% to 15% annually for the last several years, show no sign of slowing down, even though costs have been flat over most other sectors of the economy.

Along with higher costs has come an increase in the number of uninsured, not a surprising development as the cost of coverage moves ever higher, putting it out of reach for smaller employers and for individuals.

Is the health care system then on an inevitable crash course that will result in a government takeover?

We think not, and though the problems are serious enough—indeed approaching what could, without exaggeration, be called a crisis—there are remedies that can provide substantive relief to the dual crisis of coverage and cost.

On the coverage front, more than 40 million Americans lack health insurance today, and, certainly, the government can take action to reduce that number.

One step occurred last year when Congress passed legislation providing a 65% tax credit to offset the cost of health insurance premiums for individuals who lose their jobs due to foreign competition and for older employees whose pension plans are taken over by the Pension Benefit Guaranty Corp.

We'd like to see the tax credit applied more broadly—perhaps to individuals temporarily unemployed, for example. There is no question that tax credits cost the government money, but there are lots of offsetting savings. To the extent that people have health insurance, they are much more likely to receive care sooner and not in ultra-high-cost settings, such as emergency rooms.

On the cost front, government also can play a role. One of the most important drivers of cost is the increased leverage of providers due to mergers and consolidation.

We have nothing against mergers per se—indeed, consolidation can help to reduce costs through increased efficiencies. But in the health care field, mergers, especially among hospitals, seem in many cases to serve no purpose beyond the stifling of competition.

Something is very wrong when, as American Assn. of Health Plans President Karen Ignagni noted recently, the opening negotiating position of hospitals in some markets is a 30% rate increase and when an agreement resulting in a 20% increase is considered a victory by health plans.

Clearly, the federal government has to more aggressively analyze and, if necessary, stop health care mergers that would eliminate competition.

In fairness to providers, one of the reasons the rates they charge are so high is the enormous medical malpractice premiums they pay, which, in turn, are a direct result of excessive court awards. Tort reform—meaning reasonable limits on awards for noneconomic damages—is long overdue and can be implemented on a national basis only through congressional action.

For employers, there also is a call to action. Too many have neglected plan design, with plans having absurdly low deductibles and copaymentsp compared with the cost of care. Common sense dictates that employees never will be more careful consumers of health services if they are virtually insulated from the cost of those services.

These steps are only a beginning, but we think they will go a long way toward making health care coverage more available and affordable.

Letters to the Editor

Lack of consumerism flaw in health care system

To the editor: A recent study indicates that health insurance premiums will increase 50% by 2006, which is an alarming statistic considering businesses are seriously overburdened already by a decade of annual double-digit premium increases. At this rate, the ranks of the uninsured are forecasted to swell by 10 million, for a total of 51 million Americans in 2006.

Against this backdrop, the 2004 presidential hopefuls from the Democratic Party have made health care reform their "defining" issue. Yet what solutions have they brought forward, beyond universal health care? That approach simply shifts the burden from the private to the public sector but does not address the fundamental flaw of our existing system: lack of consumerism.

In our present system, insured consumers face prices that indicate to them that health care is free, or nearly so. They are insulated from the true cost of consuming services, and their consumption is limited only by their priorities.

As we look to the future, we can anticipate accelerated technological progress that will bring many new products to the medical care marketplace. These advances will rapidly expand the possibilities for spending money on health care.

There is no more important issue than the future of our health care system. There is no service that is more personal or more intimate. There is also no service that is more expensive.

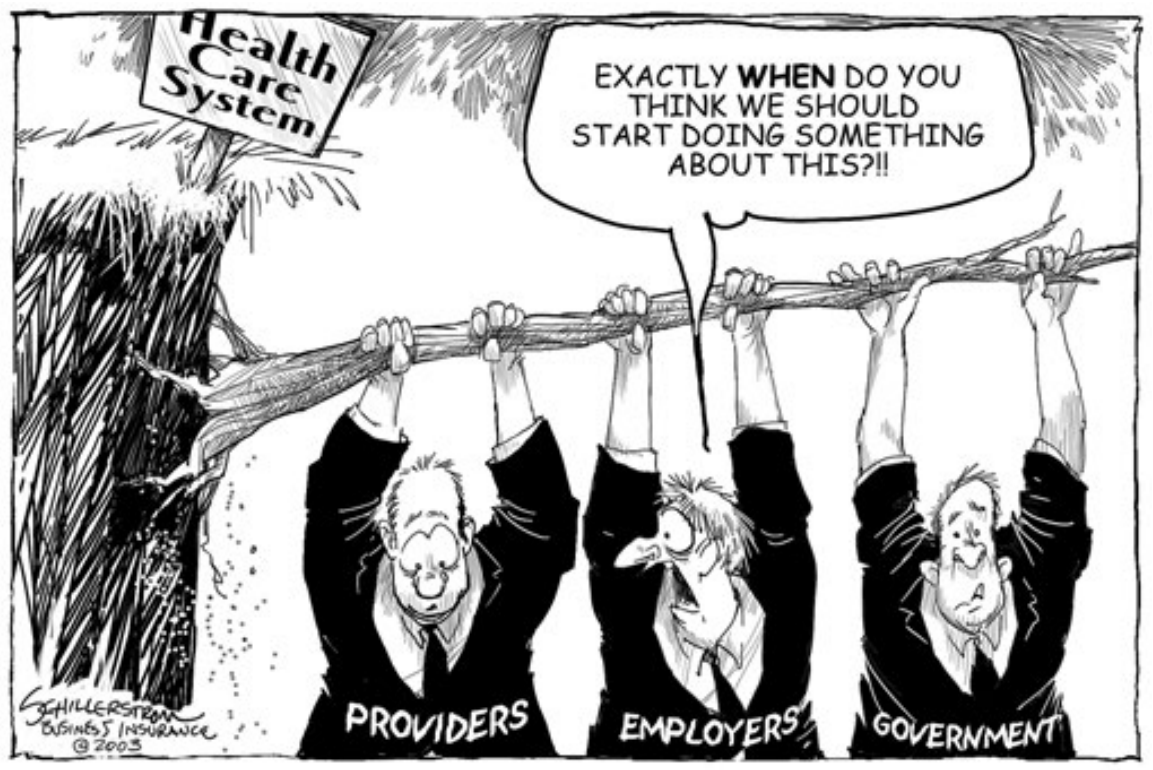
Over the past several years, payers have been looking for ways to lower health care costs. Congress has responded by making changes to the tax code providing a tax-favored status to consumer-driven health care models, specifically to medical savings accounts and health reimbursement accounts. These new plan designs represent the beginning of a free-market approach to reform the current health care system. Major organizations and even the health insurance industry have embraced plan designs that give employers and employees the ability to define contributions as a way to control—and even reduce—double-digit premium inflation.

With the emphasis of health care reform on cost containment, consumer-driven MSAs and HRAs represent an alternative plan, designed to foster cost consciousness and economically efficient choice at the level of the individual decision-maker. Most of our health care problems related to rapid expenditure growth are due to the absence of a proper pricing system. Empowering consumers to take more responsibility for their health care will make prices more meaningful and stimulate competition among providers on the basis of price and service.

No system, public or private, can meet the demands for medical care in the quantities that are generated when patients view it as entitlement. If we are ever going to stabilize the cost of health care, we need to get every employee to treat health care dollars as if they were their own. Every penny spent on health care comes from us. We pay the taxes, we pay the insurance premiums, and we earn our benefits as surely as we earn our wages.

Allen Wishner
Chief Executive Officer
Flexible Benefit Service Corp.
Rosemont, Ill.

Schillerstrom



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Spotlight Editor: Jerry Geisel

Business Insurance's report examines the reasons behind runaway health care cost increases and explores potential solutions. The centerpiece of this report is a poll of industry leaders—including benefit managers, benefit consultants, top government officials and insurance executives—on four questions relating to the health care cost crisis.

Questions and answers begin on the following pages:

Managed care backlash, drug costs and torts among key drivers

Several factors to blame for rising health care costs

By JUDY GREENWALD

Weary benefit managers who wonder why they continue to face double-digit rate hikes for their employees' health coverage will find no shortage of causes.

They range from the impact of broad social forces to Americans' weakness for French fries.

While some of the factors are trends that have gone on for decades, others are unique to 2003.

And although it is natural for them to view longingly the years during the 1990s when there was a brief moderation in the rise of health care costs, benefit observers say that period largely was the result of one-time factors.

Health care experts say critical factors that have contributed to cost inflation include a backlash against managed care; industry consolidation; an aging workforce; the economy; advanced technology; drug costs; the medical malpractice crisis; and inadequate funding of Medicare, which has led to cost shifting by providers.

"There are a lot of moving parts to this health care thing," said John Erb, senior manager with Deloitte & Touche L.L.P. in Miami. "When you think you have your arms around it, something completely unexpected, like the recession, comes along and turns things upside down."

According to Towers Perrin's 2003 health care cost survey, the average cost increases experienced by large employers' health care plans dropped from 12% in 1993 to 2% in 1995. Increases remained steady at 4% for 1996 through 1998 before beginning to rise again, reaching 16% in 2003.

But those relatively low health care cost increases of the 1990s are not expected to return.

"There were a lot of one-time savings achieved during that period," said Joanne Spetz, assistant adjunct professor, community health systems, at the University of California at San Francisco.

Hospitals, for instance, "began moving more to an outpatient setting and became much more efficient in the way they provided health care," said Ms. Spetz. "You can kind of do that only once," she said. "After a while, you can't make the length of stay, for example, any shorter."

Similarly, some managed care organizations worked very hard to cut hospital and physician profit margins, but that, too, "can only go so far," said Ms. Spetz. "Once you cut a lot of fat, you run out of things to save."

Furthermore, as employers began

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Future health plan designs

Choice, cost shifts expected to grow

By JOANNE WOJCIK

While visions of the future of health benefit plans vary, experts agree that employees will definitely be in the driver's seat—and that they'll pay for the privilege.

After years of consolidating health plan options to save on administrative costs, employers will begin to offer more choices to employees. As they do that, they'll use the Internet to manage enrollment, handle transactions and even to distribute benefit plan descriptions, as plan administration becomes increasingly paperless, the experts concur.

Employers also will give employees a "defined contribution" toward their health care premium, and employees will pick up the rest of the tab, the amount of which will depend on the type of the plan they choose, the experts say.

But the so-called "consumer-driven" health plan will either evolve or die after having served its purpose as the transition into this new era of self-serve benefits, some experts predict.

By contrast, managed care, in the form of closed provider networks, is likely to see a resurgence in popularity as employees opt for restrictions to save premium dollars.

And all health plans are expected to emphasize wellness now that there are data to back up claims that spending a few pennies now will pay off in many dollars of savings in the future.

"Plans will change quite a bit in that they will be much more tailored and customized around the individual," predicts Maureen Cotter, director of group health care consulting at Watson Wyatt Worldwide in Southfield, Mich.

Employees will decide "whether they would rather have lower premiums by going to a restricted network or an HMO, or whether they'd be willing to pay a lot more for freedom of choice and customized benefit levels. I think there will be riders for complementary health care," she said. "We're headed in the direction of a lot more choice."

"In the past several years, employers consolidated their health plan offerings because it cost too much to administer more than a few plans," Ms. Cotter explained. "They also thought that by putting their entire employee population together in one group that they could use that as leverage to gain discounts from health plans and providers, as in direct contracting."

"But now, with the advances in technology and the employee demand for more choice, we're headed back to before the consolidation occurred," she said. "Web technology has really changed all that."

Shifting responsibility

But while employees will have more plans to choose from, "there

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Inside:

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Causes: Several factors at fault

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to move to managed care, competing health plans cut rates to gain market share, but that was a trend that was inevitably short-lived. Some observers also believe the potential threat of a national health care system presented by the Clinton administration's health care proposals during that period may have put a temporary damper on cost increases as well.

Managed care loses ground

Today, a backlash against managed care and its effective, if sometimes onerous, cost controls is one of the key factors behind the resurgence in health care costs, say observers. Employees became "fed up with the tight controls of managed care and demanded more flexibility, more choices and less constraints on who they could see for health care services," said Bill Sharon, senior vp at Aon Consulting in Tampa, Fla.

Joe Martingale, national leader for health care strategy at Watson Wyatt Worldwide in New York, said the backlash has "reversed many of the gains managed care had achieved" during the 1990s. At the same time, the expansion of the managed care market slowed.

As a result, "we now have the combination of managed care running out of steam and that whole era kind of coming to a screeching halt," said Mr. Martingale.

But lost in the process have been efforts to improve oversight, accountability and the potential for using evidence- or fact-based medicine to maximize health care efficiency and quality, said Dr. Robert Forster, vp and chief medical officer for Jacksonville, Fla.-based Blue Cross & Blue Shield of Florida. "As we back away from managed care principles—because they've essentially been rejected by consumers and society in general—control mechanisms for 'disorganized care,' care that has no significant outcome over a cheaper form of care, are not being monitored or utilized as previously," he said.

Brian Klepper, executive director of the Jacksonville, Fla.-based Center for Practical Health Reform, said that there is a "lack of any accountability or transparency throughout the system. Our information systems can't talk to each other, we don't have publicly available information, we don't use best practices, we simply don't have a way to make things that are going on in the system visible, so that makes the system prone to errors and abuse and excessiveness."

The structure of traditional health plans, where an employee is effectively shielded from knowing the full cost of his or her medical care because of small co-payments, is a factor, as well.

Typically, "they're not writing the checks," said Alan Winston, vp at GE Commercial Insurance's Healthcare division, a unit of Overland Park, Kan.-based Employers Reinsurance Corp. As a result, he said, "consumers are disenfranchised from the financial impact of delivering health care."

"Basically, we'd all like everything for nothing, but we're finally seeing how much it costs. And as our appetite gets bigger, we're beginning to realize that there's a true tradeoff in costs that's exploding faster than we can control it," said Dr. Forster.

Because of this, "we have seen a lot more utilization across the board," including the use of prescription drugs, office visits and services per office visit, said Ed Kaplan, national practice leader for health care at The Segal Co. in New York. "Doctors are getting more patients through the door, and they're doing more things to patients when they're inside their offices," said Mr. Kaplan.

Providers gain clout

Providers also have started to push back against the cuts into their profitability initiated by managed care.

They are saying, "We're no longer going to be in a position to accept capitation or excessively low fee arrangements," said Scott Clark, risk and benefits officer for the Miami-Dade County public schools. "The providers are now coming back and saying, 'If you want us to be part of your program, you're going to have to pay us more money.'"

Consolidation among providers has encouraged this pushback. As hospitals consolidated, they "started to realize that their rates were not sustainable or that they, in fact, had more market leverage that allowed them to achieve" higher rates, said Chris Ohman, senior vp and chief executive officer of San Francisco-based Blue Shield of California's commercial business unit.

Single health systems today may represent as many as 30 area hospitals, said hospital consultant Wanda Jones, president of the San Francisco-based New Century Healthcare Institute. "They will dominate a market enough to where they can say (to health plans), 'If you want to be in this market, if you want to sell to employers and their employees, you have to pay us what we're asking,'" said Ms. Jones. While larger health care plans may still be able to refuse to go along with provider's demands, the more numerous smaller plans cannot, she said.

Linda J. Havlin, a consultant with Mercer Human Resource Consulting in Chicago, said that because of consolidation and the subsequent reduction in competition, "fewer plans are looking to cut prices in favor of increasing enrollment. Wall Street is making sure they are managing themselves to profitability. In the old days, it was not uncommon for health plans to discount premium rates to increase volume. That's not happening any more. There are no good deals."

Because of consolidation, "there's not much a purchaser or employer can threaten the health plan with, or a particular hospital with," said Ellen R. Shaffer, director of the San Francisco-based Center for Policy Analysis. An employer that walks away, she said, will not cause "that much of a dent."

Ron Weintraub, benefits director for the Fort Lauderdale, Fla.-based School Board of Broward County, which has 27,000 employees, said, "There's only six or seven companies that are big enough to handle us. Ten years ago, you probably had over twice as many," but consolidation has limited competition.

Hospital expansion and renovation have also added to costs, said Ms. Havlin. "It's hard to see hospitals these days that don't have a construction crane in front of it. It's a booming industry. They will tell you they're building for the future, but nobody's out there stopping them. It's not like we need the capacity now. They're just building on the bet" it will be needed in the future, she said.

Other cost drivers

The higher cost of drugs has played a role as well. "I see an out-of-control prescription drug industry," said Kevin Gallagher, director of human resources at Deerfield Beach, Fla.-based J.M. Family Enterprises, the Southeast Toyota distributor.

Increasing technology has also fueled higher health care costs. The room and board component of hospital costs, while subject to inflation, has not risen nearly as quickly as have costs associated with the use of diagnostic tools, said Jeff Dunlap, president and CEO of Indianapolis-based Alliance Benefit Group of Indiana, which works with self-insured plans.

Dr. Forster said old technology typically "becomes very cheap very quickly" when new technology is introduced. But "we don't see this in health care," where "whenever a new technology comes into the fold, the old technology continues to be used at even higher prices," said Dr. Forster.

Meanwhile, "the baby boomer bubble is moving through the workforce," said Deloitte's Mr. Erb. "It's the largest generation, and it's now in its 40s and 50s, when people start using serious health care services, not just discretionary health care services."

Today's baby boomers are "wealthy, self-made and extremely technologically oriented," said Dr. Forster. "They seek wellness, and they associate that with frequent visits to physicians' offices and testing." They also reflect the "new consumerism," which means asking the doctor more questions and being "much more demanding than the old generation that has come before them" with respect to their health care needs, he said.

At the same time, as a population, "we're super-sized" and suffer from obesity, high blood pressure, the consequences of tobacco use and a lack of exercise, said Ms. Havlin.

Part of the blame rests with employers, suggested Miami-Dade County's Mr. Clark. "I think we haven't done a good enough job as employers…introducing quality wellness programs, trying to get employees well" so that they need less medical attention, he said. "We haven't really eliminated the nexus of the problem, which is people have wellness issues and require medical attention."

The economy has also had an impact. With people either already out of work or on the verge of losing their jobs, "there may be a push to get certain things done earlier," said Harvey Sobel, Secaucus, N.J.-based principal and consulting actuary with Buck Consultants Inc.

The economy has had a more subtle impact as well, according to Dr. Forster. About 50% of hospitals' net income is derived from investments, and the stock market's recent poor performance means even conservatively invested hospitals must charge more, he said.

Finally, Ms. Shaffer noted that the uninsured have also been a factor in the cost spiral. We are spending more money on hospitalization, she said, because the uninsured are delaying treatment for conditions such as diabetes and hypertension until their conditions reach a critical state.

Q: *Who's to blame for cost increases?*

Bruce Bodaken
Chairman and Chief Executive Officer
Blue Shield of California
San Francisco

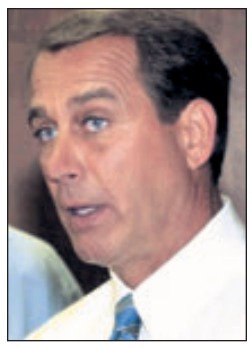
It would be nice if there were some villain to blame for skyrocketing health care costs and all we had to do to solve the problem was slay that villain. Unfortunately, it is not that easy. For starters, we (all health care consumers) are a major part of the problem. As our population has aged and new medicines and technologies have become available, our use of health care resources has increased significantly. And these two trends—aging and innovation—are inexorable. They will always be with us, fueling ever greater demand for health care services. Other contributing factors are the rising cost of hospital care and pharmaceuticals.

In addition, there are efficiency and market-related factors exacerbating the problem. Chief among these is the problem of the uninsured. People who don't

have insurance still get care, but because they often delay seeking it and turn to hospital emergency rooms for nonemergency care, it is less effective and more expensive than it needs to be. The costs of this care, most of which are shifted by hospitals and doctors onto insured patients, is a significant and growing component of overall health insurance costs.

Rep. John Boehner, R-Ohio
Chairman, House Education and the Workforce Committee
Washington

According to the most recent U.S. Census Bureau figures, the number of Americans who have no health insurance is now more than 41 million. Many of the newly uninsured are small-business employees whose employers cannot afford to offer health plans to their workers.



The ranks of the uninsured have swelled again, in part, because excessive government mandates and trial lawyer lawsuits drive up costs and put health coverage out of reach for families with limited means. According to a 2002 PricewaterhouseCoopers L.L.P. study on the factors that fuel rising health care costs, government mandates account for about 15% of the total increase in rising costs. Over the past 30 years, the federal government and especially states have passed thousands of mandates that drive up the cost of health care for employers and their workers. In fact, there are now more than 1,500 different federal and state health care mandates.

This is simply unacceptable. We should be doing more to help the uninsured, not enacting more mandates that only serve to deny them access to quality health care. Exploring ways to expand affordable health care coverage for Americans who lack basic health insurance is a key priority for the Education and the Workforce Committee this year.

Blaine Bos
Consultant
Mercer Human Resource Consulting
Minneapolis

Who's to blame? No one, and everyone. No one is to blame, because much of the present dilemma is caused by the demographic reality of the aging "baby boomers' " need for more health care services. Everyone is to blame, because purchasers, providers and consumers have been lulled into a false sense of security by a decade of the success of a relatively simple solution, managed care. Managed care addressed the supply side of the equation, not the demand side. The demand side is a much more difficult issue and now seems overwhelming because of the demographic reality.

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Q: Who's to blame for cost increases?

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Dr. Yank Coble
Immediate Past President
American Medical Assn.
Chicago

There is no one factor responsible for rising medical care costs. The continuing use of new technology, the growth in government regulation (e.g., HIPAA), and the costs associated with a wide range of benefit mandates are all contributing factors. An analysis of national health expenditure data indicates that growth in spending for prescription drugs and the net cost of private health insurance (i.e., the premiums earned by private health insurers minus claims paid) have been and are expected to be disproportionately large in comparison to overall growth in national expenditures. Also contributing to increasing health care costs are the growing number of medical liability lawsuits and "jackpot" jury awards that have caused doctors to practice defensive medicine and their medical liability insurance rates to skyrocket to $200,000 a year or more in some high-risk specialties.

While striving to control costs, however, we must remember that total benefits of health expenditures continue to outweigh total costs. In the last 20 years, the United States realized significant gains in life expectancy and health status, and the decline in disability rates among the elderly accelerated rapidly. While some of the benefits of health expenditures take the form of increased productivity, the primary benefits add value in the form of better quality of life.

Alain C. Enthoven
Marriner S. Eccles Professor of Public and Private Management, Emeritus
Stanford Graduate School of Business
Stanford, Calif.

Who's to blame? Employers, who systematically deny employees the opportunity to choose a less costly health care plan. Most employers don't even offer their employees choices, so the plan they have is one size fits all, everything is included, which is bound to be very expensive. So the market has been wired by employers to deny access to efficient, lower-cost health insurance programs.

Then there are the providers who are creating all kinds of monopolies, such as the hospital systems where you have to take all or none. And the trial lawyers who have terrorized managed care and made them afraid to do anything to manage care. Also to blame are employees themselves, who make cost-unconscious, irresponsible demands.

Finally, there's government. It does many things to make the problem worse.

One is the open-ended tax break that subsidizes people to choose more costly health insurance. The whole thing is rigged in favor of more costly health care. And economical health care systems don't get a shot at the market. Then it's government through anti-managed care laws. Twenty-one or 22 states now have any-willing-provider laws, the dream of the medical monopoly because it emasculates the ability of insurers to negotiate limits on providers.

Paul B. Ginsburg
President
Center for Studying Health System Change
Washington

In the early and mid-1990s, managed care plans—in response to employers' requests to slow rapidly rising health care costs—limited patients' choice of physicians and hospitals, required prior approval for certain high-cost services and restricted physicians' clinical authority. Health plans also expanded rapidly and demanded deep price discounts from providers in return for inclusion in plan networks. To gain negotiating leverage over health plans, many hospitals banded together in systems, leading to increased hospital consolidation in many markets.

But consumers and physicians disliked managed care restrictions, prompting a powerful backlash. Competing to attract and retain workers in a tight labor market during the economic boom of the late '90s, many employers moved away from insurance coverage with limited provider choice and care restrictions. Many health plans expanded provider networks and eased restrictions on care by eliminating prior approvals for specialty referrals and certain tests and procedures. With fewer administrative controls on the use of medical services and plans' ability to negotiate discounted fees hampered, health spending and insurance costs again began rising rapidly in the late 1990s.

William E. Hembree
Director
Health Research Institute
Concord, Calif.

No one is to blame. What's at fault is the nation's absence of a vision for health care. Since the country's founding, the USS Health System has been a rudderless ship adrift at sea with no destination and nothing to guide it. Our zig-zag movement has been caused by the winds and currents of conflicting interests of patients, payers and providers, frequent financial crises, the solution de jure and the political nonsystem.

With no vision, our medical system has produced unacceptable and unsustainable costs. The medical system also provides insufficient access for 41 million persons, only minimally improves quality, and when health is improved, it's an accident. And when the future is considered, the United States is facing the perfect storm of continually escalating, crisis proportion cost increases exacerbated by medical needs for the baby boomers and institutional needs for patients suffering from Alzheimer's Disease and medical advances-induced old age.

The solution to these challenges is deceptively simple. We must build a U.S. Health Vision to set our health ship on course. Here's a draft of a possible Vision for national discussion: The U.S. health care system must be affordable to all payers and satisfactory for all players, accessible by all citizens, and it must constantly and measurably improve quality of care and participants' health status.

Fred Hunt
President
Society of Professional Benefit Administrators
Chevy Chase, Md.

There is lots of blame to go around, but "we the people" and those who pander to us are mainly to blame. "We the people" refers to the phenomenon that the general public thinks each of us deserves Rolls Royce health coverage and care, but we only want to pay a used car junker price. I believe this is the only consumer product in which we have this dementia. If someone went to the car dealer, bought the junker and then complained that the Rolls Royce was not delivered, we'd think he was crazy. However, that's the situation in health coverage expectations. However, telling the public that it is the problem is not popular, so this obvious problem is mentioned only in hushed tones. Advertising by medical providers, and especially direct ads for drugs, and political pandering simply play on this unreality and fan the flames.

Politicians and do-gooders tend to have tunnel vision or be shortsighted. So they pander to the public's desires, often leading to mandated benefits and requirements that simply raise costs more. Imagine if, "for safety," employers were told that every company car had to be a Mercedes. It would be a nice intention but disastrous economic impact.

Dr. Pamela Hymel
Vp of Medical Services and Benefits
Hughes Electronics Corp.
El Segundo, Calif.

The costs themselves have gone up for many reasons—for example, the price tag for amazing advances we see in technology and the great numbers of new medicines entering the market every day, the cost shifting we bear to cover care of the uninsured and underinsured and medical malpractice insurance costs, and increasing care requirements of our aging "baby boomer" generation. As far as the impact we allow these costs to make on companies and their employees, there seems to be enough blame to spread around. Certainly blame falls on health care providers who are not willing to practice evidence-based medicine; health plans who have not streamlined administrative expenses nor focused on patient safety; attorneys who foster excessive lawsuits, thus driving malpractice liability; employers who have not educated their employees and asked them to take more responsibility for health care utilization; and employees/participants themselves who continue to demand open access to care without bearing financial responsibility.

John Jones
Vice President of Legal and Regulatory Affairs
Prescription Solutions
Costa Mesa, Calif.

While the simplistic answer is to blame pharmaceutical manufacturers, one factor that many people are hesitant to examine is that we've created a nation of consumers with an insatiable appetite for prescription drugs. While the value of prescription drugs to treat disease is undeniable, many Americans have chosen to use drugs in lieu of adopting positive lifestyles or they have little regard for choices in the cost of their therapy.

Have a little heartburn? Take a little purple pill (which costs more than $100 for a one-month supply). Have occasional insomnia? Take a sleep aid. And the list goes on. The reality is that many people taking expensive prescription drugs shouldn't be—or at the least they shouldn't be taking them for the length of time they are using them.

However, we need to make a very important point about the issue of over-utilization. Many prescription drugs are clinically necessary to alleviate symptoms and/or to control the progression of a disease or illness. We do not want to create an environment where people that need drugs can't access them. That's not good for people and, from a practical perspective, it's likely to drive up costs significantly on the medical side of the benefit.

Doug Kronenberg
Chief Strategy Officer
Lumenos
Alexandria, Va.

The blame lies with the whole approach to cost control that has prevailed until now. Traditional plans have tried to control costs through a supply-side strategy focused on the providers who supply health care services: they tried to manage access to care and payments to providers. The health care system has essentially left out consumers altogether, by taking away their ability to choose where and when to receive care, and shielding them from an understanding of the costs of the care they receive.

We believe that health care consumers are at the core of the health care equation; they must be part of the solution. Engaged and informed consumers, making prudent choices about spending their own money, are, by far, the strongest influence on both costs and quality. That's true in any economic sector, not just in health care.

Michael LeConey
Health Care Research Analyst
Sky Capital L.L.C.
New York

The basic problem is that the United States spends 30% more per capita on health care than comparable industrialized countries.

Analysis of the reasons for this phenomenon provides a valuable insight as to the real reasons for the high level of U.S. health care costs. Three factors explain the difference:

Societal attitudes: 25% of U.S. health care spending is expended in the last year of life. That's roughly twice the level of spending in comparable countries. "Defensive" medicine (related to liability risks) inflates U.S. health care costs by 3% to 4%. Lack of a universal health care system encourages young, healthy people to "opt out" until they reach the age (or circumstance) when/where they need health insurance. As a result, the U.S. insurance system has increasingly been left with the least-healthy population segments.

Dr. Jonathan T. Lord
Senior Vp and Chief Strategy and Innovation Officer
Humana Inc.
Louisville, Ky.

The health sector is a sprawling, complicated ecosystem driven by macro-level forces that no single actor can control. These include tax treatment of insurance (which encourages over-insuring); the structure of insurance products (which encourage overuse; the rising tide of technology (e.g., medical devices, surgical techniques, pharmaceuticals, etc., which constantly increase treatment options); the local structure of health care markets (provider consolidation, competition, labor shortages, service capacity, provider pricing, etc.); disease prevalence (e.g., flu or SARS); and even media-influenced behavior. At an even higher level, supply-induced variations in practice patterns, systematic waste and inefficiency and unsafe practices contribute to increasing cost trends.

Janet Stokes Trautwein
Vp-Government Affairs
National Assn. of Health Underwriters
Arlington, Va.

We all contribute to the increasing cost of health care and health insurance. First and foremost, we've forgotten that insurance is supposed to protect us against financial losses that can't be anticipated. Managed care changed our perceptions in this area. We've become accustomed

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Q: Who's to blame for cost increases?

Continued from page 14

to paying $10 for a doctor's visit and forget about the additional cost paid by insurance, which could easily be 10 times as much. In this day and age, a $10 copay to see a physician isn't much of an incentive to make a person consider whether a home remedy might work just as well.

Second, we need to acknowledge that, as Americans, we have come to expect a level of health care not often found in other countries. We expect to receive the highest level of care the moment we need or want it. Our health care providers have responded to this expectation with a large volume of available treatments, in addition to new technology that is revolutionizing health care. When increased technology and high utilization of care is combined with expensive blockbuster drugs and we expect that the costs be covered by health insurance, it's pretty evident why costs have increased so dramatically.

E. Neil Trautwein
Director of Employment Policy
National Assn. of Manufacturers
Washington

Perhaps the better question is, who is *not* to blame? We health care consumers are to blame because we want too much health care and technology but have become disconnected from the cost of coverage. Health care providers are to blame because they are sometimes more interested in income than in health care. Trial lawyers are to blame for the litigation tax imposed on health care in terms of lawsuits, the cost of malpractice insurance and defensive medical practices. Chronic health care conditions are to blame because of their very care-intensive nature. The American lifestyle is to blame because of the epidemic of obesity that has driven the increase in chronic health care conditions.

Technology and innovation in devices and pharmacy have both lowered and increased health care costs and stimulated utilization of services. Managed care is to blame because it helped disconnect consumers from true health care costs with small-dollar copayments. The aging of society is to blame as we baby boomers are both knowledgeable and demanding as we age. There is more than enough additional blame to throw around, too.

Given the overwhelming preponderance of blame, shouldn't we be wary of rifle-shot solutions?

Sheldon Weinhaus
Director Emeritus
Patient Advocate Foundation
Legal Resources Network
St. Louis

First, we are seeing that health insurers and managed care organizations have returned to immense profitability again. Their pricing, sometimes at 33 1/3% to 50% increases, far outstrips the small incremental increases in the costs of the doctors, labs and hospitals. In fact, in these terms, it should be a scandal. Executive salaries, bonuses, stock options, golden parachutes and the like are back in the realm of unconscionable.

Second, in terms of copays, the trend is increasing that the discounted amounts insurers and MCOs pay is not in keeping with the amount on which the percentage of the copay that the patient/policyholder is required to pay (is based)….Once again, the patient/policyholder is paying far beyond what he/she (should be) reasonably expected to pay. Most courts say this kind of fraud is perfectly legal.

Third, apart from the high cost of more effective drugs, the insurers/MCOs and PBMs have now found a way to, in essence, make the patient pay more and more for the drug that is prescribed if it does not fit into their formularies.

Dr. Donald A. Young
President
Health Insurance Assn. of America
Washington

The dominant issue in today's health care environment is the growth in costs and, consequently, in health insurance premiums. But finger pointing and laying blame serve no productive purpose. Rather, everyone involved in the health care financing and delivery system must look at the underlying causes of spiraling health care costs and then search for common solutions.

A major underlying cause of rising costs is continued advances in medical technology, including prescription drugs, and the broadening use of more sophisticated and, hence, more expensive medical tests and procedures. In turn, these advances fuel consumer demand, contributing to increased utilization of hospital and physician services.

Consumer preferences for greater choice than that offered by tightly managed care plans have resulted in larger hospital and physician networks, weakening the ability of insurers to negotiate favorable payment rates, a trend exacerbated by consolidation and vertical integration among medical providers.

The design of health insurance products also contributes to cost growth by shielding consumers from the true cost of care, providing few incentives to shop based on price and quality, or to use services appropriately. Further, there is little information available for consumers to evaluate quality of care or the medical appropriateness of services they want.

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Future: Plan designs to undergo changes

Continued from page 10

will be more shared responsibility" in terms of paying for them, said Tom Lerche, senior vp at Aon Consulting in Chicago.

Employers likely will cap their liability by moving to a defined contribution approach in which they provide a fixed "subsidy" for health care expenses and allow the employees to use it to shop from among several options available to them using the Internet.

"Employers cannot afford to pay for all of the health care employees request," he said. Therefore, employers will "find and define limits of their liability and share the risk of higher utilization and cost with the employee," Mr. Lerche said.

In many ways, health plans already are using the defined contribution approach; employers are just not calling it that, out of fear of backlash from employees, said Ms. Cotter of Watson Wyatt.

So, instead, employers and benefit experts refer to the new health plans as "consumer-driven" models, she said.

But those plans, which combine a large-deductible plan with an employer-funded health reimbursement account that can be rolled over year to year, are not going to be around a few years from now, some benefit experts predict.

"In the short term, I think it's going to be a niche product," said Geoff Schick, regional manager of health care at DaimlerChrysler in Kenosha, Wis. "That's not something, to be honest, that I've looked at real closely because I haven't heard any interest on our part in moving toward that."

"In its current form, (consumer-driven health care) is not going to take off," Ms. Cotter said. Using technology as a metaphor, she said: "This is version 1.0. The problem is, they don't save any money."

In fact, the consumer-driven plans may actually cost employers more, she said.

'I think we've taken the teeth away from managed care by demanding access, by not allowing them to control the networks.'

Geoff Schick
DaimlerChrysler

For example, according to data collected by Watson Wyatt, the only way employers will save money from such plans is by increasing the deductible amount between the health reimbursement account and the attachment point for the catastrophic indemnity coverage.

Typically, the plans have deductibles averaging $2,000, with a $1,000 HRA and catastrophic care above the deductible paid at 80% for in-network providers and 60% for out-of-network providers.

"They're changing some behavior in response to financial incentives and information on decision support, but it's not impacting the 20% of employees who drive 80%

See FUTURE/next page

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Future: Plan design to change

Continued from previous page

of the costs," said Aon's Mr. Lerche.

Furthermore, employees who opt for such plans tend to be younger and healthier, which could lead to adverse selection, he added.

"That was the same problem when we began offering HMOs," he recalled.

At least one consumer-driven health plan vendor, though, has statistics showing that the plans do save employers money.

"Claim costs are coming in lower than in traditional plans," said Doug Kronenberg, chief strategy officer at Alexandria, Va.-based Lumenos. "If the trend is running at 15%, we are seeing costs coming in at half that rate."

Despite her criticism, Ms. Cotter acknowledges that the plans are "wonderfully innovative, and I think they will spur a whole generation of creative health plans. It has value in that it shook up the market and provided something new to look at."

"This is a first major step, in terms of shifting the paradigm," Mr. Kronenberg said. "For the first time, we've got the consumer engaged in actually purchasing services."

Managed care renaissance

Moving toward a pure defined contribution approach may also stimulate enrollment growth in health maintenance organizations, some experts predict.

"I think that something that looks more like integrated delivery systems and has more constraints or limits in it, like an exclusive network, will become more attractive to consumers if they have to spend more of their own money," said Helen Darling, president of the Washington Business Group on Health.

"I think people are going to go back into those models, particularly those who consider themselves healthy, because of the lower cost," agreed Jeff Pettegrew, vp of risk management and insurance at Westaff Inc. in Walnut Creek, Calif.

But managed care will operate differently in the future, benefit experts say.

"I think we've taken the teeth away from managed care by demanding access, by not allowing them to control the networks," said Mr. Schick. "By (employees) wanting all-inclusive plans, it has not allowed them to be truly effective."

However, "if we are able to change what we ask managed care plans to do, I think they can be more effective. Obviously, we don't want to go back to what historically happened: that care was unfairly restricted because managed care plans were trying to save a dollar. We've all heard the horror stories," he said. "There's got to be something in the middle between too tight of access and access to everyone and spiraling costs."

For example, "the employer and employee will have the option of choosing a broad network that is pretty much conventional, or a network that will have fewer providers. But the carrier will have done research saying those are the providers who meet various quality and cost standards," said Mr. Lerche of Aon Consulting. He dubbed these networks-within-networks "high-performance networks."

"If we can change the broad-based networks that have every provider in a city to high performance, then the idea of managed care could be reborn," he said.

Emphasis on wellness

Another idea that will get a second look is promoting wellness. Employers have often discounted that approach because, until recently, there was no proof that emphasizing prevention helped lower health care costs.

"Employers are realizing that, after four years of double-digit increases, everything we've done so far hasn't worked," said Mr. Lerche.

But because of studies such as one that found that New Brunswick, N.J.-based medical products manufacturer Johnson & Johnson had reaped savings from a wellness program offered to its employees (*BI*, Jan 4. 2002), "there's more attention to the business argument for wellness," he said. "The theory's always been there; now there's evidence to prove it."

For example, because "up to 50% of disease is ultimately preventable, there will be a focus on the health status of the employee" and an emphasis on improvement, predicts Mr. Lerche.

Employees will receive annual health risk appraisals to identify risk factors and then they will be assigned to health coaches who will help them improve their health status, he said.

Healthy employees also will receive financial incentives, according to Ms. Cotter.

For example, individuals who receive health risk appraisals and manage their health effectively will get discounts, much in the same way that good drivers and nonsmokers get discounts on insurance, Ms. Cotter said.

The Internet will also play a pivotal role in empowering employees to become more involved in their own health care, Mr. Pettegrew said.

"The Internet will lead to a different approach to medical management from an enrollee's standpoint," Mr. Pettegrew said. "I'm hoping that people will do a lot of research" into their health conditions.

"From my perspective, the health care crisis, we can do small things to adjust it on a year-to-year basis," said DaimlerChrysler's Mr. Schick, "but until we, as a population, are healthier and use less services, we're going to be in trouble."

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Past mistakes influence reform efforts

By JERRY GEISEL

Health care reform in Washington is taking a different direction as legislators continue to apply the lessons learned from the failure of the last massive reform effort in the early 1990s and the successes achieved since then in expanding coverage.

A decade ago, the Clinton administration pushed a plan calling for universal coverage, with most individuals covered through gigantic government-organized health care purchasing alliances.

That plan floundered, as did other ambitious ones aimed at achieving universal coverage. The final act on health care reform played out in the November elections, when the Democrats lost control of both the House and Senate, with the Clinton health care debacle widely considered a major factor.

The impact of the failure of the Clinton health care reform effort was felt immediately and continues to be felt today, nearly a decade later, as federal legislators try to find solutions to problems similar to those of the early 1990s: soaring health care costs and a rising number of people without health insurance.

But instead of considering government-controlled or -directed plans to achieve universal coverage, the proposals today that have the best chance of enactment are those that would provide tax credits to help individuals without coverage to purchase policies, while other proposals would expand Medicare to provide prescription drug coverage.

This more modest effort, which nonetheless could enable a chunk of the nation's 41 million people without health insurance to afford to buy coverage and provide a new benefit for 40 million Medicare enrollees, is a direct result, many say, of the Clinton-era health reform failure.

The focus "should have been on what was essential rather than trying to do everything," said Gary Claxton, then an assistant secretary at the Department of Health and Human Services and now director of the health care market plan project at the Henry J. Kaiser Family Foundation in Washington.

"Most people had coverage and liked the coverage they had. The plan proposed doing too much absent a comprehensive health care crisis," said Frank McArdle, a consultant with Hewitt Associates Inc. in Washington.

Similarly, another lesson of the Clinton reform effort, many said, is that the role of government would have to be limited if reform were to have any chance of success.

"It can't just be a government solution. It has to be a combination of government and private," said Karen Ignagni, president and chief executive of the American Assn. of Health Plans, a managed care trade group in Washington.

"People still remember what was put on the table. They just don't see government having the fiscal capability or the wherewithal to solve all health care problems," said Sylvester Schieber, director of research at Watson Wyatt Worldwide in Washington.

"There was no consensus building, and that made the Clinton plan vulnerable to critique," he said.

All those lessons learned from the Clinton debacle—limiting the role of government, instituting incremental change and developing support through consensus—were applied by legislators in the years immediately after the Clinton plan, while other comprehensive federal reform efforts went down in flames.

For example, the first reform measure to expand coverage that Congress passed after the failure of the Clinton plan—the Health Insurance Portability and Accountability Act of 1996—was both modest and bipartisan.

The centerpiece of HIPAA's coverage provisions severely curtailed the use of pre-existing medical condition exclusions in group plans, a reform for which there long had been wide support and which made no cost impact on government and little on employers. The collaboration between then Sen. Nancy Kassebaum, R-Kan., who chaired the Senate Health and Human Resources Committee, and Sen. Edward Kennedy, D-Mass., was considered a key reason for its enactmemt.

Other reform measures, also enacted in 1996, were likewise modest, popular and bipartisan, such as one banning so-called "drive-through deliveries" and another mandating greater parity in group plans for the coverage of mental disorders.

The maternity legislation banned health plans from providing less than 48 hours of inpatient coverage for a mother and her infant after normal vaginal delivery and 96 hours after a Caesarean section.

The proposal came after legislators received tens of thousands of letters from constituents complaining that managed care plans, especially those on the West Coast, moved too aggressively to force patients out of the hospital a day or less after delivery.

The mental health parity measure banned plans from providing lower annual and lifetime dollar limits for mental disorders than for other medical conditions.

Like the HIPAA health care portability measure, the maternity and mental health parity proposals were supported on a bipartisan basis, were popular, added little to group plan costs and had little direct federal government involvement.

All those measures were enacted at a time when health care plan costs were either increasing slowly or falling and when the number of uninsured, as a percent of the population, was relatively unchanged.

Today, though, the number of uninsured is rising and costs are soaring. Between 2000 and 2001—the most recent time period for which information is available, the number of uninsured people increased by 1.4 million, compared with annual increases of about 1 million a year during much of the 1990s. In 1999, when the economy was at its near-peak, coverage rates actually increased slightly.

And cost increases—now in the range of 12% to 15% per year for most group plans—are nearly as high as they were in the early 1990s.

While the trends are ominous, few see a resurrection of federal health care reform in the form of a grand Clinton-style plan to provide a solution.

"We are not at a parallel point with 1993. The national focus seems to be in other places," said Charles "Chip" Kahn, president of the Federation of American Hospitals in Washington and a former congressional health care staffer.

But experts say that even if there is little congressional interest in sweeping reforms, reform effort will resume in a climate of rising costs and declining rates. As has been the case since the mid-1990s, though, those efforts will be on an incremental basis, they say.

"In a divided Congress, comprehensive proposals are a difficult avenue for meaningful reform to come about," said Paul Dennett, vp-health policy at the American Benefits Council in Washington.

It is, policymakers recognize, more feasible to achieve reform if the goals are narrower, he said.

Going in that direction is legislation Congress passed last year that provides tax credits to enable individuals who meet certain criteria, such as losing their jobs due to foreign competition, to partially offset the cost of purchasing new health insurance coverage.

"We may look back in five years as saying this established a new direction," Hewitt's Mr. McArdle said of the health care tax credits, which offset 65% of the cost of replacement coverage.

"If this works, it could become a model for using credits for a much broader population," he added.

In fact, House Republican health care staffers already are discussing proposals in which the tax credit could be expanded to include people who are temporarily unemployed, regardless of the reason. This would enable them to better afford, for example, the COBRA health care continuation coverage offered by their former employers or coverage provided through state pools.

Others concur that the tax credit approach, for a variety of reasons, has significant potential as an avenue for expanding coverage.

"Tax credits will be the method of choice for a Republican-controlled Congress and a Republican administration. Tax credits are less costly than direct appropriations and maintain the free-market and free-choice approach preferred by Republicans," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington.

The outlook also is good on another coverage issue: expanding Medicare to provide prescription drug coverage. Legislators, especially in the Senate, are working to pass a bipartisan package, and some believe enactment of the legislation, which could sharply reduce costs for employers with retiree health care plans, is likely.

"There are possibilities for a consensus on the prescription drug front, especially if the administration plays an active leadership role, as I expect it will," Mr. Dennett said.

Still, other once-hot health care issues have all but disappeared. Patient protection legislation, aimed at improving the rights of managed care plan enrollees and once considered a near shoo-in for passage, is no longer spoken of.

A patient protection act "isn't even flying below the radar screen. When I talk to members of Congress today, no one even discusses it," said Mr. Kahn, who attributes the issue's demise, as others have, to changes plans have made and to congressional concern about doing anything that would increase plan costs.

And then there are health care issues that members of Congress have not yet taken up, though their advocates hope they one day will. The AAHP's Ms. Ignagni, for example, sees a federal role in ensuring a uniform data system to give the public access to provider cost and quality information.

"You can't move forward when health plans are the only players reporting data," she said.

Congressional timeline

1965: Social Security Amendments Act
Creates new federal health benefits plan, Medicare, for individuals 65 and older and a state-administered plan, Medicaid, for the indigent.

1972: Social Security Amendments Act
Provides Medicare coverage—regardless of age—to individuals with end-stage renal disease and those who are severely disabled.

1978: Pregnancy Discrimination Act
Requires group health care coverage of pregnancy/childbirth to be the same as other medical conditions.

1986: Consolidated Omnibus Budget Reconciliation Act
Requires employers with at least 20 employees to offer health care continuation coverage to former employees and their dependents.

1988: Medicare Catastrophic Coverage Act
Expands Medicare benefits, including adding a prescription drug benefit, to cut participants' exposure to out-of-pocket expenses.

1989: Medicare Catastrophic Coverage Repeal Act
Repeals 1988 Medicare expansion law.

1989: Omnibus Budget Reconciliation Act
Lets disabled employees buy COBRA coverage for 29 months and permits employees in a new health plan to retain COBRA coverage for pre-existing conditions.

1993: Family and Medical Leave Act
Requires employers with at least 50 employees to continue employees' health coverage during FMLA leave.

1994: Uniform Services Employment and Reemployment Rights Act
Requires employers to extend COBRA-like coverage to employees called up from the reserves for active military duty.

1996: Health Insurance Portability and Accountability Act
Curbs use of pre-existing medical condition exclusions in group health plans and establishes a pilot program for tax-favored medical savings accounts.

1996: Mental Health Parity Act
Bars health plans from offering lower annual and lifetime dollar limits for mental illness than for physical disorders.

1996: Newborns' and Mothers' Health Protection Act
Requires health plans to offer at least 48 hours of inpatient coverage after a vaginal delivery and 96 hours of coverage after a Caesarean.

1996: Women's Health and Cancer Rights Act
Requires health plans that cover mastectomy to cover reconstructive surgery and to notify participants in writing of the coverage.

1997: Balanced Budget Act
Provides federal subsidies for states that set up health insurance plans for children in lower-income families.

2002: Trade Adjustment Assistance Reform Act
Provides 65% federal tax credit to offset the cost of health insurance premiums to individuals who have lost their jobs due to foreign competition or retirees ages 55 through 64 whose pension plans were taken over by the Pension Benefit Guaranty Corp.

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Q: What should be the government's role to ensure health care coverage and keep cost increases down?

Dr. Richard E. Anderson
Chairman of the Board of Governors
The Doctors Co.
Napa, Calif.

Government's role should be to ensure that patients who are injured are compensated fairly for their losses, but in a way that doesn't endanger access to care for the rest of the population. That means creating an environment in which a handful of cases won't elevate the risk to a level that premiums become so unaffordable that physicians, particularly in high-risk practices, are forced to stop practicing medicine or leave their state of practice.

In California, we have laws that include a $250,000 cap on noneconomic damages and that ultimately helps patients receive their money faster through fair settlements. The injured parties—rather than the attorneys—also get to keep a greater share of the award.

California's laws do more than help injured patients receive fair compensation for their injuries; they keep malpractice insurance premiums among the lowest in the nation. They also help all patients by lowering the state's annual health care costs by an estimated $6 billion. That translates into lower health insurance premiums for employers, accessible inner-city clinics and a greater availability of services for patients who receive care through Medi-Cal, the state's Medicaid program.

Charles Baker
President and Chief Executive Officer
Harvard Pilgrim Health Care Inc.
Wellesley, Mass.

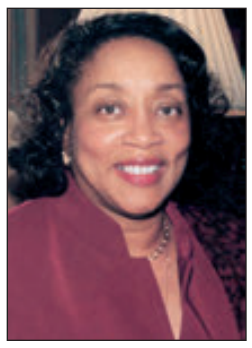
No one really knows the answer to this question, and I can't find a system anywhere in the world at this point that is succeeding in managing the growth in health care spending. In this country, the federal government probably owns the context for health care spending and service delivery.

Their efforts should be governed by three principles: everybody should have access to health insurance; the federal and state governments should coordinate their funding efforts around seniors and poor people; and government should be a regulator and a funding participant, but private health plans and private providers should carry out the day-to-day task of serving the citizenry.

Obviously, under the current set-up, we violate all three of these principles. Under these conditions, the role of government might be the following: adequately fund your own programs—cuts in Medicare and Medicaid splash back onto health plans and their members; figure out the relationship between Medicare and Medicaid and make it work for your constitutents; clean up the state and federal regulatory morass that oversees health care service providers and plans; move forward with HIPAA implementation—it is the only real attempt at standardization anywhere in health care; stop enacting unfunded mandates; enact some kind of tort reform, so that physicians don't feel obligated to over-order on tests and procedures; and develop some kind of clinical technology assessment program that could drive payment and authorization policies for all plans and providers to reduce the overuse and misuse of existing and new clinical technology.

Dr. L. Natalie Carroll
President
National Medical Assn.
Houston

If you're going to control costs, you should be looking at more than just doctors and hospitals, because there are more factors that go into the health care dollar.



The National Medical Assn. has supported universal care for some time, and we continue to support that. If you had universal health care that dealt with front-end things that were preventive, they would probably cost less than if you dealt with high-cost things on the back end that were reactive.

I think the government should seriously look at that. So often we look at it as an expense, but it really is an investment, because if you don't have a healthy workforce, you don't have a productive workforce.

Dr. Yank Coble
Immediate Past President
American Medical Assn.
Chicago

It is absolutely appropriate for the government to continue to help finance medical care for those in need, while leaving the provision of coverage and care primarily to the private market. However, the government subsidy for medical care could and should be restructured to expand coverage to the currently uninsured and foster greater choice and market competition.

Under the current system, the federal government subsidizes more than $100 billion per year in employee health benefits by exempting part of the compensation from federal income tax. This funding has the unintended effect of giving two-thirds of the subsidy to the wealthiest one-third of families.

The AMA proposes replacing the existing tax exclusion with tax credits to all individuals and families who buy health insurance. The credits would be inversely related to income and refundable to those who owe taxes less than the value of the tax credits. By offering an alternative to employee-based coverage, these reforms would rechannel much of the federal subsidy to those with lowest incomes, who are most likely to be uninsured and need assistance.

Maureen Cotter
Global Practice Director-Group and Health Care
Watson Wyatt Worldwide
Southfield, Mich.

First and foremost, the government needs to create a legislative and regulatory environment to bring about an effective defined contribution health care system through the creation of a uniform environment, appropriate tax incentives and more insurance options.

The government also must reform Medicare to provide comprehensive coverage, including prescription drug benefits. At the same time, it needs to incorporate into Medicare other proven cost management features, such as catastrophic case management, chronic care management and differential payment to high-quality providers who follow best practices in treatment and the use of technology.

The government also needs to create tax incentives that favor a 401(k)-type retirement health care plan that would allow employers to fund retiree health care benefits on a tax-effective basis and encourage workers to save for retiree health care needs. This is incredibly important, particularly as more and more companies look to get out of the business of providing future retirees with health care benefits.

Additionally, the government can help control health care costs by reducing the specter of malpractice threats and vicarious liability to plan sponsors; refraining from legislating and mandating coverage requirements; and building awareness around the public health crisis of obesity, which is leading to a dramatically higher incidence of diabetes, heart disease and other chronic conditions.

Helen Darling
President
Washington Business Group on Health
Washington

The government's role should be to provide information. It should be making certain that we have a strong science-based health care system. The government should make sure that information out of that science is made available in lay language and is made easy for people to access. Everything from television programs, libraries, senior citizen centers, the Internet. The government has a really valuable role to stimulate research and to make sure the results are available in a very objective way.

Philip J. Edmundson
Chief Executive Officer
William Gallagher Associates Insurance Brokers Inc.
Boston

Health care insurance systems for this country should work like our workers compensation system. Current government programs work well for most of the poor and the old. However, everyone who is working or in school needs to participate in health insurance plans. Employers should be mandated to offer health insurance benefits, just as there is a legal mandate for workers compensation. It is not equitable that some employers do not pick up their fair share of the expense. This approach also keeps everyone pointed through the most efficient portals—primary care physicians—rather than through the expensive doorway of the emergency room. And it keeps young people who choose to opt out of the system—a growing trend—from burdening the system through uncompensated care pools, which pick up the tab for their motorcycle accident or devastating illness.

Rick Elliott
Employee Benefits Practice Group Leader
Willis North America Inc.
Atlanta

First, the private insurance system should remain in place. We need less, not more, government intervention. We see change in the following priorities as appropriate important steps.

Eliminate "state mandated" benefits. There are 50 unique benefit mandates by each state that are often the result of special-interest lobbying efforts. This is an administrative nightmare.

Overhaul Medicare. It is outdated, difficult to understand and misses the boat entirely on the critical need of the elderly—prescription drugs.

Create a central clearinghouse containing information on cost and quality for hospitals and physicians. Today, consumers are totally sheltered from the true costs and lack the necessary information to make the informed purchases the future environment will demand.

Revamp laws such as the Americans with Disabilities Act and the Health Insurance Portability and Accountability Act to allow payers to offer meaningful incentives and disincentives for individuals to take responsibility for treatment and in managing their health.

Put in place caps on litigation and damages for malpractice but also create tools to police providers who are determined to be consistently incompetent or negligent.

Prevent people from being cut out of the system by loosening insurance company underwriting restrictions, particularly for individuals and small businesses.

Rep. Richard Gephardt, D-Mo.
House of Representatives
Washington

I believe the federal government should build on existing private and public structures to provide universal health care coverage. We should pay for it by repealing all the Bush tax cuts.

First, my plan would require every employer to provide access to quality health insurance coverage, with employer tax credits covering most of the cost. Employers that currently don't offer health insurance would receive a refundable tax credit equaling 60% of the full cost of the premium, a tax credit they'd pass through completely to their employees in the form of health insurance. For those employers that currently do offer health insurance, my plan replaces the existing tax deduction with a 60% refundable tax credit. To assist low-wage workers to pay the premium cost, the plan also provides an additional 25% refundable tax credit to workers whose income is up to 100% of the poverty level. This credit would phase out for workers making up to 200% of the poverty level.

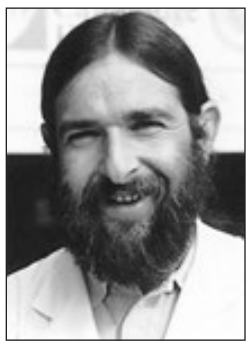
Second, my plan would expand existing public programs. A Medicare buy-in would let individuals between the ages of 55 and 64 purchase Medicare coverage. Also, a 65% federal subsidy for COBRA coverage would be created for the eligible unemployed. Finally, an extension of the State Children's Health Insurance Program and Medicaid coverage to the parents of eligible children would be combined with new efforts to enroll uninsured SCHIP-eligible children.

Barbara Hill
President
Express Scripts Inc.
St. Louis

What should be the government's role to ensure health care coverage and keep cost increases down? Three things: provide a safety net for those least able to pay, maintain the regulatory processes that will maintain quality, and encourage the use of market incentives to help control costs.

Dr. David U. Himmelstein,
Associate Professor of Medicine
Harvard Medical School
Cambridge, Mass.

Only a single-payer national health insurance plan can effectively contain costs while improving coverage. National health insurance could save hundreds of billions on administration by replacing our fragmented and duplicative insurance system with a single, more efficient, government plan. National health insurance in other nations has effectively contained costs and limited bureaucracy.



Rep. Charles Norwood R-Ga.
House Education and the Workforce Committee
Washington

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The government faces a very difficult role in both ensuring access to coverage and minimizing costs. The greater the role the government takes in providing coverage and keeping the costs down, the greater the exodus of providers from the system and the greater the strains placed on providers who cannot exit the system.

Providers are finding it increasingly difficult to accept Medicaid and Medicare patients because the reimbursement rates for those two programs have fallen so far. Hospitals are in crisis because of reimbursement levels.

Tim Padovese
President and Chief Executive Officer
Ophthalmic Mutual Insurance Co., A Risk Retention Group
San Francisco

One way the government could effect change is to reduce the number of years that pharmaceutical companies can retain rights to new drugs. Drug costs are a huge cost in the medical system, and giving exclusive rights to a company for, say, two or three years, then allowing generic drugs in should help drive down some costs.

George Pantos
Washington Counsel
Self-Insurance Institute of America Inc.
Washington

The private sector should be the primary force driving expanded access to affordable health coverage for more Americans. Any health care reform should be within the context of the employment-based private health care system. The government role to reduce the uninsured population should be to ensure that the private sector can operate in a regulatory environment that encourages innovation, competition and quality. This can be most easily done through tax credits and greater access to the favorable ERISA regulatory structure by smaller firms.

Specifically, the government can: encourage group health plans for small employers; encourage employers to fund retiree health benefits for employees who retire prior to Medicare eligibility; and expand the availability and flexibility of medical savings accounts. More than 150 million Americans now receive health coverage through private employers; this is clear evidence of how effective this approach has been over the past 25 years.

Mike Pickens
Arkansas Insurance Commissioner
President, National Assn. of Insurance Commissioners
Little Rock, Ark.

Speaking personally, I think the government's role in ensuring coverage and keeping costs down should be, first and foremost, "do no harm." Many would argue that increased government involvement in health care and insurance has stifled the free market and helped make insurance less affordable, increasing the number of uninsured. Government can and should make sure the free market works. There are also some good laws to pass. Legislated portability has proven to be a positive step and not very costly. I question whether guaranteed issue has been a success. It appears to be tantamount to allowing folks to wait to buy homeowners insurance until their house is on fire, resulting in cost increases of up to 15%.

Some experts argue we should pass laws to eliminate all preconditions for people who already have health insurance. The antitrust laws should be changed to allow local hospitals to develop specialties and jointly purchase expensive new equipment.

Government should enable and encourage people to buy insurance at large group rates and to buy medical care savings accounts. Give individual consumers tax credits or allow them to have the same tax breaks their employers get when they purchase health insurance.

Laurel Pickering
Executive Director
New York Business Group on Health
New York

The government's role should really be in the area of quality. The government should help create a national set of measures for health care providers and require the data be shared with the public. In addition, as the largest buyer of health care, the government should use its clout and give incentives to providers to improve quality and have better outcomes. This will reduce costs in the long run.

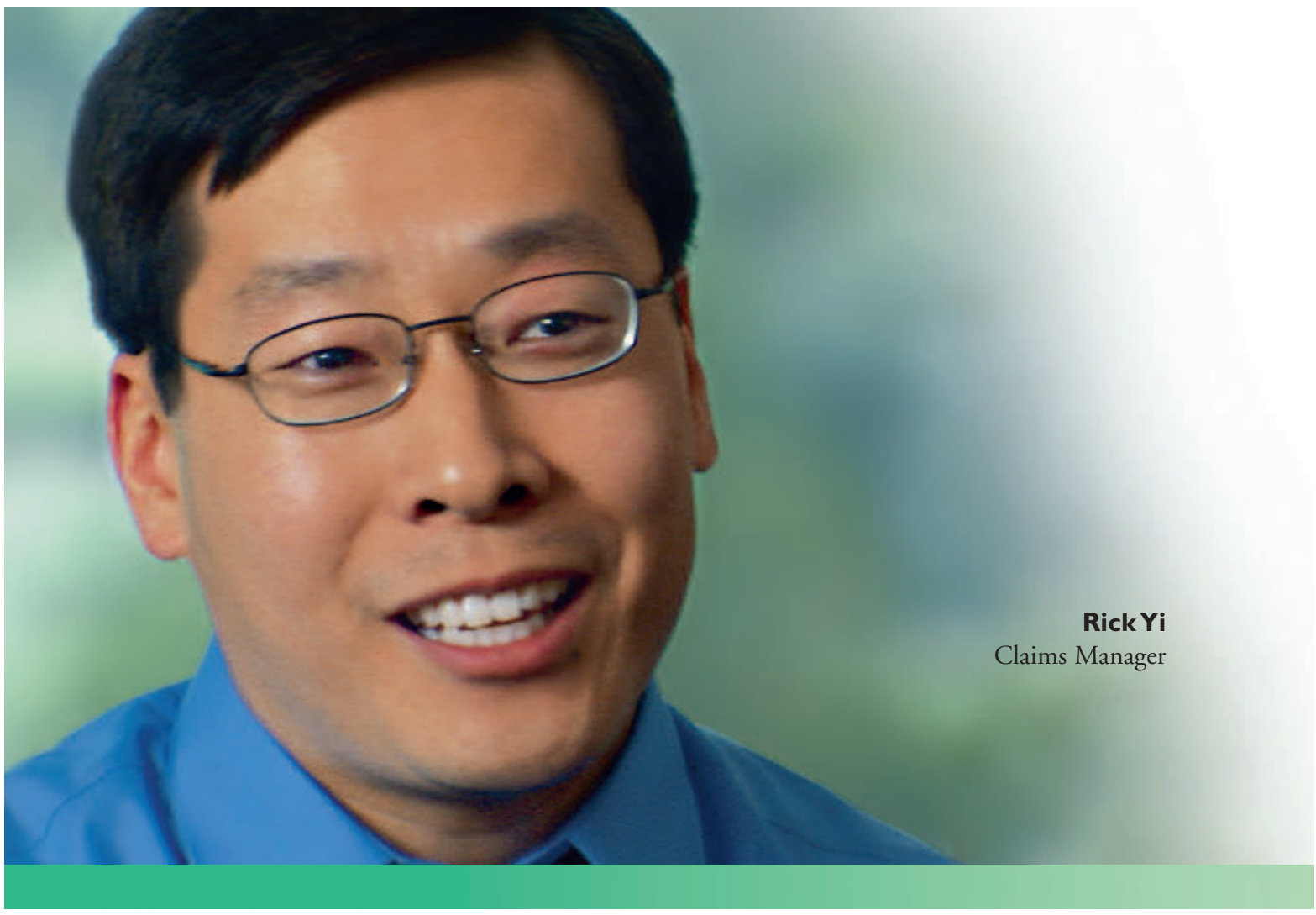
Covering the uninsured is critical, but the government has failed to adequately address this issue, and the quality agenda is something in which great strides are already being made.

J. Pat Rooney
Retired Chief Executive Officer
Golden Rule Insurance Co.
Lawrenceville, Ill.

Congress can take four immediate steps to increase coverage and control costs. Make medical savings accounts available to all Americans. In 2001, the IRS reported that 73% of all MSA buyers were pre-

Continued on page 22

"The best part of my job is helping people."



Rick's contact with customers goes beyond benefit checks and disability claims. Being unable to work due to sickness or injury has a unique impact on each of his customers. Rick and his co-workers offer the personal service their customers need to help get them through this difficult time in their lives. Want to know more? Call 1-866-491-8108 or visit www.unumprovident.com.

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Q: What should be the government's role to ensure health care coverage and keep cost increases down?

Continued from previous page

viously uninsured. MSAs are making insurance affordable for the first time for many. As far as I know, this is the only change in law that is bringing people into the health insurance system.

President Bush and Republicans and Democrats support providing money to uninsured Americans to buy health insurance. For the last 59 years, the tax-free world of health insurance benefits has been discriminatory. Congress has a wonderful opportunity to end the discrimination by providing money to the uninsured. Congress should open the door to affordable health insurance for residents of New Jersey and other states. Why can't a New Jersey family use the Internet or walk into an agent's office in Easton, Pa., and buy that policy?

Congress must strengthen state-based high-risk pools that provide access to affordable health insurance for people who can't qualify for coverage.

Nancy G. Ross
Partner
McDermott, Will & Emery
Chicago

The government should re-evaluate the private sector's current exclusive responsibility for medical care and increase the services covered by Medicare, including prescription drug coverage. The government should evaluate the advisability of cost control in the prescription drug industry as well as with respect to services by various medical providers.

Dallas Salisbury
President
Employee Benefit Research Institute
Washington

The government should continue to provide incentives for individuals and employers to have health insurance so that insured pool is as large as possible. The government should take great care as it prescribes privacy guidelines or what must be covered by a policy to assure that the cost-benefit in terms of coverage and effective medical delivery is carefully weighed. The government should either provide buy-in opportunities to the federal group pool or state employee pools for individuals who cannot find affordable comprehensive coverage in the open market, or provide a regulatory framework that assures individuals access to similar benefits at similar costs in the open market.

The government provides over 50% of the total revenue of many health facilities. What the government says it will pay or not pay for services will affect the costs to others—as well as what is available. It can help avoid cost spikes by being a sufficient and responsible payer, by avoiding mandates that add very large costs for limited value.

Greg Scandlen
Director of the Center
for Consumer Driven Health Care
Galen Institute
Alexandria, Va.

The government should revise its tax and regulatory policies to allow an even playing field for all forms of health care payment—direct pay, nongroup and employer-based coverage. Only then will we be able to determine the best form of payment for each service. If health care is a service worth subsidizing, the subsidy should the same for all Americans, at least as a baseline. Once that baseline is established, additional assistance can be provided for people with special needs. The subsidy should be set at something close to $1,000 per year per person. That is approximately the value of the current exclusion, and it is approximately what our society pays to provide services to the uninsured. The subsidy might vary according to age, since children cost less and older people cost more. But the government's role should be one of neutrality on what form of coverage an individual prefers.

Dr. Val Slayton
Chief Medical Officer
Fallon Community Health Plan
Worcester, Mass.

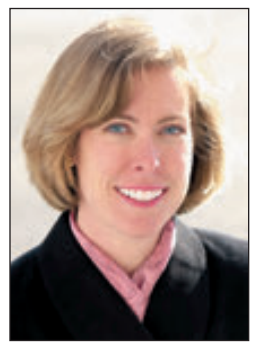
It's fair to say that there should be clearly established roles for both the government and private insurers, but I'd be in favor of approaches that occur in the context of private insurance models. For instance, with more than 44 million people uninsured in this country, creating tax incentives for small-business employers is one way to expand health care coverage. One other role of the government should be to increase the funding of public health preventive services, such as immunizations, flu shots and tobacco cessation programs, since these types of programs will reduce costs in the long run. Medicare+Choice plans have been extremely successful in improving the quality of care among seniors, and adequate government funding of these programs is essential.

Timothy J. Stanton
Partner
Gardner, Carton & Douglas
Chicago

What Churchill said of democracy could well be true about our employer-based health system: It is the worst possible system, except for all the others that have been tried. Knowing that, the government should focus on keeping employer-provided coverage viable and reducing impediments to employers offering coverage.

Kate Sullivan
Director-Health Care Policy
U.S. Chamber of Commerce
Washington

The best role for the government is that of providing financial resources for private health coverage. A careful balance must be struck between overregulating the products people can buy—which stifles market innovation to meet customers' needs and desires—and ensuring a level playing field for consumers.



The government, both federal and state, has an essential role that cannot be delegated to any other entity in overseeing health plans to make sure bad actors don't take advantage of consumers. In addition, the government should act as a safety net for those outside private insurance markets—the poor and those uninsured but living with a medical condition. These individuals may be served by formal programs to meet their coverage needs, such as Medicaid or high-risk pools, or, at the minimum, be able to access government-subsidized services in clinics and acute care settings.

Alan Winston
Vp and Manager-Health Care Division
GE Commercial Insurance
Overland Park, Kan.

For public-funded benefits such as Medicare and Medicaid, the government must stop using them as political pawns and footballs, and start running these programs like the businesses they are!

For group benefit plans: provide the incentives or regulations to let market forces tackle and solve the issues, with the cost of the solution borne equally by employers, payers, consumers and providers.

The medical malpractice crisis is a shared responsibility among many stakeholders. Tort reform and controlling runaway verdicts is one part of the solution, but that alone won't solve the problem. All stakeholders need to work together to reduce the medical errors that lead to bad outcomes. Insurers need to price liability coverage to reflect the true exposure. That's not a popular message but one that ensures they'll be there when physicians need them. And, finally, physicians and health care providers need to be reimbursed in a fashion that recognizes the value and quality of their specific services.

Systemic ailments blamed for malpractice crisis

By MICHAEL BRADFORD

Medical malpractice insurance, like other liability coverages, has seen the high pricing and availability problems of previous hard markets.

But this time around, there are some significant differences that have turned those coverage problems into a lingering crisis. The coverage has become so expensive that, in some states, physicians have closed practices or have moved to areas where the insurance costs less. Availability of care has suffered as doctors pull out of specialties such as obstetrics and gynecology and others that have been hit by frequent lawsuits and soaring insurance premiums.

In many cases, sources say, growing malpractice litigation has led doctors to practice defensive medicine by increasing the number of tests and procedures they perform. That, in turn, drives up the cost of health care.

Insurers and medical practitioners contend that the only way to solve the problem of rising malpractice coverage rates is to pass significant tort reform that caps damage awards to claimants. They face stiff opposition from trial attorneys, however, who argue that patients' rights cannot be trampled in the name of saving doctors money.

Many providers have weathered previous market restrictions, but this one comes with some twists that make it especially difficult.

"This is the third malpractice crisis since the mid-'70s," said James D. Hinton, vp-risk and insurance at HCA Inc. in Nashville, Tenn. "But things are different today," he added. For example, the growth of fixed fees paid by managed care plans and Medicare means "physicians don't have much flexibility to change their revenue stream."

Therefore, increases in premiums, which in many cases have more than doubled to well over $100,000 per year for some doctors, come straight out of the physician's take-home pay, Mr. Hinton explained.

Michael Cavanaugh, vp of marketing for GE Medical Protective Co., a malpractice insurer unit of GE Commercial Insurance in Fort Wayne, Ind., said that premiums have jumped in part because skyrocketing claims in recent years have made it difficult for insurers to price malpractice coverage. "Over the last three years, the number of (jury) awards over $1 million has more than tripled," he said.

Juries, in some cases, have developed a kind of "lottery mentality" in regard to malpractice awards, Mr. Cavanaugh said. "A million dollars doesn't sound like as much today as it did five or 10 years ago."

Worse than before

The current crisis has become more severe than those of earlier market cycles, experts agree, because of the conditions that bred the problems.

Policyholders weathered market cycles of the 1970s and 1980s only to watch the competition for malpractice premiums heat up again in the middle of the next decade. "Things were very, very right in the mid-'90s," said Dow Walker, chairman of Willis North America Inc.'s health care practice in Nashville. Insurers were making money on the coverage, and "everybody got a great idea: We need to write more of this."

The tide began to turn as competition drove rates down in the latter part of the decade. At the same time, the severity of losses began creeping up. Large jury awards against health care providers made headlines and, as combined ratios rose, insurers found themselves rethinking their commitment to malpractice insurance.

Mr. Hinton recalled that insurers' investments began to sour, and that put further strain on underwriters that were providing a coverage that was producing rising losses. The Sept. 11, 2001, terrorist attack "was a catastrophic hit for reinsurers," he said, and caused rates in many lines to spike.

The crisis became more or less official, though, when The St. Paul Cos. Inc.—then the largest writer of medical malpactice business—decided in December 2001 to exit that line. Other insurers that provided malpractice capacity failed, and many others retrenched.

"By 2002, what we had left were mostly malpractice-only compa-

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nies," many of which were physician mutuals, Mr. Hinton noted.

With a limited number of insurers and sympathetic regulators who allowed them to raise rates to levels the insurers felt they needed, prices have soared in the last three years, said Mr. Hinton.

The crisis continues today in what is a long-tail business, said Mr. Walker, as coverage written in the late 1990s still is "bringing in horrific losses."

"It's still a challenge," he remarked. "There's no question that rates will increase in 2004, and I don't think anybody will argue that they will increase in 2005."

Calls for reform

Observers agree that there is no quick fix. But insurers, brokers and policyholders say the best hope for stabilizing rates hinges on tort reform that will cap damage awards.

"The only solution is to have effective federal health care liability reform," said Lawrence E. Smarr, president of Rockville, Md.-based Physician Insurers Assn. of America, an organization of malpractice insurers. That has been proven by efforts on the state level, such as in California, where reforms that cap noneconomic damages in malpractice cases have led to a slowing of malpractice rate increases, Mr. Smarr said.

"Tort reform will work, and it needs to happen," agreed Tony Spohn, vp of state/member relations at AHA Financial Solutions, a Chicago-based subsidiary of the American Hospital Assn. "We're working as hard as we can to make tort reform happen."

As Mr. Spohn's group and others lobby for federal reforms that would cap damages in malpractice cases, they understand that the battle for changes is hard-pitched and success is not near. Mr. Walker said he thinks passage of federal tort reform would be "very, very difficult."

Although the House of Representatives has passed legislation that includes caps on noneconomic and punitive damages, few give it a good chance of clearing the Senate. Powerful opposition from trial lawyers, which makes the tort reform fight difficult in states as well, is expected to hamper passage of a federal bill, insurers say.

A spokesman for the American Academy of Trial Lawyers says that's as it should be.

Exorbitant malpractice rates have "nothing to do with payouts or litigation whatsoever," the spokesman suggested, and "limiting the rights of injured patients would have no impact" on coverage costs. "Taking away the legal rights of American families is hardly reform in any fashion."

Rates have continued to rise in states that have imposed caps on noneconomic damages, the spokesman noted, a point that insurers can't dispute. Mr. Smarr pointed out, though, that rates are going up because states are capping only noneconomic damages and not payouts for economic damages or claims-adjustment expenses. "We're going to see rates go up because these other areas are not capped," he said.

And rate increases are much less severe in states where reforms have been passed, such as California, than they are in states where no caps exist, insurers contend.

The spokesman for the trial lawyers' group said it's insurance reform, not tort reform, that will fix the malpractice insurance problem.

The elimination of antitrust exemptions, "so insurers can't conspire to fix rates," would help keep prices in check, the spokesman said, as would requirements calling for insurance companies to justify rate increases at public hearings.

Placing blame

There is, in fact, plenty of blame to share for the malpractice coverage problem, said Douglas C. Moat, chairman of Moat & Associates L.L.C., a consulting firm in Red Hook, N.Y.

"We have to be careful not to point a finger in an individual direction," Mr. Moat said. "Blame falls in a lot of places, and more significantly in some than others."

Trial lawyers deserve a good share of the blame, Mr. Moat said, explaining that while they argue that reforms would hamper the ability of patients to sue and be made whole, no indemnity is paid in most malpractice cases, suggesting that most cases are baseless.

The cost of defending those cases is huge, though, according to Mr. Moat, who cited figures from A.M. Best Co. showing that in 2001, insurers spent $35 on evaluating and defending malpractice claims for every $100 in malpractice claims payments.

Attorneys are driven by contingency fees that they earn from awards or settlements in malpractice cases, he noted, and, in many cases, insurers will opt to settle rather than face a jury. "Something is paid out, and lawyers get a piece of that."

Mr. Cavanaugh of GE Medical Protective pointed out that "as medical malpractice awards go up, so do settlements. A good attorney will leverage the latest jury award in trying to settle a case."

Doctors, though, share some responsibility, according to Mr. Moat. "They know who the weaker people are," he said, and could be more aggressive in weeding out those doctors whose practices are subpar.

"Insurers are at fault also," Mr. Moat said. "Some of them rushed in and sold coverage at premiums that were too low. Then, all of a sudden, the insurance companies were in trouble financially."

"There's still a fair number of us out there," Mr. Cavanaugh said of malpractice underwriters, although he termed it a "very fragmented marketplace."

While GE Medical Protective writes coverage nationally, many other insurers exist in only one or two states, and many are doctor-owned mutuals, he said.

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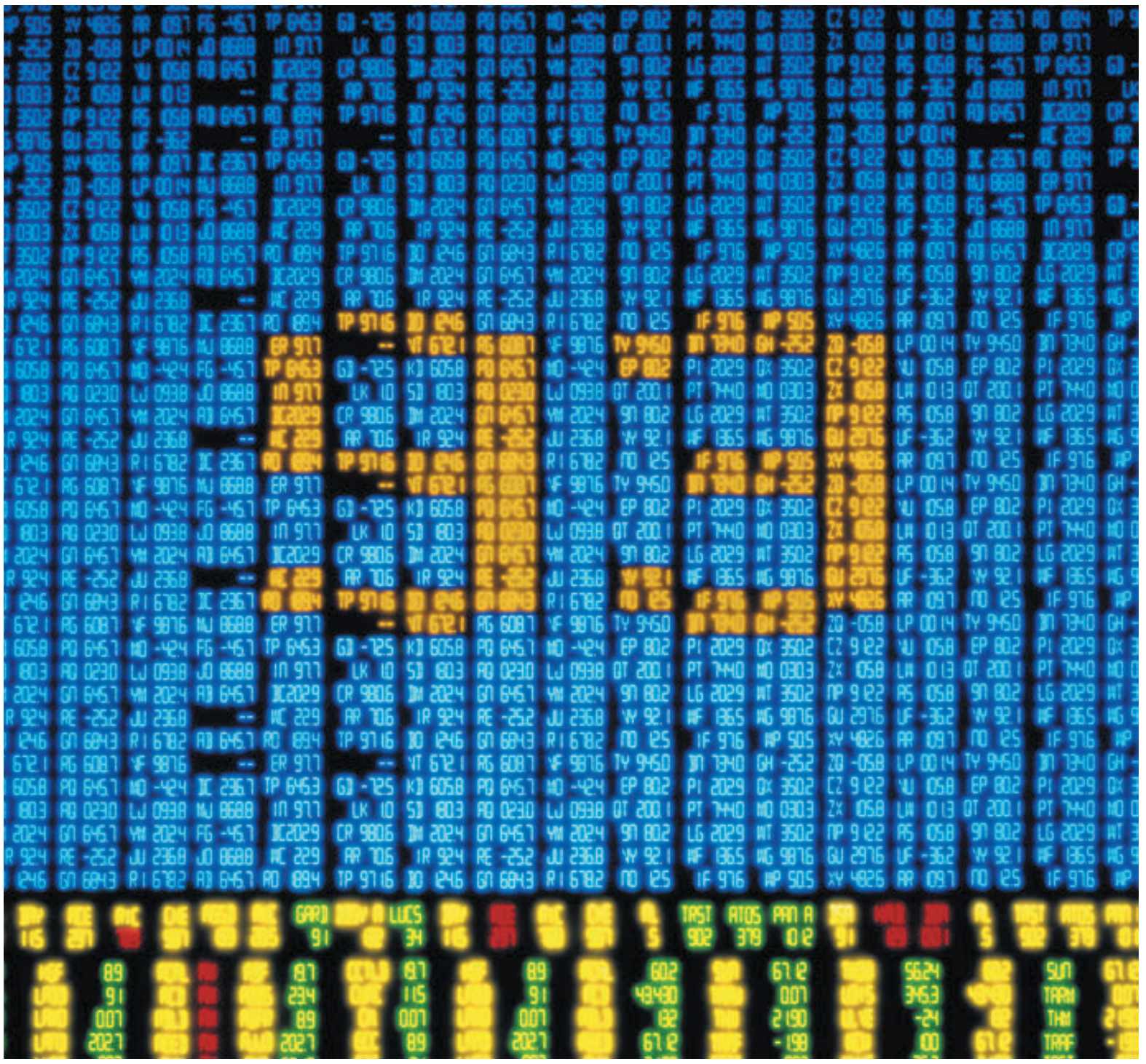

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Q: What are the most important steps that can be taken to control costs?

Drew Altman
President and Chief Executive Officer
Henry J. Kaiser Family Foundation
Menlo Park, Calif.

There are no big new ideas on the table to control costs. The managed care backlash robbed managed care of much of its capacity to control costs, but government regulation of the kind practiced in other developed nations is not in the cards in the United States.

Measures like disease management or consumer-driven health care could have some impact at the margin, but health care costs will continue to increase at a rapid rate and, ultimately, we will pay, because the American people value their health care. The big thing to worry about is that those least able to pay will be hurt the most as employers shift costs to workers and trim benefits and states cut Medicaid.

G. Lawrence Atkins
Senior Director-Public Policy and Reimbursement
Schering-Plough Corp.
Washington

The two most important steps to ensure we get the most from our health care dollars: create sensitivity to cost so consumers learn to make do with limited resources; and create value purchasing—the capacity to compare benefits and costs and make choices on the basis of value.

We won't keep costs from rising—health care spending will rise because medicine can do more and as it can do more, people want more done, and they will choose to spend their money that way. But we can get better outcomes for our money.

We need to equip decision-makers with the information—transparent pricing, medical evidence, technology assessments—that can help purchasers and patients select the items and services and use them in a way that can make the most difference.

Bruce Bodaken
Chairman and Chief Executive Officer
Blue Shield of California
San Francisco

Though it may seem counterintuitive, one of the most important steps we could take to control costs would be to establish universal coverage through a system of universal responsibility. Under such a system, all employers and individuals would be required to pay their fair share toward the cost of coverage, and the government would fully fund existing insurance programs for the poor.

Universal coverage through universal responsibility is a critical first step in controlling costs in two respects. First, it would dramatically reduce the massive shifting of costs from uninsured and government-insured patients to privately insured ones. That would immediately relieve some of the cost pressure on insurance premiums. Second, universal coverage by way of universal responsibility would make cost containment a lot easier to achieve by making more effective use of resources (e.g., primary care vs. emergency rooms).

Rep. John Boehner, R-Ohio
Chairman-House Education and the Workforce Committee
Washington

Federal and state lawmakers must stop putting excessive mandates on employers who are voluntarily sponsoring health care coverage for their workers. The drive for more mandates may be well-meaning, but the resulting cost increases have had a devastating effect on small businesses and their ability to provide health care to their workers. In many instances, these mandates are unnecessary because employers find that their own employees don't need such coverage, but employers are forced by law to pay for it nonetheless. Some states are re-examining the need for statutory mandates because of their implications on workers.

On April 11, 2002, Maine's Independent Gov. Angus King vetoed a bill to expand the state's mental health parity law, saying that while it was "well-intentioned," it was passed "in a period of dramatically escalating health care and insurance costs." Gov. King, citing health care premiums for employers that were rising by as much as 50% in his state, also said that "while expanding mental health care is a worthy goal, we cannot allow the best (comprehensive coverage including mental health benefits) to become the enemy of the good (any coverage at all)."

Lawmakers must carefully consider the impact of new mandates before enacting proposals that increase costs and force more Americans to lose their insurance.

Peter Boland
President
Boland Healthcare
Berkeley, Calif.

The most important step is to acknowledge that both traditional insurance concepts and payment systems are fundamentally out of sync with the reality of a population driven more by chronic care than acute care. If stakeholders are truly serious about stemming costs—instead of merely transferring costs—then the industry must embrace risk-adjusted outcome methodologies as a basis for payment and increasing purchaser value.

Tracey Carragher
President
Cambridge Integrated Services Group
Cranbury, N.J.

With the skyrocketing costs of workers compensation medical care and other employee health care benefits, employers have begun to recognize that comprehensive managed care services, including case management and bill-review services, can play a significant role in containing these costs. Early intervention by a highly qualified and experienced case manager is one of the best ways to ensure appropriateness of medical care services, quality of the care provided and maximum value for services rendered for both the injured party and his or her insurer.

Becky Cherney
Chief Executive Officer
Central Florida Healthcare Coalition
Orlando, Fla.

I believe the major costs involve the delivery system. We simply must improve care—and that includes safety—using evidence-based medicine and process improvement.

Information technology will be a driving factor. Some problems are simple, and some are more complex. For instance, why in the world are we still having issues with physicians' handwriting? After all, we have handheld computers that can solve the handwriting problem, serving as that little "extra brain" to give physicians reminders on drug safety and interactions.

Even with technology tools available to solve major systems problems, they will not be helpful or lead to cost savings until they are fully utilized.

Suzanne Delbanco
Executive Director
Leapfrog Group
Washington

First, we can make a concerted effort to rid the health care system of the defects inherent in how health care is delivered today. If we can get the right care to the right person, at the right time and in the right way, we will save a tremendous amount of resources that today are wasted.

Second, we need consistent, standardized ways to measure health care performance, with publicly reported results so that purchasers and consumers can make value-based health care decisions.

Dr. Paul Ellwood
President
Jackson Hole Group & InterStudy
Bondurant, Wyo.

For providers, urgent adoption of paperless information technology, Internet-based services, measurement and accountability for outcomes, and reliance on evidence-based guidelines. For consumers, a severable agreement with their physician to share knowledge and to accept evidence-based medical care. The federal government needs to establish a new quasi-public agency like the Federal Reserve (separate from their reimbursement activities) responsible for comprehensive health policy strategy and establishing standards for IT, interoperability, outcome data collection and evidence-based guidelines.

Karen Ignagni
President and Chief Executive Officer
American Assn. of Health Plans
Washington

Develop a comprehensive solution for the uninsured problem. The Institute of Medicine suggests that the uninsured are likely to receive too little medical care and receive it too late, and they often lack regular access to medications for chronic disease. The cost of care for those who lack insurance thus exceeds what it would be if individuals had regular access, and that cost is borne by those with insurance.

Enact malpractice reform. Lawsuits in record numbers are being brought against physicians, hospitals, nursing homes and health plans. Physicians can no longer afford their malpractice premiums and are moving or closing their practices. They are focused more on guarding against lawsuits than on their best judgments about care. This situation raises costs, lowers quality, limits access and erodes trust.

Promote first-class disease management. Much is known about how to care for people with various chronic diseases, but this knowledge is not being put into practice consistently.

Move to an evidence-based health care system. The IOM estimates that nonadherence to evidence-based care by physicians and consumers accounts for nearly 25% of U.S. health care expenditures.

Develop an alternative to the current approach to health care mandates. More than a dozen states have proposed or adopted mandate reform that includes analysis of quality, cost and/or impact on the uninsured before a mandate can be enacted.

Arnold Katz
President
Brokerage Concepts Inc.
King of Prussia, Pa.

The most important step that can be taken to control costs is the continuing education and dialogue among all of the parties involved in the health care process. Consumers do not approach health care in the same manner that they do other purchases; often, decisions regarding health care are made quickly and under great stress. As an industry, we have tried to influence consumer behavior by increased cost-sharing—such as deductibles, coinsurance, copayments and incentives for using generic drugs—and through elements of managed care, such as utilization management and the use of provider networks. The point is to make the purchaser think about health care before the moment of crisis to help control costs from all perspectives. In addition, we need to discourage regional hospital competition for the latest—and usually duplicate—equipment, lobby legislators for malpractice reform and control insurance abuse and fraud.

David Klein
President and Chief Operating Officer
Excellus BlueCross BlueShield
Rochester, N.Y.

For government, stop mandates and reduce defensive medicine by enacting tort reform. For physicians, prescribe more generic drugs where warranted and urge patients to exercise and watch their diets. For insurers, keep administrative costs at efficient levels and educate consumers on the value of exercise and proper diets. For hospitals, be open to performance measurements. For consumers, get off the couch and exercise and watch your diets. Nearly every cost-cutting public policy doesn't have nearly the cost-saving potential of well-educated, active consumers.

Brian R. Klepper
Executive Director
Center for Practical Health Reform
Orange Park, Fla.

Six broad steps would dramatically enhance our ability to manage cost and quality. It's important to note that these changes are more about structure and less about philosophy. They'll impact how care is delivered and how cost is created, rather than how the money flows.

We should first establish systemwide rules for a universally compatible information platform—hardware and software—so everyone involved in health care can exchange information easily. This step would provide the essential underpinnings of any larger cost-management effort.

That would allow us to develop a national data repository that we could

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mine to identify evidence-based national best practice guidelines and understand performance to create accountability throughout the system.

In addition, we should establish a national technology assessment function so we can figure out the efficacy and cost benefit of innovations before they go to market and we begin to pay for them.

Finally, we must rebalance our health care liability system—we need to fix torts and our quality management mechanisms—so that patients are protected, litigation awards are reliable and the health system remains viable.

Joe Marlowe
Senior Vp
Aon Consulting Inc.
Conshohocken, Pa.

The United States faces a significant challenge with rising medical expenditures, which, if left unchecked, will account for 20% or more of gross domestic product by 2011.

All parties with a vested interest—government, plan sponsors, insurers, medical providers and consumers—must contribute if the country is to slay the cost dragon.

Government needs to assert its leverage as the nation's largest health care purchaser to force changes that reduce the amount of unnecessary and low-quality services. One target should be the acute care-focused delivery system, in light of the growing number of people with chronic illness.

Plan sponsors should redesign employee contributions and benefit structure (e.g., coinsurance) to encourage employees to select more efficient managed health plans. They must not be afraid to experiment with new design options, such as consumer-driven health plans. They should invest in programs that keep plan members healthier.

Health plans need to increase their reliance on managed care techniques, such as hospital concurrent review, case management and disease management.

All parties need to work toward mandating the reporting of standardized quality information to consumers and convincing consumers that quality problems are real. The government, health plans and plan sponsors should reward quality outcomes with improved payments.

Tony Miller
Chief Executive Officer
Definity Health
Minneapolis

First, permit consumers to own more of their plan benefit dollars, allowing the construction of benefit plans that better reflect individual needs (create a first-party-payer system, rather than enhancing the third-party-payer system). This means developing new financial products that encourage consumers to think about investing in health care over their lifetime with annuities and insurance products, moving out of the annual cycle of funding health benefits.

Second, advance the metrics and information that make transparent key health care purchasing metrics—price, quality and service.

Third, develop services that engage consumers in shared decision-making for the choices they will face in the new health care environment, such as benefit choices, provider choices and health choices.

Rep. Charlie Norwood R-Ga.
House Education and the Workforce Committee
Washington

First, Congress can deliver to the president a bill that limits the costs of professional liability.

I am not going to argue for any specific limit; I just know there needs to be one. Congress needs to create incentives to get more people onto the insurance rolls.

The more people who are insured, the easier it is for Congress to focus on those that are difficult to insure—through high-risk pools, etc.—and on those uninsured that drive unreimbursed care.

Carolyn Pare
Chief Executive Officer
Buyers Health Care Action Group
Bloomington, Minn.

Improvements in patient safety and the effective management of overuse, underuse and waste could save money and lives. I think we need to let the consumer know that there is variability in care and outcomes and give them the financial leverage they need to demand better. In the interim, I think employer purchasers need to be more savvy in how they evaluate, select and compensate providers. We need to devise a system that pays to keep people well instead of paying for mistakes and rework.

Jeffrey W. Pettegrew
Vp-Risk Management and Insurance
Westaff Inc.
Walnut Creek, Calif.

Besides some professional liability relief, health insurers and employers need to provide more substantive wellness programs with increased awareness and education, targeted intervention strategies and more aggressive managed care. It may have to be integrated into plan design to ensure participation. Much of the general public has grown too dependent on prescription drugs and medical providers to solve their health problems when, in fact, a change of lifestyle and improved eating habits could greatly improve their health.

David Snow
President and Chief Executive Officer
Medco Health Solutions Inc.
Franklin Lakes, N.J.

The first step is to determine, as a society through sound public policy, what is enough. In an ideal world, there would be universal access to unlimited care at no cost. But that simply is not feasible. The fact is, we have finite resources and we must establish and promote prudent

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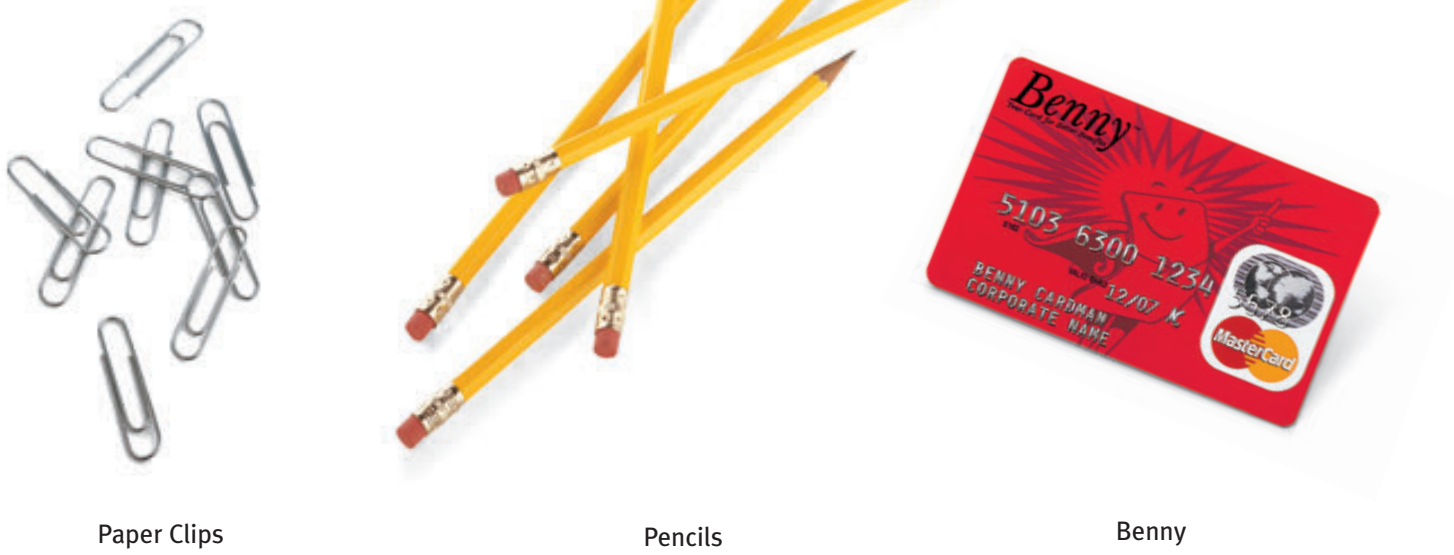

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Q: What are the most important steps that can be taken to control costs?

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buyer behavior.

Federal and state governments, as well as employers, have the greatest ability to effectively control costs by determining the level of burden they are capable of bearing. Without a doubt, there are difficult decisions that need to be made, but the outcomes speak for themselves. By initiating consumer-driven plans and empowering individuals to share in the responsibility, companies will be able to continue to offer quality health care to their employees. But we all must recognize a responsibility to do our part.

Mark Ugoretz
President
ERISA Industry Committee
Washington

You can't improve what you don't measure, so the first and most important step is to compare costs and measure performance. We literally can't afford to wait until we have perfect measures or better means of developing measures than we do today. Once we start using the measures we have now, all stakeholders will have an interest in improving the accuracy of the measures over time (which is not the case now). The second step is to design health care coverage in ways that give consumers understandable choices and financial incentives to seek out the most cost-effective treatments from the most cost-effective health care providers without exposing them to such high out-of-pocket costs that they forgo medically necessary and appropriate treatment. The third step is to implement health care provider payment systems that reward superior performance. If we take those three steps, we will be well on our way to a much less dysfunctional health care system.

John L. Ward
Chief Executive Officer
Ward Group
Cincinnati

Controlling costs will lead to a more effective system of health care and will ensure that more Americans have the opportunity to obtain health insurance coverage. Studies estimate that for each 1% increase in health insurance premiums, several hundred thousand lose their health insurance coverage. Therefore, controlling costs is important to making the system work better.

One particularly troublesome driver of costs is increasing malpractice awards. Litigation involving health care has grown dramatically over the past 20 to 25 years. The increased threat of litigation forces medical providers to perform unnecessary procedures. In addition, rising medical malpractice insurance rates require that health care providers charge higher fees for their services. Both contribute to rising health care costs and could be better managed through effective tort reform.

Also, all the affected parties must have "skin in the game." Employers and employees must continue to work together to deal with cost-sharing issues in a fair and honest manner.

Bill Van Faasen
Chairman, President and Chief Executive Officer
Blue Cross & Blue Shield of Massachusetts
Boston

At Blue Cross & Blue Shield of Massachusetts, we believe medical management is one of the important steps that health plans can take to control costs. The first phase of our strategy, disease management, works with members with chronic diseases like congestive heart failure and diabetes. In the second phase, we work with members who may be in transition for future adverse health outcomes using a proactive health management program. We have excellent preliminary results for both phases. This tells us that we can improve our members' health care, improve their clinical outcomes and avoid the predictable and undesirable health outcomes that contribute so dramatically to increased costs.

Patrick E. Welch
President
CIGNA HealthCare
Bloomfield, Conn.

Improving quality is the key to controlling costs. That means more than only reducing administrative inefficiencies and medical errors, although that is an important start. For sustained cost control, health care industry resources must be focused on helping the 20% of the population who typically drive 80% of the costs. Disease management and case management programs, for example, help people deal more effectively with chronic or severe health conditions. Technology enables us to identify patients at risk, and then we can help them manage the risk and stay healthy longer.

Likewise, we need to help people care for their total health by integrating medical with pharmacy, dental, behavioral and other specialties. There are people who take medications that are inappropriate, either in terms of potential interactions with drugs related to another illness or because the medication is ineffective for their condition. By evaluating data across a person's entire medical program, we reduce costs and sometimes even save lives.

Finally, adopting a common set of quality standards for health care programs and delivery would go a long way toward ensuring consistent, high-quality health care while achieving greater cost efficiencies.

Steve Wetzell
Founding Member and Strategic Consultant
The Leapfrog Group
Minneapolis

There are three critical elements: vastly improving the disclosure and transparency of provider- and treatment-level quality and efficiency information, linking provider payments and market share to these measures, and creating incentives for consumers to use the most effective providers and treatments based on publicly disclosed standard performance measures.

We should set a national goal to have a comprehensive set of publicly reported national performance measures for individual hospitals, physicians, treatments and health plans fully implemented by Jan. 1, 2007. These measures should include indicators of clinical quality, patient experience, efficiency and equity.

Federal and state purchasers should take immediate steps to lead by example by demanding the rapid development and implementation of a national performance measurement set. Work should begin now to restructure Medicare and Medicaid to pay providers based on these measures and encourage beneficiaries to use the most effective treatments and providers.

Employers and private insurers should also take immediate steps to structure programs that link provider and consumer incentives to the standard set of national provider and treatment performance measures so public and private payers consistently reward providers and treatments that show superior quality and efficiency.

Steve Wiggins
Chief Executive Officer
HealthMarket
Norwalk, Conn.

There is no single silver bullet. Controlling costs is possible only by doing a lot of little things right—and any one can cause big problems.

Here are a few to focus on. Improve fraud detection. Get the right patients to the right disease management programs. Unleash the power of the consumer with plan designs that encourage more comparison shopping. Expose the market's variable provider pricing and encourage the most price-sensitive consumers to access the lowest-cost service providers, since there is

Buyers joining coalitions to stem costs

By MICHAEL PRINCE

As health care costs continue to rise, more employers are joining health care coalitions in an effort to contain spending.

These coalitions, often called business groups on health, have existed in most metropolitan areas for years and count employers—and sometimes health plans and hospitals—as their members. With coalitions, employers join forces and pool their buying power in an effort to obtain better prices from health plans.

"Employers don't need us when things are going well. Now they do," said Laurel Pickering, executive director of the New York Business Group on Health.

"In the last two years, there has been a lot of interest in what we do," said Jerry Burgess, president and chief executive officer of HealthCare 21 Business Coalition in Knoxville, Tenn.

Many employers formed coalitions during the 1980s, before managed care became the dominant form of controlling costs. As the health care cost crisis grows worse, not only are more employers looking to coalitions but they are also energizing them with a newfound zeal for collective action.

"The coalition movement has never been stronger. With the return of double-digit cost increases, employers are searching for partners to help them. When costs flattened through the mid-'90s, some interest was lost, but the momentum is growing now," according to Becky Cherney, president and CEO of the Central Florida Health Care Coalition in Orlando.

For an employer, the advantage of joining a coalition is "leverage," said Teresa Riggs, benefits administration manager at Bechtel Jacobs Co. L.L.C. in Oak Ridge, Tenn.

"It's a smart way to try to leverage your power and the No. 1 way to save costs or, at least, contain costs," Ms. Riggs said.

Simply put, buyers become bigger by combining forces. And size commands a better price, experts say. This collective power gives coalitions the ability to make changes that individual employers cannot make.

"A single employer in a marketplace, no matter how large they are, is not able to change the delivery system," according to Ms. Cherney.

Just as important, though, is the fact that coalition members can also share information about best practices and methods that have worked to rein in costs.

"You can learn a lot from some of the ways other people are doing things," Ms. Riggs said.

Collective action also can push health plans and health care providers to improve quality and provide employers with better value for their dollars, Mr. Burgess said.

For example, numerous coali-

Simply put, buyers become bigger by joining forces. And size commands a better price, experts say.

tions support the efforts by The Leapfrog Group—a Washington-based national coalition of more than 100 public and private organizations that provide health care benefits—and they have aggressively pressed local hospitals to implement the Leapfrog programs aimed at reducing medical errors. Employers have more clout as a group to press hospitals for changes than if they were to act individually, Mr. Burgess said.

Also, numerous employers in the New York Business Group on Health are using a coalition-issued request to health plans for information that focuses on quality, said Arleane Soto Baltrusitis, vp of benefits at American Express Co. in New York. By working in unison, the employers get more detailed responses from the health plans than if each acted alone, "because our numbers were now so much larger," Ms. Baltrusitis said.

An example of the power of group buying is a program launched this year by HealthCare 21 Business Coalition, Mr. Burgess said.

To help counter the rising cost of prescription drugs, the coalition negotiated a drug plan with various prescription benefit managers and selected the one with the best combination of price and service. The coalition's members were then invited to switch to this new program, offered by the Deerfield, Ill.-based Walgreens Health Initiatives, Mr. Burgess explained.

As part of its analysis, the coalition compared the Walgreens plan with employers' past drug claims and calculated that their members could save between 8% and 12% on their drug costs by switching, he said.

This better price stems directly from the greater buying power of the group, Mr. Burgess explained.

Since its inception in January, eight employers have signed up for the program. Others are planning to add it once their current programs expire, Mr. Burgess said.

The program demonstrates both the strengths and weaknesses of coalitions. While coalitions can indeed demand better prices, few employers utilize them.

Many employers do not want to relinquish their independence and submit to a group approach, Ms. Riggs said. For example, the most successful coalitions have a common strategy to health care purchasing. To become involved in a coalition means an employer must compromise, she said, "and they don't always want to do that."

To succeed, a coalition's members have to agree on a plan, said Helen Darling, president of the Washington Business Group on Health. But this is not always easy. For example, a national employer often will refuse to participate in a coalition's group buying plan if it means adopting a different plan design than the one it uses for its employees throughout the United States, she explained.

The lack of employer cooperation represents the biggest barrier to success for a coalition, Ms. Pickering said. "Some employers don't see the value right away of working together," she said.

Coalitions have the ability to bring together talent and create

See COALITIONS/next page

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Q: How will health care plan design change in the future?

Tom Beauregard
Consultant
Hewitt Associates Inc.
Norwalk, Conn.

We're currently moving from traditional managed care co-payment designs to a prevalent design model that will incorporate more deductible and coinsurance features.

This is a good first step as it creates "skin in the game" for the participant and results in a bit more price transparency at the provider level.

With this, we are seeing employers more aggressively utilize health reimbursement arrangements as incentives for employees to elect lower-cost plans. Beyond these fairly basic design directions, I expect to see models that incorporate choice that goes beyond these simple risk/coverage decisions. I expect employers to begin to give employees designs that offer lower price points in exchange for narrower provider networks, commitments to participate in disease management programs and commitments to elect lower cost options for more then one year.

In other words, we will see designs that offer employees more explicit choices in risk, medical management and provider access in exchange for less cost-sharing.

In order for this next generation of choice to be meaningful and effective, we need to continue to make progress on identifying providers based on quality and price measures.

Barbara Blakeney
President
American Nurses Assn.
Washington

Most health care plans, including Medicare, provide coverage of acute medical needs but fall short in some important areas. For example, Medicare does not offer adequate coverage of the range of primary and preventive health care services to meet people's needs. Health care plans should shift from a primarily illness-focused medical model to one that addresses the continuum of Americans' health care needs, with an emphasis on prevention and primary care, including outpatient prescription drug benefits and adequate mental health benefits.

Plans also should eliminate inappropriate restrictions on nursing practice to enable full utilization of registered nurses, including advanced-practice nurses, nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified nurse anesthetists. APRNs have been providing primary and preventive care to patients for more than 35 years. All APRNs must meet rigorous education, certification and continuing education requirements. Today, there are more than 160,000 APRNs in the United States, and research shows that, in terms of quality of care, patient satisfaction and cost-effectiveness, they are among the best values in health care.

Mary Case
Principal
Buck Consultants Inc.
New York

How will it change, or how should it change? Over the short term, I think

Continued on next page

Coalitions: Leverage sought

Continued from previous page

programs, "but then, it's up to the membership to take it and implement it," said Ted Chien, national thought leader at Watson Wyatt Worldwide in Minneapolis.

Coalitions also lose their potency if they spend too much time talking and not enough time devoted to action, Mr. Chien said. These coalitions become purely about information sharing and don't develop the important buying power that coalitions naturally possess, he said.

Alain Enthoven, Marriner S. Eccles professor emeritus of public and private management at Stanford University Graduate School of Business in Stanford, Calif., said coalitions haven't lived up to their potential. "Coalitions have failed to pull together on a coordinated, rational strategy to make the market work," he said.

In general, coalitions have been strong in measuring and promoting quality but have performed poorly in controlling costs, he said. He blamed employers for failing to adopt health care buying strategies that push plans to become more efficient and less costly.

"Employers are all over the map," he said. "They don't have a coherent strategy."

But even working together, the group buying power might not have much impact on costs, Ms. Baltrusitis said. In particular, self-insured employers will see little savings from group purchasing negotiations with health plans, she said.

Ms. Baltrusitis also acknowledged that the added negotiating power simply would not be sufficient to lower costs that are rising for all employers due to many factors.

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Q: How will health care plan design change in the future?

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we'll see mostly incremental changes within today's "traditional" offerings, as employers work through their views on health care, benefits compensation and competitive positioning. If health care continues to increase at its current clip, I think we'll see more fundamental change.

I think the new consumer-based designs have a lot of appeal, mostly because they try to make health insurance look like insurance again. As cost-sharing increases on claims, I wouldn't be surprised to see some employers—particularly those with wide variations in pay levels—moving toward some kind of pay-based designs ("catastrophic" has a very different meaning at $25,000 a year than at $300,000). I also think there will be increased focus on the level and design/allocation of the employer subsidy of the cost of coverage (active vs. retiree, employee vs. dependent, etc.)

Over the past year, I have seen less focus on "what do the other guys do?" and more on "what can we afford, and how should we allocate the funds we can afford?" which I consider encouraging. The current buyer's employment market creates a window of opportunity for employers to move out of the follow-the-leader mode and to change their program designs to meet their own and their employees' needs.

James E. Crockett
Manager of Risk & Benefits
Denver Water
Denver

From an employer's perspective, as premium costs continue to rise, I think they will reach a point where they are unaffordable for employees and employers. So, I think health plans of the future will have high deductibles, limited coverages and will be customized and designed for individual employees, who will pay the appropriate costs. This would mean that an out-of-shape, overweight employee who smokes and drinks will end up paying a greater share of the health plan costs than someone who is relatively healthy.

Gary Earl
Vp-Benefits
Park Place Entertainment
Las Vegas

The future plan design will have an open, directed access channel to preventative, diagnostic and wellness-based benefits and initiatives.

Prevention, education and wellness-related programs will be filtered into the actual plan design, eliminating today's challenges relative to accessibility and affordability. Conversely, program design will need to be tailored to accommodate, or tolerate within reason, poor behavior and lifestyle choices, yet balance these plan design components with compassion and appropriateness as it relates to disease and/or areas such as addictions.

Tomorrow's plans will remain optional; however, strong and fully communicated incentives and penalties will exist in order to balance flexibility and viability. Incentives will need to become a standard and no longer an option. People will need to be consistently rewarded for process understanding and program utilization as well as lifestyle behavior and modification.

Creative networking and channeling will need to become a standard and will need to be designed to accommodate the ever-changing professional environment from a provider/supplier standpoint.

Finally, a system of education and communications as well as support will need to become a component of the core program plan design. Several of today's optional services, such as employee assistance programs, will need to take on more active roles such as that of system navigator.

Dr. Richard H. Egdahl
Founder
Health Care Entrepreneurship Institute
Boston

The focus will increasingly be on benefit changes to fix the rate of increase in corporate expenses. Many different plans, with a key goal of achieving a defined contribution from the company, will be available. Benefit changes, such as corporate payment only for employees, but not their families, or increasing copays to cover health care inflation greater than general inflation, will be the norm.

John C. Erb
Senior Manager
Deloitte & Touche L.L.P.
Miami

The prevailing copayment design seen in managed care and prescription plans will, at some point, revert to more traditional cost-sharing mechanisms such as deductibles and coinsurance. Managing the financial risk associated with health care must be a priority not only for employers but also for the participants in employer-sponsored plans.

The emergence of employer-funded health care reimbursement accounts may smooth the transition for employees long used to minimal out-of-pocket health care expenses. But we must return to the basics of insurance in our programs if we are to preserve employer-sponsored health care benefits.

Marianne Fazen
Executive Director
Dallas-Fort Worth Business Group on Health
Dallas

Changes will include: tiered provider networks based on patient outcomes, patient satisfaction and cost efficiencies; "pay-for-performance" arrangements with providers that reward superior performance with higher reimbursements and greater market share; higher deductibles and copays for employee health plans; steerage toward generic drugs through financial tiering in formularies; and designated "centers of excellence" for selected hospital procedures, such as bypass surgery, angioplasty, aortic aneurysm repairs and childbirth.

Ken Feltman
Executive Director
Employers Council on Flexible Compensation
Washington

I think that employers for many reasons will continue to move toward the defined contribution approach. As they do that, employees are going to demand more information and more control, as they should. The idea of the benevolent government or the benevolent employer providing something is over. Now, the employee will be more involved in very specifically designing a health care program for his or her family, and, therefore, plan design will have to take into account the needs of the more mobile society, the job-changing society, the gaps-in-employment society.

Paul B. Ginsburg
President
Center for Studying Health System Change
Washington

The main premise of managed care was a generous benefit structure—minimal out-of-pocket costs and coverage of preventive services—and tight administrative controls on the use of care, along with limited choice of providers. Consumers liked the generous benefit structure but didn't care for the restrictions, so they rebelled. As employers increase consumer cost-sharing, benefit structures are becoming less generous, and employers are trying to readjust worker expectations and give employees more of a financial incentive to economize. Insurers are developing new products, including tiered-provider networks and consumer-driven plans that link a spending account with a high-deductible policy. But so far, most employers remain skeptical of the new offerings.

Frederic S. Goldstein
President
Specialty Disease Management Services Inc.
Jacksonville, Fla.

Health plans will place more emphasis on the beneficiaries taking control of and having greater responsibility for their health care decisions. This will include higher copays or out-of-pocket expenses and programs that reduce beneficiaries' costs for those with chronic illnesses who make healthier lifestyle choices or participate in disease management and wellness programs. Payers will focus on evidence-based medicine for payment of services and increase the use of metrics to monitor outcomes and target interventions at both the beneficiary and the provider levels.

Regina Herzlinger
Nancy R. McPherson Professor of Business Administration
Harvard Business School
Boston

U.S. health care is characterized by a lack of productivity.

Elsewhere, U.S. consumers reward the innovators who give them what they want: more for less, with cars and computers as an example. But in health care, one-size-fits-all health insurance policies get in the way. They stop suppliers from innovating and consumers from expressing their needs. For example, a productivity-enhancing integrated heart failure program reduced costs by $8,000 by improving health status, but it failed financially because insurers would not cover it.

The solution is a consumer-driven system that offers enrollees a considerable variety of insurance options and providers freedom to innovate. In this system, governments require the information needed for choice, prosecute fraudulent insurers and providers, subsidize the needy, and then get out of the way.

J. Robert Hunter
Director of Insurance
Consumer Federation of America
Washington

A migration toward a national health insurance system has occurred over generations. It must be maintained.

A logical next step would be to migrate toward a fully unified system by offering catastrophic care for all using the federal employee sort of group system, thus maintaining private competition. A national catastrophic illness/injury system is something all Americans could use. This would eliminate annual or lifetime maximum payouts embedded in private health insurance plans, lowering the cost of such plans. Everyone is at risk of a catastrophic illness or injury that might require millions of dollars of care. No one is fully covered today. Such a plan would allow complete coverage. It would place all catastrophically ill people into one system so that specialist institutions and physicians could be brought to bear in a

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unified system on these patients. Costs could be controlled by applying lessons learned from this unified system. Also, the government could lower or raise the deductible to control outlays. Private insurance could compete below the deductible with lower prices than today because injuries and illnesses above the deductible would not be its responsibility.

Chip Kahn
President
Federation of American Hospitals
Washington

I think, at least in the short run, you're going to see increased cost-sharing in its various forms for those covered by insurance, clearly on the private side and possibly on the public program side. And you're going to see continued experimentation with ways to constrain costs on drugs, encourage individuals to use generics or other kinds of less expensive drugs.

In addition, there likely will be continued experimentation with disease management as a way of reducing the costs by increasing the efficiency and quality of services and coordinating the services for those who actually spend most of our health care dollars—the small number of Americans at any given time who are extremely ill.

I think what we've learned, though, over the last three decades is that there's no magic bullet for containing health care costs.

We've gone through a period in the 1970s and into the 1980s when either regulation of the health care system or the development of more sophisticated pricing in Medicare itself was believed to be the Holy Grail of controlling costs. And then came the age of managed care, when the anticipation by experts was that…managed care would control costs and provide the model for future benefit design. At this point, I think we have no secret weapon in terms of plan design to contain health care costs.

Dr. Arnold Milstein
National Health Care Thought Leader
Mercer Human Resource Consulting
San Francisco

Larger out-of-pocket variation for consumers based on the quality and efficiency ratings of the providers and treatment options that they select and their willingness to participate in best-in-class health risk reduction programs.

These two categories of consumer choice provide the greatest leverage on premium costs. Larger out-of-pocket variation does not imply greater economic hardship for sicker consumers.

On the contrary, it would enable decreased spending by sicker consumers who select better-performing providers and participate in health risk reduction programs.

Margaret O'Kane
President
National Committee for Quality Assurance
Washington

This is a period of active thought and experimentation related to plan design. There is clearly an interest in greater cost-sharing for consumers. There is discussion of incentives to patients to choose providers that deliver value—in other words, better coverage for selecting value providers, a higher degree of cost sharing if you don't. There is also some consideration of promoting good health behaviors through benefit design. There is a great deal of interest in the consumer-directed health plan, with and without the health reimbursement account feature.

And there are products that cannot be called insurance (that are) basically a pool of money to use for health care without a catastrophic back end. Given the enormous pressure that health care costs are creating, I think it is likely that many small employers will seek to limit their exposure with products like this.

Leonard D. Schaeffer
Chairman and Chief Executive Officer
WellPoint Health Plans
Thousand Oaks, Calif.

There is a lot of talk about employers moving to consumer-driven or defined contribution-type products. The fact is, few are actually doing it.

My view is that after the Sept. 11, 2001, terrorist attacks, many employers realized that employees look to them to enhance their sense of security. For this reason, I believe that the business community will be reluctant to shift costs in a big way to their employees.

In the not-so-distant future, the workforce will downsize as the baby boomers retire.

In that environment, employers will continue to use benefits to attract and compete for labor.

Overall, I think we will continue to see innovation in benefit design that includes varying cost-sharing arrangements, personal health accounts, and tiering approaches.

But we will also see health benefit programs incorporating a new generation of health improvement programs, care management techniques, and financial incentives to not only participate in such programs but to maintain better health-related habits.

Allan Zaremberg
President and Chief Executive Officer
California Chamber of Commerce
Sacramento, Calif.

The introduction of a voluntary "essential benefits plan" that would allow employers to offer essential and emergency health care packages to their employees, at a lower cost than is currently required by state law requiring a rich package of benefits. A voluntary essential benefits package would allow smaller employers, which currently cannot afford to provide health, to be able to offer coverage to employees.

We also must fight to streamline government regulations to increase efficiency and reduce overall administrative burdens. The health care system is drowning in paperwork.

Further, we must also stop the drive toward more government-mandated health care systems. For example, in California, there is consideration of a pay-or-play system where employers would be required to pay for health care for employees and all dependents, or pay into a new health care fund. However, the 7% to 10% payroll tax being considered to fund this program will never cover health care costs for low-wage employees, much less their dependents. Therefore, we would see yet another system subsidized by private employers.

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Between the Lines

Compiled by Joanne Wojcik

It's in the cards

While traveling in London recently, Lance Ewing, president of the Risk & Insurance Management Society Inc., noticed that a few underwriters had included their A.M. Best Co. ratings on their business cards.

When he asked why, one of them said it added credibility and demonstrated to risk managers the financial strength of their companies at a time when so many insurers are under scrutiny.

"We were awarded the rating earlier this year and have been using it on our business cards for just a couple of months," confirmed Martin Reith, chief executive officer of Ascot Underwriting Ltd., which manages Lloyd's of London syndicate 1414. "As we have been rated A+ by A.M. Best, we think it's something to promote strongly."

After all, he said, "an insurance policy is only as good as the security behind it."

The Pepsi challenge

The National Labor Relations Board is reviewing unfair labor practice charges filed by Teamsters Local 848 in El Monte, Calif., after Coca-Cola Co. fired a driver for drinking Pepsi on the job.

Rick Bronson, who was suspended without pay, was caught drinking a Diet Pepsi he purchased from a vending machine at a store on his route. He was reported by another Coke employee, who claimed to be on a "special assignment," according to Jim Santangelo, president of the labor union's Joint Council 42.

While Coke claims it was justified in firing the driver for violating the company's code of conduct that bars "slander" of its products, Mr. Santangelo claims the soft drink maker had an ulterior motive: Mr. Bronson had been among the leaders of a union organizing effort several weeks prior in Sylmar, Calif., where he is the shop steward.

Coca-Cola did not respond to *Business Insurance's* request for comment.

Fraudsters reach new low

Ringleaders of an insurance fraud ring in Chicago recruited homeless people to pose as accident victims and then broke their arms or legs with an ax handle, alleged detectives announcing charges against six individuals who reportedly bilked insurers out of hundreds of thousands of dollars.

Chicago Police Detective Ken Bigg said members of the ring scoured homeless shelters for people desperate enough to pose as auto accident victims. They would then take the victims to a garage and break one or more of their limbs using a homemade ax handle. After the bones were broken, the victims would be transported to staged accident scenes. The scam artists then posed as relatives of the injured and told the insurers that they were desperate for money and willing to settle in a hurry, Detective Bigg said.

The homeless individuals received "anything from nothing to $1,500" on settlements that ranged from $10,000 to $100,000, he said.

Police learned of the scam when authorities at various homeless shelters began reporting unusual numbers of residents showing up with broken arms or legs.

Cantor sued for WTC rent

Property tycoon Larry Silverstein is suing securities firm Cantor Fitzgerald for back rent owed prior to the Sept. 11, 2001, terrorist attacks that destroyed its offices at the top of the World Trade Center.

"That obligation to pay rent continues unabated notwithstanding the heinous attacks of September 11," Mr. Silverstein's lawyers wrote in the lawsuit filed in Manhattan's Supreme Court last week.

Mr. Silverstein, who held the lease on the twin towers, said all of the former tenants except Cantor Fitzgerald had paid rent on the final weeks before the terrorist strike.

Cantor Fitzgerald lost almost two-thirds of its 1,050 employees, including its chief executive, in the attack. The firm did not respond to *Business Insurance*'s request for comment.

Tips and feedback from readers are welcomed. Please send information to jwojcik@crain.com.

Terror: Crisis planning is key

Continued from page 4

peaked and is now on the downswing, he said.

Given that keeping individuals safe is a primary concern, Mr. Francis said, employers need to have crisis communications plans in place. "Have town hall meetings with employees, telling them their roles and what the company is doing for them," he said.

Every corporation needs to designate someone who will speak for the company if a crisis occurs. The company must have "clearly defined the responsibility as to who is the mouthpiece," he said. The company must also keep in mind that "sometimes, 'No comment,' is the worst comment," he said.

Mr. LaFleur stressed that in dealing with another facet of corporate crisis management—the simulation of and training for catastrophes—companies should work their way up to a full-scale drill. Those responsible for planning simulations and drills have to take into account external as well as internal factors that could play a role in a real catastrophe, he said. And, he said, the plan must integrate everyone, from those on the factory floor to those in the boardroom.

Mr. Francis urged his audience to pull together a good plan and program before launching the simulation, and to make sure that the people involved in the simulation know their roles ahead of time.

Mr. Francis also stressed that the simulation needs to be based on a situation that would have a real impact on the company. A tornado preparedness drill wouldn't make a lot of sense in New York, he said.

Gail P. Norstrom, managing director-property practice group of Aon Risk Services Cos. Inc. in Avon, Conn., moderated and participated in the discussion (see related story).

Terrorism Risk Assessment and Insurance Coverage Seminar

TRIA's transience a problem

By MARK A. HOFMANN

WASHINGTON—The 2002 Terrorism Risk Insurance Act, while a "step in the right direction," still presents risk managers with significant challenges, according to a brokerage executive.

"It's pretty clear that the (program's) temporary nature is a problem," said Gail P. Norstrom during the Terrorism Risk Assessment and Insurance Coverage Seminar, held in Washington earlier this month.

The federal terrorism coverage backstop authorized by TRIA, which was designed to allow insurers to build private capacity for terrorism coverage, is scheduled to end in 2005.

The fact that the backstop is temporary can make it difficult for risk managers to formulate long-term risk management plans; the future of a key tool in their risk management toolbox is uncertain, said Mr. Norstrom, managing director-property practice group of Aon Risk Services Cos. Inc. in Avon, Conn.

The New York-based Strategic Research Institute presented the seminar.

Policyholders looking for terrorism coverage have several options, he noted. They can buy TRIA-backed commercial insurance, which would provide coverage if the federal government certified that a terrorism attack meeting the criteria set by TRIA had occurred. They can buy stand-alone coverage that would respond to noncertified terrorist attacks, such as those caused by a domestic terrorist. Or policyholders may choose to buy a combination of both types of coverage to ensure protection in the event of certified or noncertified attacks, he said.

"From a policyholder's point of view, the aftermath looks much the same," he said.

Despite the availability of TRIA-backed coverage, few companies—perhaps as few as 15%—have chosen to the buy it.

"An awful lot is an issue of being in denial," said Mr. Norstrom. Some buyers don't feel exposed, some can't quantify risks and a "chaotic" rollout process alienated some, he said.

In addition, "pricing is all over the map," with some insurers not wanting to offer the product. The price of terrorism coverage runs anywhere from 2.5% to 300% of the underlying premium, said Mr. Norstrom, with the median running about 12%, and perhaps 18% in areas regarded as higher risk. Compared with stand-alone terrorism policies, the TRIA-backed coverage generally costs less and provides higher limits, he said.

"Terrorism is unique," he said. "A single event can destroy your business, whether you are a target or not. This is a moving, morphing, constantly changing target."

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E.U. insurance market expanding

By NEIL HODGE

LONDON—The addition of 10 member states to the European Union in May next year could provide a jolt to insurance markets in Eastern and Central Europe, as local insurers rush to comply with EU laws, according to some observers.

The expansion of trade with existing E.U. states could also lead to increased needs for commercial insurance coverage as companies in the accession states pay more attention to issues such as corporate governance, they say.

But, other observers say, several international insurers have already penetrated many Eastern and Central European insurance markets so the effects of the expansion on the commercial insurance market might be limited.

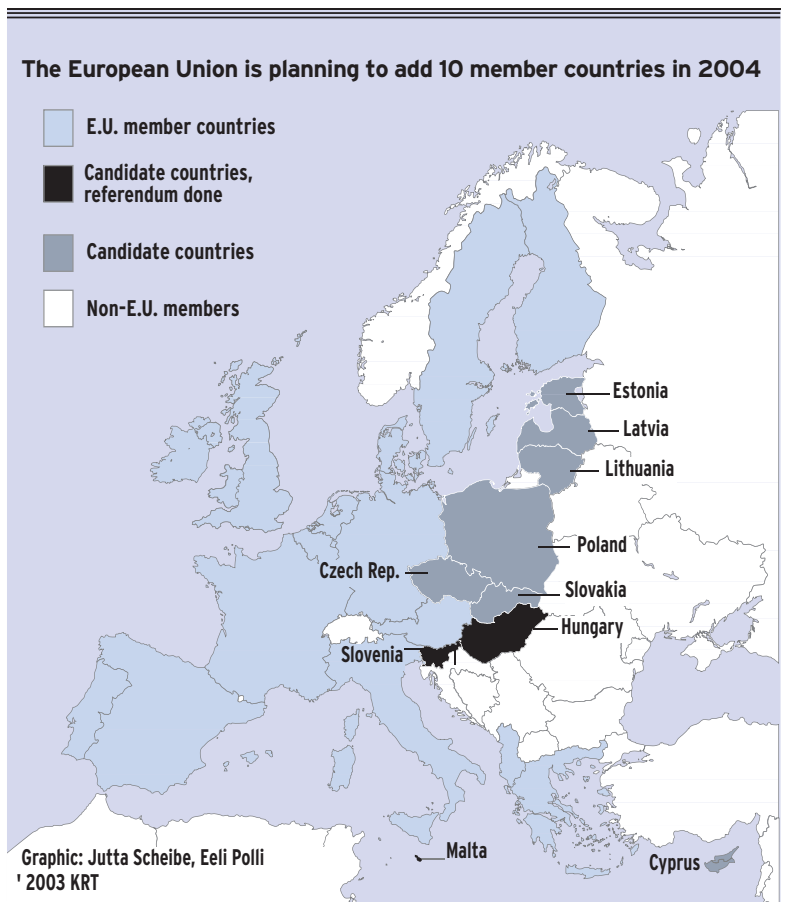
Poland and the Czech Republic—widely seen as two of the most sophisticated insurance markets in Central and Eastern Europe—both conducted referendums this month, with the public overwhelmingly backing E.U. membership. The remaining eight states joining are Cyprus, Estonia, Hungary, Malta, Latvia, Lithuania, Slovakia and Slovenia.

Ian Bethune, a broker in the Central and Eastern European practice of Aon Ltd. in London, said that the Czech Republic and Poland, as well as the other accession states, may be hard pressed to meet the European Union's deadline to pass all necessary legislation before entry on May 1, 2004. Among other provisions, insurers in the accession states will have to comply with the European Union's insurance and freedom of service directives, which dictate solvency requirements and allow companies to purchase coverage from providers based anywhere in the union.

"Accession states are going to have a tremendous rush" to ensure they have "all the legislation in place and that their local insurers and businesses are aware that foreign companies will no longer be required to buy cover from a local insurer any more," he said.

He added that Polish and Czech entry into the European Union should make their domestic markets more stable and stimulate their

See E.U./page 33



Australian risk managers to vote on merging groups

ARIMA, institute would combine

By MICHAEL BRADFORD

SYDNEY—Australia's largest risk management associations are planning to join forces.

Members of the Assn. of Risk & Insurance Managers of Australia Ltd. and the Australasian Institute of Risk Management are expected to vote later this year on whether the two organizations should become one. If they do vote to join, a single association for risk managers could come about by the middle of next year.

Kevin Knight, the president of the Victoria-based institute, said the move would be more of a "reunification" of the two organizations. The institute, he pointed out, was spun off from ARIMA in 1987 to create a body that would allow individual members and could include brokers, consultants and others who are not risk managers.

ARIMA, formed in 1977 and based in Sydney, at the time allowed only corporate members, although its bylaws have since been changed to allow individuals to join. ARIMA has around 400 corporate members and 200 individual members. The institute has around 800 individual members.

A merger would make sense, because many of the two groups' efforts to serve their memberships are being duplicated, Mr. Knight said. "We need a good, single strong organization rather than two bodies tripping over each other," he said.

Brad Greer, ARIMA's president, agreed. "Our synergies are coming closer together," he said of the two groups. Mr. Greer said that members could be more efficiently served by the organizations combining and eliminating duplicate efforts.

Mr. Greer also emphasized that one large organization would make for a stronger lobbying force on insurance and risk management issues.

The two groups have been working together as they move toward reunification. They have hosted joint seminars and staffed committees with members from each other's associations, among other things.

For the first time, the associations will this year hold a single annual conference. ARIMA invited the institute to partner with it in holding ARIMA's national conference Nov. 30 to Dec. 3. It has been several years since the institute held a national conference.

Mr. Greer called ARIMA's invitation a good-faith move to bring the bodies together. He said a vote on the merger could come during the meeting.

"I have yet to have anybody

See MERGER/page 33

E.U. ministers drop EIL mandate

Pollution liability proposal advancing

By NEIL HODGE

BRUSSELS, Belgium—The European Council of Environment Ministers has approved a proposed directive that would make companies jointly and severally liable for environmental damage caused by their actions, though it dropped from the proposal a provision to make environmental liability insurance compulsory.

Under the council's revised directive, E.U. member states would be "encouraged"—rather than compelled—to make mandatory the purchase of environmental impairment liability insurance. In addition, the revised directive states that companies would not be held responsible for cleanup costs if an emission had been authorized by the government of the country in which it operates.

The council recommended that the European Commission review the matter of compulsory environmental coverage five years after the directive takes effect.

The council also recommended that member states pay for any cleanup when a company cannot be held liable for damages.

The regulation would apply to companies governed by the European Union's Integrated Pollution Prevention and Control regulations, which apply to high-risk enterprises such as petrochemical, mining and agricultural companies.

The draft directive will now go

PHOTO: AFP/TORRECILLA

Workers clean up a 2002 oil spill on the Spanish coast.

before the European Parliament for a second reading, though no date has been announced.

European insurer trade group Comite Europeen des Assurances welcomed the council's proposals. In a statement, the CEA said insurers are opposed to imposing mandatory insurance coverages, as there currently is no established insurance market for all of the exposures involved. The CEA also is calling on members of the European Parliament—who wanted a more-radical approach to environmental liability reform—to support the council's decision.

"If the European Parliament backs the council's common position, the basis will be there for our industry to develop new and innovative insurance products," CEA Director-General Daniel Schante said in a statement.

World Updates

FERMA adopts U.K. standard

The Brussels, Belgium-based Federation of European Risk Management Assns. has formally adopted a risk management standard launched last year by the London-based Assn. of Insurance & Risk Managers, the Assn. of Local Authority Risk Managers and the Institute of Risk Management. The standard, intended to encourage best practices in risk management, will be translated into Danish, Dutch, French, German, Italian and Spanish.

XL to increase property capacity

XL Insurance Global Risk, the worldwide property/casualty large commercial account unit of XL Capital Ltd., will increase its property underwriting capacity to $250 million, from $150 million, on July 1. XL said the capacity increase would enable the company to lead more property programs.

W.R. Berkley forms London market unit

Greenwich, Conn.-based W.R. Berkley Corp. is launching a new London-market specialty insurer that will be capitalized at £80 million ($133.4 million). The unit, W.R. Berkley Insurance (Europe) Ltd., will offer specialty casualty insurance and will initially focus on professional indemnity coverage. W.R. Berkley Insurance (Europe) will start operations in the third quarter and will be 80% owned by W.R. Berkley and 20% owned by Kiln P.L.C., a Lloyd's of London company. W.R. Berkley has a 20% shareholding in Kiln.

Court upholds sale of Gerling reinsurer

An administrative court in Kassel, Germany, has upheld a lower court's ruling that Gerling Group may sell its reinsurance arm to a runoff company. Germany's financial services regulator blocked the proposed sale in February, though it did not state why it opposed the deal (*BI*, March 3). Gerling appealed the decision, and in March a lower administrative court said that the Cologne-based company should be allowed to sell Gerling Global Re to runoff company Globale Management GmbH.

Briefly noted

XL Insurance Switzerland is relocating its operations to Zurich from Winterthur by year end.... Andre Clerc was named chairman of the aerospace division of **Willis Group Holdings Ltd.** He formerly was an executive with La Reunion Aerienne in Paris.

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No. 3653 of 2003
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(Scheme Administrators Appointed)
and
IN THE MATTER OF THE COMPANIES ACT 1985

NOTICE IS HEREBY GIVEN that by an Order dated 9 June 2003 made in the above matter ("the Order"), the Court sanctioned a scheme of arrangement pursuant to section 425 of the Companies Act 1985 ("the Scheme") between United Standard Insurance Company Limited ("the Company") and its Creditors (as defined in the Scheme). This followed a meeting of Creditors held in London on 27 May 2003 at which the Scheme was overwhelmingly approved. An office copy of the Order sanctioning the Scheme was delivered to the Registrar of Companies for registration on 12 June 2003 and therefore the Effective Date of the Scheme is **12 June 2003.**

Douglas Nigel Rackham and Mark Charles Batten of PricewaterhouseCoopers LLP, are the Scheme Administrators responsible for implementing the Scheme. Anybody believing themselves to be a Creditor who has not received notice by post of the Effective Date of the Scheme, should contact the Scheme Administrators at the address below.

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Should you have any questions regarding this notice please address them to:
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All inquires for additional information regarding the Invitation For Bid are to be directed, in writing, to Gene Silvers, Broker, Tillinghast-Towers Perrin at the aforementioned address/phone.

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E.U.: Insurance market growth expected

Continued from page 31

growth as the solvency requirements of local insurers increase.

Mr. Bethune said he expects to see "tremendous growth" in liability insurance. "The increase in cross-border trade that countries like Poland and the Czech Republic will experience, as well as an increased awareness of effective corporate governance and regulation, will mean that director and officer and product liability insurance will really take off," he said.

Some brokers and insurers are keen to take advantage of E.U. expansion. Lloyd's of London has already signaled that it wants to target more European business in light of E.U. expansion next year. Its chairman, Peter Levene, Lord Levene of Portsoken, said in May at Lloyd's European symposium in London that the market wants to take a more-aggressive stance to attracting more European business, including business from the accession states (*BI,* May 26, 2003).

James Sutherland, head of development and strategy for worldwide markets at Lloyd's, believes that the recent increase in weather-related catastrophes and a shift of liability to the private sector in accession states would "lead to increased demand for property catastrophe and professional liability insurance over the next two years."

"As demands for improved corporate governance begin to impact organizations within the accession countries in the same way that internal control is now a big issue in the West, professional liability insurance will become big business in the more developed economies of Poland, Hungary and the Czech Republic," he said.

'The increase in cross-border trade...will mean that director and officer and product liability insurance will really take off.'

Ian Bethune
Aon Ltd.

But other observers doubt that the expansion of the European Union will create much of a stir.

"I am not expecting any big changes to happen," said Jeffrey Manners, head of operations at Marsh Ltd.'s Central and Eastern European practice based in Brussels, Belgium. "I don't think there will be a rush of Western insurers into the marketplace now that these countries are joining the E.U. Those insurers that want to operate in those markets are already there."

Some of the biggest players in the region providing commercial insurance include Allianz A.G., Assicurazioni Generali S.p.A., American International Group Inc. and Wiener Stadtische Allgemeine Versicherung A.G.

David Laxton, director of financial services ratings at Standard & Poor's Corp. in London, said that Czech and Polish insurers are already providing most kinds of business cover and that take-up—especially by multinationals and big companies—is growing.

Mr. Laxton said that, according to S&P's estimates, the average spent on insurance coverage by E.U. member states is 8.2% of gross domestic product. Of those countries joining the European Union next year, the Czech Republic spends 3.4% of its GDP on insurance—the highest in Central and Eastern Europe—while Poland spends 3.1% of its GDP buying insurance coverage.

"These figures may seem low, but within the space of 12 or 13 years, these countries have managed to capture enough business to equal around 40% of the E.U. average spent on insurance cover. That's a terrific achievement," he said.

But Mr. Laxton also noted that the region was not attractive to reinsurers because of massive floods that hit the Czech Republic in 1997 and 2002. According to Swiss Reinsurance Co., in Zurich, Switzerland, the insured loss in the Czech Republic was 600 million euros ($709.8 million) in 1997, with an economic loss of 2 billion euros ($2.37 billion) caused by last year's floods. Swiss Re estimates that its loss exposure was around 250 million Swiss francs ($187.5 million).

More worrying for reinsurers, said Mr. Laxton, is that the floods occurred in different parts of the country, caused by the flooding of two different river networks. That means, he said, "from the viewpoint of reinsurers, the whole of the Czech Republic is a flood risk, which means that they will want to limit their exposure to property, business interruption and flood damage claims."

Doug Pritchard, manager in the Prague, Czech Republic, office of Willis s.r.o, believes that, since the floods, premiums for property and business interruption coverage have risen by about one-third, on average. While this might be low compared with rate hikes in the rest of Europe and the United States for some commercial insurance, heard added that "several insurers…have capped their payout limits for flood risk, while other insurers are reluctant to provide flood risk cover."

But Jaroslav Mesrsmid, secretary-general of the Czech Insurance Assn., said he believes the experience will only strengthen the industry. "Local insurers are now working harder to develop better risk management, risk modeling techniques and underwriting to prevent such high exposures in the future."

Merger: Groups to vote

Continued from page 31

express any indignation or outright opposition" to the two groups joining, Mr. Knight said. "All the feedback to date has been extremely positive."

He said a merger makes sense in a country such as Australia, where "we don't have the luxury of running a lot of organizations" for a membership that is not as vast as in some other countries. He cited the Risk Management Federation of South Africa as an example of how members can be better served when activities are consolidated.

The South African organization was created in 2000 to take over activities that were jointly handled by the Society of Risk Managers of South Africa and the South African Risk & Insurance Management Assn. While those two bodies still exist, such responsibilities as conducting an annual conference, holding membership meetings and presenting a yearly risk management award are handled by the federation. The federation also serves as the lobbying body for both associations.

Whirlpool: Retiree copays grow

Continued from page 4

firm Watson Wyatt Worldwide, future retirees can expect to shoulder more of the burden of health care benefits due to rising medical costs, the growing population of future retirees, uncertain business profitability and federal regulations.

The study shows that 20% of the employers surveyed have eliminated retiree medical programs for new hires altogether since 1993 and 17% will require them to pay the full premium for coverage. Other employers have capped contributions, linking them to the retiree's length of service, or have imposed stricter minimum service requirements for future retirees.

Introducing retiree medical accounts similar to Whirlpool's new program is also an option for companies looking to cut costs.

"Plans like this are definitely becoming much more prevalent and will become more so in the next few years," said Stephen Parahus, a vp from The Segal Co. in New York.

Helen Darling, president of the Washington Business Group on Health, considers plans like Whirlpool's to be very generous.

"They're very lucky to have retiree health care at all, because most employers don't offer it," said Ms. Darling. "I don't see any cons; it seems like a very good plan to me."

Plans like Whirlpool's are equitable, said Mr. Parahus, and they also control the level of the plan sponsor's cost exposure.

"It's predictable, budgetable, and it's a big, big reduction with a tremendous element of control," Mr. Parahus said.

IBM declined to comment on its retiree health care plan because its implementation was too recent and only a handful of employees have retired under it.

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Taking stock

P/C industry walks like a duck, but is it a canard?

By Myron M. Picoult

My daughter recently presented me with a book titled "The Superior Person's Book of Words" by Peter Bowler and published by David R. Godine. It is described as a dictionary for those who perceive a difference, a handbook for superior persons who love words.

While I do not consider myself a superior person in any way, shape or form, I do love to play with words and their meanings.

Hence, her surprise gift was right up my alley.

On my first perusal, I flipped open to a page that had a definition of "canard." The definition read, "A fabricated anecdote or sensational report; a phony yarn; a hoax…."

I immediately drew a parallel with one of my favorite topics, the property/casualty insurance industry.

Clearly, the pricing and underwriting recovery that is currently under way has proved to be a more labored process than was envisioned by company managements or industry observers. Notwithstanding the belief by many executives that their company is "an above-average carrier," not every entity can be above average.

As noted recently, the hole that the industry excavated due to the last pricing war was far wider and deeper than many had realized. This is underscored by the adverse development of business written in 1998, 1999, 2000 and, probably, 2001.

There are many factors that argue for the sustenance of hard pricing, albeit at a slowing pace.

One is that not all insurers hit the ground running on Jan. 1, 2002, as some observers believe, in terms of rate increases. In reality, it takes a full 15-18 months for insurers to get through their entire books of business once rate increases are implemented. Hence, it would appear that 2003 is really the first year in which the full impact of rate increases will be felt by many companies.

Substantive questions continue to overhang the industry's prospects that are not being insightfully articulated by industry executives.

While progress has been made in correcting reserve deficiencies, there still appear to be many instances where the holes have not yet been adequately filled. The operating environment calls for a higher level of conservatism in setting reserves, addressing prior shortfalls and working on refilling the pot for a rainy day.

One of the thorniest problems facing many insurers today is the credit quality of reinsurance recoverables— and an unclear willingness on the part of some reinsurers to pay!

There is a material gap between gross and net reserves for many insurance entities, and a closer review is needed to cover both the quality of the credits and how the doubtful recoverables stack up against statutory surplus. Another factor to be sensitized to is prospective charges relating to relatively recent insolvencies.

There seems to be a fairly broad array of return-on-equity prognostications in the property/casualty industry. The fact is, low interest rates make double-digit ROEs quite challenging despite markedly improving cash flows. While industry risk characteristics argue for relatively high returns, the question is how many multiples of the risk-free rate is the industry entitled to achieve?

Exacerbating this situation is pressure from the rating agencies for insurers to get more capital, putting additional pressure on the achievement of satisfactory returns.

Meanwhile, pressures on state budgets are having some impact on state insurance departments. A push for seasoned regulatory professionals to retire could further encourage rating agencies to seek to become even more diligent in their reviews of insurers.

Most earnings models assumed there would be stable or increasing rates. Few companies had the foresight to also factor in lower interest rates. With average durations in the 4- to-5-year range, there is a considerable yield shortfall that has to be covered.

The pressure to raise rates clearly will be notched up if loss costs begin to rise faster than the Consumer Price Index.

The industry's back-to-basics focus of late is laudable, but underwriting and pricing discipline must not waiver. This is part and parcel to the industry regaining credibility on its numbers.

Only time will tell whether the willingness of some insurer managements not to be all things to all people is for real or just a convenient phase for the time.

For those that adhere to the new principles, the underwriting recovery will remain real, while for those that stray from the fold, the recovery may well prove to be a canard.

Myron M. Picoult is an adviser to Lazard Freres & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. An archive of Mr. Picoult's columns for Business Insurance can be viewed on the World Wide Web at: www.businessinsurance.com.

Codes: Medical billing cited as factor in higher costs

Continued from page 1

CPT handbook annually, the codes may not be evolving fast enough to accommodate changes in the health care system that could reduce costs, some health care experts assert.

For example, even when a physician assistant or nurse treats a patient, the codes require the provider to bill health plans at the higher physician rate. Likewise, if there's no code for a less expensive alternative medical procedure, the code for a similar but often more expensive standard treatment is frequently submitted.

In response to the alleged shortcomings of the CPT system, a company in New Mexico has developed an alternative set of codes that it claims are more extensive and, therefore, better describe the actual procedures taking place as well as who is administering them. The U.S. Department of Health and Human Services has authorized a two-year study of these alternative codes.

"There is a lot of miscoding that is going on right now," said Synthia Molina, chief executive officer of Alternative Link, the Albuquerque, N.M., firm that has developed the codes.

"What happens is, a lot of alternative medicine and nursing practitioners have learned that if they code incorrectly, using physician codes, they can very often get payment for their services. That, frankly, is illegal. So many code using inappropriate codes," she said.

"Some really mean well and want to code accurately, but the CPT codes just don't accurately describe this area, so they end up miscoding by default because there isn't another alternative," said Ms. Molina.

Some providers, such as Highland Park, Ill.-based Alternative Medicine Inc., have been translating their providers' procedures into standard CPT codes in order to be reimbursed by health plans, according to Dr. Richard Sarnat, co-founder and president.

"For instance, say we spend an hour doing all sorts of energy balancing and energy healing as well as cranial sacral therapy, we just code it as massage," he said. "Is it accurate? No. But does it give us a place to code? Yes."

AMI is an independent practice association that includes both traditional medical doctors and chiropractors. Blue Cross of Illinois has been subcontracting with the IPA since 1999.

But Dr. Tracy Gordy, chairman of the AMA's CPT Panel and a neuropsychiatrist who practices in Austin, Texas, maintains the CPT codes are not static.

"Any medical specialist can submit a request for a code, any medical equipment maker and any member of the AMA can request a code. As a result, we actually developed some codes for acupuncture back in 1998," he said.

The criteria for code approval are that the procedure must meet prevalence and technology assessment filters, such as clinical studies proving efficacy. The procedures are divided into three categories, showing their level of acceptance by the medical and scientific community.

For example, Category I CPT codes, which are numeric, describe a procedure or service consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Category II codes are assigned to procedures that are still being studied, and Category III are assigned to procedures considered "emerging technology" or experimental.

The criteria for code approval are that the procedure must meet prevalence and technology assessment filters, such as clinical studies proving efficacy.

Sometimes a procedure that starts out as a Category III code will move up to become a Category I code after sufficient research has proved its effectiveness, according to Dr. Gordy.

For example, the gamma knife, a type of X-ray beam, once had a Category III code but now is a Category I code, he said.

But Ms. Molina maintains the CPT coding system is too exclusive, thereby giving the AMA a monopolistic hold on health care billing.

The development of the new set of codes, called Advanced Billing Concepts, or ABC, dates back to the passage of HIPAA, which established coding standards for medical procedures.

A gap was discovered in the areas of alternative medicine, nursing and integrative health care in the five code sets the government approved for HIPAA transactions, Ms. Molina explained.

Acknowledging the void, Secretary of Health and Human Services Tommy Thompson gave Alternative Link the authority to solicit participants to commercially test the codes in electronic HIPAA transactions for the next two years.

More than 10,000 entities—including more than a dozen Medicaid agencies, insurers, managed care and provider networks, information technology companies and practitioners—have signed up to participate in the demonstration project. The deadline for registration was May 29.

The current coding can be slow to accept changes in medical procedures, said Helen Darling, president of the Washington Business Group on Health.

"It is true it's hard to get anything through (the AMA)," she acknowledged. "But I don't think you have to change the CPT codes to get reimbursed. Right now, most employers can pretty much decide what they want covered."

She was also skeptical that the ABC codes would be a true substitute for CPT codes.

"Lots of things get promoted to employers as cost-saving. But it must be a real and appropriate substitute and not just an additional layer," she said. "Companies aren't looking to spend more money."

Regardless of whether the nation's health care coding system is ultimately revamped, the AMA's Dr. Gordy is doubtful that any change will persuade insurers or other third-party payers to compensate nonphysician providers or to pay for alternative medical procedures.

"He who holds the gold makes the rules," he said, meaning: "Insurers decide what they're going to cover."

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Class action: House OK might help Senate effort

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ban the practice of awarding larger amounts of money to members of the class who live close to the courthouse. The bills also would require judges to subject noncash settlements—such as giving members of a class coupons toward their next purchase of the defendant's product—to greater scrutiny than is currently the case.

The bills' backers have held that such changes are necessary to prevent what they view as abusive "forum-shopping," where plaintiffs attorneys seek to file suits involving plaintiffs and defendants from a number of states in the state court that they deem friendliest to plaintiffs. Opponents have argued that the change is not necessary and that it will further burden already-overburdened federal courts.

The House action has lead proponents of class-action reform to feel more positive than ever before over the chances of reform becoming law.

"It will be helpful," said Lawrence Fineran, vp-regulatory and competition policy for the National Assn. of Manufacturers in Washington. "The vote was a lot stronger than last year; we certainly hope that will help persuade some of the senators who are on the fence. I think Rick Boucher probably had it right when he said this is court reform, not tort reform," said Mr. Fineran in reference in the repeated position of Rep. Rick Boucher, D-Va.—one of the bill's original sponsors—that the measure deals with making the courts work more effectively.

'We're very pleased that the ball is rolling again; however, we've been down this road once before in 2002, and the Senate failed to act.'

Lance Ewing
Risk & Insurance Management Society Inc.

"I don't think there's any question that this is the best shot we've had," said Sherman Joyce, president of the American Tort Reform Assn. in Washington. "The vote in the House was strong. There was a pretty solid bloc of Democratic support—that's a very favorable sign. The need for this proposal has never been clearer."

"It helps us build momentum," said AIA's Ms. Shelk. "We doubled the number of Democrats that supported the legislation in the House from last year, due in large part to the adoption of the Sensenbrenner amendment," she said, referring to the amendment offered by House Judiciary Committee Chairman James Sensenbrenner, R-Wis., which raised the threshold to $5 million and gave federal judges discretion in returning cases to state court.

The president of the Risk & Insurance Management Society, Inc. was somewhat more guarded in his assessment. Class-action reform was one of the major policy issues highlighted at the RIMS on the Hill Washington event earlier this month (*BI*, June 16).

"We're very pleased that the ball is rolling again; however, we've been down this road once before in 2002, and the Senate failed to act," said RIMS President Lance Ewing.

"We are cautiously optimistic that this bill will curb the unfairness corporations have endured in the past regarding class action," said Mr. Ewing, who is also executive director-risk management for Park Place Entertainment Corp. in Las Vegas. "Hopefully, if passed, this would diminish the gun-to-the-head mentality that corporations have had to put up with when plaintiffs and their counsels have shopped various venues. We are pleased with the support that we've seen from the Democratic side of the House. Now, onward and upward to the Senate."

"I still am optimistic," said NAM's Mr. Fineran. Reform advocates are encouraging senators "not to wait too long, so they can take advantage of the House momentum."

"The problem is getting worse rather than better," said ATRA's Mr. Joyce, who said the measure "re-establishes the differences between federal and state jurisdictions. It's a limited but important reform that only Congress can enact."

Maine: Can state make universal care program work?

Continued from page 1

compensated care, will be sufficient to subsidize health insurance premiums for the uninsured—a key component of the program.

But there are many unknown factors, not the least of which is whether universal coverage can wring savings out of the health care system and whether small employers, even if offered a lower-cost health insurance plan, will buy it, critics of the law say.

Still, some Maine business groups say, given the soaring cost of health insurance and an escalating number of uninsured people, a new course of action is needed.

"This may not be a perfect answer, but we think it is a good place to start," said Kristine Ossenfort, senior government affairs specialist with the Maine State Chamber of Commerce in Augusta.

"It is a huge step for the state," said Jim McGregor, executive vp of Maine Merchants Assn. in Augusta.

While it could be years before the results of Maine's experiment are known, it clearly is the most imaginative state plan to expand coverage since Massachusetts, which took a very different approach, tried and failed in the late 1980s.

The Massachusetts plan, dubbed "pay or play," would have required employers to pay a huge tax, which would have been offset by premiums employers spent on health insurance.

The plan, which drew vociferous opposition from small employers, was never implemented and ultimately was repealed.

Maine's plan, by contrast, is voluntary, involving no mandatory financial burden for employers. Still, according to Gov. Baldacci, it is "bold and comprehensive," addressing state residents' growing concerns about access to care.

At the heart of the plan is the creation of a quasi-public agency, Dirigo Health, that will contract with commercial insurers to provide coverage to small employers that join the program, as well as to individuals such as the self-employed.

By pooling the risks of what could be tens of thousands of people, Dirigo would have far greater buying power and leverage with insurers than the small employers or individuals would have on their own, advocates say.

Employers who obtain coverage through Dirigo cannot be required to pay more than 60% of the premium, while Dirigo will subsidize premium contributions of lower-paid employees. The lower an employee's income, the greater the subsidy will be.

A key revenue source for those premium subsidies—available to those earning up to 300% of the federal poverty level—will be an assessment, known as "savings offset payments," imposed on health insurance premiums and claims handled through third-party claims administrators for self-funded employers.

The amount of the assessment, as well as the methodology of the assessment for self-funded employers, would be determined by Dirigo. The level of the assessment would be linked to the amount of savings insurers and employers would achieve in a system of universal or near-universal coverage, however, the assessment would be capped at 4% of premiums a year.

Such savings would be possible, backers of the plan say, because hospitals and other health care plan providers would reap a huge reduction in the amount of uncompensated care they now provide. Such care is estimated to cost hospitals and other providers in the state about $275 million a year.

That reduction in uncompensated care would mean providers would no longer need to shift the costs onto the bills of insured patients. And that could mean considerable savings to employers and insurers, backers of the plan say.

Gov. Baldacci, in a bill signing ceremony last week, warned that it "will take time to get the important details right" and that patience will be needed. Still, he pledged "help is on the way."

While it could be years before the results of Maine's experiment are known, it clearly is the most imaginative state plan to expand coverage since Massachusetts, which took a very different approach, tried and failed in the late 1980s.

But others aren't so sure the plan, which would start next year, is viable and say it is based on uncertain assumptions.

One uncertainty, critics say, is whether a significant number of small employers will buy insurance through Dirigo, even if the cost is less than other products on the markets.

"There are many unknowns, the chief of which is whether employers will purchase coverage," said Katie Fullam Harris, director of government relations for Anthem Blue Cross & Blue Shield in Augusta.

"Are employers who haven't purchased coverage now going to be suddenly willing to purchase it?" asked Godfrey Wood, president of the Greater Portland Chambers of Commerce.

In addition, it isn't known whether providers, reaping the benefits of a reduction in uncompensated care, will reduce their charges to reflect those savings.

"Nothing compels them to pass those savings on," said David Bernier, a partner with the law firm Phillips & Bernier in Waterville who represents the Maine Insurance Agents Assn.

"They think providers will lower prices because of a reduction in bad debt and charity care. But we don't see that happening," said Candace Snow, legislative chair of the Maine Assn. of Health Underwriters and president of C.J. Snow Insurance Agency in Litchfield.

Others say it isn't fair to compel Maine employers that are already providing health insurance to their own employees to help pay for the uninsured in the form of the assessment.

"There is a real question of fairness," said Abby Holman, executive director of The Maine Forest Products Council in Augusta.

Mold: Exclusions OK pending

Continued from page 3

Minnesota, New York, North Carolina and Virginia. Thirty-seven states have approved commercial property exclusions, while 44 have approved mold exclusions for general liability policies, according to the Alliance.

The spokesman said the Office of Insurance Regulation does not consider the State Farm dispute a test case, but he acknowledged that insurers may look at it differently.

William Stander, government affairs representative with the Alliance of American Insurers in Tallahassee, said commercial insurers should rest a little easier with the ruling.

Homeowners insurance is the bigger concern for Florida regulators regarding mold coverage, and regulators did begin acting on some commercial filings near the end of last year, he said.

With the recommended ruling providing some guidance as to how a court feels on the coverage issue, any "remaining concerns on commercial insurance—which are minimal compared to personal lines—should have evaporated," Mr. Stander said.

Because some insurers were waiting for a ruling before filing for limitations, the recent order likely will spark an increase in filings, Mr. Stander suggested.

Frank Catapano, risk manager for Volusia County, Fla., said exclusions aren't a big concern for him. "When we have mold, our facilities people go in and clean it up; it's not going to make the building fall down," Mr. Catapano said.

The county's high property deductible means a mold claim probably wouldn't be covered anyway, he added.

An exclusion "wouldn't have any effect on what I do," Mr. Catapano said. He said he was unaware whether his insurer had filed to exclude mold-related claims.

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Late News

Continued from page 1

CalPERS, HMOs agree on rates

The California Public Employees Retirement System has negotiated an overall average increase of 16.7% to 18.4% for health maintenance organization premiums, which is significantly below the 31% average increase the HMOs had sought. The two HMOs with the largest CalPERS enrollment, Blue Shield of California and Kaiser Permanente, will see rate hikes averaging between 16% and 18.4%. Premiums for the system's Sacramento-area regional plan, Western Health Advantage, will increase between 32.8% and 34.5%. Final rates will be subject to talks over the cost impact of granting reduced co-payments for members who need medically necessary non-formulary drugs.

PHOTO: NICHOLAS MIRISIS

Rep. Ernest Fletcher, R-Ky., introduced a bill to allow small businesses to form association health plans.

House passes AHP measure

The House of Representatives has approved a measure that would allow small businesses to form association health plans. The Small Business Health Fairness Act, H.R. 660, would amend the Employee Retirement Income Security Act to allow the Labor Department to certify AHPs, which would then be subject to regulation under ERISA rather than state insurance regulations, provided the AHPs meet several size and funding criteria. The bill, introduced by Rep. Ernest Fletcher, R-Ky., is backed by the administration. The Senate has yet to act on companion legislation.

Frontenac inks Near North deal

Private equity firm Frontenac Co. L.L.C. has entered into a binding agreement to purchase the insurance brokerage and other assets of Chicago-based Near North National Group. The deal also includes Near North's reinsurance brokerage, structured settlement and excess/surplus lines operations in Chicago, Dallas, Las Vegas, London, Los Angeles, New York, Tampa and Washington. Terms of the agreement were not disclosed. The deal is expected to be completed in 30 to 45 days.

Asbestos bill makes slow progress in panel

The Senate Judiciary Committee will continue marking up asbestos liability reform legislation this week. The committee's chairman—Sen. Orrin Hatch, R-Utah—had initially planned a final committee vote on the Fairness in Asbestos Injury Resolution Act for June 19. But with members offering about 60 amendments to the bill, S. 1125, a swift resolution was impossible even though Sen. Hatch and Democratic panel members had already agreed that numerous amendments would be accepted.

GE, union settle benefits dispute

General Electric Co. has called off its efforts to push a larger share of health care costs onto its union employees. The manufacturer reached an agreement with its main unions on a new, four-year contract that essentially maintains GE's current health care cost-sharing system. The agreement ends a long-running labor negotiation that centered on GE's efforts to increase employee co-payments to reduce its share of health care costs to 70% of the total, according to the unions. Under the deal, GE will continue to pay 82% of health care costs, with employees paying the remainder.

Chubb share issues to raise $1.2 billion

Chubb Corp. is raising $1.2 billion through two share issues. The insurer will sell 13.5 million shares of common stock at $59.50 a share and 16 million convertible equity units at $25 a unit. The proceeds will be used for general corporate purposes, including capital contributions to Chubb's operating units to support growth, according to the insurer's filing with the Securities & Exchange Commission.

Federal employees to get FSA access

Federal employees soon will begin enrolling in what eventually will be the nation's largest flexible spending account program, after a controversial plan to charge enrollees fees was dropped. The program will be offered to the federal government's 1.8 million employees, who will be allowed to make up to $3,000 a year in pretax contributions to health care FSAs and $5,000 to dependent care FSAs. Most employees will be able to make contributions beginning July 1.

WBGH forms group to reduce obesity

A coalition of employers, health plans, drugmakers and government agencies has formed to help reduce the incidence of obesity. The coalition, the Institute on the Costs of Health Effects of Obesity, will present information, promote proven strategies and develop written briefs to help employers reduce the number of people suffering from the condition. The group's goal is "to take a look at one of the nation's most serious health problems," said Helen Darling, president of the Washington Business Group on Health, which formed the coalition.

Briefly noted

Standard & Poor's Corp. has placed its A- rating of **SCOR S.A.** under review with negative implications. The rating agency said the review stems from SCOR's "disappointing" first-quarter 2003 results and the potential need for the reinsurer to further strengthen its reserves....The Senate passed by a 94-1 vote a proposal that could speed the introduction of **generic drugs** to the marketplace. The bill would limit drug makers to one automatic 30-month delay of federal approval of a generic equivalent. Currently, drug makers often obtain numerous delays, postponing for years the introduction of lower-cost generic drugs.

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Online Poll

[6/16 - 6/20]

Do you think the House of Representatives approval of class action reform legislation is likely to encourage action on other liability issues such as asbestos and medical malpractice reform?

Yes	55.9%
No	33.8%
Don't know	10.3%

BI Stock Index

[6/16 - 6/20]

Up-to-the-minute data for all 87 companies that comprise the *BI* Stock Index can be found at *www.businessinsurance.com*

Percentage change of *BI* Stock Index vs. key indicators

***BI* Stock Index**	1969.10	-0.42
Dow Jones	9200.75	0.92
S&P 500	995.73	0.72

Largest gains

Navigators Group	10.40%
American Safety Ins.	8.00%
RLI Corp.	7.08%
Fairfax Financial Holdings	5.30%
ACE Ltd.	4.62%

Largest losses

SCOR	-14.27%
EMC Insurance Group	-8.08%
Vesta Insurance Co.	-6.80%
CNA Surety	-5.67%
Aetna Inc.	-5.50%

Weekly change by market segment

Brokers	-1.57%
Insurers/Reinsurers	-0.20%
Managed Care Organizations	-0.13%

Source: CNET Investor (investor.cnet.com)

Pollution: Court limits exclusion

Continued from page 3

Columbia Court of Appeals to interpret the exclusion.

General liability insurers began adopting the absolute pollution exclusion widely in 1986, in the wake of new federal and state pollution cleanup statutes.

The exclusion supplanted the highly litigated sudden-and-accidental pollution exclusion. Insurers argued that the sudden-and-accidental exclusion limited coverage to third-party cleanup and bodily injury claims arising from only temporally quick industrial pollution incidents. Policyholders also sought coverage for claims arising from gradual pollution that was unintended and unexpected.

The absolute pollution exclusion was designed to make clear that insurers would not cover losses caused by pollution, but the exclusion created another wave of coverage disputes. Insurers have invoked it to deny claims involving any kind of pollutant, including carbon monoxide emitted by malfunctioning furnaces and other noxious fumes traced to carpeting, chimneys and swimming pool chlorine tanks.

Policyholders have argued that the exclusion applies only to environmental damage caused by industrial polluters.

The state and federal courts that have ruled on the issue are divided, though counts by policyholder attorneys and the District of Columbia Court of Appeals give the advantage to policyholders. Considering only state appellate and supreme court decisions, policyholders hold a 15-8 or 16-8 advantage, according to policyholder attorneys Robert M. Horkovich and Lorelie S. Masters.

Besides being a state supreme court-level victory for policyholders, the District of Columbia Court of Appeals' ruling is significant because of the extent of the court's analysis, asserted Mr. Horkovich, a partner with Anderson Kill & Olick P.C. of New York.

"This is a very extensive analysis in which the court went through case law, regulatory history and the purpose of the exclusion," Mr. Horkovich noted.

Another important component of the ruling is that the court pointedly considered the position of the District of Columbia insurance commissioner, who supported policyholders' position, noted Ms. Masters, a partner with Jenner & Block L.L.C. in Washington.

"Other courts are going to look at it for the extensive analysis provided in it," Mr. Horkovich said. That should be particularly helpful to policyholders in the approximately 20 jurisdictions where courts have not ruled on the exclusion, Mr. Horkovich said. The ruling also might aid policyholders in jurisdictions where courts have sided with insurers, he said.

In addition, the ruling circumvents insurers' arguments that claims like the one at issue in the District of Columbia Appeals Court case are fact-specific and must be evaluated individually, Ms. Masters said. The court ruled that the exclusion applies only to industrial polluters and that "this is a matter of law" and should not be revisited from case to case depending on the policyholder or the nature of substance at the center of a claim, Ms. Masters said.

Because the court adopted policyholder arguments that some other courts have rejected, the ruling is "disappointing," said insurer attorney Laura A. Foggan, counsel for the Complex Insurance Claims Litigation Assn. The insurer-backed group filed an amicus brief in the case.

But the dissenting opinion was "quite strong" in "recognizing some of the—what we believe to be—errors in the majority's reasoning," said Ms. Foggan, a partner with Wiley Rein & Fielding L.L.P. in Washington.

Columbus, Ohio-based Nationwide Mutual Insurance Co., the insurer involved in the dispute, has not decided how it will respond to the ruling, a spokesman said.

Antoinette Richardson vs. Nationwide Mutual Insurance Co., certified question from the U.S. Court of Appeals for the District of Columbia Circuit to the District of Columbia Court of Appeals; Nos. 01-SP-1451 and 00-7203, June 12, 2003.