Editor's Note: HIU would like to extend our heartfelt appreciation to Kellie Bernell for her work in coordinating this roundtable discussion and pulling this special report together for us. Over a short period of time, the project blossomed into far more than we had expected and much of the legwork was performed by Kellie on her own time. We hope our readers reap the fruit of her labor. —JH

The momentum of health care costs failed to slow last year. Many carriers and health care professionals worked on reducing costs through well-intended initiatives. Agents took on more responsibility and time to educate consumers about the plentiful choices coming available. Landmark legislation impacted all with new “financial solutions” such as Health Savings Accounts. But are they really as hot as most believe them to be?

Collaboration among all players in the health care delivery system is showing signs of positive change. However, time and patience will be needed to further realize the true impact of these changes. This roundtable offers an overview of the last decade and solicits views from experts in the various areas of the industry to comment on future trends such as the delivery and financing of health care.

The participants selected and interviewed as part of the roundtable discussion were:

Peter Boland, Boland Healthcare
Greg Baird, SVP, Large Group Sales, Blue Cross of California
Dan Perrin, Publisher, HSA Insider
Alexander “Sander” Domaszewicz, Senior Consultant, Mercer Human Resource Consulting
Phil Lebherz, LISI, CEO/Chairman
Jude Thompson, VP and GM Individual and Group Business, Anthem Blue Cross and Blue Shield
John Kurath, VP Agency Sales, UniCare Life & Health Insurance Company

Kellie: Let’s get started. What has been going on over the last decade that has brought us to where we are today in our health care system?

Phil: Today, we are in the aftermath of three decades of playing the hot potato game. In the 1970s employees paid 34% of their health care costs, either through co-pays or deductibles. With the debut of managed care in the ’80s, the hot potato was passed to providers, as insurers tried to recover from the risks shifted to them by the government in the previous decades. In this last decade, we saw employees pay only 15.3% of their total health care costs. Because of such a hot economy in the 1990s—and the need to compete for employees—employees were insulated from the real costs of their health care. Competition for employees has eased and the trend is going back to higher deductibles with employees paying about 17% and adopting new concepts such as Health Savings Accounts.

Greg: The ‘entitlement’ attitude has been a big contributor to getting us to where we are today. Health care costs have skyrocketed over the past decade, yet members’ out of pocket expenses—as a percentage of total costs—have dramatically diminished. The entitlement attitude has been fostered by employers that haven’t adjusted their plan designs to address rising health care costs. As a result, the insurance plan automatically bears a greater burden each year as health care costs rise. Provider consolidation, legislation and shifting demographics have also been drivers of escalating costs. The big hospital systems have more negotiating clout than a decade ago. They negotiate on behalf of the entire hospital system on a ‘take it or leave it’ basis. Legislation makes up over 20% of total health care costs. California, in particular, has been one of the most active states in the nation on imposing health care legislation. Demographics include baby boomers moving into an age grouping that incurs significantly greater health expenses. Despite efforts to control health care costs, the impact of the baby boomer tidal wave will continue to drive up the average cost of health insurance costs.

Kellie: The most profound change is the realization that ‘more of the same’ will not meet anyone’s needs going forward, especially in the face of chronic care demographics. Industry stakeholders are beginning to realize that both the economic model and the care delivery model will undergo fundamental change, spurred by technology, medical science and consumerism.

Sander: While there are many forces—demographic, political, systemic and cultural—that hold sway over the health system, one interesting area of increasing focus is the ever-elusively defined delivery of quality health care. To achieve highest quality at lowest cost is an ongoing challenge our industry faces. Health care provider quality, as outlined in the 1999 Institute of Medicine and subsequent reports, has been patchy at best. Credentialing and admittance to a network has not equated with best quality or best practices. There has been a growth in tiering of providers around quality and cost. Provider pay for performance incentives have also been getting more vigorously tested, with over 85 programs now listed on the Leapfrog Group site (www.leapfroggroup.org).
Kellie Bernell (kellie.bernell@wellpoint.com) is manager of investor and corporate communications for WellPoint. She supports and manages the corroboration of corporate communications and media relations activities for the Individual and Small Group business units. Working as the communications liaison with sales teams, Kellie is an award-winning author and has developed a series of seminars on how to incorporate public relations and marketing into a successful sales strategy. Kellie is also a licensed agent and is currently serves on boards for many professional and volunteer health care related organizations. She can be reached at 805-557-6755.

Roundtable Participants

Dan Perrin (danperrin01@yahoo.com) publishes The HSA Insider website and newsletter. He is a recognized expert and advocate of Health Savings Accounts. Perrin also serves as the executive director of the HSA Coalition, a Washington, DC-based group of non-profit organizations. Prior to his work on health care, Perrin served as a staff member for six years on two U.S. Senate committees, the Steering Committee and the Committee on Foreign Relations.

Greg Baird (greg.baird@wellpoint.com) is senior vice president of large group sales and sales support for Blue Cross of California. He oversees large group sales, sales support and field office service operations. Baird began his tenure at the company in 1990, as director of Blue Cross of California sales in charge of the Orange County office. A year later, he was promoted to vice president of sales for Southern California, and was named as senior vice president of sales (statewide) in April 1993.

Alexander “Sander” Domaszewicz (alexander.domaszewicz@mercer.com) is a senior consultant in Mercer Human Resource Consulting’s Newport Beach, California office. He is a national resource for Mercer’s Health Care & Group Benefits practice, specializing in emerging benefits and areas where technology intersects with human resources, benefits and health care. Areas of focus include health care strategy, consumer-directed health care, health and benefits decision support tools, Web health resources, online benefits enrollment, benefits outsourcing and HR portals.

Phil Lebherz (phil@lisibroker.com) founded LISI in 1977. Today, LISI serves thousands of brokers from six fully staffed offices statewide. As chairman and CEO, Phil is charged with working on the bigger picture for LISI and its subsidiary, CoPower. His leadership in finance, acquisition and negotiation has made LISI into a multi-million-dollar company. Phil is well-known in the industry for being a passionate broker advocate, committed to reframing the issues affecting the brokerage community. In 2003, he started the Foundation for Health Coverage Education, a non-profit organization aiming to simplify public and private health insurance eligibility information in order to help more people access coverage. His foundation’s California Health Care Options Matrix™ illustrates the important role of the broker and provides a valuable solution to communicating health care options for the uninsured.

Peter Boland, PhD (pboltan@bolandhealthcare.com) has been analyzing and forecasting industry trends for 20 years. He is a management consultant on business strategy, product development and technology innovation to leading stakeholders in the healthcare industry. He was the founding editor of Managed Care Quarterly and the principal author and editor of Redesigning Healthcare Delivery, The Capitation Sourcebook, The New Healthcare Market and Making Managed Healthcare Work. He has been cited in The Wall Street Journal, The New York Times, Los Angeles Times, San Francisco Chronicle, Business Week and The Economist.

John Kurath (john.kurath@wellpoint.com) was named vice president, sales of UNICARE’s Individual and Small Group Division in January 2003. Based in Bolingbrook, IL, Kurath is responsible for the marketing and sales of individual and small group products. He reports to the Chicago UNICARE office. Most recently, Kurath was regional vice president at BenefitMall, the largest general agency in the U.S. Before that, he was responsible for third-party administrator sales and brokerage services at Health Intermediaries. He began his health insurance career in 1989 with The Alliance, a Denver based, PPO cooperative started by the Colorado Business Coalition on Health.

Jude Thompson (jude.thompson@anthem.com) is president and general manager, Individual Business Unit and Kentucky Group Business Unit of Anthem Midwest. He joined Anthem in 1989 as director of public relations and advertising. In 1994 he was appointed president and CEO of Acordia Senior of the Southeast, a former Anthem subsidiary. He served as vice president, sales from 1998 to 1999 and was appointed vice president and general manager, Individual Business Unit in 1999, and in 2000 acquired oversight of the Kentucky Group Business Unit. He is responsible for all aspects of the Midwest Individual Business Unit and the Kentucky Group Business Unit.
Jude: There are a number of profound forces that have shaped our health care system today. During the past decade we have seen very tightly managed care, which helped control rising health care costs and a subsequent reduction in managed care in response to market demands for more choice. The most pressing challenge of our industry is to design and offer affordable health plans both to employers and the growing individual market. Individual plans are fast becoming an option as employers are finding it harder to bear increases or to shift costs. Listening to our customers and developing innovative health plans is the key to the future.

Kellie: There is much "finger-pointing" in our industry over increasing health care costs. What collaborative efforts have you seen over the years to adapt change and provide solutions?

Phil: Unlike other market influences, we all have to pay for the uninsured, the undocumented immigrants and others who don't pay for their care. The more we provide care for those who aren't signed up, the more we have to pay. Carriers and brokers are working together to provide solutions. Carriers now offer newer, more affordable products designed for uninsured individuals or groups. The biggest challenge in getting more people insured is education. Did you know that of the 41 million uninsured 14 million are eligible for public programs but have not signed up? And another nearly 18 million have moderate-to-high incomes? Brokers must become the educators. Earlier this year I started the Foundation for Health Coverage Education. Our mission is to simplify public and private eligibility information in order to help more people access coverage. We created the Health care Options Matrix and additional tools in order to help brokers and other professionals communicate about our health care delivery system (www.coverageforall.org). To complement this effort we launched the California Uninsured Help Line in January 2005.

Greg: We have worked closely with our providers, brokers and clients to better understand emerging issues and seek solutions. Examples of this include our advisory groups, which have resulted in new products and more effective services. We have assigned Blue Cross executives to hospitals and medical groups. They serve as "relationship managers" who listen to issues with a different perspective and seek mutually beneficial solutions. We are also working with the California Association of Physician Groups and the DMHC on plan design changes that would help us offer a balance of cost and quality in our plan designs.

Jude: Finger pointing doesn't get any of us to valid solutions, but working in collaborative ways helps all players win. From its historical roots as a Blue Cross Blue Shield plan, Anthem has worked with organized medicine and local providers to effect positive change. An outstanding example of this collaborative approach is the Hospital Quality Program, a cooperative effort between Anthem and the hospitals within its networks to collect and redistribute quality information to facilitate benchmarking and best practice adoption. Anthem also works with hospitals during rate negotiations to offer positive incentives for improved quality processes, as measured by Hospital Quality Program results. Likewise, Anthem offers payment for value programs for physicians that tie increased reimbursement to improvement in specific cost and quality measures, such as evidence-based treatment for diabetics and proper use of generic medications. Approaches like these will also help us tackle the issues of dealing with the uninsured and underinsured.

Kellie: Agents and brokers are a key constituency in the health care delivery system. They understand the shifting demands of the market, offer a vast knowledge of the plentiful products and services available and play a critical role in impacting policy af-
fecting our business. It is clear that agents will seek to work with carriers that maintain loyalty in business practice and culture. What are carriers doing to better educate agents and brokers on the shifting dynamics of insurance? How can they better support this very important sales distribution channel?

**Phil:** Carriers and general agents are expanding their continuing education repertoire. For example, this year alone my general agency added five new CE courses approved by the state, all with the focus of bringing brokers to the next level. I call it ‘redefining a job well done.’ Up until now, we brokers were only expected to educate folks about private options. Now is the time for us to fully understand the public options, as well as the private. Is our job well done if we sign up a group and ignore the dependents that may qualify for MediCal or Healthy Families? If we all work together to learn more about these plans and help our groups receive as much coverage as possible, aren’t we doing our part to help the uninsured? And aren’t we protecting ourselves from the ravages of mandated government-run care?

**Jude:** Improving broker communication is critical in responding to the market needs quickly. Likewise, information gleaned from brokers via training, face to face meetings, teleconferences and webcasts provide a vast amount of information back to the carrier. Education about reaching out to the uninsured, Health Savings Accounts, Medicare reform, ethics and other relevant topics are in demand.

**Kellie:** What is your view on ‘consumer-driven’ approaches? Are they hype or reality?

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**Likely** to offer CDHP in 2005 or 2006

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*Selected 4 or 5 on a 5-point scale, where 1 = not at all likely and 5 = very likely

Source: Mercer’s National Survey of Employer-Sponsored Health Plans

**Phil:** Acceptance and full utilization of the consumer-driven approach will take four to five years but it is a reality. It is slow moving because it takes time to essentially re-educate the marketplace. What was perceived as ‘my fair share’ or ‘your fair share’ of health care costs is changing. The resistance to change is natural in the beginning but through education there will be acceptance and more balance.

**Sander:** Supply and demand are good litmus tests for hype vs. reality. On the demand side, account-based consumer-directed plans have grown from virtually no enrollment in 2000 to over 1.2 million members in 2004. And this 2004 enrollment is largely without HSA adoption. Most large employers are interested in including at least some elements of health care consumerism, if not full-blown account-based plans, into their health benefits strategy over the next few years. On the supply side, almost every administrator of private-sector health benefits has or is planning to create consumer-directed...
delivery capabilities. This kind of activity undoubtedly makes health care consumerism a significant force on the health care landscape. However, for consumerism’s influence to continue to escalate, there will have to be further evolution and wider availability of credible quality and prospective (vs. retrospective) cost information. The special needs and concerns of providers and the chronically ill will need to be more fully addressed in more consumer-directed solutions. While the specifics and tactics of consumer-directed programs will no doubt change as the movement matures, the underlying goals of adding market forces to health care and encouraging greater member involvement in health care will continue.

Peter: Consumerism represents a fundamental shift in attitude, market expectations and resources. It has also dramatically influenced other sectors (e.g., financial services, hospitality, communications/entertainment) and created enormous opportunities for some and wrenching consequences for others. There is no turning back to the good old days. Brokers and agents cannot ignore this sea change; they must adapt and do so quickly.

Jude: As companies reduce or eliminate their subsidies of health care benefits, more people are becoming aware of the true costs of health care. This trend alone will drive consumerism. Individuals are spending a growing proportion of premium dollars. Just like they do in every other product and service category, they will look for the best products and service. This will require the entire industry to become much more sensitive to consumer needs, to better understand their motivations and ultimately become consumer-driven. More sophisticated market research and innovative product development will help reduce the size of the uninsured market. The ones that take ‘consumer-centricity’ seriously will overtake those participants in the industry who do not embrace this wholeheartedly.

Kellie: Looking forward through 2005, are Health Savings Accounts going to work?

Dan: The days of employers accepting cost increases, year after year, are coming to an end. As a result, the days of someone else paying for your health care are coming to an end. It is clear, for many reasons, that the status quo is an unsustainable situation. For example, one of the largest American employers announced recently that it is not investing another dollar in America because of U.S. health care costs. Unless health insurance companies and agents work together to lower health insurance costs, there is not going to be a market because the political system will intervene and likely institute socialized medicine (and our economy over the long run will be wrecked because of it). The way this will happen is that as costs rise, many will find health insurance unaffordable. The net result will be the reasonable conclusion that ‘I know government-run health care is bad, but bad is better than none.’

The health care cost problem is clearly illustrated in the graph below. In a nutshell, the graph shows that the more third parties pay for someone else’s health care, the more health care costs. However, the more out-of-pocket costs consumers bear, or the more individuals pay, the less health care costs.

The only way to control costs in any serious manner is an HSA. There are many examples of individuals and companies cutting their health care costs by switching to HSAs. There are some challenges to be overcome for widespread adoption, specifically how consumers can find reliable price data and the proper design of HSAs in group plan settings.

The key criteria for HSA plan adoption are:

- how much is the employer depositing in the account?
- does the insurance cover 100% after the deductible?
- is a hospitalization rider offered which will mitigate the out-of-pocket risk while funds in the HSA build up?

Over time, it will become apparent that 80-90% of those with an HSA will never tap into their insurance. Health insurance will become like car or home insurance—you only use it when something bad happens. The rest of the time, you are in charge of your own care.

Phil: Health Savings Accounts are not a fad. They are a critical tax policy. They emphasize self-responsibility for long-term health care. Sales will start slowly as the process for administration is put in place. It’ll be another four to five years before the majority of consumers will come to fully understand how HSAs work. Once we have the administration down and the third-party administrators get online, HSAs will start their momentum. It takes time for the administrators to educate the brokers, who, in turn, educate the consumers.

Sander: In the group market, there is a significant trend towards adoption of health plans that ask members to become more involved in seeking maximum value (highest quality, lowest cost) from the health services they seek. There is also a trend toward greater cost sharing at the point of service in exchange for lower premiums, both in the group and individual market. Health Savings Accounts fit well with both these trends, plus are the most tax-advantaged account in the tax code. The creation of HSAs in December 2003, with availability starting January 2004, was too late for many potential large group adopters on January 1, 2005. Interest and adoption of HSAs are exploding and brokers or carriers that don’t at least explore the option of an HSA-compliant plan will be distinctly behind the curve. Preliminary 2005 account-based enroll-
ment, including HRA- and HSA-based plans, will be at least in the 2 to 3 million member ranges.

Greg: We are very hopeful that HSAs will work. Current efforts in controlling health care costs are falling short. HSAs facilitate getting consumers more directly involved. Consumers should spend their own money more carefully than they will spend someone else's money. Consumerism should foster improved communication about treatment options, quality and cost. It's too soon to say how effective these high-deductible PPO/HSA plans will be in terms of controlling health care costs. Here are some important considerations for brokers and agents to recognize in sizing up the potential savings for their customers: Is the employer willing to replace all existing programs with this arrangement? If they continue to offer HMOs, conventional PPOs, or point-of-service plan alternatives, they should expect dilution impact. For example, HMO's are typically 15-20% less expensive than PPOs in the California large group marketplace and, in a multi-plan option arrangement, many employees will continue to opt for the HMO.

Critics of these plans point out that the majority of health care costs are borne by relatively few individuals. At Blue Cross of California, eight percent of our members account for 70% of our total medical claim costs. These individuals hit their out-of-pocket maximums early in the plan year and may have little interest in switching to more cost-effective providers or treatment plans because they wouldn't directly save any money. Although the HSA program savings may look fantastic, the overall savings to the employer need to be collectively reviewed based on the costs of all offered plans.

There isn't enough evidence about CDHPs to indicate, with any high degree of confidence, whether they save money when all of the factors are considered. Studies to date are relatively small sample sizes based on initial experience, and many of those studies offer conflicting results. Our philosophy at Blue Cross of California is that we provide choices for our customers. We think it's important for agents and brokers to inform their customers about these plans and educate them on the potential opportunities they afford.

John: While there has been quite a bit of 'noise' from carriers surrounding individual health plans and HSAs, the interest in the market is very real. From a carrier perspective, HSAs do not actually generate additional premium on a per-member basis because premiums are in fact lower than our traditional PPO co-pay plans. There have been several recent announcements regarding acquisition of individual carriers by group carriers. Remember, some of the carriers making acquisitions today exited the individual marketplace in the past. Recent growth in the individual market and the creation of HSAs has perhaps made this segment even more interesting to them.

While the large group market has led the CDHP charge, HSAs make sense for the individual and small group market and may be the driver for more CDHP demand in those segments. Although HSAs are being compared to IRAs, in the group market they may be more akin to 401(k)s. One reason 401(k)s have been widely adopted as a core benefit is that employers wanted to get out of the business of offering pension and retirement plans. They were willing to facilitate the administrative process for 401(k)s as long as they were able to abdicate the financial liabilities. The same can probably be said for health care. Employers are looking for ways to control health care costs and to reengage their employees in the process, and HSAs may very well help them do that.

Brokers are beginning to see the long-term benefits and advantages of HSAs for certain clients and are presenting them as an option. Over time members who elect to stay in plans with more generous benefits will experience higher increases in costs than those who move to less generous plans as has been the case in the past. It is obviously the broker's job to assess the short- and long-term needs of their clients and advise them accordingly.

Jude: HSAs make sense for some consumers—especially those who want to maximize the tax advantages of such a plan. Different types of consumers will require different types of products. Through our broker-partners, Anthem offers a range of products designed specifically for different consumer needs. We are all best served by giving the consumer the best product we can for their personal circumstances. In many cases, the HSA product will be the most appropriate option. At the same time, HSAs will improve as we learn more from consumers reacting to them. The key will be to make them as user friendly and as easy to understand as possible.

Kellie: These new consumer-driven choices can be complex. Are employers responsible and/or accountable for educating these choices to employees? How can we work together to better communicate/educate consumers of their health benefit options?

Sander: Many employers are asking these questions as they look to move forward with (or position themselves for future) significant health program changes. There is a tendency to try to squeeze costs out or skimp in this area when immediate cost issues are a central reason for change. Yet solid communications and education is one of the critical legs of the stool for a successful new program. Employers need to play an active role in education, but they can find strong support in dedicated carrier partners, aligned provider efforts and even the general media if channeled properly.

Peter: The most important thing that employers, agents and brokers can do in the next two years is to listen deeply to the underlying needs of consumers and groups of individuals who share common illnesses and diseases. This is different and far more profound than coming up with a few more benefit options that are largely variations on the same theme with a few more bells and whistles. Brokers and employers may be surprised at what individuals want in terms of ‘value’ and what they are prepared to do with the right financial and emotional incentives.
Phil: Employers cannot and should not be responsible for educating employees about new choices. This is how brokers can be most useful and most successful. It’s up to brokers to get through to employers. Brokers are responsible for being the conduit to care and for making it happen.

Greg: Employers have a critical role in educating their employees about health care issues. They have the access to and credibility with their employees to more effectively communicate important messages to them. They need to educate their employees about how much health care costs their company, remind employees about how much of it is being paid for by the employer, alert employees that they would be taking a huge financial risk by not signing up for insurance coverage, and tell them about how they can be more effective consumers of health care. Certainly brokers and insurance carriers also have an important role. We need to provide access to consumer-friendly information about sickness and wellness, educate the employers about the direction of the marketplace and discuss innovative plan design alternatives to fit the employer’s needs.

Jude: The entire supply chain can make the process of buying health insurance more straightforward. By passing on more of the costs to the employees, group plans are indirectly encouraging consumers to be more involved in the process, but health care is still a confusing product to buy. Health insurers can help by developing more consumer-friendly communication about their products and doing everything possible to eliminate jargon. The products themselves can be simpler, too. The brokers are already on the frontline of educating consumers, but all of us will benefit by remembering that working in this industry, we take our knowledge and familiarity with these products for granted. We need to shift more to an educational and consultative role and further away from a pure sales role.

Kellie: What trends can we see in 2005?

Sander: Cost may moderate somewhat for health plan sponsors, but even if trends aren’t in double digits, they will still likely be at multiples of the increases in workers’ earnings and overall inflation. In response, many health purchasers will continue to explore solutions to health care cost and quality problems that are more sustainable than cost shifting and aggressive/intrusive utilization management.

In initiating and implementing these long-term solutions, companies will expect more from their insurance carriers and health vendor partners. It will no longer be sufficient to be competent around core transactions such as paying a claim, providing customer service or assembling a provider network. Increasingly, administrative partners will be asked to be active and engaged in monitoring and improving member health status, while simultaneously increasing satisfaction and education levels around health issues. It will become more common place to provide robust predictive modeling and risk assessments to help identify opportunities for health improvement and cost containment early. Delivering comprehensive reporting will be increasingly required on interventions such as large claim negotiations, significant case management and even member use of tools. Showing that solution such as network discounts, behavior interventions, disease-management programs and consumerism tools are working and having the desired positive impact will be important. We’ll even see some add a key differentiator by guaranteeing claims targets are not exceeded (with fees at risk), to prove the effectiveness of their solutions. Plan sponsors will continue to ask for and get more to help control health costs and improve workforce health.

And members/employees, around whom the health system financing and delivery should ultimately revolve, will continue to raise the bar for expectations on service delivery, accuracy and quality from insurers. Providers and plan sponsors must see continuous improvement. After all, members are learning what to expect from other service experiences with Amazon and Charles Schwab, and the health care world has a long way to go to catch up.

Phil: Again, we must redefine ‘a job well done.’ We are under constant attack with the negative hype form mainstream media on the health care system. Brokers have a responsibility to undo the damage from the media and from decades passed. Brokers, our tools and the new Uninsured Help Line can serve as the necessary education channel. The demand is there. We must be the educators.

Greg: We will continue to see double-digit rate increases (10 to 12%). There will be increasing focus on fostering consumerism with a lot of interest in high deductible/HSA plans. Continued consolidation among insurance carriers, brokers and customers is also likely. There may be increasing interest among large employers in the national, and even international, capabilities of the insurance carriers. Employers are expanding their markets and they, more and more, have employees in disperse geographical locations. We may see continued acquisitions of brokers by financial institutions and partnerships with insurance carriers. Further, financial institutions are looking for non-interest-sensitive income and want to tap into HSA banking arrangements. Finally, there will be new, low-cost products designed to attract the uninsured market, new regulations on disclosure of broker/agent compensation and new drugs/medical procedures that will save lives, improve health and probably increase health insurance costs.

Jude: Addressing the uninsured and keeping health care affordable are key issues. This will involve reaching out to a market that either does not know there are options available that they can afford (true for brokers, as well as insurers) or developing products where we do not have suitable options already. We need to better understand all of our consumers and work harder to satisfy their needs. In addition, we must all focus in a collaborative way to keep health plans affordable. Here in the Midwest, we recently launched an ‘Economy’ plan aimed at providing access to health care at a price individuals and families can attain.

Conclusion

The foregoing conversations indicate that we are well on our way to doing our part in ebbing a turbulent health care system.

Solutions to address changing demands, demographics and costs include collaboration among all players in the health care delivery system. As seen in this roundtable discussion, some experts view new financial tools like HSAs as the future of financing health care expenses, while others see it as another choice rather than end-all-be-all solution.

The strongest message from all participants is that our industry needs to work together to provide resolution and educate consumers. Furthermore, agents and brokers are the conduit to knowledge among the general public. They are critical in facilitating new options as well as garnering feedback to share with health insurers and other professionals. Moving forward, let us agree to disagree once in a while. Since we all represent different areas of the health care system, we should embrace the varying views of experts and think of new ways we can succeed in growing the integrity and prosperity of our industry.

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