FLORIDA SUMMIT ON HEALTH CARE COST CONTAINMENT
SPONSORED BY
ASSOCIATED INDUSTRIES OF FLORIDA

PRESENTATION OUTLINE
COST CONTAINMENT: A THIRD PARTY PAYOR PERSPECTIVE

BY
WILLIAM E. FLAHERTY
PRESIDENT OF BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

D. A. Lipp
MAR 28 1984

March 27, 1984
I. INTRODUCTION

A. Appreciate opportunity to be here in two-way communication.

B. Understanding issues and perspectives necessary to reaching sound solutions. Industry involvement is crucial.

C. My role as CEO of large insurance company in Florida, five years on HCCB, 15 months on Governor’s Task Force gives me a perspective on costs.
   - Why they are rising
   - That we are at a critical juncture
   - That prompt action is needed
   - That there is strong political momentum for regulation of hospital budgets

D. What is needed.
   - Market Reform that introduces effective price competition in the health care industry
   - Innovation and risk-taking that promotes change in both health care delivery and financing
   - Need to avoid the seductive appeal of seemingly simple solutions that promise a quick fix - there are neither simple solutions nor quick fixes
   - Need to avoid direct economic regulatory approaches that focus only on hospital prices

E. I would briefly like to provide:
   - Brief introduction to health insurance: 1932-1970
   - Describe early efforts at cost containment: 1932-1970
   - Discuss cost containment of the 70’s: 1970-1982
   - Provide an update on current situation
   - Discuss the future of cost containment focusing on current trends and employer’s role
   - Discuss our conclusions
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A. National perspective - Florida largely non-industrial

B. Growth and Role of Health Insurance
   • Depression - hospitals endangered - began programs

C. 1932 - 1970
   • WWII - many medical advances made during the war plus pent up demand government policy was to ensure access regardless of ability to pay
     - Tax free employer paid health insurance
     - Expenditures on R & D
     - Fund expansion of hospital system
   • Early consumer acceptance and public programs resulted in
     - Explosive growth (people covered)
   • 1955 on - began benefit expansion
   • Medicare (T18) and Medicaid (T19) introduced in 1965
   • Result of programs plus benefit growth was perception of unlimited access free from anxiety over $/income level

SILENT ASSUMPTION - The health care industry like others would efficiently deliver care.

NOTE: Auto industry thought they were competitive and efficient before 1973.
Airline industry thought they were efficient under regulation.
III. EARLY EFFORTS AT COST CONTAINMENT (1932-1970)

A. Qualify providers beyond licensing before payment
   • Necessity in community
   • Adequate records, access, audit
   • Responsive to community need

B. Limit costs to - "Reasonable": analogous to United Way review of Agency mission, operations and budgets.
   • Hospitals - Early Efforts
     - Allowable costs, i.e., limits on pension, interest, margin, annual rate of increase compared to peer group average
     - Provide industrial engineering on a cost basis
   • Physicians - Early Efforts
     - Fee schedule
     - Limits on billing by contractual arrangement
     - Participating agreements
     - Initial problems of equity for specialists in early 60's
     - "UCR" - impact of Steel industry and Medicare resulted in a national pattern

   • Dental
     - Similar but more sophisticated U. R. claims
     - Pre-authorization and quality review
     - Usage very discretionary by patient
IV. 1970 - 1982 - DISCOVERY OF A "CRISIS"

A. Increased emphasis on cost containment
   - Many things tried without true results - short simple answers just don't work

B. Government (State and Federal) Initiatives at Cost Containment
   - CON - restrict hospital beds
   - Health Planning
   - Utilization Review - PSRO's
   - State Rate Setting
   - HMO Activities
   - Efforts were ineffective (reference our paper)

C. At least one insurer (BCBS) Experience
   - Make up of a premium - BCBSF percentages
   - Hospitals
     - Prospective Reimbursement
     - Expanded out of hospital benefits (for more expensive in hospital benefits) - only increased total cost
     - Second Opinion - inconclusive evidence
     - Pre-admission certification and length of stay certification
     - Pre-admission Testing
     - Tightened medical necessity - (limited by courts) plus "waiver of liability" and "hold harmless"
   - Physicians
     - Index physician fee profiles versus paying the "true" UCR
       - Negotiations
       - State government
     - Utilization Review
       - Claims cost control
       - Fraud and abuse
- Other
  - Computer assisted claims adjudication and analysis for fraud/abuse

- Employers (Ford, DuPont)
  - Comprehensive major medical (coinsurance and deductibles) replacing first dollar coverage (demand side incentives)
  - False hope that this will introduce market incentives by making the employee pay for part of the cost
    - Incentive not strong enough
    - Consumer ignorance
    - Emotion laden decisions
    - Will only generate initial savings
  - Comprehensive major medical may be a good device for holding down corporate cost
    - Other ways may be more effective, e.g., employer contribution
    - Will not overcome perverse supply side incentives

- Emergence of self funding and third party administrator
  - Self insurance eliminated risk charge and third party administrators emerged to administer
    - Encouraged by insurers due to health insurance losses
    - High interest rates and tight capital markets
      - Initial first year savings due to lower "price" the first year
      - Earn interest on reserves
    - Willingness to accept the risk of claim fluctuation in place of 1% - 2% risk charge
      - Gave the employer access to data they may not have been able to from carrier
      - ERISA exemption from mandated benefits, premium taxes and other costs

- Insurers
  - Engaged in all of the above
- Pressures on Life products
- Continued losses in health
- Tightened underwriting/encouraged benefit reductions
  - Increased bad debt adds to cost shift
- Today - many insurers taking a shotgun approach - don't know what works, therefore, proposing all of the above - no clear theme
- Many insurers have given up - proposing that the government fix it
D. Governor's Task Force Commissioner's Proposals

- Governor's Task Force went through 15 months effort encountering some of the same difficulties as HCCB
  - Lacked data
  - Unable to deal with complex issues
  - Staffing problems
- Governor's Task Force endorsed competition with a regulatory hospital budget review program to serve as a safety net
  - Use hospital input index and points to catch outliers
  - Plus points decline over time but "give competition a chance to work"
- Governor's Task Force has recommended a program to assess hospitals to resolve indigent care problem
- Commissioner Gunter's bill is a hospital budget review - CPI+4

E. Basic problems with any regulatory approach

- Competition and regulation incompatible
- Stifles innovation
- Regulation begets regulation (as these less stringent or intrusive regulatory measures fail, e.g., HCCB)
- Sets up the false expectation that the government will fix it
- They ignore impact of indigent care and malpractice assessments which would put many hospitals under regulation
- Hospitals will game the system
- The ceiling rate of increase becomes the floor
- More fundamental: putting pressure on price will not deal with total costs, e.g., Maryland data - utilization will rise

F. A Barrier to Competition - Indigent Care Problem

- Must be addressed if competition desired

Problems
- Maldistribution
- Program structure and administration
- Program cost and efficiency
VI. FUTURE OF COST CONTAINMENT

A. Current Trends/Conditions Favoring Competition

- Importance to Florida Medicare accounts for 51% of the days
- Current Federal Policy
  - Shift in policy from access to efficiency in health care
  - Shift from regulation to deregulation (airlines, trucking, communications, etc.)
- Deep concern over Federal expenditures and deficits
  - Medicare Program solvency
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  - Most fundamental change since 1965
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    - HMO's
    - Private sector alternatives
- Oversupply of hospital beds in Florida
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  - High debt ratios (literature on marketing hospital services has grown profusely
- Oversupply of physicians
  - Glut of physicians by 1990
- Distinction between delivery of services and financing is blurring — competing for patients and market share

B. Emergence of PPO's/Growth in HMO's

- Growth of PPO's
  - Hospitals and physicians willing to negotiate
  - Primarily impacts price side
  - Future many PPO's will evolve into HMO's
HMO's

To-Date, the only proven delivery and financing mechanism that has demonstrated ability to contain costs (days/1000)
- Opponents charge inferior care with emphasis on dollars
- Success of HMO is control of utilization - changing physician behavior

C. Growth of Coalitions

D. Insurers and the Future

- Choices different for full line carrier versus the health specialist
- Must undertake basic review of products and programs
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E. Employer's Role

- We believe that it is in your own best interest to foster price competition in the health care industry and health care financing
  - Need to ensure development and maintenance of price competition
  - Regulatory approach has failed and will preserve the status quo
- We believe that all interests must be involved in the solutions: customer, payors, providers and legislators
  - Need to understand each other
  - Need for communication
  - Need to listen to some unpleasant messages
  - Can't negotiate from across an empty table
- **Individual Interests/Actions**
  - Employee relations programs - need to change policies - allow for experimentation - don't expect everything will work
  - Basis for evaluating insurers
    - Administrative cost versus claims cost
  - Get involved with the local health care industry
    - Local planning
    - Hospital boards
    - Etc.
  - Let your legislators know where you stand

- **Collective Interest and Actions**
  - Form coalitions
  - Initiate local planning
  - Hold conferences such as this
  - Report to legislature
GOALS:

1. Position Blue Cross and Blue Shield of Florida as uniquely and distinctly capable in the cost containment arena.

2. Demonstrate that Blue Cross and Blue Shield of Florida is:
   - Knowledgeable on the cost containment issue.
   - Actively involved in cost containment.
   - Sensitive to the needs of the employer.

3. Educate the employers on the cost containment issue and the current debate as to the appropriate public policy to be pursued.
THEME:

The cost containment issue and attempts to resolve it have proceeded while federal government pursued a policy of ensuring unlimited access to health care for all citizens regardless of income in an industry which was not subject to rational economic forces. Private health insurance was one of the vehicles used to implement the policy. Many proposed solutions have been tried including direct economic regulation and none have been effective in solving the issue. Rising program costs, deficits and public pressure have caused federal policy to shift from access to efficiency to be achieved through market forces consistent with their approach in other industries. Federal government and private actions are consistent with this policy. States are however, pursuing regulatory alternatives. Trends are underway to ensure growth of competitive forces and to introduce effective price competition in health care. At the state level the best public policy course is to ensure market reform, innovation and risk taking in a competitive environment.
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V. CURRENT DEBATE

A. Political Momentum and support for legislation,

- Politicians in the marketplace for votes have increasing pressure "to do something this year"
  - Public opinion polls
  - Contact with the public
  - Feedback from groups such as yourself
  - A week doesn't go by where an article is not written about the problem - heavy media coverage
  - Natural reaction for politician is to seek a "political or regulatory solution"

B. The Debate

- Agree on need for change
- Which approach - competitive, regulatory or both
- Arguments for each approach

C. HCCB - has asked for restructuring, staffing and increased regulatory authority (reference our report)

- HCCB has been ineffective
- Problems
  - Unable to deal with complex issues and problems (workload, staffing, politicization, lack of data, etc.)
- Causes
  - Insufficient and inadequate tools
  - Complexity of innumerable questions, e.g., what is reasonable margin? Effects of margin on capitalization?
  - Structure
  - Background of Board and staff
  - Staffing - civil service
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  - Maldistribution
  - Program structure and administration
  - Program cost and efficiency
- Blue Cross and Blue Shield of Florida paper and solution
- Redistribute load through assessment
- Expansion of the program
- State adopt prudent buyer
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• Collective Interest and Actions
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  - Initiate local planning
  - Hold conferences such as this
  - Report to legislature
VII. CONCLUSIONS

A. Restate - Critical juncture and decisions to be made.
   - What we need is market reform that introduces effective price competition in the health care industry - promoting innovation and and risk taking
   - Need for change in both health care delivery and financing
   - There are no easy answers and certainly no quick fixes
   - Must work together toward a sound but not a lavish health care industry
   - Some difficult issues need to face up to e.g., indigent care

B. Need to end the Debate
   - Not without cost
     - Cash cost in anticipatory pricing
     - Psychological cost that government can fix and that the cost problem is a public versus a private matter

C. Hope to have been some help in giving my perspective
   - Don't have easy answers
   - Pledge our continued effort in developing cost containment programs
Cost Containment:
A Third Party-Payor Perspective
• Why costs are rising
• Critical Juncture
• Prompt Action Needed
• Strong Political Momentum
What Is Needed

• Market Reform
• Innovation & Risk Taking
• Avoid Appeal of Seemingly Simple Solutions
• Avoid Focus on Hospital Costs
Introduction to Health Insurance:
1932-1970
Growth of Health Insurance

• National Perspective

• Depression - Hospitals Endangered

• 1930-1970
  - Consumer Acceptance
  - Government Policy = Promote Access
  - Explosive Growth
    • People Covered
    • Benefits (1955)
  - 1965 Passage of Medicare & Medicaid
Silent Assumption

HEALTH CARE INDUSTRY WAS EFFICIENT

- Autos
- Airlines
Early Efforts at Cost Containment: 1932-1970
Early Efforts

A. Qualify Providers

B. Limit Costs to Reasonable Cost
Hospitals

- Allowable Cost (Pensions, Margins, Peer Grouping)
- Industrial Engineering
Physicians

- Fee Schedules
- Limits on Billing
- Participating Agreements
- Equity for Specialists
- "UCR": Steel, & Medicare Set National Patterns
Dental

- More Sophisticated Claims Utilization Review
- Pre-Authorization & Quality Review
- Highly Discretionary
Cost Containment of The '70s: 1970-1982
Government Initiatives of The '70's

• Certificate of Need (Con)
• Health Planning Act (93-641)
• Professional Standard Review Organizations (PSRO's)
• State Rate Setting
• HMO Act
COMPONENTS OF HEALTH INSURANCE PREMIUM

Note: Percentages shown are for Blue Cross & Blue Shield of Florida.
Hospitals

• Prospective Reimbursement (Keep "Profits"/Incur Losses)
• Expand Out of Hospital Benefits
• Pre-Admission Certification
• Pre-Admission Testing
• Tightened Medical Necessity
Physicians

- Index Physician Fee Profiles
  - Negotiation
  - State Government

- Utilization Review
  - Claims Cost Control
  - Fraud and Abuse

Other

- Computer-Assisted Claim Adjudication
- Analysis for Fraud/Abuse
Employers

- Comprehensive Major Medical Replacing 1st Dollar Coverage
- Increase Coinsurance & Deductibles
Emergence of Self Insurance

- Eliminated ½ to 2% Risk Charge

- Third Party Administrators
  - Offer Less Than Full Service

- Self Administered
Self Insurance: Causes of Growth

- Encouraged By Health Insurance Losses
- High Interest Rates & Cash Flow Advantages
- Willingness to Accept the Risk
- Employer Access to Data
- ERISA Exemption from Mandated Benefits
Insurers

- Engaged in All of the Above

- Pressure on Life Profits
  - High Interest Rates
  - Increased Competition

- Tightened Underwriting
  - Increased Bad Debt Adds to “Cost Shift”

- Many Now Taking Shotgun Approach
  or

- Have Given Up & Propose Government Regulation
Update On Current Situation
Political Momentum

• Public Opinion Polls
• Public Contact
• Feedback from Employers
• Media Coverage of the Escalating Health Care Costs
• Concerns of Potential Federal Government Actions Over Program Cost
  - Medicare
  - Medicaid

PRESSURE — "TO DO SOMETHING"
We Can All Agree on The Need For Change

Current Debate
Can or Should We Rely On

- Competitive Approach
- Regulatory Approach
- Both
<table>
<thead>
<tr>
<th>ALTERNATIVES</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>• Competitive Approach</td>
<td>→ Regulation hasn’t worked &amp; price competition was non existent.</td>
</tr>
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<td>→ Competition hasn’t worked; regulation can work.</td>
</tr>
<tr>
<td>• Both</td>
<td>→ Regulation can be structured loosely enough to serve as a safety net but yet allow competition to work.</td>
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HCCB

- Has asked for more regulatory restructuring, resources and increased regulatory authority.

- Has been ineffective:
  - Unable to deal with increasingly complex problems.

CAUSES

- Lack of Tools/Data
- Complexity of Issues
- Structure
- Board Background
- Staffing
Current Proposals

GOVERNOR'S TASK FORCE

\[ \text{Market Basket Hospital Inputs} + \text{"Points"} \]

\[ \% \text{ Allowable Increase} \]

\[ \text{Time} \]

\[ \text{Market Basket Input Index} \]
Commissioner's Proposal

CPI + 4%
Basic Problems of
Regulatory Proposals

• Competition & Regulation Incompatible
• Regulation Stifles Competition
• False Expectations
• Hospitals Will Capture Regulators & Preserve Status Quo
• Ceiling Becomes the Floor
• Pressure on Hospital Prices Won’t Lower Total Cost
  - Use Will Increase
  - Shift Services Out of Hospital
Indigent Care - A Barrier to Competition

THREE PROBLEMS

• Inequitable Distribution of Burden
• Medicaid Program Structure & Administration
• Program Cost & Efficiency
Indigent Care - A Barrier to Competition

BCBS OF FLORIDA RECOMMENDATIONS

• Redistribute Burden - Through Hospital Assessments

• Expand Program

• Restructure the Program

• Alter Hospital Reimbursement - Propectively Determined

• Prudent Purchaser on a Capitation Basis

• Management Audit of Medicaid Program

• Measure the Size of the Problem
• Discuss Future of Cost Containment

• Current Trends

• Employers Role
Movement Toward Competition

- Federal Policy of Deregulation
- Concern Over Federal Expenditures and Deficits
  - Medicare Program Cost
  - Medicaid Program Cost
**Competition in Florida**

HOSPITAL INDUSTRY HAS EXCESS CAPACITY

- Beds/1,000 Population 1971-1981

  Florida = +16.0%
  U. S. = +4.0%

- Occupancy Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>FL Average</th>
<th>U.S. Average</th>
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<tbody>
<tr>
<td>1971</td>
<td>76.9%</td>
<td>76.7%</td>
</tr>
<tr>
<td>1981</td>
<td>73.2%</td>
<td>76.0%</td>
</tr>
<tr>
<td>1983</td>
<td>69.4%*</td>
<td>73.9%*</td>
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<tr>
<td>1987</td>
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<td>73.1%*</td>
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*Projected
**Competition in Florida**

**EXCESS SUPPLY OF PHYSICIANS**

- Physicians/1,000 Population

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<td>1.37</td>
<td>2.07</td>
<td>51%</td>
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*For 12/31/81*
Blurring the Distinction Between Financing and Delivery of Health Care Services
Growth of HMOs and PPOs

HMO Growth in Recent Years in Florida

• 13 Operational

• 7 in Development Stage

• BCBSF to Launch Development of an Additional 3 in 1984

PPO DEVELOPMENT

BCBSF Will Have Operational PPO's in 1984
HMO Hospital Utilization

JUNE 1982
INPATIENT DAYS/1,000 MEMBERS/YEAR

713/1,000
National Blue Cross-Blue Shield

961/1,000
Florida Blue Cross-Blue Shield

458/1,000
All HMOs Nationally

496/1,000
Florida Blue Cross-Blue Shield HMOs
Competition In Florida
Growth in Coalitions

FLORIDA BUSINESS COALITIONS

Source: Blue Cross & Blue Shield of Florida
INSURERS

BASIC REVIEW OF PRODUCTS AND PROGRAMS

• Data Collection, Analysis, and Negotiation
• Must Allocate Resources to Cost Containment
• Development of PPOs
• Development of HMOs
Employers & The Future of Cost Containment

• Effective Price Competition in the Health Care Industry will Benefit the Consumer

• All Interests Must be a Part of the Solution:
  - Employers
  - Employees
  - Third Party Payors
  - Physicians
  - Hospitals
  - State Government
Individual Employers

- Employee Relations & Benefit Programs
  - Examine
  - Experimentation/Flexibility

- Evaluate Carrier’s Impact on Claims Cost vs. Administrative

- Get Involved in Your Local Communities
  - Local Planning
  - Hospital Boards
Employer Collective Actions

- Form Coalitions
- Initiate Local Planning
- Enhance Understanding & Communications
- Provide Input to Legislature
Conclusions
Conclusion

• At a Critical Juncture

• Need for Change in Financing and Delivery of Health Care Services

• No Quick Fixes

• Need a Sound But Not Lavish Health Care Industry

• Need Market Reform and Innovation
Need to End the Debate

THE DEBATE HAS NOT BEEN WITHOUT COST

- Anticipatory Pricing

- False Expectations That The Problem Is A Public Matter & Government Will Fix It.
TOPIC: 1985 - 1989 Corporate Strategic Planning

GOAL: To share with Corporate Employees the results of the second Executive Staff meeting in the 1985 - 1989 Corporate Strategic Planning Process.

OUTLINE:

1. Introduction
   - Bridging to the March 28th meeting

2. Corporate Purpose
   - Changing for the future.

3. Planning and Control
   - Objectives vs. Activities
   - Key Indicators/Milestone Reporting
   - Planning Team Responsibilities

4. Market Planning
   - Overview of Strategic Planning
   - Assignment of Planning Teams
   - Jekyll Training
   - May Development Session

5. Market Assessment Reports
   - Individual Markets/Financing and Administration
   - Government Agency/Financing and Administration

6. Questions and Answers
TABLE OF CONTENTS
TWO-WAY COMMUNICATION MEETING
APRIL 18, 1984

I. Summary of meeting reaction forms from March 28, 1984 meeting.

II. Two Way Communication.

III. Planning and Control.

IV. Measures of Performance.

V. Elements of Performance Reporting at BCBSF

IV. Market Planning

VII. Market Assessment Reports

A. Individual Consumer/Financing and Administration of Health Care.

# MEETING REACTION FORM

**Leader:** Flaherty/Dodd  
**Date:** March 28, 1984  
**Area:** All Management Meetings

Please give us your evaluation of how true each of the following statements is by checking the appropriate column. The “not applicable” column should be checked only if the question does not apply to you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree Strongly</th>
<th>Agree Somewhat</th>
<th>Disagree Somewhat</th>
<th>Disagree Strongly</th>
<th>Not Applicable</th>
<th>Total Recd</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The meeting was well organized.</td>
<td>61/53%</td>
<td>34/47%</td>
<td></td>
<td></td>
<td></td>
<td>115</td>
</tr>
<tr>
<td>2. Questions were answered to my satisfaction.</td>
<td>67/64%</td>
<td>36/34%</td>
<td>2/2%</td>
<td></td>
<td></td>
<td>105</td>
</tr>
<tr>
<td>3. I kept waiting to speak but didn’t get a chance.</td>
<td>1/1%</td>
<td>1/1%</td>
<td>6/5</td>
<td>47/42%</td>
<td>56/50%</td>
<td>111</td>
</tr>
<tr>
<td>4. The meeting was worth my time.</td>
<td>80/76%</td>
<td>31/27%</td>
<td>4/3%</td>
<td></td>
<td></td>
<td>115</td>
</tr>
<tr>
<td>5. The leader appeared to be open and honest with us.</td>
<td>87/76%</td>
<td>27/24%</td>
<td></td>
<td></td>
<td></td>
<td>114</td>
</tr>
<tr>
<td>6. I was encouraged to ask questions.</td>
<td>89/78%</td>
<td>20/17.5%</td>
<td>1/1%</td>
<td>1/1%</td>
<td>3/2.5%</td>
<td>114</td>
</tr>
<tr>
<td>7. The leader listened to group members.</td>
<td>64/57%</td>
<td>27/24%</td>
<td>1/1%</td>
<td></td>
<td>19/18%</td>
<td>111</td>
</tr>
<tr>
<td>8. I felt free to participate in the meeting discussion.</td>
<td>59/52%</td>
<td>23/20%</td>
<td>9/8%</td>
<td>3/3%</td>
<td>20/17%</td>
<td>114</td>
</tr>
<tr>
<td>9. Members supported each other and showed acceptance.</td>
<td>32/29%</td>
<td>35/32%</td>
<td>6/5%</td>
<td></td>
<td>38/34%</td>
<td>111</td>
</tr>
<tr>
<td>10. The general group atmosphere was relaxed.</td>
<td>28/25%</td>
<td>59/34%</td>
<td>22/20%</td>
<td></td>
<td>1/1%</td>
<td>110</td>
</tr>
<tr>
<td>11. The meeting was dominated by the leader.</td>
<td>34/31%</td>
<td>26/24%</td>
<td>9/8%</td>
<td>15/14%</td>
<td>23/23%</td>
<td>109</td>
</tr>
<tr>
<td>12. In this meeting I thought people were open and honest with each other.</td>
<td>40/35%</td>
<td>43/38%</td>
<td>9/8%</td>
<td></td>
<td>21/19%</td>
<td>113</td>
</tr>
</tbody>
</table>

**HOW DO YOU FEEL ABOUT TODAY’s MEETING?**

Great 19/17%  
Good 23/47%  
All Right 16/14%  
So-So 1/1%  
Bad 109
1) What questions, thoughts, or concerns do you have about today's meeting topic?

- Constant concern over quality of performance, yet very little actually done, we continue to process claims, write correspondence, handle phone calls etc. in a very unprofessional manner.
- Growth in the correspondence area is evidence that problems are not solved they are just ignored.
- Meeting was much too long--poor planning. Need to spend less time talking and more listening.
- Have W.E.F. shorten his comments to a few brief points.
- Room too damn warm.
- Excellent overview of environment and timely. Room too hot.
- Not on schedule.
- Room not comfortable.
- This is not my understanding of T.W.C.'s.
- What happened to quality - we can develop all the products in the world but if we cannot deliver what is expected we eventually lose.
- I'm glad we are to have a long-range strategic planning document to use for 1985 and beyond. Good job!
- Time.
- Planning (short notice).
- How can this information be relayed to clerical staff effectively without causing great apprehension about their future with our organization?
- Some of the topics are so broad, how will this be presented to the clerical staff so that they will understand and not be confused?
- Thank you for providing this "update" and the opportunity to be a part of our future.
- Repetition of questions on subjects already discussed.
- Too long.
- Appreciated the opportunity to hear about the 85-89 planning process at its early stages.
- Excellent. Very informative meeting, information presented is critical to each job success.
Question 1 continued

- Good start on communicating strategy.
- Good forum for communicating with members of the management team how strategic planning and annual planning/budgeting fit together. Also helpful to let management know what senior management is developing and working through in terms of strategic planning.
- Excellent meeting - I appreciate knowing what's going on for our company.
- Directions, alternatives, concerns very frustrating.
- Would like to speak to you personally sometime on how to give an effective and more important "AFFECTIVE" T.W.C.! How about an ice breaker!
- If a timeframe for the meeting is established, it should be adhered to. You spoke of planning, isn't timeliness an intimate part of that? Thanks to Bill Dodd for his attempt to keep schedule.
- Gave me an uneasy feeling about the future of BCBS. What looms on the horizon for BCBS?
- This type of planning has been long overdue in our company.
- We need to be careful that sensitive portions of our business strategy does not become readily available to our competitors.
- Excellent.
- Extremely important! Future reports are welcomed and looked-forward-to.
- I felt that too much time was spent early in the meeting explaining the purpose of the meeting.
- Too hot in area.
- Discussion of what is planning, too elementary - we had this too many times in T&D sessions and other forums.
- Need smoking/non-smoking sections.
- I really enjoyed the meeting and discussion on strategic planning by the corporation.
- Need to improve on our present business of claims, inquiries etc., and image "fast" to be able to take on so much new type business and programs.
- Really enjoyed hearing corporate strategy and plans.
- WEF was open, honest and congenial.
- Hope we continue to have these sessions.
Question 1 continued

- I am glad this meeting was held and I hope this type continues. It gives a different perspective to all planning and corporate activities. It brings the department/divisions together as necessary functions - parts of a visible whole.
- Thank you for opportunity of meeting.
- These meetings are needed. Thanks. But we need to stick to the planned time schedule.
- The divisional responsibilities outlined for strategic planning was not made clear.
- Excellent - glad staff took this time with us.
- Outstanding job by Mr. Flaherty - especially on questions and answer session.
- Encourage people to stand-up and ask their questions?
- Bill preached too much.
- Good. Timely. Could have taken longer to work down to supervisor level, (planning).

2) What topics would you like to discuss at future meetings?

- More specifics re: how the environment will impact the plan's management.
- I would like to see results and comments further answers of feedback forms. Pass out summarization.
- What steps are being taken to improve the health of CRT oriented position?
- Results of market analysis.
- Probably need to follow up on topic in more detail.
- More discussion on our strategy. When is the classification for Supervisors going to be looked at? We are required to do more and more and the career path is bleak. We are the most overlooked part of management.
- New developments of the future of the Medicare Program.
Question 2 continued

- More specifics and endorsements for operating areas that are successful -- to encourage building on successes in place--rather than completely reinventing the "wheel" in new ventures.
- You drew a very gloomy picture. How about "how great we are doing"--all areas --marketing took up 30% of your speech -- what about the rest of us?
- To be kept abreast of HMO-PPO.
- PPOs.
- HMOs.
- Involvement in decision making by supervisor staff on issues that are relevant to their circle.
- Progress of PPO and HMO development - measurements of success, in terms of money, enrollment, etc.
- I would like to see meetings (TWC) with VP and senior VP members of each division with the management staff on a regular basis. Topics to be presented for feedback to higher levels concerning issues and ideas generated at lower levels. Have not received too much feedback on ideas filtered up.
- Future of B.C.
- During the recent management dinner at the Sheraton, I felt Medicare A contribution to the success of the company was undersold. Perhaps during Mr. Flaherty's future meetings, he could express the on-going successes and contributions of various divisions who are making continued contributions (private, Med A and Med B).
- Strategic assumptions and the way they have evolved - key assumptions.
- More of the same. Specific plans and goals to create more awareness of corporate activities.
- Why it takes so long for some management to get yearly reviews. Apparently the notifications from personnel are only enforced at lower management levels. Supervisors/Managers are required to do reviews in timely!
- Why we continue Matrix Management when other major corporations have abandoned it, such as Boeing Aircraft. Because of its failure.
- Financial picture of corporation with regard to other BC/BS plans, Jackson-ville industry, all health insurers and board expectations.
- This meeting had nothing to do with two way communicators.
Question 2 continued

- 2-way implies open forum. By controlling agenda topic, it might minimize input. Consider soliciting issues prior to next meeting or following up on comments on the reaction forms.

- The problems/conflicts between T&D’s excellent training on MBO, job clarification, etc. and the “real world” where this is not put into practice by upper management, but is expected by first-line supervisors, who have yet to receive clarification support from their managers. What is being done or will be done to resolve this very real problem.

- Continued topics of corporate purpose and strategic planning and perhaps again in the fall in the midst of the planning process -- to clean our heads of the clutter generated by planning processes.

3) Other comments about today’s meeting?

- I agree with your comment that until we reach the point where all questions written on cards can be asked openly, then and only then will we have achieved true 2 way communication.

- I don’t think these meetings should be called T.W.C. for management as they are ‘one-way’ informational meetings. There is not any real interaction between members and or leader or shared leadership.

- I would like to see T.W.C. on topics like: compensation for exempt employees.

- Too crowded, too warm. Could meetings be scheduled earlier?

- Too many people at one time, should have 2 or 3 sessions or by Sr. V.P. area.

- Area was too hot! Too many people helped cause it but...

- Why can’t we have these meetings earlier in the day?

- Next time, have a meeting this long in a more comfortable place. Chairs, air, smoking and non-smoking.

- The room was very HOT! The meeting should have been scheduled 2:30 til 5:30. We need another meeting observation form. Too many statements were not applicable for this meeting. Need meeting notice sooner to plan and schedule “our” time.

- Facilities - room was too hot.

- Need two-way meetings in smaller groups pertaining to issues relevant to the group.
Question 3 continued

- Need more interaction and participation.
- Too Hot!
- In my three years with the plan, this was the best meeting I participated in. I felt involved with the company, its opportunities, and its problems. I particularly appreciated Mr. Flaherty's openness, honesty, humor, and intelligence. It was terribly refreshing to hear that Sr. Management does not have all the answers, and that we are all in this together!
- Discomfort level high - same thing occurs at evening meetings in this area.
- Room very warm.
- Too hot, too crowded.
- Good meeting, thanks!
- This type of meeting should be held more frequently, the information shared is very helpful.
- Room is too warm. Notify management of meeting earlier than day before meeting.
- Very appreciative to learn the background of the strategic planning process.
- Uncomfortable - too warm, too long.
- Too hot, too crowded. Would have been a good presentation for our management dinner. Start and end on time.
- Have you thought about paying for interns - putting potential doctors through medical school for obligation in future for participating in BC/BS plans?
- Extremely warm.
- Good communication, several of my concerns were explained.
- Might be a good idea to solicit questions and give responses at next TWC.
- Too hot. Can't these meetings be scheduled earlier?
- Good
- The most interesting portion of the meeting was the question and answer period. The length of the meeting was detrimental to the subject matter - in a warm and uncomfortable room.
- Need to improve meeting facilities.
- Maybe in the future, management groups could break in subgroups to brainstorm planning ideas.
Question 3 continued

- I think the meeting went well and look forward to future meetings.

- Today's meeting was an excellent example of the type of topic deserving of a two-way meeting of this group. However, please don't hold them on a fixed schedule because of the tendency of developing topics to fill the need for a meeting, but hold them when the topic requires it.

- I was enlightened by Mr. Flaherty being so informative. I felt he shared very open, very briefly, many important information. I was also delighted to learn we are going to develop our own staff and utilize our skills and expertise for future planning and analyses.

- Start meeting on time. Have meeting in morning.

- Started late, ran way over time, room too hot.

- Needless to say the room was crowded and hot.

- Answers were too long.

- Like to have meeting earlier in the day.

- Would like to receive a written Q & A sheet.

- What about earlier meetings?

- Thanks for having it - I appreciate it.

- More, more.

- Yeal - on hours, your understanding of that is appreciated.

- We need more upper management inspiration to produce productive perspiration to achieve our goals.

- Poor visuals, poor environment (no cooling).

- More advanced notification of the meeting would be helpful to rearrange schedules. Turn air on sooner! Proper planning.

- The meeting was too long; the room too hot and crowded and not adequately set-up (seating).

- This was a thought provoking meeting and stirred many ideas of what the future may hold and how we must re-look at our own attitudes internally. Some behind-the-times management styles still exist which inhibits/prohibits progressive thinking.
Two Way Communication

In these times of rapid change
• It is only with each employee's awareness, understanding and support that BCBSF can accomplish its business objectives and maintain its status as leader in the health care industry. This dictates that communications serve four main functions within the Corporation:
  - Information sharing is needed to gain understanding of the business and commitment to the Plan's goals and objectives;
  - Employee actions need to be guided by clearly communicating task assignments and expectations of employee behavior as it applies to job performance.
  - Information enabling employees to carry out their jobs is needed at all levels; and
  - Communication is needed to build trust and to coordinate the various resources.
• These functions of information exchange are two-way.
  - Communication needs to be shared down, up and across the organization in a timely, consistent, and ongoing manner.
• Management has the crucial role of being the vehicle that enables and facilitates the exchange of information.
• Management is responsible for ensuring that effective channels exist and are used to promote downward, upward and lateral communication throughout the Plan.

Every employee is responsible for initiating and facilitating the two-way process, but it can only be achieved when behaviorally encouraged, supported and monitored by management as well as employees at all levels.
Two Way Communication continued

• Each of you are expected to communicate with your staffs significant information from the topics discussed at these meetings; soliciting feedback/input on key topics shared with employees.

• Finally let us not forget the objectives of our Two Way Communication Program. They are:

  (1) To provide an atmosphere in which management is willing to discuss openly the facts about the Plan which are of direct concern to employees and which relate to their success and welfare as members of the Plan;

  (2) To provide the opportunity and channels for communication so that employees may share their ideas, attitudes and concerns at all organizational levels; and

  (3) To personally and publicly recognize employee achievements and their positive impact on the Plan and their individual development.

• Accomplishing these three objectives will help create an open environment and promote helpful feedback. This environment will strengthen the Plan's ability to accomplish its business goals and objectives.
OBJECTIVES

- ONGOING OPERATING RESULTS
- OPERATIONAL IMPROVEMENTS
- ORGANIZATIONAL IMPROVEMENTS
MANAGEMENT PLANNING AND CONTROL

It includes:

1. **Long Range Planning** of the organizations activities based on the corporate purpose, objectives, and broad goals; identification of performance indicators to measure implementation of the plan.


3. Monitoring Performance to ensure accomplishment of the organization's objectives and goals.

Comments:

1. The process of establishing goals and monitoring, evaluating and taking corrective action based on actual results is a critical management responsibility.

2. It is within the process of planning and control that management ensures resources are obtained and used effectively to accomplish the organization's plans.

3. The performance monitoring process provides the link between plans (both long and short range) and the accomplishment of the organization's goals.
• ITERATIVE PROCESS FOR PLANNING AND CONTROL
PERFORMANCE REPORTING: AN ITERATIVE PROCESS
FOR PLANNING AND CONTROL

1. The corporate performance reporting system supports the planning and control process by providing the mechanism for establishing meaningful indicators of performance and measuring actual results against planned performance.

2. The corporate performance reporting process can be described as an iterative process of control which includes the following elements.

   o **Analysis** - to determine true indicators of performance (cause/effect relationships).

   o **Establishing Standards** - performance expectations/targets which describe the level of performance necessary to achieve desired results.

   o **Development of Plans** (forecasts, budgets) based on performance targets.

   o **Implementation of Control Systems** to facilitate the measurement of actual versus planned results.

   o **Review Results**

   o **Analyze Variances**

     . take corrective action; or

     . adjust/revise performance targets.
MEASURES OF PERFORMANCE

- Top-down perspective
  - Measure of overall corporate performance
  - Cross Divisional Lines
  - May aggregate up through organization

- Must support/measure how effectively the organization is achieving its objectives and goals.

- Bottoms-up perspective
  - Traditional, transaction-oriented
  - Activity/unit level indicators
  - Measures of quality, quantity, cost, timeliness
1. The selection of measures of performance is critical to the organization because what we choose to measure defines what people will pay attention to and identifies the means by which we monitor implementation of our plans.

2. As a corporation we have had some success at identifying operational indicators of performance, we have not been as successful identifying corporate indicators.

3. It is senior management's responsibility to identify areas of performance which are critical to the success of the corporation and to define the qualitative/quantitative indicators which will be used to measure the organization's performance in these areas.

4. Performance indicators provide a yardstick for the corporation to compare historical performance with current performance. They must, however, be dynamic, responsive, and flexible in order to meet changes in the organization's strategy, environment and structure. Corporate indicators will change as external and internal conditions change.

5. The identification of Corporate Indicators is being emphasized during the current Strategic Planning process.

Notes:

1. The selection of measures of performance is critical to the organization because what we choose to measure defines what people will pay attention to and identifies the means by which we monitor implementation of our plans.

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5. The identification of Corporate Indicators is being emphasized during the current Strategic Planning process.
ELEMENTS OF PERFORMANCE REPORTING AT BCBSF

- Monthly Progress Report
  - Production Results
  - Project Results - Milestones

- MBO Process
  - "Boss/subordinate" review of results vs. plans.

- President's Report
  - Communication of corporate performance to Board of Directors

- BI-Monthly Progress Meeting
  - Facilitate peer review and the identification and communication of progress, problems, and barriers across divisional lines

- Quarterly Report
  - Cumulative and Comprehensive Analysis of divisional performance.
  - Emphasis on identification of trends and analysis of exceptions.

- Quarterly Review Meeting
  - President review of divisional results in comparison to plans.
MARKET PLANNING TEAMS
RESPONSIBILITIES

RESPONSIBLE EXECUTIVE

- Define project objectives
- Establish market planning team leadership
- Project clarification and goal setting
- Ongoing review and support
- Linkage to executive staff
- Removal of barriers to planning team progress

PLANNING TEAM LEADER

- Project planning
- Identification of areas impacted and team members
- Job clarification with team members
- Coordination of team activities
- Feedback to team members and their management regarding individual performance
- Ensuring development of quality end product
- Status reporting to responsible executive
- Recommend appointment/replacement of team members as appropriate
LINE MANAGEMENT

- IDENTIFICATION OF TEAM MEMBER TO REPRESENT THE AREA
- ADJUSTMENT OF AREA WORKLOAD AS APPROPRIATE
- MONITOR MEMBER PERFORMANCE AND TEAM PROGRESS
- PROVIDE TECHNICAL INPUT TO TEAM MEMBER

PLANNING TEAM MEMBER

- ATTEND AND PARTICIPATE IN ALL SCHEDULED MEETINGS
- COMPLETE AGREED UPON TASKS IN TIMELY AND EFFECTIVE MANNER
- PROVIDE TECHNICAL INFORMATION TO TEAM FROM FUNCTIONAL MANAGEMENT AREA
- ENSURE THAT FUNCTIONAL MANAGEMENT IS APPRISED OF TEAM ACTIVITIES AND PROGRESS
- COORDINATE TEAM ACTIVITIES WITH FUNCTIONAL MANAGEMENT AREA
Corporate Strategic Planning

- Market Strategy
- Systems Strategy
- Human Resource Strategy
- Organizational Strategy
- Financial Strategy

Annual Operating Plan/Budget

- Approved by Executive Staff
- Monitored by Operations Committee
BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
Market Identification Matrix

Out of State Market

Florida Market

Individuals
- E. Riegler
- R. Richards
- K. Kaminskas
- J. Summerlord
- D. Sibley
- J. Hornberger
- C. Nowlis
- C. Herring
- J. Davis
- P. Kirk
- J. Chaires

Employers
- J. Oetjen
- M. Johnston
- N. Young
- T. Riggs
- J. Hornberger
- C. Nowlis
- C. Herring
- J. Bayless
- P. Kirk
- J. Chaires

Government Agencies
- C. Scott
- J. Hinson
- L. Reynolds
- J. Eddy
- D. Powell
- M. Yost

Financing and Admin. of Health Care
- R. Chaffin
- M. Svenson
- K. Towns
- P. Davis
- L. Jones

Consumers

Out of State Market

Florida Market

Financing and Delivery of Health Care

Delivery of Services to Industry

* Denotes Planning Team Leader
PLANNING TEAM FOR MAY DEVELOPMENT

TEAM MEMBERS

BOB CUNNINGHAM
JUDY DISCENZA
BARBARA HOFFMAN
KAREN HUBER
TONY HUBBARD
LARRY PAYNE

TECHNICAL ADVISERS

BILL DODD
GEORGE CASSADY
AL LOMBANA

Design to be completed by Thursday, April 26, 1984.
PURPOSE STATEMENT FOR AD HOC MAY TRAINING DESIGN GROUP

This committee is appointed to assist the Training and Development Department in designing a 4½ day off-site residential development module, for Director level and above, that will:

1. Allow maximum utilization of all participants as members of market-specific work groups,

2. Increase understanding of the strategic planning process, its tie-in to operational planning and to programmatic management,

3. Allow individuals and groups to identify how they relate to market segments,

4. Provide greater motivation to achieve goals developed through a participative approach,

5. Provide opportunities to discuss and work issues in depth relying on the knowledge, skills and attitudes of the participants,

6. Provide an opportunity to test whether strategic goals are attainable,

7. Demonstrate that the Corporation is moving to a market-driven strategy,

8. Determine easier ways to monitor performance and results,

9. Maximize executive staff’s leadership role in assisting and supporting market-specific groups to be more effective in their overall planning efforts,

10. Allow for extensive hands-on experience, for all participants, regarding the critical importance of coordination and collaboration across corporate units in the addressing and achieving of corporate goals and objectives.
Individual Consumer Financing and Administration of Health Care

- Over 65 Market
- Under 65 Market
I. Market Definition —

Over 65 or Senior Citizen’s Market

Market Potential —

Estimated 1.85 million Floridians 65 and older

1.7 million Floridians 65 and older Medicare eligible

1.3 million Floridians 65 and older Medicare eligible excluding group covered and Medicaid recipients
II. Basis For Segmentation

1. Non-Medicare Eligible

2. Medicare Eligible
   a. Medicaid Recipients Over Age 65
   b. Group Covered
   c. FEP Annuitants
   d. Over Age 65 Individuals Not Covered by Group or Medicaid
      • Low Option Medicare Supplement Product desired
      • Standard Option desired
      • High Option desired
III. Market Needs

A. Needs and wants for Medicare Supplement products identified in 65+ Market Opportunities Study. Order of importance of policy or company features:

1. Benefits offered
   - 20% of physicians' charges not covered by Medicare
   - Payment of hospitalization gaps
   - Unlimited hospital coverage after lifetime reserve days
   - Payment of Part A hospitalization deductible

2. Price

3. Services
   - Accurate payment of claims
   - Easily understood contract
   - Easy to fill out and file claims
   - Timely and accurate billing

4. Company Name/Reputation

5. Representative or Agent

B. Needs for products/services other than Medicare Supplement products have not been fully explored.
## IV. Under 65 Market

<table>
<thead>
<tr>
<th>Market Definition</th>
<th>Market Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current:</strong> Individuals who are self employed, unemployed, and employees in groups who do not meet underwriting regulations.</td>
<td>902,000 minimum</td>
</tr>
<tr>
<td><strong>Proposed:</strong> All under age 65 Floridians.</td>
<td>8.8 million</td>
</tr>
<tr>
<td>Perceived Need Category</td>
<td>Translated Into</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Pre-paid health insurance protection; essential core coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>“Extra” protection that augments essential core coverage.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Broaden scope of protection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Submarkets

Based on employment status and extent of coverage provided by employer

1. Self Employed.
2. Employer Does Not Provide Health Coverage.
3. Employer Provides Minimal Coverage.
4. Employer Provides Good Level Of Coverage.
5. College Students.
6. Part Time Employees.
7. Leaving Employment (group covered by Blue Cross and Blue Shield of Florida, Inc.).
8. Leaving Employment (group not covered by Blue Cross and Blue Shield of Florida, Inc.).
10. Unemployed (but healthy).
11. Unemployed (unhealthy).
12. New Florida Residents.
“MARKETING OPPORTUNITIES FOR THE FINANCING AND ADMINISTRATION OF TRADITIONAL AND INNOVATIVE GOVERNMENT HEALTH CARE PROGRAMS WHICH ARE MARKETED TO GOVERNMENT AGENCIES AND TO ORGANIZATIONS THAT ADMINISTER THESE PROGRAMS.”
GOVERNMENT AGENCIES FINANCING AND ADMINISTRATION
MARKETING ASSESSMENT

0 56 POTENTIAL SUB-MARKET OPPORTUNITIES WERE
   BRAIN STORMED

0 AFTER REVIEW, 24 POTENTIAL SUB-MARKET OPPORTUNITIES
   WERE DEFINED

0 SOME EXAMPLES OF POTENTIAL MARKETING OPPORTUNITIES
   ARE:
   - MEDICARE PART A WITHIN/OUTSIDE FLORIDA
   - MEDICARE PART B WITHIN/OUTSIDE FLORIDA
   - MEDICAID
   - CHAMPUS
   - INTERMEDIARY/CARRIER AT RISK CONCEPT
   - INDIAN HEALTH SERVICES
   - SUB-CONTRACTING WITH OTHER ORGANIZATIONS
GOVERNMENT AGENCIES FINANCING AND ADMINISTRATION
MEETING FEEDBACK

0 Initial marketing assessments should focus on
Medicare Part A and B businesses

0 It is very important that we understand the needs
and the conflicting needs of government agencies,
providers, beneficiaries and other components of
the health care delivery system

0 Need to critically assess the components of
Environmental and Situation Analysis:
- Assumptions
- Internal strengths and weaknesses
- Barriers
- Threats
- Competitive Analysis
GOVERNMENT AGENCIES FINANCING AND ADMINISTRATION
PLANNING TEAM'S NEXT STEP

- Analyze and determine the marketing needs of government agencies, providers and beneficiaries

- Rank marketing opportunities based on agreed evaluation criteria

- Conduct marketing assessments of high potential markets, which will identify:
  - Markets to be pursued now
  - Markets needing further detailed study
  - Markets not to be pursued

- Develop alternative strategies

- Develop recommended strategies

- Develop programs to make strategies happen
REGULATORY EFFORTS THAT HAVE FAILED

USE

- Certificate of need (CON)
- Professional Standards Review Organizations (PSRO's)

PRICE

- State rate setting
## ACCIDENT & HEALTH INSURANCE
### FLORIDA - 1982

### TOTAL UNDERWRITING GAIN/(LOSS) AFTER DIVIDENDS

<table>
<thead>
<tr>
<th>Company</th>
<th>Gain/(Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prudential</td>
<td>($36,066,734)</td>
</tr>
<tr>
<td>Aetna Life</td>
<td>24,559,640</td>
</tr>
<tr>
<td>Gulf Life</td>
<td>1,341,690</td>
</tr>
<tr>
<td>Travelers</td>
<td>(33,093,685)</td>
</tr>
<tr>
<td>Connecticut General</td>
<td>31,581,675</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>16,969,244</td>
</tr>
<tr>
<td>Equitable</td>
<td>(79,457,119)</td>
</tr>
<tr>
<td>American Heritage</td>
<td>(2,882,297)</td>
</tr>
<tr>
<td>Crown Life</td>
<td>(16,477,529)</td>
</tr>
<tr>
<td>Massachusetts Mutual</td>
<td>(56,299,823)</td>
</tr>
<tr>
<td>Gulf Life Group</td>
<td>(486,828)</td>
</tr>
<tr>
<td>Pacific Mutual</td>
<td>(27,666,426)</td>
</tr>
<tr>
<td>Integon</td>
<td>(11,602,600)</td>
</tr>
<tr>
<td>Colonial Penn</td>
<td>(44,167,779)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>($227,748,571)</strong></td>
</tr>
</tbody>
</table>

*Source: State Insurance Department, 1982 Annual Statements (Exhibit H)*

*Note: The Argus Chart data (based on NAIC Statement Blank, Schedule H) do not include any sources of income other than premiums. Therefore, it is possible that any given company's underwriting results may appear more negative than their reported net gain.*
BLUE CROSS AND BLUE SHIELD OF FLORIDA
Enrollment and Contingency Reserves Level (1975-1983)
PRICE x USE = TOTAL COST
$400/procedure x 60 procedures = $24,000

COMPOUND EFFECTS OF PRICE AND USE
$400 (1.11) x 60 (1.10) =
$444 x 66 = $29,304
+ 22.1%
### 1981 Statewide Opinion Survey

... Which of these have contributed most to rising health and medical care costs?

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>47%</td>
</tr>
<tr>
<td>Doctors</td>
<td>46%</td>
</tr>
<tr>
<td>Insurers</td>
<td>28%</td>
</tr>
<tr>
<td>Government Programs</td>
<td>20%</td>
</tr>
<tr>
<td>Improved Care</td>
<td>11%</td>
</tr>
<tr>
<td>Individuals</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Blue Cross & Blue Shield of Florida Corporate Communications Division, 1981

Note: Respondents could cite more than one category.
<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>1981</th>
<th>1982</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Insurers</td>
<td>($1,431.3)</td>
<td>($2,035.1)</td>
<td>($2,314.2)</td>
</tr>
<tr>
<td>Blue Cross - Blue Shield</td>
<td>(426.5)</td>
<td>($463.8)</td>
<td>($494.5)</td>
</tr>
</tbody>
</table>

Source: Argus Charts, 1981-83
Blue Cross & Blue Shield Association

Note: The Argus Chart data (based on NAIC Statement Blank, Schedule H) do not include any sources of income other than premiums. Therefore, it is possible that any given company's underwriting results may appear more negative than their reported net gain.
Accident and Health
Underwriting Gains/Losses
300 Largest Commercial Writers

*In millions of dollars

Note: The Argus Chart data (based on NAIC Statement Blank, Schedule H) do not include any sources of income other than premiums. Therefore, it is possible that any given company’s underwriting results may appear more negative than their reported net gain.
MARKET FAILURE

• Inefficient reimbursements
  Hospitals - Cost based
  Physicians - Fee for service

• Incentives for specialization, technology and high cost care.

• Uninformed consumers.
THE EFFECT ON CONTINGENCY RESERVES OF UNDERESTIMATING PAID CLAIMS TREND

Level if estimated trend is correct.

Level if estimated trend is in correct*

Nominal Contingency Reserve Levels ($1,000,000)

*Annual paid claims trend exceeds estimated trend by five percentage points.
**BLUE CROSS AND BLUE SHIELD OF FLORIDA**

**Enrollment and Contingency Reserves Level**

(Dollars in Thousands)

(1975 Dollars)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment (Average Contracts)</th>
<th>Enrollment Indices</th>
<th>Financial Statement Contingency Reserve Level</th>
<th>Financial Statement Contingency Reserve Indices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nominal</td>
<td>Real (CPI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Real (Medical Care)</td>
<td>Nominal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Real (CPI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Real (Medical Care)</td>
</tr>
<tr>
<td>1975</td>
<td>956,646</td>
<td>100</td>
<td>$12,978</td>
<td>$12,978</td>
</tr>
<tr>
<td>1976</td>
<td>913,035</td>
<td>95</td>
<td>12,390</td>
<td>11,213</td>
</tr>
<tr>
<td>1977</td>
<td>853,543</td>
<td>89</td>
<td>15,885</td>
<td>12,851</td>
</tr>
<tr>
<td>1978</td>
<td>811,388</td>
<td>85</td>
<td>40,503</td>
<td>29,365</td>
</tr>
<tr>
<td>1979</td>
<td>797,576</td>
<td>83</td>
<td>58,245</td>
<td>36,869</td>
</tr>
<tr>
<td>1980</td>
<td>752,833</td>
<td>79</td>
<td>60,040</td>
<td>31,461</td>
</tr>
<tr>
<td>1981</td>
<td>747,267</td>
<td>78</td>
<td>60,281</td>
<td>25,137</td>
</tr>
<tr>
<td>1982</td>
<td>699,486</td>
<td>73</td>
<td>78,013</td>
<td>23,482</td>
</tr>
<tr>
<td>1983</td>
<td>714,425</td>
<td>75</td>
<td>89,057</td>
<td>21,106</td>
</tr>
</tbody>
</table>

*Real dollars representing 1975 dollars.
RATE MAKING PROBLEM

$ t_1 t_2 t_3 t_4 \text{ MONTH:}

$ t_1 t_2 t_3 t_4 \text{ 30 months}

$ t^* = \text{today}$
TOTAL EXPENSE PER ADJUSTED ADMISSION FOR FLORIDA AND THE NATION (1977 - 1981)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>1305</td>
<td>1443</td>
<td>1603</td>
<td>1809</td>
<td>2140</td>
</tr>
<tr>
<td>Florida (age-adjusted)</td>
<td>1218</td>
<td>1346</td>
<td>1495</td>
<td>1688</td>
<td>1997</td>
</tr>
<tr>
<td>Rate-setting states</td>
<td>1573</td>
<td>1721</td>
<td>1885</td>
<td>2099</td>
<td>2403</td>
</tr>
<tr>
<td>All states and D.C.</td>
<td>1215</td>
<td>1360</td>
<td>1528</td>
<td>1729</td>
<td>2026</td>
</tr>
</tbody>
</table>

Source: Florida Hospital Cost Containment Board (1983)
## FLORIDA PHYSICIAN MANPOWER

<table>
<thead>
<tr>
<th>Year</th>
<th>MD's</th>
<th>DO's</th>
<th>Total</th>
<th>Population (In Millions)</th>
<th>Physicians/1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>7,544</td>
<td>573</td>
<td>8,117</td>
<td>6.79</td>
<td>1.20</td>
</tr>
<tr>
<td>1972</td>
<td>9,600</td>
<td>625</td>
<td>10,225</td>
<td>7.44</td>
<td>1.37</td>
</tr>
<tr>
<td>1974</td>
<td>11,400</td>
<td>730</td>
<td>12,130</td>
<td>8.25</td>
<td>1.47</td>
</tr>
<tr>
<td>1976</td>
<td>13,400</td>
<td>810</td>
<td>14,210</td>
<td>8.55</td>
<td>1.66</td>
</tr>
<tr>
<td>1978</td>
<td>15,450</td>
<td>890</td>
<td>16,340</td>
<td>8.91</td>
<td>1.83</td>
</tr>
<tr>
<td>1980</td>
<td>17,500</td>
<td>980</td>
<td>18,480</td>
<td>9.80</td>
<td>1.89</td>
</tr>
<tr>
<td>1982</td>
<td>20,200</td>
<td>1,100</td>
<td>21,300</td>
<td>10.35</td>
<td>2.07</td>
</tr>
</tbody>
</table>

Source: K. Penrod, The Community Hospital Education Program
1981 STATEWIDE OPINION SURVEY

. . . Which of the following could do the most to keep down the cost of health and medical care?

- Government: 39%
- Doctors: 35%
- Hospitals: 28%
- Insurers: 21%
- Individuals: 16%

Source: Blue Cross & Blue Shield of Florida
Corporate Communications Division, 1981

Note: Respondents could cite more than one category.
HOW IS YOUR MEDICAL BENEFITS PLAN FINANCED?

<table>
<thead>
<tr>
<th></th>
<th>Private Sector</th>
<th>Public Sector</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>47%</td>
<td>42%</td>
<td>47%</td>
</tr>
<tr>
<td>Self Funded</td>
<td>35%</td>
<td>39%</td>
<td>36%</td>
</tr>
<tr>
<td>Minimum Premium</td>
<td>15%</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### NATIONAL HEALTH CARE EXPENDITURES BY CATEGORY - 1981

($ billion)

<table>
<thead>
<tr>
<th>Category</th>
<th>$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>55</td>
<td>19</td>
</tr>
<tr>
<td>Hospital</td>
<td>118</td>
<td>41</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>24</td>
<td>8</td>
</tr>
<tr>
<td>Drugs</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Other Personal Health (dentists, eyeglasses, home health)</td>
<td>37</td>
<td>14</td>
</tr>
<tr>
<td>Other Health Expenditures</td>
<td>32</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$287</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Florida Hospital Cost Containment Board (1983)
**1981 STATEWIDE OPINION SURVEY**

...Compared with other costs during the past few years, how have health and medical care costs changed?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risen faster</td>
<td>60%</td>
</tr>
<tr>
<td>Risen about the same</td>
<td>27%</td>
</tr>
<tr>
<td>Risen less rapidly</td>
<td>5%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>8%</td>
</tr>
</tbody>
</table>

100%

Source: Blue Cross & Blue Shield of Florida
Corporate Communications Division, 1981
• Possible approaches to market reform:
  1. More effective use by government of its power as a buyer and subsidizer.
  2. Reimbursement that gives providers greater incentives to practice economy.
  3. Decisions by government about kinds of services taxpayers should support.
  4. More effective government regulation — maximum emphasis on using incentives rather than regulatory prescription.
Regulation of Providers Will Beget Counterproductive Regulation of Health Insurance Rates in that:

1. Some will feel if it’s reasonable to regulate the price of what health insurance buys, it’s reasonable to extensively regulate the price of health insurance.

2. Rate regulation of providers will be ineffective or counterproductive and the total cost that health insurance pays will go up.
Regulation in Health Insurance

1. Rates
2. Contract language
3. Legislatively mandated benefits and contract provisions.
   a. More expensive to administer
   b. Restricted consumer choice
   c. Increased utilization
   d. Raised insurance premiums
4. Contributed to movement to self funded programs.
## NATIONAL HEALTH CARE EXPENDITURES
### BY PAYOR — 1981
#### ($ BILLION)

<table>
<thead>
<tr>
<th>Payor</th>
<th>$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
<td>84</td>
<td>29</td>
</tr>
<tr>
<td>State and Local Government</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>Private Health Insurers and Other Private Parties</td>
<td>82</td>
<td>29</td>
</tr>
<tr>
<td>Patients</td>
<td>82</td>
<td>29</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$287</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Florida Hospital Cost Containment Board (1983)
1. Be fully aware of your company situation.

2. Be knowledgeable about the health care industry in your area.

3. Help stimulate development of competitive health care markets by:
   
   • Promoting development of alternative delivery systems (HMO’s and PPO’s).
   
   • Offering alternative delivery programs to your employees.
   
   • Implementing cost containment measures in your benefit design.
4. Encourage healthy lifestyles among your employees and sponsor supportive programs.

5. Participate in and reorient health planning and regulation.

6. Develop coalitions and engage the support of other businesses in achieving coalition objectives.
CON CASELOAD IN FLORIDA

249 Administrative Hearings
29 District Court of Appeals
4 Circuit Court of Appeals

Source: Florida Department of H.R.S. (1983)
• Current products of industry reflect primary goal of public policy - access to care.
• Goal has now shifted from "unlimited access" to "efficiency."
• Choices for insurers:
  A. Invest in redesigning products ensuring cost effective delivery of health care.
  B. Reduce benefits significantly in traditional product.
  C. Drop health insurance.
CONTINGENCY RESERVE LEVELS — DEFLATED

Real Contingency Reserve Levels (1975 dollars)

(CPI deflator used)

(CPI Medical Care deflator used)
"Mandated benefits have motivated more and more employers to switch to self-insured plans, a trend that obviously does not help the insurance industry. Nor does the trend protect persons covered by self-insurance plans, because there is no regulatory review to make certain that such plans are adequately funded."

Susan Mitchell
Wisconsin Insurance Commissioner
"In every state, and in every line of insurance, there are regulations that inhibit competition without offering protection to insurance buyers. These regulations range from significant impediments to competition to petty rules that simply waste time, protect no one, and add to the cost of insurance."

Susan Mitchell
Wisconsin Insurance Commissioner