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HEALTH SERVICES COMPANIES

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1. What are the interaction and competition of Health Service Companies and traditional health insurers likely to be in the future?

2. What are the advantages and disadvantages associated with each of the types of carriers?

3. What are the long term prospects for survival for each of the types of carriers, as well as the prospects for diversification and development of new services?

MR. JOHN P. COOKSON: The title of this whole session of the Society is Competitive Strategies and certainly the health insurance industry is in need of reexamination of its competitive strategy. The traditional health insurance industry is in the midst of a crisis which is manifested by severe financial setbacks, decreased market penetration, poor image in the marketplace and loss of credibility. This is certainly an appropriate topic then for the health insurance industry to address at this time. The next several years will determine who will be among the losers and the winners in the struggle to survive the current crisis. In my opinion, those with the foresight to develop and carry out innovative strategic plans will be among the winners.

I believe historically the risks within the health insurance industry have been underestimated by both the public and the industry itself. The high volatility of the economy in recent years has considerably magnified these risks. Profits have been too low to adequately compensate for the risks that have been taken. There is a growing perception by the public that the insurance industry cannot satisfy its needs. One of the most obvious sources of dissatisfaction has been with premium levels. The marketplace is saying that the cost of health insurance is too high. Recent responses to this have been to transfer more of the insurance cost back to the employee either through higher cost sharing of the premiums or through higher deductibles and coinsurance.

Alternative responses to the cost problem have begun to appear in the marketplace and have become very successful. These include Third Party Administrators (TPA's), HMO's and more recently Preferred Provider Organizations (PPO's). These alternatives frequently set and achieve significantly higher profit objectives, produce lower costs, experience lower risks and result in generally higher growth than the traditional health insurance industry.

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The most recent alternative, the development of Preferred Provider Organizations, attempts to reduce costs through concentration of market share in a smaller number of providers who will discount their charges. This development appears contrary to the HIAA's attempts to oppose the discounts enjoyed by many of the Blue Cross and Blue Shield Plans.

I believe that ultimately the public's dissatisfaction with the cost of health care will lead to a reduced number of providers. The marketplace and hence the industry wishes to reduce costs. The only way to accomplish this reduction is to lower the income to providers through a) reducing overhead by elimination of some of the providers, b) reducing income to individual providers, or c) a combination of both. I believe the nature of the current adjustments in the marketplace points towards a reduction in the number of providers. Certainly the developments in HMO's and PPO's appear to resemble a battle for patients by the providers, where marginal pricing and volume discounting are becoming common. Furthermore, I think there is a trend away from the independent solo practitioners towards health professionals associated with corporations. Optometrists and pharmacists have demonstrated this tendency. Dentists appear to be going in this direction and I believe that the HMO and PPO movements indicate that physicians may go this way as well.

We are likely to see a continuation of the success of these alternatives and delivery mechanisms. In some respects the industry has responded in these areas. Traditional insurers are sponsoring HMO's, others are sponsoring Third Party Administrators, and many are now interested in Preferred Provider Organizations.

In addition to the need to provide affordable health care, other problems besetting the industry include the poor financial experience of small group and non-group markets, the absence of insurance coverage in large segments of the population, and the periodic lack of health insurance experienced by the unemployed.

Some of the industry practices with respect to the financial problems of the small group/non-group markets may ultimately result in unfavorable regulatory action. Some carriers are attempting to identify the small groups with chronically ill patients and are either terminating their coverage or increasing rates to prohibitively high levels. These groups must seek coverage elsewhere or go without. If the industry fails to provide adequate medical coverage for these segments of the population, government intervention in the health insurance arena could easily increase.

The area of underwriting and risk control also needs to be addressed by the industry. The rules on eligibility and coordination of benefits were developed in the 60's and early 70's and ignore the significant socio-economic changes which have occurred since that time The increase in two-worker families, the divorce level, the growing problem of unemployment, and dual-choice HMO coverage have all changed the risk elements affecting underwriting and eligibility standards. In my opinion, there has been insufficient recognition of these changes in pricing and underwriting policies.

On our panel here today we have representatives from a Third Party Administrator, an HMO and a Blue Cross/Blue Shield plan to help discuss these issues and provide us with their perceptions of appropriate strategies for the 1980's.

Our first speaker will be Leonard Abramson, President of United States Health Care Systems, Inc. and HMO of Pennsylvania, the largest and most successful IPA organization in the country and the largest HMO on the east coast.

MR. LEONARD ABRAMSON: I am really pleased to participate this morning. Our company, United States Health Care Systems, finds ourselves asking our actuarial consultants the same questions you are discussing today, namely:

1) the future interaction and competition with traditional insurance forces
2) the advantages and disadvantages of each entity
3) longer term prospects for survival
4) the prospects for diversification and new development.

My initial remarks are more of an analysis rather than a statement. I believe that before one can ascertain the competitive posture of today's insurance marketplace, one must understand the environment in which we are doing business. We believe the future of health care in our country is in the hands of innovators. Those organizations and individuals who can demonstrate the courage and flexibility to introduce change into a medical care delivery system will succeed. Those who resist will not. The existing system of care simply cannot be allowed to continue, for it could severely damage the fabric of the American economy. We have all heard the litany of statistics of rising health care costs. Let me just take a moment to bring you up to date on the latest.

In 1990, if health care cost increases continue unbridled, at the present rate of increase we could spend $800 billion for health care or $3,000 per person per year. We have already gone past 10% of the GNP and continue to climb. Many economists believe that once the industry reaches that level, the process of regeneration begins whereby other areas of the economy are inextricably linked to growth, and growth control becomes virtually impossible. Secondly, purchasers of health care have become accustomed to receiving comprehensive care. Our society will not settle for less and the issue clearly stated is that we need appropriate health care that is affordable. There exists a vital need for well organized, well motivated health care systems which can package health care innovatively. At United States Health Care, we are looking for new ways to provide medically appropriate, cost-effective health care. We continue to find that the two are not necessarily exclusive. In fact, they are decidedly complementary. We believe that we need marketforce competition. In Pennsylvania we believe that a competitive environment exists, as it does in New Jersey.

The thesis of my talk is that the medical delivery system is becoming more sensitive to the economic forces of the marketplace and will continue to do so. This economic view is rooted in some observations:

1) Resources are limited.
2) Resources in society have alternative uses.
3) People's wants and desires will direct limited resources to more effective means.

The health care industry has grown in good times as well as bad. Much faster than GNP. The conflicting forces fiercely fighting for these resources are the physicians, hospitals, the pharmaceuticals industry, medical manufacturers, and the insurance industry. Included in this confrontation, of course, is the federal government. At the forefront of the vanguard of this new social dilemma is a new leadership role being filled by medical management companies. The solutions to this dilemma are now evolving and being tested, proactively, not reactively.

It is further my assessment that the present health care industry is not prepared to cope with the present medical care delivery system. Let me explain. The present health care delivery system has been acclimated to maximize reimbursement, and the system's providers are good at it. Health insurance companies are ill-prepared to handle these types of programs. Insurance companies can try, and really in vain, to design deductibles and copays and a variety of other threshold mechanisms and limitations, but they don't work. The medical provider has greater expertise in billing for its services and the very system encourages abuse. The providers have learned their lessons well.

Design of insurance company products is based on retrospective analysis rather than prospective analysis. If one looks at the annual report of traditional health care companies throughout the country, the red ink is flowing and will continue to flow. On the contrary, the well trained executive staffs of hospitals are skilled in maximizing their reimbursements, and their profits increase.

In the long run, I believe insurance carriers have limited choices. These are:

1) To become directly involved as an insurer/producer/provider of health care,
2) link up with forces that have the ability to give them this capability,
3) get out of the health care insurance business,
4) hope that the regulatory environment can give them the relief that they need from today's health care delivery system.

Incidentally, I was asked this morning about PPO's. I will give you a short answer: they won't work. This is more of the same, discounting for service. Think about it. If a provider gives you a 15% discount and sees you one or two times more, what good is the discount. Control of the health care delivery system is in the providers, not in the insurers. Therefore PPO's are a feeble attempt and they won't work.

I am sure that we can come up with other alternatives and variations on this theme which may be workable. However, the final chapter will be written in the provider portion of health care, not the insurance portion. We believe that the HMO industry has some present day capability. We believe the HMO industry can demonstrate that as insurer/producer/provider, this type of combination does work. It works well for our company. United States Health Care Systems operates on the philosophy that the primary physician is the fulcrum for bringing about change to health care.

The entree point of health care is the primary physician. He or she has the checkbook for the health care system in his hand. When you go to a specialist, when you have laboratory work, when you get an x-ray, when

you are hospitalized, whatever, the key is the entree point. Here is where we exercise the major portion of our expertise. We redesign the system based on direct capitation to primary physician, direct purchasing of laboratory services, direct negotiation with hospitals on negotiated per diems, etc., etc. We have defined the system, we know the system, we have taken it apart and put it back together again and it works well.

Permit me to illustrate a scenario which we can all relate to. Suppose health care expenditures per physician increased more slowly than they do now. A critical element would be to determine how to direct revenue expenditures as related to a physician's own income.

By 1990, the physician surplus will become a real problem. You cannot close medical schools down and they are turning out more doctors than we need. The surplus becomes more acute as time goes on. Given limited health care expenditures, physician income will depend heavily on their success in controlling health care costs. It is not out of ideology, not as a consequence of exhortations from economists or politicians, but rather in pursuit of reality. This will create a greater competitive force and change the status quo.

How do you design a new service-oriented health care system? The chief feature we believe in all these modes is physician-centered control and responsibility for the health care bill, and incentives which are linked to this. It is the total bill that really matters to the taxpayer, the patient and the insurance company. In the end it will be the total health care bill that is going to matter to the physician. In terms of preserving their own earning power they will look for ways in which to maximize their earning power again by changing the system. I believe this system is going to be more organized and competitive as a consequence of these forces.

Recently, Dr. Arnold S. Rehlman, head of the New England Journal of Medicine, has written a stimulating article, entitled "The New Medical Investor Complex." (I read it as being complimentary; he meant it to be not so.) In that article, he discussed the rise of for-profit institutions in the health care field, especially hospitals, and particularly large chains of hospitals. He stated that these well managed organizations cope with health care better because they can adapt to change in economic factors, and because incentives play a major role. Many non-profit organizations do not share the same incentives.

Look to the leaders in the health care delivery for change, look to insurance companies to have the ability to change. Change is what is needed and I believe actuaries can help bring about this type of change. You have to help the insurance companies redesign the way in which they are developing programs for insurance. Deductibles, copays, and thresholds aren't going to work. Get your clients and companies involved in direct on-line confrontations with the health care providers.

MR. DONALD L. GALLIE: I'm quite sure everyone in the audience recognizes the HMO of Pennsylvania, the HMO of New Jersey, and the Blue Cross and Blue Shield. But yet who is Johnson Administrator and who are the Johnson Companies. We are a typical regional brokerage consulting house involved in all areas of the business. We have a pension department. We

have a property casualty operation, executive benefits — just a typical regional brokerage house. In addition, we are a Third Party Administrator, or TPA for short. As it stands today, we have approximately, to put it in perspective, about 850 group insured clients that range from the small groups (10 or more employees, we're out of that baby market less than 10), up to our largest employer on a fully insured basis of about 3,800 employees. Our largest insured groups are typically experience rated with various funding gimics, minimum premium, premium drags, retroactive agreements and so forth.

Approximately in the summer of 1978, our clients started to be approached, sought out, cajoled by various consultants, brokers and third party administrators about the glories of self-funding and all the advantages. Our posture initially was very defensive. Remember back four years ago. Our objections were the same as the insurance industry. But what about reserves, what about the liability? Can TPA's deliver what they promise? What's the future of the reinsurance market going to be? There is no conversion privilege available if you go self-insured. We fought it for about three months. Two of our larger clients wrote the cancellation letter to us and said, "Fine Johnson Companies and Don Gallie. We're going self-insured." So we decided we better learn a little bit about the system, join the trend, and not fight it.

From the fall of 1978 to the summer of 1980, we learned all we could about the self-insurance marketplace. We became the consultants, we recommended it where we thought it was appropriate, and we farmed out the administration to other regional TPA's. In the middle of 1980, we decided we wanted to be in the TPA business. We were leaving too much money on the table and some of the other TPA's were making some pretty good profits out of it. We co-ventured with a major insurance company. They were the money partner. We put the organization together and opened our doors January 1, 1981. After a lot of computer work, and a lot of programming, we were in business. We're now in our 21st month of operation, and that breakeven point is always another month or two away. We're not discouraged as yet. We're going to be honest with you. We have approximately 62 clients and 15,000 employees covered.

We think we're successful because we're operating in both camps. For our own internal clients and clients of other brokers or consultants that come to us, we try to show them both approaches, fully insured, and self-insured. I think a lot of TPA's have had problems because the client doesn't really understand that there is some rolling of the dice involved in becoming self-insured.

It's ironic, in my estimation, that the the TPA's really have not brought anything new to the concept of health care. The TPA's have essentially rearranged the component pieces and called it self-funding. They have used the legislative authority of ERISA to deliver a more efficient package to the buyer. Now I often wondered why the industry ever allowed the TPA's to obtain such a firm foothold in the marketplace. Your industry, the industry that I made a living at for over 20 years, has massive financial strength. You're fiercely competitive and you normally react quickly to innovative ideas. You're recently doing it with shared funding approaches, bringing down your minimum premium limits. But maybe it's too little, too late. What's happened? I think the answer is two-fold. I think the

life insurance carriers made marginal profits out of their health insurance business. I think the Blues organizations were so large that they were unresponsive to middle corporate America. Also, I think a new and perhaps until now dormant force has arrived in the marketplace and its exercising its powerful muscles, and that's the employer. The buyer of our services. He's saying he is no longer content to be merely an interested party in the health care process. He intends to be involved.

We speak from a self-interested point of view. That buyer is the purchaser of about $7 billion annually in actual health care benefits. The movement is underway. The movement is not the TPA and really not the HMO. It's rather that business wants to exercise control over an area of expense that has been paid too little attention in the past. The key word after movement is control. Back before the TPA, I made my sale to the benefits department and the human resources people. I had very little involvement with the treasurer or the CFO. Today when we make the self-insured sale, we're not making it through the human resource people or the benefit people. We're aiming at and going through the CFO/treasurer. We have noticed in our marketplace that the buyer today is the financial, not the benefit person. Now, I think, business wishes to control this area of uncontrolled cost.

When I use the term self-funding, I am referring to self-insured plans administered by a TPA, protected against catastrophic claims by stop loss coverage and typically funded through the use of a 501 (c)(9) Trust. What is the market for this self-funded approach? Why have we been successful? Who is the buyer who is looking for a viable alternative to the traditional insurance vehicles? Large corporations over 4,000 or 5,000 employees or more? No, I don't think so. These are companies who are large enough to negotiate special arrangements with the carriers, ASO's, good deals on minimum premium. They control and administer their own plans in-house. This is the group that the established insurance industry has been sensitive to and creative for. This is the employer who is large enough to have a sophisticated benefits department, monitoring experience, and demanding special services. This is not a ready market for a TPA of modest size to lead away from the comfort levels of the long established relationships with carriers. So much for large companies.

What about those at the other end of the spectrum? Many of you have heard about the self-funding of baby groups, those under 100 lives. Now let me first rule out the self-funded MET's which are operated in many parts of the country. In my opinion, they are extremely risky and of very questionable permanence. Most professional TPA's avoid involvement with such arrangements. The employer with 50 - 100 employees is more likely to be successful with so called split-funded or high deductible programs rather than the usual self-funded program with stop loss.

Therefore, most TPA's are concentrating their activities and having success in the corporate middle America. The mid-size business between 100 - 1500 employees. These corporate buyers are looking to slow down some pretty scary rate increases. That we all know. It is very difficult when I'm in a sales situation and the client says the CPI is a little bit less than 5% last year, the health care component is a little bit over 11%, and the carrier is out asking for rate increases of 20% to 50%.

The buyer wants to know what changes he can make to control costs. The fashionable buzz word for this activity is called cost containment. I really have trouble with that term. I don't know what it means. I can put a lot of words around it. Truly down here in my heart and soul, I don't know what cost containment means. We can not afford to "contain" costs at the present rate of increase.

As administrators, clients are coming to us, and leaving the traditional insurance industry, because we work with them and their consultants to formulate long-term strategies for cost control on a micro level. In defining this strategy, the TPA has a very close working relationship with the employer. To be successful, the TPA has to work with all involved areas of company management. Not only the benefits manager, but the chief financial officer, the human resource people, and general management as a whole. In companies of modest size, one or more of these functions are obviously combined in one job. The involvement is the same. If we have formulated a four part strategy for our clients. It involves:

1) refinancing and funding mechanisms,
2) plan design,
3) employee involvement, and
4) claims management.

Let me briefly detail some specifics about these four areas.

Clearly the most attractive funding vehicle for many corporations is the 501 (c) (9) Trust. For a very professional company in a sound financial position with good cash flow, the 501 (c) (9) Trust can be very attractive. It allows the CFO control over the plan finances, and has the added incentive of tax sheltered earnings. Depending on corporate size and risk appetite, stop loss cover can be arranged to protect the fund against catastrophic losses. In any case, the administrative fees of the TPA's are lower, sometimes much lower, than the insurance carrier's overhead charge in the retention. Premium taxes also can be reduced.

This combination of funding vehicle and lower administrative cost has often been enough to attract a corporate buyer into self-funding and the utilization of our services. But we have found it not enough to stop there. We work with clients and their consultants in the second area of plan design. We don't have any magic designs. But you would hardly be surprised that the majority of insured plans in force today are virtually unchanged over the last 5 to 10 years. They often have a base plan plus major medical, $100 deductible, 80/20 coinsurance, with a 100% feature after $2,000, $3,000, $4,000, or $5,000 of eligible charges.

We review plans to encourage lower cost alternatives. They are all familiar to us. We recommend adoption of comprehensive plans instead of first-dollar plans, and help institute pre-admission testing and mandatory second opinion surgery programs. It is not strictly fair to include some of these activities under the heading of cost control. Most of them are shifting cost back to the employee. The effect is complex. We find that it is absolutely essential that the employee maintain a financial interest in the plan. Excuse me Blue Cross and Blue Shield, but we train all our salesmen that are involved with Blue Cross and Blue Shield, that the Blue Cross and Blue Shield I.D. card is the credit card mentality. The credit card opening to the CFO's financial pocketbook.

The third piece of strategy is to encourage greater employee awareness and involvement. We all know employees need to be better informed medical consumers. Programs such as second surgical opinion help. But even more important, the employee needs to be educated to know what questions should be asked. These include what alternative courses of treatment are available, and how will this treatment affect my health, and lifestyle.

The fourth important factor in cost control is what I call plan management. In discussions on health care, I often hear your claims are going to be your claims, no matter which carrier you go with, whether you go self-insured or not. Now in my opinion, that is just not true. There are some very conscientious claim departments out there in the industry and there are those that are not paying attention. The good administrators spend a lot of time on basic claims' examination. The examiner should always work on eligibility controls, plan maximum controls, COB, R&C, medical necessity, always do student status checks, pursue subrogation, pursue prompt payment discounts. The TPA has to be very careful with what is paid. You see, it is not our money, it is the client's money. (You talk to any claims adjuster, any claims department in your operations, and it's not the client's money, it's the carriers' money.)

Good plan management also provides the data that we need for management information. I grew up, and we all grew up, in an industry with tremendous computer capacity. The management information we provided to our clients was often too little, and often too late. It was designed by actuaries, underwriters, and sales representatives to do one thing, and that was to support renewal rating action. The corporate buyer now spending $1,000 or more per employee expects and is entitled to more meaningful management information than he has become accustomed to. The second most important item in our sale and our inroads is our management information service. This information can be used to make informed decisions on plan design changes, to review utilization by providers and employees, and to spot problem areas. In short, to exercise control over the program.

On the future interaction and competition with traditional insurance forces, I think that competition has clearly been joined by the TPA's. It is no doubt going to increase. The professional administrator has really brought little new to the arena. He is paying more attention to the fundamentals in order to remain competitive.

In considering the longer term prospects of survival for TPA's, you have to remember most are relatively small in comparison to the giants of the industry. They are often overlooked when new legislation is introduced on a federal level. Survival for many of us is a little like avoiding being stepped on by the giants. Self-funding is through the missionary stage, and is more commonly accepted as a valid alternative. Survival is, therefore, I believe, linked with the prospects for diversification. I am convinced that without diversification survival is less secure. The history of health insurance is liberally strewn with carriers who were not able to adapt, or did not price their products competitively.

Geographic or regional expansion is certain to take place, since most TPA's are one location facilities, operating within a radius of maybe 500 miles. This is part of their attractiveness and at the same time a weakness.

Diversification for survival must include services other than self-funded plans. For example, some carriers now use qualified TPA's to either supplement or replace their own claims departments.

Other prospects include work in the international market. For example, we administer a travel insurance program, marketed in Europe for visitors to the United States. Despite their problems, insured MET's continue to be popular for baby groups, and the TPA's are now competing and will compete with carriers to provide services in this marketplace. One thing is certain. We all must be able to cope with change and in the 80's we must expect change to confront us even more rapidly.

MR. WALTER C. WOODWARD: I would like to discuss the Blue Cross perspective on health service companies and the interaction and competition between third party administrators and HMO's, Blue Cross, Blue Shield and the insurance industry in general. First of all, I would like to address some of the stand-alone scenarios.

I am not here to knock TPA's, or praise them or HMO's. I think they both have their place. Third Party Administrators sell services, not financing or budgeting of risks, but services. However, in western Pennsylvania in particular, one of the things which concerns me (and I think should concern the insurance industry in general) is the incursion by TPA's into the baby group/micro group market. Self-funding arrangements are being sold to groups of 3 or 4, and I'm afraid a lot of these TPA's are causing themselves a very serious problem. They are selling 125% paid stop-loss limits, and I think some companies could go under - not TPA's, but some small businesses. I believe third party administration does represent a reasonable alternative for some moderate size employers with stable workforces and reasonably predictable costs. I think the biggest advantage of a third party administrator, and Don pointed this out, is that they have the ability to be innovative and flexible in the design of benefit packages. I think there is a place there for them.

With respect to HMO's, influx of federal monies into the HMO movement during the 1970's helped the spread of this "innovative" concept (which dates back to the 1940's by the way), across the continent. The idea is relatively simple and Len expressed it fairly well. The HMO accepts the health risk, and then goes about controlling the services delivered. They are able to control costs while delivering quality health care to everyone. Numerous organizational structures have been found to have varying degrees of cost containment. HMOPA is an IPA, group practices are common, other types have been tried with varying degress of success. Generally though, except for the east coast, where we are now, and the extreme west coast entrenchments, HMO's currently lack strong consumer appeal. Possibly this is because the insurance industry has attempted to downplay their potential. There are exceptions, as Len pointed out to me, and there are HMO's in Kansas City and Chicago. We all know this. But really it is the east and west coast where they have their greatest concentration. HMO's, I believe, if they wish to proliferate throughout the heartland of the United States over the next decade, must develop alliances with insurers, including Blue Cross/Blue Shield, who can provide financial and management expertise and are willing to market their corporate name in conjunction with the potential advantages of HMO coverage.

Another marriage that is evolving gradually is one between totally unrelated HMO's around the country to provide their members with reciprocal benefits. These are great for the members of these HMO's and I think HMO's have to continue to seek reciprocity agreements. I think it is good for everyone. My own perception, though, for the 1980's for HMO's is this: barring the Pacific and Atlantic coastal areas, HMO's lack the public awareness on their own and the marketing expertise to become a dominant force in a stand-alone scenario.

Now what about Blue Cross/Blue Shield and the rest of the traditional health insurance carriers. First of all, non-profit health care corporations, Blue Cross/Blue Shield Plans, developed during the depression years of the 1930's to serve a then unmet need. For approximately twenty-five years Blue Cross/Blue Shield prospered almost unchallenged, in providing broad hospital and medical/surgical coverages to their subscribers. The dominance of Blue Cross/Blue Shield in the marketplace today is known to most of you; this is not a lesson of how or why it happened -- they earned it. In formulating my thoughts for the talk today though I felt it appropriate to bring the rest of the health insurance industry into the discussion because in today's environment all carriers offer the same basic insurance program to the same kind of employer/employee groups with the same basic concepts of insuring a risk.

There is no doubt that the commercial industry will survive the next decade - the industry has such mind-boggling assets that only multiple, cataclysmic blunders could put an end to it and put it under. I am sure that carriers would rapidly withdraw from the health marketplace before they totally went under. These carriers, the commercials and the Blues, will remain the dominant third-party payer force during the 1980's and will watch their market share grow and shrink with the high and low tides in the economy. This doesn't mean that they do not have to adapt to change. I concur with both the preceding speakers. We've got to adapt, we've got to address benefit design, and we've got to be more flexible in our product offerings. We will find ourselves, the commercial industry and the Blues, fighting each other over the next decade, and we are our own most visible enemies. Third party administrators and HMO's will quietly sit back and enjoy a bigger and bigger share of the marketplace (that we have jointly held for a number of years), at our mutual expense while we are trying to compete with each other.

I have talked a little bit about interactive relationships, but mostly about stand-alone scenarios. In order to be faithful to the program, I will talk about some of the successful marriages that are likely to occur over the next decade. Some of the successful marriages that I think may occur are more alliances of third party administrators to commercial insurers. Conversion privileges and reinsurance arrangements against catastrophic losses will be required by accounts, and I think the commercial industry will move into such alliances with greater vigor.

Preferred Provider Organization, or PPO, was mentioned by John in his opening remarks and also by Leonard The PPO's are a relatively "new" concept, but actually they encompass some of the original philosophy of the Blue Cross/Blue Shield movement of the 1930's and 40's. Third party administrators have the ability to contract with and set up their own

PPO's. Third party administrators, (and I mean responsible third party administrators and there are many of them) that are looking to develop new, and maintain existing, relationships with customers have an opportunity to pursue the PPO concept.

I mentioned marriages of HMO's to the Blues and to commercial insurance carriers earlier. I think this marriage has occurred repeatedly around the country and, as Len pointed out, Blue Cross/Blue Shield among the insurance industry is one of the most active group of carriers in the HMO movement. The insurance industry has the financial resources and the marketing skills to supplement the HMO's delivery capabilities. I think that the capability to deliver high quality health care and control the cost and utilization is immense. Our challenge, the industry, is to determine which of the seeking HMO's are able to contribute to our company's objectives in this marketplace.

Other scenarios which are likely to crop up during the 1980's are the establishment by insurance carriers (and this is already occurring), of subsidiary corporations which are able to set up, own, and/or operate their own HMO's, establish their own PPO organizations and contract with them. All of these are events will probably occur repeatedly throughout the 1980's.

Part of the agenda was the advantages and disadvantages of the various organizations; with John's permission I shall gloss over this very briefly. I will only say that we, the industry, buy risks. Every commercial carrier I know and Blue Cross buy risks. HMO's buy risks, but then they exercise control over treating the individual who constitutes a potential loss. Within Pennsylvania, and a number of other states, the ability of Blue Cross/Blue Shield to negotiate reimbursement contracts with hospitals and physicians offers an immediate advantage to any group or individual health insurance purchaser. I think this is the strongest advantage in Pennsylvania.

Longer term prospects for survival — I think that both preceding speakers touched on this. On our present collision course with double digit inflation in the Medical Care Component of the CPI, there is none. We are facing an almost certain collapse. We have got to change, not Blue Cross, not the Industry, the whole system has got to stop and look at itself. Right now, Federal and State governments are running from a Frankenstein monster which they have largely created through some of their entitlement programs. Several possibilities exist. Government may just decide to bite the bullet and nationalize the entire system, so that we all go out of business, or largely go out of business. There is also the possibility of a business revolution because our customers can no longer afford our premiums, as they can't afford employee claims. Finally, the entire industry, consumer, government, third-party payers may end up sitting down to determine how much of the billions being spent by corporations and by governments is appropriate to sustain life and health in America. This latter possibility, the most socially radical of all, may prove the only viable long range solution to one of Society's most pressing problems - the high cost of health care.

MR. D. DALE HYERS: I want to pursue the question of what we can do to go beyond the employer to get the insured employee concerned about the cost of his medical care. The "progress" we have made in marketing our group insurance

products has removed concern for cost away from the point of medical care delivery. Neither the doctor nor the patient have concern for the cost of medical care. The only point of concern comes once a year when the employer is delivered a rate increase. Possibly this concern surfaces monthly when the treasurer pays the premium.

Let me digress a moment. You will understand my purpose at the end of the story. We are all aware that the automobile industry has been in trouble for a few years. I know a way out of it. Devise a means of collecting a monthly premium from each adult citizen sufficient to cover the cost of adequate transportation. Then apply a deductible and coinsurance to the purchase of an automobile, but guarantee, through a stop loss provision, that no one has to pay more than $1,000 or $2,000 out of pocket. Let the "insured" go to any dealer and buy the automobile he "needs." I should note here that the dealer is the transportation expert who is best able to define "need."

Imagine all of the research in new safety and comfort devices to be added as necessary equipment for automobiles. In a few months the automobile industry will be back on its feet; and all we have done is remove concern for cost from the point of purchase or delivery of the automobile.

Back to medical care.-- We can get the insured's concern if there are personal financial reasons for his concern. Let me roughly sketch two plans for you:

1. Start with a standard comprehensive plan with deductible, coinsurance, and a limit on out-of-pocket expenses. The deductible needs to be high enough so that only those that are sick exceed it. (What purpose is served by a deductible which is exceeded by a majority of healthy people?) Then place on each medical service an inside limit (schedule) which is low enough so the insured is cost conscious of medically unnecessary care.

   The insured will keep this consciousness if the plan does not begin to pay 100% of cost until cost represents something more than a short-term burden. This level might be at $2,000, $3,000, or $5,000 of our of pocket expenses, depending on the judgement of the carrier.

2. Consider a modified comprehensive plan administered by a TPA in Louisville, Kentucky for a few large self-insured employers. The modification comes from placing a specific deductible on each and every medical service. For example, $10 each physician visit, $10 each x-ray or lab service, $50 each day in hospital. On top of this there can be coinsurance on the remainder of the bill. Your first reaction is probably like mine - that sure is an expensive administrative headache. (Naturally, the TPA enjoys the added administrative expense.) But the results show a substantial reduction in total cost through reduced utilization.

These two roughly defined plans get the patient concerned for cost at the point of medical care delivery. Then and only then will the physician be concerned about cost. The physician's concern may result from the financial burden placed on the patient or from the difficulty placed on himself for the collection of his fee. Either way, concern is necessary at the point of delivery.