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INVOLVEMENT OF INSURERS IN HMO'S, PPO'S, EMPLOYER COALITIONS AND WELLNESS PROGRAMS

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We are at the beginning of a revolution in the financing and delivery of medical care, and this revolution is caused by competition. Employers are trying to take control of their health benefits plans. Physicians are forming Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Legislation is being introduced which either protects a particular health care delivery system or seeks to create a new one.

Insurers are heavily involved in these efforts. During this session, panelists will discuss:

- . A successful HMO
- . An emerging PPO
- . A dynamic employer coalition
- . An industry-sponsored "wellness at the worksite" program

MR. VINCENT W. DONNELLY: Good Afternoon. Our subject today is really health care cost containment. Each of the panelists is involved on a daily basis in a specific cost containment effort. Paul Cooper directs an HMO in Oklahoma; Bob Broaddus is setting up a PPO in California; Bill Kizer is participating in an employer wellness coalition in Omaha, and I'm helping in the promotion of an industry-wide "wellness at the worksite" effort. Each of us will tell you how our particular program will serve to contain health care costs - from the practical viewpoint and not the theoretical.

MR. PAUL P. COOPER, III: This afternoon I am going to omit the standard speech on what is an HMO, because I am assuming that most of you have heard it or read it and are basically familiar with what prepaid health care is. HMOs have become a very common part of the employee benefits scenery, at least in most metropolitan areas. I understand we want to focus more closely today on cost containment and how various forms and arrangements for financing health care are able to achieve cost containment. It is therefore important to emphasize a key distinction between HMOs and health insurers, because by virtue of this difference, HMOs are able to approach cost containment from a different and more direct angle than health insurers have been able to do historically.

Up until very recently, health insurers have not considered it their role to become involved in the provision of services. From an underwriter's perspective, episodes of care are events over which the insured and the insurer have little or no control. We have known this was not the case for a long time -- that is, there is often an elective element on the part of the insured, but this perspective is still somewhat implicit whenever insurance is used as a financing vehicle.

* Mr. Cooper, not a member of the Society, is Senior Vice President, Prudential Health Care Plan of Oklahoma, Inc.

In contrast, HMOs are providers of health care. They are directly involved in the provision of services, and they are able to organize and operate in a fashion so that many of the factors that influence or determine health care costs are under their control.

My remarks this afternoon will be drawn from experience largely in three group practice HMOs that report to me and are located in Oklahoma City, Tulsa and Memphis, Tennessee. The Oklahoma City program is slightly over three years old and has grown in that time to approximately 26,000 members. Our financial projections indicate that the program will break even in the latter part of this year, approximately one year ahead of initial projections, with the accumulated financial losses very close to projected levels. The Tulsa and Memphis programs are each approximately two years old with correspondingly lower membership, in the neighborhood of 15,000 members each. Prudential has been actively engaged in the management of HMOs for over ten years. Our program in Houston opened in 1974 and has over 100,000 members. It has been profitable for over six years and is still growing rapidly. All of the operating Prucare divisions are organized as cooperative ventures between a group practice of physicians, who are responsible for providing or arranging all health care services, and Prucare, who is responsible for the marketing, data processing, and financial functions. In effect, these programs are managed very much like single entities with both parties working closely together on long-range planning and major operating decisions. We refer to the relationship with our medical groups as a "partnership", and in a very real sense it is.

The one thing that any of our medical directors in these Prucare cities can tell you is that, of the factors that determine the cost of health care, the most significant by far is physician behavior. Within this category there are a whole host of variables which can make one physician's behavior considerably more or less costly than the next when treating the same patient with the same disease. These include rates of referral to specialists, decisions to perform surgery and/or diagnostic workups in or out of the hospital, lengths-of-stay, treatment decisions within the hospitals, use of laboratory and radiology procedures to name a few. And none of these variations in behavior involve giving versus withholding necessary treatment. They simply involve the knowledgeable and conscientious management of costly resources -- just as they need to be managed in any other business or service.

Now the level at which we are trying to impact physician behavior is difficult to reach. Many of the devices that have been tried or supported by health insurers including provider discounts, retrospective utilization review, and even statewide all payor hospital rate regulation systems -- are of limited effectiveness because they do not significantly impact the key variable -- that is, the physician's behavior in treating patients. DRGs, incidently, may turn out to be one of the first devices implemented successfully by payors to influence physician behavior. This will happen as hospitals perceive powerful incentives to analyze their costs in a fashion that will identify physicans whose behavior is cost-effective and those whose is not. These hospitals will find ways to provide both positive and negative reinforcement for appropriate and inappropriate physician behavior. I am not saying that DRGs are going to be a great thing, because I honestly don't know, but I think that they may be the first thing the medicare people have come up with that will significantly

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impact physician behavior -- whether positively or negatively remains to be seen.

The activities our HMOs engage in to induce cost-effective physician behavior are quite numerous, and time won't permit a detailed discussion of all of them. I would like to tell you about some of the ways we manage the provision of inpatient hospital care, and give you a few examples of our results.

Hospital utilization control in our HMOs begins with a thorough budgeting process out of which come prospective hospital utilization targets. These targets relate specifically to the HMOs membership, population and whatever special characteristics or needs it may have. What is an appropriate target may vary considerably from one HMO to another. In Oklahoma City our target for 1984 is 440 inpatient days per thousand members per year, which is significantly below the community average for an under-65 population. Nearly a third of those inpatient days are for obstetrics because Prucare of Oklahoma City experiences a birth rate far above the community average. That is not the case in some of our other HMOs, and so an appropriate target elsewhere might be a different figure. Once the target is set, our agreement with the medical group provides that any savings to the program that result from holding utilization below the target level will be shared between Prucare and the medical group. It thus becomes important for the medical group to monitor their performance against the objective. This is accomplished in the short run through the production of a daily hospital census report which is prepared each morning and distributed to the medical director and department heads. For each member confined in the hospital, the report shows the admitting physician, the admitting diagnosis, clinical progress notes, a projected length-of-stay and the dates of admission and discharge. This information is obtained by the medical group's utilization staff staying in daily telephone contact with the admitting offices of the hospitals we use, as well as information provided by our continuing care nurse who makes rounds on each hospitalized patient daily to monitor their progress and assist in discharge planning.

Every month a report is distributed to all physicians identifying all hospital days used inappropriately. These include length-of-stay beyond what was medically necessary, unnecessary surgical admissions prior to the day of surgery, and any services, such as preadmission work-ups performed in the hospital which could have been done prior to admission. Your average physician today would probably react very emotionally to a report of this kind. It works in our setting because we have an excellent relationship with the medical group, a joint commitment to utilize medical resources effectively and an understanding that unnecessary services do not constitute quality medical care. Another reason it works is that the medical group themselves -- through their own staff and procedures are producing and distributing these reports.

Periodically we have what we call economic grand rounds for the medical staff. This consists of taking hospital bills for particular cases and analyzing the economic outcome as well as the clinical outcome. In one study we compared the cost of intravenous versus oral medication in the hospital. Most physicians do not know that IV medication can cost over ten times as much for the same dosage of the medication compared to oral when it is administered in the hospital. By making sure a patient is

transferred to oral medication as soon as appropriate can save hundreds of dollars in a single hospital stay. This is not cutting corners, but rather good management of resources.

Another study compared the cost of certain surgical procedures in the hospital versus a free standing surgicenter. Day surgery is an interesting subject. Fortunately, not all advances in medical technology automatically mean more cost for those who pay the bills. Some are actually cost effective. Advances in surgical techniques and anesthesiology make it possible to do a number of surgical procedures in a properly equipped office or free standing surgicenter that were generally done only on an inpatient basis a few years ago. Some of these include cataract operations, tonsillectomies, laparoscopic tubal ligations and hernia repair. The development of arthroscopy, which is an orthopedic surgery technique in which a fibre optic tube with a cutting instrument is inserted directly into the joint through a very small incision, can significantly reduce length-of-stay and post-surgical complications on knee and other joint operations. While these advances have been readily available for several years, large numbers of surgeons still do not use them. In the HMO we make certain that our surgeons do where it is appropriate.

Providing care in alternative settings that are less costly than the hospital is a key element of resource management. Besides the surgicenter, the skilled nursing facility as well as the home can be an appropriate or even superior setting for the convalescing patient or the patient on intravenous medication who does not require the intensive services of a hospital. One of the key functions of our continuing care nurse is to contact the attending physician when a patient may be ready for discharge or transfer to a less acute setting.

The results of some of these activities speak for themselves. I reviewed length-of-stay data on three of our most common types of hospital admissions since the first of the year. Our average length-of-stay for uncomplicated deliveries is 2.33 days, which compares to a 50th percentile for the southern region of the United States of three days. On caesarean deliveries our average length-of-stay is 4.17 days compared to a 50th percentile of five to six days, depending on the patient's age. On cholecystectomies, which is the surgical removal of the gall bladder, our average length-of-stay is 3.57 days compared to a regional average of six to nine days, depending on age. Our management of these cases also includes pre-operative and in-hospital counseling by the surgeon and by our personnel, which increases the patient's comfort level with the entire procedure, as well as giving them an advance idea when they can expect to go home, barring complications.

Another example of different behavior in the HMO involves the acquisition and use of medical technology. Prucare of Oklahoma at the present time is considering acquiring fluoroscopy equipment in-house. All our lower and upper GI studies with barium swallow etc., are now referred out at a cost of anywhere from \$70 to \$100 per procedure. We looked at how many procedures were being ordered and developed a projected cost per procedure if we purchased the machine, furnished staff, supplies, radiologist's time and all the other components of the service. We have determined that we are doing sufficient necessary procedures to cost-justify acquiring the equipment. That kind of process describes a typical "make or buy"

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decision which service or manufacturing organizations in other industries go through all the time. Physicians in fee-for-service practice might go through a similar process, but because revenue is dependent on the number of procedures performed, there is an ever-present incentive once the machine is acquired to order more procedures in order to pay for the machine. There is very compelling evidence that economic incentives do influence behavior, and can do so positively or negatively. Cost-effective physician behavior is more likely to occur when the economic incentives reward such behavior.

Prudential initially entered the HMO field on a largely experimental basis to determine if they could be attractive to consumers, could deliver high quality medical care, do it cost-effectively and produce an adequate return on investment. Several years of operation on this basis convinced us that the answer to all these questions was "yes", and since 1978 we have been engaged in a very aggressive expansion of Prucare which now includes programs in twelve cities with a projected total enrollment of 400,000 by the end of this year. This has not been an easy task. As the first HMO in town, we met with great resistance initially in many communities. Some of our medical directors and group physicians have received shameful treatment from some of their fee-for-service competitors. I have been impressed with their dedication. We also find that after a few years pass, the HMO is accepted as a legitimate alternative by most, if not all, local physicians once they develop even a superficial first-hand acquaintance with us.

I have also been very impressed at how receptive most physicians, especially younger ones, are to becoming educated about how to be a smart consumer of economic resources, once they find themselves in the kind of informed, supportive environment we try to create with our medical partners. What has been mainly lacking in my opinion have been enough incentives for physicians to engage in cost-effective behavior and enough serious co-operative efforts between those who are concerned with the cost outcomes and those who are concerned with the medical outcomes. Group practice HMOs are one way to make that happen, and in our experience we believe it has happened very successfully.

MR. ROBERT L. BROADDUS*: If we could judge the success of preferred provider organizations by the pounds of publicity written concerning them, on that basis alone we would have to admit they have been fabulously successful! PPO's have been attributed with being everything from the next best thing to the cure for the common cold to a revolutionary, money grubbing plot of the enemies of medicine to economically break the medical provider and lower the quality of medical care to that of the dark ages!

Like so many things that receive over exposure in the media it is none of the above. However, what it is, is an excellent opportunity to bring the medical care system into the economic marketplace and start to value medical services on the basis of supply and demand as other services or products have had to do.

To properly realize the potential that an approach like this holds, I think it is first necessary to briefly sketch the present system that we are attempting to change.

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Starting after World War II hospitals were encouraged to expand both their physical facilities as well as the services they provided. At the same time and reflective of the movement of individuals from the city to the suburbs new hospitals located in these suburban areas were built to bring medical services close to where potential patients lived. This eventually resulted in this country having essentially a duplicate set of hospitals, one for the city the other for the suburbs with a much greater than needed bed capacity as an end result.

In the early 1960's under the mistaken impression that this country was under doctored and on the assumption that more doctors might create cost competition and lower physician prices, the federal government supported both legislatively and financially the expansion of medical schools and larger classes of students.

The result of this today is a significant oversupply of physicians, in many cases over-specialized, and with that problem aggravated by a movement of foreign trained physicians to this country to practice. By the way, I am sure that I don't have to tell you, but the price did not come down.

The combination of this oversupply of physicians and facilities, the government's move to limit its financial outlay for medical and other programs and business' concern for the ever increasing costs of medical care provide the basic ingredients and receptivity for change as offered by the PPO concept.

With the provision for prospective contracting with medical providers now allowed for in California there was an almost instantaneous rush to the marketplace with organizations who called themselves PPOs. Most of these new organizations were represented by hospitals and medical staff groups incorporating with a new name to protect their market share and hopefully take some business away from another hospital. Clinics and medical groups who had been involved in delivering care to patients under a HMO plan also looked at the opportunity to expand their practice base with this new alternative. Then there was the inevitable entrepreneur promising miraculous arrangements with the best hospitals and physicians at savings you could not believe. They were right, you could not believe them for when you checked on the actual arrangements and their financial status they were all hype and no substance.

After examining many of the organizations, we decided on a basic strategy as follows:

1. With a large part of our business in Southern California, our previous experience in cost containment programs which had told us a great deal about individual hospital effectiveness and our concern for objectivity on the part of hospital networks we had talked to, we decided to put together and manage our own hospital network.
2. On the physician side of the network, we decided to work with a group who had been involved in HMO and prepaid practice, as well as one composed primarily of independent physicians, to construct separate products and compare the performance of the two types of providers.

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3. In the role that we felt as an insurance company we must play was to track the utilization by both the hospital and the physicians and actively manage the network so that there was a reasonably placed physician or hospital available to the insured who had agreed to our standards.

We began our first hospital contract negotiation with St. Johns Hospital in Santa Monica, California. Our intention was two-fold in contracting with the hospital. First, we were interested in a per diem rate to put the hospital on a basis of having to live within a budgeted amount. Secondly, we were requiring as part of the contract that there be a retrospective review using a professionally developed review instrument called A.E.P. (Appropriateness Evaluation Protocol), a product of Health Data Institute in Boston, Massachusetts. Our desire was to make sure that on the one hand they learned to operate within a budgeted amount, and on the other, when auditing that their review mechanism performed at a level of what A.E.P. would suggest. This was because our intention in the second and subsequent years of the contract was on retrospective review if it was found that there were significant instances of unnecessary services or unnecessary days, we would require the dollars for those instances to be returned to the insurance company and no balance billing be made to the patient. Our discussions with St. Johns went over several weeks as both parties learned about this new relationship and what involvement it would bring. The contract was signed on August 15, 1983, and from that joint effort we have gone on to where currently we have 18 hospitals which we have directly contracted within our network in Los Angeles and Orange Counties. In reference to hospitals I think there are some points worth mentioning. First is the differential between profit and not-for-profit hospitals. In many cases the for-profit hospital can give you a more competitive rate than the not-for-profit. However, a question that must be asked is "How have they arrived at that capability?" Typically, they restrict themselves wherever possible to the patient base on which they can have a fast turn-around in terms of length of stay, yet give them a full complement of ancillary services which offers the greatest profit margin.

Conversely the not-for-profit hospital is often required to provide facilities for the acute care patient or for those that require difficult and extensive case management. Since as an insurance company we represent insureds which potentially will need a full variety of services, it has been our intention to work with not-for-profit hospitals wherever possible. The second thing to consider is the time frame in contracting with hospitals. Even though boards of directors of contracting hospitals are becoming more exposed to the new environment, it can be an extremely time consuming thing.

Many hospitals, in cooperation with their medical staff groups, have created separate corporations, calling themselves PPO purely for the purpose of protecting their market share or hopefully increasing it. The real motivation towards effective cost containment by these new entities has to be suspect and even though many good hospitals are represented in this arrangement, there tends to be a conflict of interest, therefore another reason why we chose to develop our own network.

Many hospitals have inquired as to the availability of quoting on a DRG basis since they are having to develop their procedures and accounting

for that format based on their medicare business. At this particular point in time we do not encourage this since we currently do not have that system capability. But more importantly, we felt that the DRGs as presently constituted are not going to effectively deal with the cost containment issue. In fact the experience of many hospitals that have gone into it is that they have had their best revenue years ever, using that system.

With the aforementioned staff groups associated with hospitals, you had potential for developing a physician's network necessary in a PPO. The problem was to try to link those separate groups together in a network. This required a lot of complicated logistics and communication to the insured. Another important area to realize in dealing with physician providers is there is no track record as to how cost effective the physician is that is basically a public document. Individual physicians have personal view points regarding other individual physicians, but that is not anything that you can build a network out of or could you substantiate in court for defending your action of excluding a physician from a network.

There is another aspect which is extremely important in working with physicians. The requirement that they be working to a common standard of utilization review. The most important element of any PPO is the utilization review. It should be one that results in cost effective professional performance, be professionally creditable and be defendable with the doctor and with the patient.

Unfortunately, many physicians believe that if they have to accept a reduced fee schedule or a reduction in increases from what they have come to expect, the area where they can "get well" is in charging for utilization review monitoring of performance. We had several groups that we had to dissuade from the viewpoint that they had found a "pot of gold" with this function and some were very unhappy because they had counted on this to make everything right.

Even though typically claim costs are about 60% to 70% hospital costs as opposed to about 20% physician costs, the physician is responsible for approximately 80% of those in-hospital costs by his admission of patients and the requesting of services for them. If you cannot change physician behavior to a more cost effective one irrespective of what kind of hospital contracts you have negotiated, you are not going to have an effective PPO. Doctors must understand this and understand that you realize this and will be working with them to make sure that this performance is tracked and monitored. It is extremely important, however, that doctors not feel that an insurance company is going to make professional medical decisions on patient care, since they are at risk for that patient's care and their worst fear is that "corporate medicine" will be practiced, which is only involved with the bottom line of profit potential.

All of this activity is pointed at being able to deliver a more cost effective and, from a premium standpoint, less costly health insurance product to the consumer. There are some differences, however, that must be taken into consideration in marketing this concept.

1. There are two sales to be made with a PPO product. The first, as with an indemnity plan, to the employer, and second, and most importantly, to the ultimate consumer, the employee! Since in almost all

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situations the PPO will be an option (as opposed to an Exclusive Provider Arrangement) it will be very important to secure maximum participation in the option.

I believe it will be necessary to take a page from our HMO friends here to focus efforts on the employee both to secure initial participation and on an ongoing basis, to keep them in the option. Some of them have experienced initial penetration rates of about 5% where they are not personally involved in the employee solicitation, to over 20% where they have been.

2. Incentives must be a basic part of the option to provide the motivation for an employee to change from the indemnity plan to the PPO option. These can take the form of differentials in premium contributions, copayment levels, deductibles or combinations of the above. In doing this it is well to be careful of a potential trap: spending the premium credit twice.

For example, let us assume that the PPO option will result in a 15% premium differential between a comparative indemnity plan. If the employers motivation is lower premium contributions and to secure employee participation better benefits are to be offered you must be certain to remember that there is only 15% to be spent in aggregate.

3. Similar to the HMO product, the PPO is very much a partnership situation. The primary motivator for participation by hospitals and physicians is volume anticipation in an over supplied market. If the volume is not developed by the insurance company or other payor partner the network's continuation is in jeopardy. This has always been someone else's problem in the past. In this partnership, this is no longer true.

In making the decision to develop and market a PPO product some basic elements must be dealt with in every instance and I would offer some views based on our experience.

1. Don't assume that physicians and hospitals are natural partners. It is true that each needs the other however. Each is also extremely concerned over being dominated by the other.
2. There is a wide variation between hospitals in their data capture and analysis capabilities. Some are quite sophisticated while others are literally still in billing and cost accounting applications.
3. Beware of the low, low price. If the deal offered on rates seems too good to be true it probably is! A hospital is and always will be an expensive place to stay. Contracting only impacts that fact by degree, not by wholesale change. If offered a very low price be sure to look for the not-covered conditions, services or terms.
4. You must know your case mix and what the mix expectation will be for the period of the contract to be able to determine if the contracted rate will be to your advantage. The sophisticated hospital will know more about your insureds (their patients) than you will and if you don't have the basic data it is you who is at risk.

PANEL DISCUSSION

5. A reduced fee schedule for physicians is not the most important cost containment feature. The utilization review is. Without a good utilization review system, good efforts on the other components will never be enough to overcome the cost drag of an inferior system.
6. Most physicians want to practice medicine. Don't try to make business people out of them. The construction of their part of a PPO network should be along the lines of maximizing their practice of medicine and minimizing their involvement in administration. In dealing on business matters they may say they understand but assume they don't and act accordingly and you will not be far off.

The PPO will in all probability not be the ultimate in a cost effective product for delivering medical care and at this point I don't believe that is even important. What is important is the opportunity for the payor to become part of the system and help influence some of the decisions that impact costs. We should not be too timid to seize that opportunity as it may never come again if costs continue to rise and the clamor for federal intervention becomes overwhelming.

MR. DONNELLY: Paul and Bob have described two approaches to health care cost containment which address the health care delivery system. There is another way to contain the rising cost of health care, one which does not necessarily operate in competition with HMOs and PPOs. I am talking about the wellness movement, which to a certain degree produces total cost containment. In order to describe the "wellness at the worksite" movement, I am going to take about 20 minutes to show you a film prepared by the Health Insurance Association of America which contains excerpts from a teleconference on wellness held on March 13. The teleconference involved hundreds of people located in 25 different cities across America. Its ultimate purpose is to encourage employers, either individually or collectively, to take an interest in the lifestyles of their employees. The message is clear -- healthier lifestyles mean healthier employees and a healthier bottom line.

MR. WILLIAM M. KIZER*: My purpose today is twofold. The first is to tell you how the insurance industry, through the Health Insurance Association of America, is planning to capitalize on the momentum and the nationwide visibility that was gained through the recent March 13 Wellness Teleconference. One way we will do that is by undertaking a program to promote the organization of wellness councils in major cities throughout the United States.

My second purpose is to tell you about one such council - as far as we know, the first of its kind - The Wellness Council of the Midlands, which I will refer to sometimes by using the acronym we use in Omaha - WELCOM. I am very pleased to be one of its founders and to be currently serving as its Chairman.

I am confident that with this audience, and because of the video that you have just viewed, that I will not have to continue to either build the case for wellness at the worksite; nor, I am sure, will I have to tell you again just how wide sweeping and how quickly this movement is

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growing.

After all, your own statement of purpose says that ... "Actuarial science is built on the evaluation of the financial, economic and other implications of future contingent events. The actuary is trained to analyze uncertainty, risk and probability."

I am personally convinced that the worksite wellness movement is a contingent event that is already having a tremendous impact on the financial and economic health of our nation. The worksite wellness movement just may mean the difference between basic survival and long-term profitability.

It may also determine, as the consumer revolts of the 1980's hit with full force, whether we in the insurance industry will be seen as the friends of the American people, or ... whether we will be seen as just one more ripoff in a growing clamor that may very well lead to a nationalized health care industry; which, of course, is tantamount to nationalizing the health insurance industry.

I applaud the direction that our industry is taking. Every viable business and every industry must continually ask itself, "What business are we really in?" Success, even survival, depends on the answer to that question. The examples abound. AT&T asked years ago, "What business are we in?" and came to the conclusion they were no longer in the telephone business but in the "communication" business. Many of our great railroads fell on hard times because they could not understand that they were fundamentally in the "transportation" business, of which railroads would become an increasingly smaller component. IBM and Xerox are among our greatest corporations because asking "What business are we really in?" led to an understanding that they were not just in the typewriter and copy machine business, but fundamentally in the "office automation" business.

I am proud of our industry, because it is not just a few progressive companies but the entire industry that is asking, "What business are we really in?"

I want to give you an answer that certainly is not original with me or anyone. It is an answer that continues to evolve.

We are in the health and life business. For years that primarily meant we were in the business of protecting people from financial tragedy that can accompany sickness, accidents and death. Protecting people from financial crisis will always be a part of our industry.

Fundamentally, however, I and many others, many of you, have come to feel that our business is also improved health and prolonged life. For our own continued prosperity, and because it is right and is in the best interest of our customers and the nation, we must continue to let it dawn on us and guide us through the next crucial years that we are fundamentally in the business of insuring people's health by also helping them to take responsibility for their own health and well being.

It is becoming increasingly clear that unless we begin to redefine our business in this way, our customers will not be able nor want to afford our protection, forcing on us tremendous financial risk and almost

inevitably government intervention.

Most of us, most of you, are keenly aware of the growing significance of the worksite wellness movement. There are still too many, some in our own industry, who cannot seem to see or hear or grasp the activity that is happening right before them.

You know, the Bible says "let him who has an ear ... hear!" I heard a story that illustrates this point.

A famous violinist was on a tour of the great cities of Africa. He had a few days break in his concert schedule and he and his party decided to take a couple of days trek through the beautiful countryside. On the second day toward evening the violinist took his violin and walked a little distance from the camp, found a grassy knoll and began to play in this beautiful setting. After a while of being lost in his music, he looked up and was startled to see a big lion sitting just fifteen yards away. The violinist quit playing and slowly started to get up. The lion looked perturbed and began to move toward him. The violinist figured, "well, if I must die, I will do so while enjoying my music," and he began again to play - at which the lion sat back down, cocked his head and began to listen. Soon the first lion was joined by a second, then a third and the violinist continued to play. Everytime he stopped the lions got restless and began to move toward him, at which he quickly started to play again, hoping he would soon be missed by someone in the camp. After a while the violinist saw an obviously much older lion moving very slowly and yet very determinedly toward him. The violinist began to worry whether the old lion would stop. Sure enough, when the old, slow moving lion got to the other three, he kept right on going, right up to the violinist, whom he proceeded to devour on the spot. The other lions were furious. "Why did you do that?", they roared at the old lion. The old-timer looked up from his meal and said, "Huh? What did you guys say?"

Well, some of us are really hearing the beautiful strains of the worksite wellness movement and we must communicate and promote its principles before some unthinking and unaware elements eat up the patient right before our eyes.

The time is right for us to move. In addition to the March 13 Tele-conference, several developments have occurred, some in just the last few weeks and days that provide a timely and opportune moment for HIAA to pursue its goal. The one I stated earlier, "To promote the formation of wellness councils in major cities around this country." As excited as I am about what I am about to report to you, I must also be honest and say it is all very tentative. The Board of HIAA just this week agreed to the basic plan that I will tell you about, but it is still very tentative. I have great confidence that at least some version of it will occur.

First, a consortium of groups has been formed to promote the wellness council concept. I am very pleased that one of the contemplated partners will be the United States Department of Health and Human Services, which recognizes the very natural tie-in to its specific wellness objectives for the nation to be achieved by 1990. I hope the HIAA will be the second member of the consortium and will provide funds support.

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The National Center for Health Education will be the third member of the consortium. The National Center for Health Education was formed 10 years ago as the result of a presidential commission by Gerald Ford with the task of promoting health education in the schools and the workplace. The Center has agreed to restructure itself to carry the primary professional lead in spearheading this national effort.

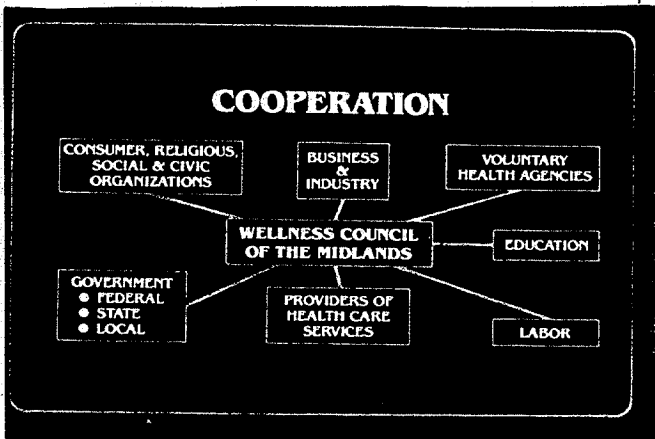
The fourth member, the Center for Corporate Public Involvement, which was identified in the Teleconference materials as the health insurance industry's resource on worksite wellness, has begun to already identify prospective cities interested in starting a wellness council. Groundwork has already been laid in key cities. Our goal will be to establish at least five new councils during the first year.

The entire effort may likely be given the name Wellness Councils of America, sponsored by the Health Insurance Association of America, in cooperation with the U.S. Department of Health and Human Services, the National Center for Health Education, and the Center for Corporate Public Involvement.

Now, let me just take a few minutes to describe the Wellness Council of the Midlands -- its mission, objectives and structure. This will also give you a better idea of how these councils might function, although it should be understood that each city will have to tailor their approach to fit the needs of their particular community.

For the employer, wellness councils act as a clearinghouse and consultant. For the workforce, wellness councils disseminate information and identify action programs. For the community, wellness councils climatize the environment by extolling the many advantages of healthy lifestyles -- or the harmful effects of unhealthy lifestyles.

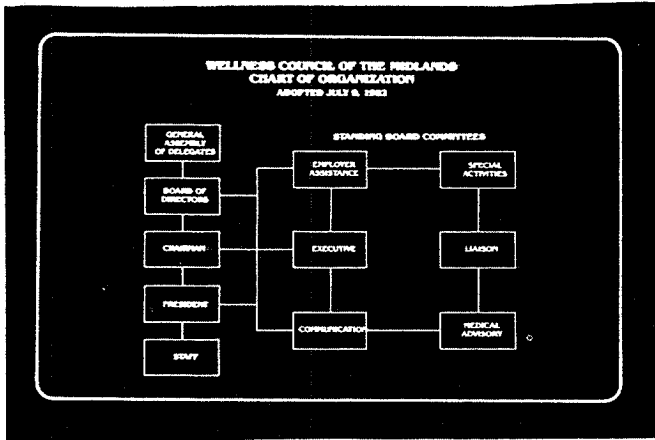
Welcom's written goal is to foster a total community environment that through its commitment to health promotion will result in the Midlands being recognized as ... The Wellness Capitol of the World. The Wellness Council is a means of helping people cooperate.



PANEL DISCUSSION

Perhaps one of the most significant private sector initiatives in our area's recent history, we always envision the Wellness Council operating on private dollars. We will support ourselves through membership fees, contributions, and gifts from foundations.

The first executive director of Welcom was appointed on August 1, 1983. For now she is our only paid staff person. Member companies provide secretarial and inkind service. We office in the Omaha Chamber of Commerce. We think we have designed a format, however, which will ensure that the Wellness Council will be one of this community's strongest voluntary organizations. The Wellness Council is made up of a volunteer army of advocates ... we are organized.



The General Assembly of delegates meets six times a year. Every other month over 100 delegates and guests convene and are informed about Council activities and treated to an outstanding speaker and program. We have a Board of Directors consisting of 12 members. The Executive Committee exists to implement the policy decisions of the Board of Directors and supervise the day-to-day operations and activities of the Council. The other committees are all chaired by skilled volunteers -- most of whom possess an almost missionary zeal for health promotion. For example, our Medical Advisory Committee, chaired by a prominent M.D., assures that all Council programs, activities, consultations and materials are medically sound.

Our Employer Assistance Committee assists employers in the selection of worksite wellness programs most appropriate to their needs and in line with necessary budget parameters. It also serves as a clearinghouse of reference and resource information.

Our Liaison Committee conducts an ongoing liaison with public and private agencies whose services relate to wellness and can be used to help people learn skills necessary for the maintenance of healthy lifestyles.

INVOLVEMENT OF INSURERS IN HMO's, PRO's, EMPLOYER COALITIONS & WELLNESS PROGRAMS

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A guide to health promotion was prepared by the Liaison Committee. It lists and describes all the available health promotion and health services available in our area.

Our special Activities Committee plans and carries out unique community-wide activities that will motivate people to adopt more healthy lifestyles. For example, in 1983 two full-day seminars were conducted. They were immensely successful.

The Communications Committee publicizes the existence, purpose, programs and results of the Council to the public as well as member firms and their employees. This is accomplished through the Welcom newsletter. The executive staffs of corporate members and all employee members receive quarterly a complimentary issue of the Welcom newsletter. Also, each year employees of all corporate members annually receive 26 payroll stuffers designed as "wellness reminders." In 1983 we delivered over 1,000,000 payroll stuffers at a total cost of 25 cents per employee -- less than 1 cent per employee for each of the 26 pay days. Other communication aids include slide presentations, a speakers bureau, and even bumper stickers and descriptive brochures. We also have produced a series of 12, 30-second public service announcements. Based on the report of our area's T.V. stations, we will exceed \$150,000 worth of free T.V. time in 1984 through the use of these PSA's.

The PSA's were done generically. They are, therefore, available for purchase and can be tailored by simply changing the tag line that comes up at the end. Other councils or health coalitions could use them for commercials.

The Wellness Council of the Midlands is pleased with the direction being taken by HIAA and the industry. We stand ready to share our experience with any groups that want to start something similar in their area.

To that end we are also pleased with the case study on Welcom prepared by the Center for Corporate Public Involvement. The case study not only tells the story of Welcom that you heard today, but tells how we got started and based on our experience offers "key strategies" for those cities interested in starting a council.

Thanks for allowing me to tell you the story of Welcom.

