More Firms Carrying Health Costs

Faced with health insurance cost increases of as much as 20% this year, many companies are dumping their traditional HMOs and switching to self-insurance to better manage costs while providing medical care for their employees.

But self-insurance, in which the employer assumes the brunt of the financial risks, comes with its own potential problems. That was illustrated last month in California when the self-insured Sunkist Growers & Packers Benefit Plan Trust went bankrupt after it was clear that medical claims would far exceed the trust’s ability to pay. That briefly left 23,000 farm workers scrambling to find new insurance.

Unlike traditional health coverage, in which employers pay an upfront premium to an insurer, companies that self-insure save that money and pay the health-care providers only when medical claims come in. The employer assumes the financial risk of providing benefits to employees in exchange for greater control and potential savings. It sets up a reserve or trust fund to pay those claims. Self-funded insurance has long been used by large multi-state employers that can manage the risk of heavy medical claims better than smaller companies. About two-thirds of the nation’s largest employers employ some form of self-insurance, experts say. The big employers also avoid a bewildering array of state insurance regulations when they self-insure and avoid insurance premiums and taxes. But now many mid-size and smaller employers also are willing to take on the risks of self-funding. And with costs of health maintenance organizations rising as fast as or faster than traditionally more expensive health plans, the percentage of employers that are self-funding their HMO coverage also is on the rise, having climbed from 6% to 13% from 2000 to 2001, according to a survey by William M. Mercer Inc.

One company that recently switched to self-funding is Flat Rock Furniture in the rural Indiana town of Waldron, a company of about 75 workers. Owner Van McQueen said that less than two weeks before the close of enrollment, his company’s health insurer proposed a rate increase of 80%.

"When I heard that, I got busy," said McQueen, who was unwilling to give up a company staple: 100% health coverage for each of his employees and their dependents. McQueen hired a third-party administrator to help him run a self-insurance program.

Now McQueen says his company is building up a cash re-
serve while saving about 20% in premiums and is protected from severe medical claims by so-called stop-loss or excess insurance.

"We're just a little Podunk company, but we can fight back," McQueen said.

Service Rock Products, a Victorville company that provides construction materials for highways and buildings, switched to self-insurance seven years ago. It has only 171 employees and lacks the deep pockets of a Fortune 500-size company that could withstand a surge in medical bills. Dan Scorza, the company's vice president for administration, sees few alternatives for keeping his employees covered.

Even under self-funded insurance, Scorza's company has seen more than a 51% increase in health-care costs for its single employees since it switched to self-funding in 1995 and a nearly 71% increase for families over the same period.

Without self-funding, Scorza said, the costs would be even higher and "we would lose flexibility and our employees would lose benefits. We just couldn't afford it."

**Insufficient Reserves Sank Sunkist Trust**

But these smaller employers must keep a wary eye on their projections. Big corporations can weather unanticipated problems--such as a spate of premature babies--long enough for subsequent premium increases to absorb the financial blow. Smaller companies can't afford such mistakes, which is why secondary stop-loss insurance, which kicks in when claims exceed a certain preset amount, can be essential to a careful strategy.

Although the reasons remain in hot dispute, it was the inability to track the amount of medical claims and the lack of a sufficient reserve that ultimately deep-sixed the Sunkist trust.

In a report released last week to the state Senate and Assembly insurance committees, it was confirmed that the trust's problems were apparent as early as last June. By the time the Department of Insurance cobbled together a recovery plan involving higher premiums, benefits restructuring and other measures, it already was too late.

Sunkist's situation may illustrate the perils of self-insurance, but it's also partly a reflection on California's system of "multiple employer welfare arrangements," which is different from self-insurance plans in most of the rest of the nation.

According to officials in the state's Insurance Department, MEWAs are rather loosely subject to state regulations and requirements, but those requirements aren't nearly as tough as those set for insurance companies licensed to do business in California.

For example, insurance firms operating here are required to have $5 million in capital available in the event of unforeseen problems, said Norris Clark, the state's deputy commissioner of financial surveillance. For MEWAs, the requirement is only $1 million.

**Large Employers Seek to Consolidate, Simplify**

Only six states, including California, have MEWAs or some variation on them. Virtually every other form of self-funded insurance is federally regulated under the Employee Retirement Income Security Act. That's one of the reasons large employers prefer self-funding, because it alleviates the need to follow various state regulations.

Many large employers, meanwhile, either are dropping HMOs to consolidate, simplify and/or reduce their benefit options or are streamlining how they work with HMOs. Because doctor and hospital groups have had such success recently in pushing through fee increases, HMOs have lost much of their ability to contain costs.

In response, Connecticut-based Xerox Corp. has overhauled its health coverage, according to Larry Becker, the company's director of benefits. First, rather than deal separately with 220 HMOs around the nation, including dozens of Blue Cross, Aetna and Kaiser affiliates, Xerox decided to expand its self-insurance programs and to negotiate with only one affiliate of the big managed-care companies, with every other affiliate expected to go along for the ride. Also, Becker said, other HMOs, particularly those with the highest cost increases, were dropped outright. Becker added that Xerox spends about $300 million a year on health care and will save on administration, paperwork and premium taxes because of the self-funding and the streamlining.

Albert Lowey-Ball, who runs a Sacramento management consulting firm specializing in the managed health-care sector, said, "I expect this trend toward more self-insurance to accelerate. This is something that will be good for employers but not to consumers, who in some cases will see their costs increase and their choices reduced and their benefits reduced as well."

Becker sees an advantage in that, even if consumers continue to be dazed by sticker shock.

"We have to get people more in-
Health-care Costs Take Biggest Leap in Decade, Report Says

Fueled by soaring hospital and prescription drug costs, medical spending is accelerating faster than government economists had expected, reaching 14 percent of the gross domestic product last year for the first time, according to new projections.

The development marks the end of nearly a decade of fairly stable health expenditures, which have remained just above 13 percent of the GDP since 1992, the office of the actuary at the federal Centers for Medicare and Medicaid Services said in a report released Monday.

It also marks official confirmation that rising medical costs are consuming a larger slice of the economic pie and that they appear on course to do so throughout the next decade. By 2011, health-care expenditures are projected to more than double to $2.8 trillion annually and account for 17 percent of GDP, the government forecasters predict in the new study, published in Health Affairs.

While this long-term outlook is fraught with uncertainty, the scope of sharply escalating health-care costs is becoming clearer, according to the latest data from the government.

Last year, for instance, public health-care programs grew by 10.4 percent, compared with a 7 percent growth rate in 2000, analysts estimated. Medicare expenses increased 9.5 percent, as Congress decided not to enact some planned payment cuts for hospitals, home health agencies and nursing homes. Medicare is the federal government's health program for nearly 40 million elderly Americans.

Political pressure by health-care providers to forestall payment cuts is a virtual certainty in the years ahead, experts said. Currently, doctors are trying to roll back a planned 5.4 percent reduction in Medicare fees scheduled for next year, claiming the results for their elderly patients' access to services would be disastrous.

Meanwhile, Medicaid expenses swelled 11.5 percent in 2001, after an 8.6 percent increase the year before. Medicaid is a joint state-federal program for people who are poor and disabled. As the economy tumbled into recession last year and states' budget surpluses were depleted, soaring Medicaid costs have become one of lawmakers' biggest headaches.

Many states, including Illinois, are trying a variety of strategies to rein in Medicaid expenditures, including slashing fees to medical providers, limiting drugs the program will pay for and eliminating some programs. Such efforts probably will continue for the next several years, health economists said.

Public health programs are getting new funding after the anthrax attacks last fall. Federal spending on public health is set to climb 34.2 percent this year, following a 15.9 increase in 2001, government analysts said. Most of that represents a substantial budget increase for the Centers for Disease Control and Prevention, which is leading the nation's fight against potential bioterrorism.

On the private side of the health spending equation, sharp increases in premiums for employer-sponsored insurance have been well documented over the last year, as has another trend: the decision by employers to pass on more costs to employees in the form of higher deductibles and co-payments.

While government forecasters predict a slow-down in expenses for private medical plans after 2002, they warn this probably will happen because employers will reduce their share of insurance-related costs and turn again to more restrictive forms of managed care such as HMOs. Consumers who want a broader range of hospital and doctor choices will pay significantly more, predicted Paul Ginsburg, president of the Center for Studying Health System Change.

Also, analysts believe more employers are likely to drop insurance coverage for employees, swelling the ranks of the 39 million uninsured people in the U.S.

Many cost control strategies used during the late 1990s have stopped working as managed care has fallen into disfavor, Ginsburg said. When consumers rebelled against HMOs' restraints on care, constraints on medical providers relaxed and hospital costs, in particular, began to rise again after a decade.

Aging Work Force Challenges Health Insurers

America's work force is aging. Already one in three workers is over 55, and the Monthly Labor Review projects the number of workers between the ages of 55 and 64 to increase by nearly 50% between 2000 and 2025, creating a greater de-
mand for employer-provided health benefits.

Greater utilization of health plans by a larger population of older working Americans will add to an already increasing problem of keeping health care affordable. "Our challenge in insuring 82 million Americans is how do health insurers keep it affordable," said Maureen Sullivan, senior vice president of strategic services for the Blue Cross/Blue Shield Association. "We think we can [keep health care affordable] in the employer-based health system, but we think it's going to drive changes."

The cost of employer-based health insurance is driven by several factors, including the age and sex of the work force. As age increases, so does utilization, which impacts the employer's claims experience. Older workers are more costly to insure, because the incidence of disease is usually higher with age, said Rick Shaw, an assistant vice president in the life/health division of A. M. Best Co. "Older populations have higher utilization rates and a greater chance of being out due to illness."

For instance, a 20-year-old may experience knee problems requiring surgery and a short period of rehabilitation, but a 65-year-old could experience a hip fracture requiring hip-replacement surgery, a longer hospital stay, longer duration of physical therapy services and possibly even a visiting nurse, Shaw said. "Illnesses and injuries are more serious [for older people]."

From 1994 to 2000, the number of older working people grew significantly due to demographic changes and a strong economy, according to the October 2000 issue of the Monthly Labor Review. In the next 10 years, the number of older workers in the U.S. work force is expected to jump by 47%, compared with the meager 1.2% increase anticipated in the 25- to 54-year-old age range, the Monthly Labor Review reported.

At the root of the aging worker phenomenon is the baby boom generation--76 million strong and the largest single sustained population growth in the history of the United States. Baby boomers are Americans born between 1946 and 1964, and the first of the baby boomers will reach the retirement age of 65 in 2011. Those born at the end of the baby boom will reach retirement age--which is 67 for people born after 1960--in 2031.

The percentage of workers age 70 to 74 rose to 13.5% in 2000 from 11.3% 10 years earlier, according to the Bureau of Labor Statistics. For those 75 and older, it grew from 4.3% to 5.3%.

The Centers for Medicare & Medicaid Services estimate that healthcare expenditures will equal $2.6 trillion by 2010, or 15.9% of the United States' gross domestic product. And yet, the full baby boomer generation will not have reached age 55.

Health-care costs have been increasing at double-digit rates for several years, and experts see this trend continuing. The Centers for Medicare & Medicaid Services also report that out-of-pocket spending for 25- to 34-year-olds is 57% of that for 55- to 64-year-olds. The centers also report that half of the elderly population take more than five prescription drugs each week. Many of the increases in health-care costs are being attributed to the strong demand for services, increases in prescription drug costs, pressure for increased profits as health insurers become publicly traded companies, technological advances that drive up diagnostic and clinical procedure costs, and higher patient expectations.

Also, as age increases, there is a shift in the male/female cost ratio, said Jessica Waltman, manager of state health policy at the National Association of Health Underwriters. "Under the age of 55, women are in their child-bearing years and are more costly to insure. They visit doctors more often and use prescriptions more." At 55, the balance shifts, and men become more costly to insure, many times because they didn't care for themselves when they were younger, she said.

So, employer-based health plans will need to provide more and different benefits as the population ages. "There will be a lot more people living longer, requiring more medical care and needing services to support them," said Beth Bierbower, vice president of product development for Humana Inc. "Baby boomers, and other segments as well, are expecting more from their health insurance than just catastrophic coverage or routine preventive exams." People will be looking for insurance to help them maintain a quality of life, which means meeting needs that traditional health insurance has never been called on to meet.

"People are going to live longer. Thirty is no longer middle age, and 60 is not what it used to be," said Bierbower. "Baby boomers do not picture themselves sitting in a rocking chair. They are going to expect health insurance to help them support a reasonable level of physical activity."

Insurers are not waiting, however, for the full impact of boomers' increased demand for health benefits to hit. "If you took how we function now and moved it six years into the future with no changes, I feel we would have a real problem," Sulli-
van said. "However, the expectation is on the aging boomers-to be much more educated on health-care choices and have more of a stake. And they will be much more satisfied than people today as they access the health-care system."

Health insurers are focusing on several areas to ensure that health-care coverage remains affordable: enhancing benefit design, improving consumer education, implementing disease-management practices, increasing the cost sharing between insurers and consumers, using technology to reduce costs, changing legislation and regulation, streamlining processes to increase efficiencies and eliminating fraud and waste from the system.

"The aging population will force health insurers and employers to be more creative with benefit packages, such as fewer benefits or higher copays," Shaw said. "Or backing off on certain coverage as employees get older."

Benefit design is one of the first areas that will see changes, Sullivan said. Traditionally, health insurance has offered a list of covered procedures and a list of services restricted to a set number of visits, such as physical therapy treatments.

"What we are starting to see is more customization of products to the employee, so the employee can have a greater role in making their health-care decisions," Sullivan said. One example is a scheduled-benefit plan that allows benefits up to a certain dollar amount, while another option is to wrap discounted services, such as nutritional counseling, around the plans. The hope is that greater member participation at the benefit-structure level will lead to better utilization and ensure that the member receives the appropriate care, she said.

Group health insurers do not plan to take on the health-care cost burden alone; they expect employers and members to share in a greater proportion of the cost of coverage. And Rich Ostuw, a senior consultant with Towers Perrin, believes that employers cannot keep absorbing the double-digit increases, so they will be forced to pass them on to employees if total costs cannot be reduced to an acceptable level.

"We have to begin to think of health insurance in a different light: How much does the consumer want to spend, and in what manner will they want to fund it?" said Bierbower. This may include looking during the underwriting process at how much cost sharing is in the plan or adding incentives to plans so employees use services wisely. It also entails tweaking benefits, possibly by increasing copay amounts, using a tiered drug copay or removing options, such as vision coverage.

"The member will play an increasing role in paying for health care," Sullivan said. At the same time, consumers will play an increasing role in determining the benefits that are right for them. "We think it will still be affordable to the employer and the employee, but we all need to work to make that happen," she said. With 80% to 90% of the health-care dollar going to medical expenses, "we have to be relentless in our effort to look at every part of the health-care system to generate savings and educate stakeholders to make sure there is a collective will to change."

Increasing rates are dependent on many things, such as the health of the group, the age of the group, inflation and utilization. "With the increasing aging population, certainly, rates will go up," said Judy Anderson, a staff fellow with the Society of Actuaries. But the aging of the work force population is beginning spread gradually over time, "so it will be eased into."

But, analysts say, hefty increases in health costs can't continue to be absorbed, given a sluggish economy and relatively low overall inflation. "No one has the money to pay for it," said Jeff Goldsmith of Health Futures Inc., a consulting firm. "We'll need to make hard choices as a society, something we're not very good at."

On the lighter side...

National Workplace Napping Day

Boston University professor William Anthony and his wife, Camille, co-authors of The Art of Napping at Work, have declared Monday, April 8, 2002 as National Workplace Napping Day, and they are on a mission to erase the stigma of napping that permeates our culture.

“It is time to plan ahead for the lost hour of sleep that occurs with daylight savings time,” says William Anthony, who also serves as director of Boston University’s Center for Psychiatric Rehabilitation. Anthony encourages employers and employees to “promote a 20-minute workplace nap and experience the amazing effect it has on productivity, alertness and well-being.”

**Cities Named after People**

Look at a map of the United States and it's easy to spot cities named after famous people such as Columbus, Ohio; Jackson, Miss.; and Lincoln, Neb. Here are some other cities named after less well-known persons:

**Dallas, Texas** — named after Commodore Alexander Dallas, a close friend and associate of John Neely Bryan, a lawyer from Tennessee who founded the city.

**Cody, Wyoming** — named after frontiersman William F. Cody, also known as "Buffalo Bill," so called because one of his first jobs required him to kill 12 bison a day to feed railroad workers.

**Pontiac, Mich.** — named after the Indian chief of the Ottawa tribes who led an uprising against British troops during the 1700s.

**Cleveland, Ohio** — named after General Moses Cleaveland, the agent and chief surveyor of the Connecticut Land Co., who founded the city. As a result of a printing error in a newspaper ad, the first "a" was dropped to give the city its current spelling.

**The First Self-Serve Grocery Store**

Traditionally, grocery store customers would give their shopping lists to clerks who would gather the goods from the shelves. Clarence Saunders thought this wasted time and labor, so he opened the first self-serve grocery in 1916 in Memphis, Tenn. Despite predictions of certain failure, the first Piggly Wiggly was a huge success. When asked why he chose such an unusual name, Saunders replied, "So people will ask that very question.” The store was also the first to provide checkout counters, put price tags on every item, use refrigerated cases, and make the employees wear uniforms. Today, there are more than 600 Piggly Wiggly stores in 16 states, primarily in the Southeast.

**Invention of the Band-Aid**

The Band-aid was invented in 1920 by Earle Dickson, a cotton buyer at the Johnson & Johnson Co. Dickson's wife, Josephine, was prone to cutting her fingers in the kitchen. She would dress the cuts with gauze and adhesive tape, but the bandages kept falling off. To solve her problem, Dickson placed small squares of gauze at intervals along an adhesive strip and covered them with crinoline. Josephine could simply cut off a length of tape and wrap it around her finger. Johnson & Johnson was so delighted with the idea, they made Dickson a vice president.

**The International Breakfast Table**

Here's the story behind such "international" foods as French toast, English muffins, and Canadian bacon:

French toast was first prepared in ancient Rome, where a cookbook listed it as a "sweet dish" and the recipe called for stale white bread to be soaked in milk and eggs, fried in oil, and served with honey. The dish spread through Europe. An American cookbook in 1871 was the first to call it "French toast."

English muffins are thought to have originated in Wales in the 10th century. The Welsh called them "bara maen." They were yeast cakes baked on hot stones.

Canadian bacon got its name during War World II, when Britain had a pork shortage and had to import sides of pork from Canada. Hence the term "Canadian bacon" for the smoked end product.