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DEBATE - FUTURE OF HEALTH CARE FINANCING

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This session will focus attention on the questions being asked about the future of health care financing:

- Will the traditional insurer-based program be the predominant financing mechanism in the future?

- Will Preferred Provider Organizations, Health Maintenance Organizations or other mechanisms displace current approaches? What additional institutions will enter this field?

- What major factors will determine the outcome?

MR. RONALD L. HOMANS: I want to discuss a case history of an insurance company's involvement in establishing a Preferred Provided Organization (PPO).

The PPO in question was established a year and a half ago in Winston-Salem, North Carolina under some favorable environmental circumstances. A significant employer, the Hanes Group, a Division of Consolidated Foods, was determined to sharply curtail the accelerating cost of their medical plan. They decided to establish a PPO in Winston-Salem to help them with that effort. Two other favorable environmental circumstances to establishing a PPO in this community were a mild over supply of physicians and an excess of hospital beds.

The first step in establishing this PPO was to contact the physician community in Winston-Salem. The physicians' receptiveness to our contact was greatly aided by the Hanes representative who already had some contacts established. We presented the PPO concept to these physicians, including such things as the need for them to grant fee concessions, in return for the PPO enhancing their market share: that is, more patients. We also explained the need for the physicians to abide by the utilization review decisions of the PPO utilization review staff as a requirement to be included on the preferred provider list which would ultimately increase their market share of patients.

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We next contacted hospitals in Forsyth County, where Winston-Salem is located. Again, Hanes personnel helped us with our contacts. We explained the theory of why the hospitals needed to grant rate concessions to their market share. From the practical circumstance of this particular location, as things evolved, we did not achieve any direct discount on hospital charges. The reason was that a large teaching hospital in Winston-Salem had rates considerably above the community hospitals. Therefore, the teaching hospital was not a primary candidate for being a preferred hospital. The Forsyth County Hospital was the only nonteaching hospital in Winston Salem large enough to provide an adequate range of services. This placed the Forsyth County hospital in a position to become the preferred hospital without it granting any discounts. We also explored the need for Forsyth County hospital to cooperate with us in setting up the mechanism for utilization review, particularly the concurrent and retrospective aspects of utilization review.

The third step in our process was to analyze practice patterns and fee structure information gathered from the initial survey of the physician community. In this process, we first examined the primary care physician, family practitioners, interns, pediatricians, and obstetrician and gynecologist practitioners. We did some preliminary classifying of these physicians according to the charge levels they were currently using. The high-charge physicians were marked as unlikely candidates for membership in the PPO. For physicians in the medium range, we noted the fees we thought should be lower and indicated that we would negotiate for that. Finally, those physicians whose fees were below the medium level were identified as candidates we would try to enroll into the PPO.

Because we had established that there was only one candidate to be the preferred hospital, we needed to identify those doctors with staff privileges at this hospital. And finally,-- unique to this situation because there was an employer involved from the beginning-- physicians who already had a significant share of the Hanes employees as patients had to be identified.

Then, we solicited a firm indication of the primary care physician's desire to participate, including the negotiation aspects. Once the primary care physicians were signed up, we examined their referral patterns. This was done to establish a panel of specialists who had no relationship to the primary care physicians and who probably would not receive many referrals from them. Our objective was to sign up a sufficient number of physicians to cover primary and specialty care but not sign up all the physicians in the community. We felt this would create a spirit of competition which would ultimately hold down fees and stimulate a willingness among physicians to abide by the utilization review decisions.

The next step in our process was to orient the Hanes workforce toward a PPO, by explaining the concept and benefits. In Winston-Salem, the incentives attracting patients to use the preferred physicians included waiving the deductible and coinsurance in the existing benefit structure which would otherwise apply to physician office visits.

This made it financially attractive for employees and their dependents to visit the preferred provider because it was less out-of-pocket expense. We did, however, require a $10 per office visit co-payment designed as a "hesitation" fee so that everybody wouldn't visit the doctor everytime the mildest ailment was troubling them, resulting in higher costs. We had to explain the need to have all benefits assigned to the physicians to make the administration of this arrangement work more effectively and also the need for precertification of all in-patient confinements. Finally, there was a need to iron out all the details involved in setting up something new like this and to begin operation.

In closing, I would like to comment that a PPO is not a rigid concept, it needs to be adapted to the specific circumstances of an overall community, the medical community, and the employer community with which you are dealing. This need has resulted in a wide variety of specifics relating to PPO design and operation throughout the country.

MR. ALLEN J. SORBO: The best available statistics indicate that slightly in excess of 15 million people were covered by health maintenance organizations (HMO) as of June 30, 1984, an increase of nearly 22 percent over a year earlier. This explosive growth was due not only to a rapid expansion of existing plans, but also due to approval and development of nearly fifty new plans. How does this relate to our more traditional measurement of market share by the carriers?

In an interesting article from the Health Care Financing Review, which brings the estimates more up-to-date by measuring administrative services only contracts (ASO) and third party administration, Gordon Trapnell estimates HMO revenues to be about 6.1 billion or 6 percent of the total expenditures for private health insurance. The internal data from our clients in the trade associations indicate that the share of the prepaid health plans is even higher. Based on recent estimates of the average premium revenue per person enrolled per month, we estimate that HMO revenue in 1984 was 11.5 billion, or approximately 10 percent of the private health insurance pot. It should be noted that reporting methods are not consistent and a number of HMOs are including substantial medicare income at this time in their revenue figures.

I would like to comment just briefly on what I see as near term trends in the HMO marketplace. Between fifty and one hundred new HMOs or branches were opened during 1985, which with continued growth of existing plans may come close to duplicating the changes in experience during 1984. Premium rate increases are much reduced, thus, HMO's share of the total market will probably rise to about 11 percent or so during 1985. Minnesota is a good case in point to look at what can happen in a highly competitive environment. For 1984, of the six largest carriers in terms of reporting premium revenue to the state of Minnesota, the largest was Blue Cross and the next five were HMOs. Of course, this data excludes claims paid through administrative services only (ASO) or self-insured contracts.

Will this growth continue for the foreseeable future? We see considerable rumblings in the marketplace today which indicate that marketing HMO programs, unless the premiums are held artificially low, will become much more difficult.

In 1984, the modest HMO premium rate increases of about 11 percent were sheltered by carriers' exaggerated estimates of inflation rates which in turn resulted in many employers overpaying HMOs. Inflation rates dropped sharply; utilization dropped sharply; and the PPS system to reimburse hospitals has substantially reduced the amount of cost shifting, at least temporarily. The carriers still seem insistent on using high inflation rates in projecting benefit plan costs, which will again rebound to the positive interest of HMOs and negative interest of the employer.

In spite of this, many health plans had either no rate increase or they had a small reduction. We expect that insurance companies' annual reports, will show a tremendous upsurge in profit margins, allowing insurance companies to produce more competitive rates. Employers have sharply reduced benefit plans in many instances. The adding of health care expense accounts confuses the cost comparison. Many of our HMO clients with what would normally be considered competitive rate increases in the seven to eight percent range, currently are finding themselves in a poor position in the marketplace. The choice is to reduce rates and profitability margins or suffer a slowdown in enrollment. While it is likely that growth in HMOs will continue because of the tremendous impetus of new starts, it seems likely that growth will slow down. It will stay that way unless a very high inflation rate combined with increased cost shifting on medicare, together with a resurgence in utilization, from the very low levels we have seen during 1984, will again make HMOs competitive.

We think that the declining utilization probably has another year to go and that the federal government will not bring down medicare reimbursement rates until fiscal year 1987 at the earliest. Thus, we feel there will be continued HMO growth but at a somewhat lower level of profitability.

What effect will medicare risk contracts have? Seventy-five organizations have applied for designation as comprehensive medical plans and forty or fifty HMOs have filed an intent to develop a medicare risk contract. The federal government is predicting that 600,000 medicare eligibles will join HMOs by the end of 1985. Enrollment may be rapid, but we have strong actuarial feelings that the medicare risk contract will not be all it is cracked up to be. In the very high cost areas, such as Miami or Boston, with a very tightly controlled group practice program, considerable profits and market share may be obtained. In many other areas, the advantage to HMOs is not that clear. Also, our initial indications are that the fee for service type models particularly with a large participation of the medical society, may develop a rather extreme antiselection and higher than average utilization when adjusted for age, sex, welfare status, and institutionalization status. The jury is still out on whether the Individual Practice Association (IPA) model can successfully enroll

medicare, but earlier information we have would raise some doubts whether this is possible.

The question of selection for medicare enrollment has both a positive and negative aspect for the federal government and the HMO. The federal government does not want to pay more than they would otherwise pay if the HMO gets a favorable selection. The HMO does not want to lose money if it gets an unfavorable selection. Health status measures and other accurate measures of degree of risk are being investigated by the Health Care Financing Administration for inclusion in the medicare payment formula.

There has been a rapid conversion from a not for profit status to a for profit status recently. In many cases this has been to raise capital, and in other cases it has been used as a vehicle to make the entrepreneur rich and attract high level personnel. One might compare this to the computer industry where someone has introduced a new product which sells very well in the market. Much profit is made but increase in competition and better products either overwhelm or bankrupt the original company.

There is such a proliferation of developing HMOs of different models with different sponsors, duplicating the same metropolitan areas, that it seems hardly possible they can all survive, even two or three years from now. I would have to question whether the pockets are deep enough for many of them. For example, we understand there are twenty-one licensed HMO's in the Chicago metropolitan area and more are forming every week. No major employer is going to enroll in twenty-one HMOs. In Minneapolis, we have begun to see some signs of consolidation; seven HMOs have now become six, although new programs have been started out of state.

The stocks of profiting HMOs have done very well, although a number of them are down 50 percent from their highs (similar to the high-tech comparison). With our cloudy crystal ball, some of us have visions of the many small plans being started, expanding and being bought or merged when they get into financial difficulty or at the end of their capital rope in two or three years. Unfortunately, there is frequently not enough management to go around. The major HMO corporations, insurance carriers, or hospital management companies may be the survivors and pick them up one at a time when it seems to their advantage. I hope there will not be many disastrous bankruptcies since this will cast a cloud on the whole movement and result in rather extreme demands for insurance department regulation that will undoubtedly stifle real innovation. Nevertheless, we may be entering a very high risk era, where not everybody who seems successful today can survive.

MR. RAY MCCASKEY: Blue Cross has been internally debating many, if not all of the questions, that we will be discussing. One of the most interesting things to me is how we are trying to gain control over health care costs in the country. For a number of years benefit expansion consisted of adding extra benefits and expanding benefits. Inflation and the increased use of medical care caused the industry and our customer base to attack the problem of health care cost. We started

where the savings were the smallest and then only gradually moved to the real savings.

The first savings in health insurance was the squeeze on cashflow. We didn't affect what the payments were; we just affected the timing of those payments and hopefully saved something in the time value of money. The next savings were the squeeze on administrative costs, the advent of ASOs, the unbundling of cost, and so on. Finally, after many years we are dealing where the dollars are - the claims costs and the actual major expenditures that go for health care in one form or another. But as we start to deal with the claim cost issues, most areas of concentration are still on the pure price of the service, that is the unit cost, and aren't dealing with the total management of the health care dollar and controlling utilization as well as cost. PPOs and HMOs are two innovations rising out of the desire to control health care expenditure.

Looking at the market, Blue Cross of Illinois has just one foot in each camp, which is getting a little cumbersome because we have at least three distinct areas. We obviously have a traditional insurance portfolio in the group insurance marketplace. We have been a developer of an HMO in Illinois which has existed for almost ten years. Last fall we launched our first PPO in the state. It is a very turbulent time, but there is one key observation that puts things into perspective for us in our decision making.

The first thing we had to do was look past the terminology. We can find ourselves too neatly categorizing the various kinds of delivery mechanisms and finance mechanisms by labeling them. We found that many variations in the marketplace were trading off blends of access to care; that the access was limited on one hand; and that access was being traded off against price. By price, I don't mean the unit cost of the service but the total cost of health care for a given population, a given group of employees of an employer, or an insured population of a carrier. The mechanisms that we were looking at varied in balance of access and price. We viewed the HMOs as having a tightly controlled access to the health care marketplace, but at least on an apples to apples basis a very cost effective and a low cost benefit program. Traditional insurance is, of course, at the other end of the spectrum. The real debate, in the PPO area especially, is still in the process of definition. The little PPO activity I see can range anywhere from being a slightly expanded HMO without all the regulatory trapping to something very close to the traditional insured plan with just mild limitations on where care can be received. In looking at the control of the price and product, if that is the underlying goal, the key is to look beyond the unit cost to the price of discounts, and the PPO has been awfully discount oriented in its development up until now, to the system that controls the utilization. When we say utilization, we mean not just whether something is in-patient or out-patient or what the average length of stay is, but also what services are provided in what setting, and how often those services are provided. Total cost savings are probably at a lower detail and information level than most people have been able to deal with so far.

Whatever PPO system results, it is going to have a patient channeling feature to it. This feature will introduce competition into the provider-oriented marketplace that is between the doctors, the hospitals, and other institutions that are direct providers of medical care. This is the only way to achieve the economies and competition we desire. In many areas of the country, bedding is a big problem. A mechanism like this will cut down too many facilities and too much care. Prospectively the hospital and the medical community will become turbulent.

Any PPO program will have to control utilization and what services are provided in what setting to be effective in controlling health care costs. This will require an extensive data base, which is very difficult to develop. So, as we move into the next several years, the insurers, the HMOs, and the PPOs will all be competing in the marketplace for the same group health care dollars but in very different ways. One of our big debates now is whether to offer a PPO, an HMO, or traditional insurance to a new or potentially new group customer. It's a difficult strategy decision for us but one that any insurer getting into the business will have.

Twenty-one HMOs are licensed to do business and operating in Illinois. As of July 1, 1985, if all the filings are correct, that number would be up to twenty-five. Our own HMO, the Blue Cross sponsored HMO in Illinois, has had roughly a 40 percent growth rate for the last three years and has lost market share. Things are really happening in Illinois and maybe, when we get to the point were HMOs permeate the market to the extent they do in Minneapolis or on the West Coast, that pace will level off. Just the new entries in the marketplace have stirred up things. Obviously, the way the market is going, the HMOs are going to have some segment of the market for sometime to come. But there is always the limited access that they bring with them.

Our own preferred provider option is too early to tell. We launched our first trial in Peoria, Illinois last fall, and our Chicago and statewide operation is going into effect during the second quarter of this year. If the bids and the process with the provider community is any indication, it should be a very major event for us.

Patient channelling is a long-range issue. The real long range success story will be the one that finds the correct or optimum balance of access and patient channeling, having the ability, the data base, and the skills to control the utilization. What we are actually getting into here is almost the employee counseling or employee directing operation. We did a joint venture on developing the program for our first major client, Zenith, where we have a medical services advisor for all nonemergency, or as we called it, nonurgent hospitalizations. The employees are required to go through a medical service advisor to evaluate the need for hospitalization, the length of stay, and what hospital to go to.

The final issue is going to be the quality of care. We have heard some quality of care discussion in the HMO area, but those discussions are going to be increased as we move over to the preferred provider area.

When you get to the point of directing and channeling patients from one institution to another, the major question will be "are we channeling patients simply to the low bidder, without regard to the quality of medical care that is going to be provided?" That question will have to be dealt with for those who are going to have long-term success in the marketplace. The ultimate goal of all these efforts, is to make the consumer, whether it is through an employer group mechanism or individually, an educated, intelligent buyer of health care services as opposed to an ultimate payer of bills for the services whatever they may be. There is nobody right now who is really adequately filling this role, although there are plenty of folks who are interested in filling it. Not all of them will succeed but there will be a few that do.

MR. WESLEY J. BURBANK: Humana is a hospital company. We own 92 hospitals across the country; we also own about 180 medical clinics. These are emergency clinics open from 7:00 am until 11:00 pm. We have watched the hospital census go down due to changes in the payment pattern of the insurers paying 50 percent or 80 percent or not paying at all for certain procedures done on an in-patient basis. The hospital census in Humana's hospitals and other hospitals have been going down roughly 10 percent over the past year.

When the hospital census goes down, revenues are reduced, but overhead is not materially reduced because of the high degree of fixed cost involved. At Humana, we felt a need to increase our census. We talked to customers and found that they want the provider to be partially, if not wholly, at risk. So Humana decided we could set up a health division and take care of the risk portion of it. We have gone into the risk-taking business as a provider. Now HMOs limit physician and provider usage. The traditional insurance industry does not limit usage and choice of where you want to go. PPOs are in between where you have insurers or other carriers going out and contracting with providers. Even then, the provider is not at risk.

I talked to one group case who said they would never go self-funded with us because we could just have the people stay in the hospital another day longer and still get the same amount of revenue, even reducing the charges roughly 15 or 20 percent. Humana is taking the risk and going strongly into the marketplace. We want to direct people into our facilities to increase our hospital census and still give the necessary high quality of care.

We started the Humana Care Program about three and a half years ago, as a training program for the employees, to teach the employees and to provide the necessary and high quality of care. Our insurance or HMO programs are now at an affordable price and very competitive. We are taking the risk as a provider, providing a high quality of care at various benefit levels, and an affordable price.

In five years time traditional health insurance, as we know it today, will no longer exist. I worked in California with Blue Cross for a

couple of years, and found cases where 80 percent of the group (and these are cases of 2,000 lives), were in three or four different HMOs. Kaiser is moving back East and in the Northeast. Maxi-care is entering Kentucky. AMI, the third largest hospital company located in Beverly Hills, is looking for underwriters and actuaries because they bought an insurance company. Hospital Corporation of America, which is the largest company, bought Hill Richards, a third party administrator (TPA), out of Orlando, Florida. They hired a fellow out of the Florida Blue Cross plan as their top marketing executive. Humana provides the client with what I have described, which is working. Blue Cross plans, like the one in Alabama, are in and of themselves PPOs because they get discounts from the providers. Other states have the same thing. California Blue Cross developed a PPO and signed up 190 hospitals state wide with 9,000 physicians. But is this not also restricting the use of physicians? Five years from now traditional health insurance of today will no longer exist.

MR. EDWARD A. FLICKNER, JR.: Having been associated with a state insurance department for about thirteen years, and during the last five or six years being very close to the health maintenance organization development, I will discuss the roles of the federal and state government. Funding is certainly one and regulation is another.

Funding is now limited to medicare and medicaid patients, the needy not qualified for either, and the medically indigent. While the federal government appropriated $360 million in grants and loans to get health maintenance organizations started, further funding of that nature is not likely in the near future (two to four years). The medicare program is part of the federal budget and will continue as such. Federal funding is only a part of the total health care budget which was more than $360 billion in 1983. This is about 11 percent of our gross national product as compared to 6 percent in 1965. The latest estimate of the 1984 figures was a very encouraging reduction to something under 10 percent of gross national product. In 1985, it is predicted that our total health care budget will be the third largest budget in the world behind only the federal budget, and the budget of the Soviet Union. We are spending about $400 million a day more on medical care in this country than we are spending on national defense. Within the federal budget, medicare is second only to social security in size.

The unsolved problem in funding is the case of the medically indigent. Until recently, medical providers took charity patients; now they are resisting. In Atlanta, we have a large charity hospital, which is probably an exception, not a rule. In Georgia the 1984 legislature for the first time appropriated only 1.2 million dollars, to fund a limited medically needy program effective January 1, 1985. The total budget with state funds added to federal funds would approximate about $4 million for the first period which was January 1 to June 30 of this year. The legislature is still studying and trying to come up with an acceptable solution.

As for regulation, the biggest argument is over price control, as well as other pros and cons pertaining to regulations. Medical care is not like a public utility and shouldn't be regulated like one. It has been

predicted that very large conglomerates will develop and own hospitals, out-patient medical facilities, HMOs and insurance companies (where Humana is right now). These conglomerates would also own pharmacies, nursing centers, hospices, and many equipment companies. Hospital Corporation of America is merging with American Hospital Supply Corporation, to form a $7 billion corporation. Hospital Corporation of America also has an interest in nursing centers. Now if one of these large conglomerates should become the head monopoly in the area, I have no doubt that it will be viewed as a public utility and probably subject to regulations.

Now where might we expect governments to inject themselves into health care financing? Here are some ideas:

1. We already have diagnostic related groups (DRG) for hospitals and the medicare program. Will that be extended beyond medicare, either by law or by private enterprise? Have the DRGs been effective? Atlanta has five HMOs operating in the metropolitan area, that had some 150,000 members at the end of 1984. This was up from no membership on January 1, 1980. The Blue Cross/Blue Shield hospital days per one thousand members were in excess of eight hundred for the year 1980 through 1983 but had about a 25 percent drop below seven hundred in 1984. The annual increases in premium rates were in the range of 20 to 24 percent from 1980 to 1983, but the increase dropped to below 7 percent in 1984. For the HMOs during this same period, the members per thousand hospitalized was in the range of below 340 days per thousand to a high of 580. Each of these HMOs stayed at about the same level without the significant drop in 1984 hospitalization days observed in Blue Cross/Blue Shield. HMO rates are all trying to catch up financially, and are still increasing substantially.

   One HMO had a substantial decrease in the state plan that was filed just within the last month. This is an actual rate decrease to state employees. So we don't know whether the decrease in Blue Cross/Blue Shield is due to DRGs or whether it might be a combination of DRGs or inroads made by the HMOs.

2. Is a prospective reimbursement system for physicians likely to be added to the medicare system?

3. Are all payer systems on the order of those in effect in the four states of Maryland, Massachusetts, New Jersey, and New York going to be adopted elsewhere? One of our largest insurers is lobbying strenuously for that type of legislation.

4. One survey shows that eleven states have rate-setting commissions. Will other states follow? Colorado and Illinois passed rate-setting statutes and repealed them before they

were fully implemented. If costs were brought under control, the case for price control would simply evaporate.

5. It appears that the federal government is going to have to do something about malpractice suits. Few malpractice suits are won, and in those cases which are won, the patients get only about 25 cents of the dollar awarded. The idea that the individual physician is the only one that suffers financially from malpractice is totally fallacious - we all suffer. A system of peer review is the only possible approach to weeding out incompetent physicians. In the event of alleged malpractice, payments should be limited to all medical bills, loss of wages, and expensive rehabilitation of the patient. Also, all malpractice cases should be required by law to be referred to a peer review board with authority to suspend a physician's license to practice medicine. In such cases, outrageous malpractice premiums ($40,000 or $50,000 for one year's premiums) should plummet with a corresponding reduction in medical care costs.

6. Incentive legislation for patients seems likely with mandatory cash refunds to employees who use less costly health plans or PPOs. A voucher system for medicare or medicaid patients so they have the cash in hand and can shop for their best deal could be another legislated incentive.

7. The federal government might perpetuate programs that promote good health and reduce overall health care cost. For example, it should keep and enforce the fifty-five miles an hour speed limit, beat down the tobacco lobby, and step up efforts to decrease cigarette smoking.

8. The government could provide incentives to reduce the beds for more hospitals like putting medical care on a seven-day week. Except for emergencies and other medical necessities, beds are empty, operating rooms and millions of dollars in very expensive medical equipment stand idle for the most part two days a week, that's one hundred days a year. Incidentally, some insurance policies do not cover nonemergency admissions on weekends prior to 3:00 pm on Sunday.

9. A change in the medicare system, requiring a needs test for the payment of the 75 percent of premium now paid by the federal government could be instituted. There are always complications, for employees between age 65 and 70 whose employer's plan is by law primary and is required to pay the medicare Part B if the employee wants to be a part of the plan, and gets absolutely nothing in return.

10. The balance between over and under utilization has been mentioned and the politicians would like to avoid that one like the plague.

Somewhere along the line, some decisions will have to be made. As medical technology progresses, the potential for prolonging life interminably increases sometimes without terribly expensive medical procedures. It could be, for example, a breakthrough in the control of cancer that is relatively inexpensive. Now should such a control be used with a patient who is very old (90, 95, 100, disabled, senile) or should the patient be allowed to die?

11. Finally, I suspect there will be a federal law passed that will incorporate some or all of these ideas I've discussed and some I haven't discussed. It might have a provision much like the Baucus Amendment, giving states two years to adopt comparable legislation to be administered by the states themselves. Of course, each state will have its own variations of that law. If not adopted by a state, then the federal law will apply. Now I hope that the federal law encourages innovation and competition but still offers adequate protection for all of us.

MR. HOWARD J. BOLNICK: Mr. Burbank, when you made your presentation, you hinted that the major reason, for Humana getting into health care was to fill empty beds. Now my understanding of hospitals is that the marginal cost of filling an empty bed is about half the average cost which us poor insurance companies have to pay. I am curious when you go and price that contract, whether you are looking at it as a marginal cost, or are you looking at it as paying the average cost of care?

MR. BURBANK: What you basically are asking is "do we discount to ourselves?" We look at the total cost of the incremental hospitalization, and we price the premium as such so that it is affordable. For those people who have competed against our premium, you will probably find that we are considerably less than traditional insurance, and it is passed along to the client in the form of a premium reduction.

MR. ROBERT J. MYERS: Mr. Flickner stated that in Part B of medicare, the affluent should somehow or another have a means test applied to them, particularly in regard to the portion of the premium that is financed out of general revenues (approximately 75 percent). Sometime ago I suggested a test and it is just now being discussed congressionally. It's not exactly a means test in the normal sense of the term. You can't go out and look at twenty-nine million people to have a means test to decide how much premium they ought to pay. You do it in reverse by saying that the portion of the premium rate, which is essentially three times what the enrollee pays, should be considered to be taxable income. This could be handled very well administratively because all social security beneficiaries are getting statements of how much supplementary medical insurance (SMI) or Part B premiums they pay each year. You could give them instructions to take three times the figure on Line X and move it over to Line Y to come through to the income tax. I think that is a good "means test", and I speak as a diplomat because I am getting this nice amount from the general treasury tax free.

Mr. Flickner also said that people who are employed beyond age 65 have to pay the Part B premium and get nothing for it. That is not completely correct. First, if they do pay it, they probably don't get their money's worth, even for the 25 percent, because all it does is fill in all the gaps in the deductible. Second, when the legislation was originally enacted, if people dropped out of Part B, they had to pay a surcharge when they came in later. But now, a person with an employer who has a group health plan can drop out of Part B and not have to pay a surcharge when they come back in. So I don't think that criticism applies any longer.

MR. FLICKNER: I wasn't aware of the lack of a surcharge.

MR. MYERS: It was done retroactively in 1984 in DEFRA. This was a great help in improving the equity of the arrangement.

Could Mr. Homans answer as far as hospitals are concerned,if a PPO can bargain to get lower rates and if a hospital is just operating on a break even basis or very low margin, if you give somebody lower rates, don't you have to charge somebody higher rates? I want to know who is paying the higher rates? My second question is even if you can bargain down a physician's fees, you often pick the physicians with the lowest charges anyway and get them into the PPO. Is there any relationship between the level of fees the physician charges and his or her ability?

MR. HOMANS: In response to the first question the circumstances are that we are in the marketplace trying to do the best we can for our customers. Where discounts are negotiated and the physician or hospital has an income level they want to reach, they are going to pass extra charges off to those who don't have the clout to negotiate these discounts. This is something that has been going on for a long time. I am referring to cost shifting.

About picking doctors with the lowest charges, we make a great effort to choose those who provide high quality care. We are attempting to weed out those doctors who are charging high prices and have a patient load such that they aren't interested in the PPO. There's a balance between finding those physicians who will charge lower prices so that the employers' PPO option can benefit from those lower costs and finding those physicians in a position to provide a high quality of care. You need to have representatives from the local medical community who are most knowledgeable about who is providing the high quality of care in the community involved in setting up your PPO.

MR. PAUL BELL: Does a PPO require a large community in order to have the competitive forces needed to create it? Also, does the insurer picking the physicians have any liability in medical malpractice suits?

MR. HOMANS: Typically, you are giving patients some financial incentives to use preferred physicians. Whether or not you are opening yourself up to be a party in a malpractice suit is something that remains to be decided in any litigation that may evolve as PPOs become more prevalent and circumstances like this arise. There are

some factors involved in the size of the community, but an oversupply of physicians, and an oversupply of hospital beds make a community ripe for a PPO. If you don't have physicians and/or hospitals that want to enchance their market share and are willing to submit to controls on their practice in the form of utilization review and pressure to discount fees, you will not find any cooperation for your project. The size of the community is not nearly as important as having an oversupply of both physicians and hospital beds.

MR. JOSEPH W. MORAN: I would like Mr. McCaskey to expand on the role of the medical services advisor that one large corporate employer has engaged. Does that advisor actually become a negotiator on behalf of the employee with respect to medical care providers to try to get as good a deal as possible?

MR. MCCASKEY: Negotiator is probably too strong a word. We do have a relatively standardized program that comprises about a dozen large employers. This program trains and helps an employee of each employer to become a medical services advisor. Basically, I think the Zenith model, which was the first one that we put together, is pretty much the way they are all working. Each employee, on the back of their identification card, has a list of questions that they are supposed to ask their doctor anytime the doctor talks about hospitalization. Is it necessary? Can it be done on an out-patient basis? Which hospital and how long do you expect me to be in? If it is a nonemergency situation, they then call the advisor at Zenith. Now the key that makes all this work, is the advisor at Zenith is armed with a tremendous amount of statistical data on health care costs and utilizations for all of the hospitals in the areas where Zenith has employees. Down to the diagnosis level, they can tell you what the average cost is for a normal delivery or for tonsillectomy or whatever procedure. That advisor then will first counsel the patient or potential patient, and if the patient is comfortable, we will send the patient back to ask the doctor some more hard questions. Does the patient have to go in the hospital or not? If it is clear that the patient has to go in the hospital, he may ask the doctor what other hospitals he has privileges at. If the patient is uncomfortable, the medical advisor will directly call the physician and, using the statistics, point out that of his colleagues in the same geographical area for the same exact diagnosis, a percentage is treating on an out-patient basis or if on an in-patient basis, two of the three other hospitals the physicians have privileges with have substantially lower costs for the treatment for whatever reason. The Zenith programs, which are the ones that most of the employers are using at this point, leave the final decisions to the physician and the patient. But it's a very heavily leveraged counseling role that's provided at this point.

MR. MORAN: But it doesn't include telling the patient he might get comparable service at lower cost if he used a different physician who had access to other hospitals?

MR. MCCASKEY: Well, we have not started directing patients from one physician to another yet. Our whole program up to this point has been very heavily hospital oriented because it is much easier, and our

database is really organized around hospital data. Within the next several months, we will have a usable database of the same type on a physician basis. We are not 100 percent sure exactly how we are going to use it. We may use it more for our own staff to counsel physicians on their practice patterns as opposed to trying to put the employee in the middle.

MR. THOMAS M. DANT: Several of our larger clients have asked us to come up with some prefunding of postretirement medical benefits. As part of that, we need to come up with some idea of long term inflation rates on these types of programs that are typically coordination of plan benefits around medicare, where medicare is primary. Will anyone on the panel like to give some advice to a pension actuary about the long-term inflation rates on such programs?

MR. MCCASKEY: There are so many factors in the marketplace right now and one major problem is analyzing long-term trends. The potential for federal or state governmental action can, in terms of our traditional actuarial role of predicting the future, be based on the past absolutely throw everything out of the window. Whatever the ultimate medical care inflation rates are, I can't believe you will get them down for a prolonged period to the level of say, the general consumer price index. There are still too many things happening out there. They may moderate and the gap may close if all of these programs really start to work, or they may actually fall far below on a very temporary basis. I see them going higher in the long run.

MR. DANT: Can anyone contribute to the relationship of government to cutting medical care benefits considering the fact that medical inflation may be a higher rate? How would this affect underwriting?

MR. FLICKNER: I suspect from reading the newspaper that politicians will finally make the decision. They are not going to alienate that many votes by cutting medicare.

MR. MCCASKEY: Of course, the issue might be that they cut just the funding. The potential problem is in terms of a shift in the payment levels between various patients in the groups. That's probably an issue that up until now has been hotly debated and discussed under various headings, cost shifting, and the like, with varying opinions I'm sure.

MS. MARIA R. TRASKA*: I was happy to see that Mr. Flickner peripherally approached the issue of indigent care. I think whenever the subject of the future of health care financing comes up, the big questions that health care providers have are "who is going to cover uncompensated care, in other words, bad debt and indigent care, and what's going to happen to medical education costs?"

When you put together your PPO, in considering the prices that you got from the hospitals for in-patient care, did you take into account how uncompensated care cost might affect the prices that they were quoting to you? Second, why or why not did you consider that? And

*Ms. Traska, not a member of the Society, is Business Editor of American Hospital Publishing, Inc.

third, if you did, would you please explain how you went about taking that into account, and of course, that would include the medical education cost for the teaching institution?

MR. HOMANS: Well, Ms. Traska, the circumstance in Winston-Salem was one where the community hospital that became the preferred hospital did not grant us any discounts. The issue of the proportion of their rates that was increased because of uncompensated care didn't arise. Perhaps the others on the panel who have been involved in PPOs where discounts are granted might want to comment.

MR. MCCASKEY: We launched a PPO in Peoria and are in the midst of launching one in the Chicago area. We considered indigent care, especially in regard to teaching hospitals and hospitals with a heavy medical education load. We divided the metropolitan area into geographical zones. Very heavy portions of the medically indigent population are grouped together. Hospitals in that zone were competing with one another in that physical area of the city, so we selected preferred hospitals, if you will, out of each geographical zone. We also had a number of zones that were not geographically based but were specialty based. These were specialty hospitals providing particular types of services, tertiary care hospitals which by the very nature of the institution and the types of patients and cases they handle will have higher costs in many respects, and also university teaching hospitals. Our arrangement picked a number of preferred providers in each of those categories. It may be an indirect measure but the intent anyway in establishing the network was to take indigent care under consideration.

MR. ALAN N. FERGUSON: I am interested in the marketing and the administration of the PPOs and perhaps Mr. Homans and others would like to comment on this area. In presenting a PPO, is it sold to an employer so the individual employee can decide whether he wants to stay with the traditional plan or go to the PPO, or is it sold as a package to the employer so the employees have no choice? Today is the first day General Motors has opted for a choice plan. Now 800,000 employees have had the choice of going into a PPO or some more traditional plan. The penetration of the PPO which is the employees' option, has been very modest, to say the least. If a choice is offered to the employee at the outset, will there be a reopening? If so, how often will it be done? What sort of inducements or incentives have you been thinking of in order to encourage enrollment into PPOs?

MR. HOMANS: The approach of Provident's subsidiary is that the employee or the dependent of the employee makes the choice as to which provider they use everytime they seek care. At the outset there is no requirement that they choose any particular physician. The plan design is modified to give incentives to the employees by waiving the deductible or coinsurance in the existing plan to make it more attractive for them to use the preferred providers. The reverse approach is becoming common. We've encountered some Blue Cross plans in the areas in which we operate who go the disincentive route. The benefit structure that's in place is the one that is used if the patient uses a preferred provider. If they don't use the preferred provider, then a

lesser coinsurance, perhaps 60 percent, is used as a penalty of sorts for not using the preferred provider. But the approach that the Provident has taken so far is to give the employee or the patient a choice everytime they seek care.

MR. FERGUSON: How long has the plan been in effect?

MR. HOMANS: The one in Winston-Salem has been in effect since October 1983.

MR. FERGUSON: Have you any data on the proportion of times employees are using the preferred network?

MR. HOMANS: Thirty-five to 40 percent are using the preferred providers for office visits. That's the element of seeking treatment we have measured thus far.

MR. FERGUSON: Mr. Burbank, in the plans you are selling, if you sign up with Humana, you use a Humana doctor. Is that the only choice you have?

MR. BURBANK: When you use the Humana Hospital, you have freedom of choice of physician.

MR. FERGUSON: What happens if you are out of the area, or are you never out of the area?

MR. BURBANK: If you are out of the area, and there is no Humana facility available, and it is an emergency, you would get the same benefits as you would at the Humana facility.

MR. HOMANS: The physician choice is wide open, but what are the circumstances when the physician that's being used does not have staff privileges at the Humana Hospital, and therefore is not in a position to use that hospital? What are the circumstances you use to remedy that problem?

MR. BURBANK: The Humana Hospital has set up a temporary staff privilege where physicians that currently do not have staff privileges can gain them for that specific case, then file for normal staff privileges from that point on. We ran across a case where an individual's physician did not want to use the Humana Hospital, so he called the referral service that we have and we referred him to a physician that would use Humana Hospital and he went in a Humana facility.

MR. DANIEL L. WOLAK: Basically what you just described with the PPO plans is really two types of designs. Incentive plans where you receive rewards for using the PPOs and the disincentive plans where you might have a penalty for not using the PPO. Of course, with the reward plan, the cost of a reward plan would be very similar probably to the existing plan. On the other hand, if you go with the penalty for not using the PPO, you could possibly reduce the cost which you offered to the employer. Therefore, how important is the rate, the

price of the plan to the employer, when you offer a PPO?

MR. STEPHEN T. CARTER: Talking about a plan design with a PPO is like saying a comprehensive plan is a medical plan. I've seen every kind of arrangement possible, from a downpayment of ten dollars on the first doctor visit and 100 percent thereafter to 100 percent coverage if you use a PPO, 70 percent if you don't. You can have any one of these different plan designs available under these arrangements and then when you are pricing it you have to look at the percentage of people you think will make use of the PPO. For example, if you are working out a PPO arrangement in Birmingham, Alabama, on the northside of town, and you have a case on the southside of town, the PPO, depending on the percentages, is not going to be much of a factor. You also have to take into account what kind of hospital discounts you will get if the PPO is also a hospital arrangement. In Birmingham, we have been working with one particular hospital where it was mentioned that a doctor had signed up for thirty PPOs in Birmingham. What is a PPO and how long are PPOs going to be with us, at that kind of a rate?

MR. HOMANS: The incentive approach does indeed present a hurdle. You are increasing plan cost by waiving deductible and coinsurance and you must overcome this hurdle before there are any net savings. This is definitely a drawback to that approach. The success we have had in Winston-Salem has been the result of the significant decrease in in-patient hospital utilization. The significant element of savings is not in the physician discount or even in the hospital discount unless they are very substantial. It's in decreasing the rate of admission and the length of stay. The circumstance in Winston-Salem was that the employer we were working with was committed to not reducing benefits for its employees. The only alternative we had was the incentive approach. The disincentive approach does have an advantage over the incentive in that you don't have the waivers of deductibles and coinsurance to overcome.

MR. SORBO: Our experience in working with the PPOs and from observing what's happening in Minneapolis and other areas, is that many PPOs tend to throw around a lot of numbers in terms of tremendous savings they are going to produce for the employers. Realistically, I don't think they really know. I am sure that in most cases they have not considered all the variables. In pricing the PPO product, we think one of the most important factors is looking at the number of people in the employer group that are going to be switching from some other hospital or physicians to one of the PPO hospitals or physicians. Certainly, you have a number of employees in that group who are already using those providers, and in fact you may be increasing the cost of those people who are already using those physicians and hospitals. Unless you get some tremendous shifts from the rest of the employee and dependent population, it is not going to do you any good. Our experience is that most employers are not buying these inflated figures of savings and most of them want some guarantee of the cost and savings and some risk sharing on the part of the PPO. That's the direction we think it's going to go.

MR. BURBANK: If you provide a reward and the provider waives the deductible and coinsurance, what's to keep a non-PPO provider from doing the same thing?

MR. WOLAK: Let me follow-up my question here. You've mentioned it is very important to know what percent of the population will use a PPO. Have you thought of trying to design a PPO plan and a non-PPO plan where the net cost for the two plans, taking into effect the utilization change in the PPO, is going to be the same so that on the bottom line it won't matter which one is used?

MR. CARTER: That would be nice. The problem is, there are two very different kinds of PPOs. One is in the small group area, and one is in the large group area. Typically in the large group area, it's a combination of the employer having very definite ideas as to what he wants to do and working with Mr. Homans and our people in that area. In the small group area, anything goes, and the fieldman has to see what will sell out there in the marketplace. We try to head them towards very sensible things that will lower their prices, but actually they end up with a PPO design that will cost them more money than if they were selling a regular plan without the use of a PPO. These things get very complicated; if, for example, you have a $10 deductible type of PPO, and if you think about small groups having a $200 or $300 deductible as being standard, then what happens to your coordination of benefits (COB) savings? What happens to your utilization of care? A heavy percentage of people will never file a claim under a $300 deductible, but they will under a PPO that has a $10 deductible per service.

MR. DONALD M. PETERSON: Mr. Burbank, have you formed insurance companies? Are you having insurance companies as HMOs? What is the regulatory authority or the relationship of the local and state insurance department over your operation? Will it be subject to premium tax or federal income tax if it is an insurance company? Mr. McCaskey, the Illinois Blue Cross joined the ranks of the mutual insurers recently. Was there any impact as far as taxation or regulation by the Illinois Insurance Department on that change to your operation?

MR. BURBANK: Commercial State Life Insurance Company is a wholly owned subsidiary of Humana, Inc. Humana Health Insurance of Florida, Inc., is a wholly owned subsidiary of Humana. Humana Health Insurance of Nevada is a wholly owned subsidiary of Humana. We have licensed HMOs in Kentucky, Georgia, Alabama, Texas, Nevada, and a couple of other states. We are regulated by the insurance laws in the specific states that we are operating including Illinois. From an HMO standpoint, we are regulated by the specific states. We are a profit making entity and therefore do pay federal income tax. Since we are governed by the insurance departments in the various states, we pay state premium taxes where we are not domiciled.

MR. MCCASKEY: The PPO products that we are offering at Blue Cross of Illinois really are just another product in the Blue Cross portfolio in the way we are marketing them at this point. There are no special regulatory problems noted to date. We had the Illinois Insurance

Department preview our pilot program in Peoria before it was launched. I guess the only other indication is that our state employees group made approval by the Illinois Insurance Department a requirement of their bids, which were just opened on Friday, so it will be a very interesting conflict if they decide it was not an appropriate thing to do.

You also mentioned the effect of our mutualization on the PPO or on taxes and other issues. When Blue Cross of Illinois mutualized, we became the sixth Blue Cross plan in the country to become a mutual. The only change in our tax status was the change in classification of tax exemption at the federal level we fell under. We became liable for local state sales and use taxes, but the change did not have an impact on the federal situation. I guess we really have not changed the basic nature of the company at all, other than the way we are regulated by the State Insurance Department. Of course, as a domestic Illinois carrier, we don't pay premium taxes in the state anyway.

MR. BRYAN GILLESPIE: Mr. Burbank, it seems to me that with hospital lengths of stay declining by 10 or 15 percent within the last year, and more surgical procedures being performed on an out-patient basis, that the number of hospitals or hospital beds in the country is likely to decline in the next five or ten years. Do you have any projections on that?

Mr. Sorbo, it seems to me that HMO growth is constrained to the extent that you can't get physicians to work for the HMOs. How long is it going to be before HMOs have problems getting enough physicians to work for them if they continue to expand at the rate they have been expanding in the past?

MR. BURBANK: In the future I foresee some of the hospitals basically being bankrupt, such as the one in Richmond, California (Richmond Hospital) across the bay. It's going to happen, because of competitive pressures from PPOs, HMOs, and the like. Humana basically plans to expand its hospital bed capacity as we increase the market penetration from our insurance and HMO activities.

MR. SORBO: I think that even the closed panel plans may not have difficulty hiring physicians for the foreseeable future. The IPAs and the group practices and many of the closed panel plans are using contracts with medical groups to expand so they become kind of a high bred, closed panel staff with hired physician employees and medical group practice models contracting with ten or twelve small (three or four) primary care doctor groups in the community. Some of the group practice or closed panel plans are also investigating the possibility of expanding in the market through an IPA mechanism. This would be through a contractual arrangement exclusively with primary care physicians who practice individually in their office rather than in groups. That's the way many of them are expanding currently. So I don't think there is going to be any effect or impact on HMO growth due to a shortage of physicians to the HMOs.

MR. CARTER: I've always thought finding good statistics on HMOs was

like nailing jello to the wall. Do you know of any good sources of statistics on HMO experience?

MR. SORBO: I understand there is a group in the trade association, the Health Insurance Association of America, that has been commissioned to study this problem of developing some reliable statistics for HMOs. There are various documents that are available from the federal government and published quarterly by the Office of Health Maintenance Organizations. Those tend to cover only a small percentage of the total. By looking at the experience reports of their clients we know that a lot of the numbers are not consistent. There is a terrible lack of consistency in the definition that is used to produce utilization data reported to the federal government or to the state governments. In Minnesota, all the HMOs are subject to regulation under the Health Department rather than the Insurance Department. They do report annually to the state and the state published fairly extensive documents of fifty to sixty pages with what seems to be a wealth of data, although looking through the statistics, there is a terrible lack of consistency. So, there isn't anything standard and reliable on statistics right now, and I don't know how many years it is going to be before there will be anything.

MR. JOSEPH W. MORAN: I am interested in the PPO operation that Provident established with respect to the secondary impact of having entered this program for your one major client in Winston-Salem. How did that impact on your dealings with other group customers located in the same area and their employees, other patients of the same doctors who were not insured under that one major carrier's group plan,and so on?

MR. HOMANS: We didn't have a lot of business in that particular community. The PPO is available for other employers. The Hanes Group assisted in setting this up. But this is not something only for that company, it's available for any employer. In fact, for this PPO to really be profitable, we need more than just the Hanes employees.

MR. CARTER: If a large self-insured employer let a federally qualified HMO come in, it might actually raise the cost of the medical plan. For example, if you allow a federally qualified HMO to come in and solicit four thousand or five thousand of your employees out of fifty thousand most likely they are going to be the very young employees who don't file any claims. You still will be left with the claims on the rest of your people and will be paying the HMO a fee for a pretty rich plan.

MR. SORBO: A lot of companies are very concerned about the trends of 60, 70, and 80 percent of their employees converting to the HMOs. There are three, four, or five major employees in Minneapolis with five thousand or more employees that have seen this. The lower utilizers tend to convert to the HMO, and the 10, 20, or 30 percent remain to be a much higher cost than average. Over three or four years, 80 percent of the employees end up in the HMO. The employer's cost could increase due to this phenomenon because when the penetration of the HMO reaches 30 or 40 percent, the employer's self-insured cost for what's left may rise or has risen above the HMOs cost.

Employers are looking at alternatives for determining their contribution rates to the HMOs to try to adjust for and anticipate this result. Some employers who have seen this happen are analyzing the demographics of the enrollments in the HMO and in the indemnity plan and making adjustments to their HMO payments to try to stem the tide.

The approach has been based simply on the demographics of the people switching to the HMO. They take a look at the demographic mix of those people and develop a theoretical cost if those employees remained in their own insured plan. They pay that amount to the HMO rather than the actual and self-insured cost because the people that have enrolled are mostly younger. That hasn't been a real savings either in some cases because there are a lot of offsets. Just taking the age and sex as a basis for making your adjustments is limited, because the HMOs draw a lot of females and get a lot of maternity. When you balance that with some of the age results, the demographic factors alone may not produce the results you want.

MR. MYERS: There has been reference to the great difficulty in obtaining data about HMO enrollment. I wonder what proportion of actuaries who are interested in medical care and health insurance as evidenced by the group here belong to HMOs? It looks under represented.

MR. MARTIN STAEHLIN: Will anybody on the panel take direct issue with Mr. Burbank who said that health care as we know it won't be here in five years? Is there any proponent on the panel for the status quo and the traditional actuarial view that it will be about the same and that HMOs and PPOs will grow for a couple of years and then slow down?

MR. FLICKNER: In Atlanta, Georgia, we have five HMOs all of which are technically insolvent, but about breaking even. All the huge investments in these are subordinated loans; some are federal loans and some are from their parents like the John Hancock and the Prudential.

Within the next year, Atlanta is going to have five more HMOs, that will make ten in a city with about a two million metropolitan population. Can all ten of those survive?

I have heard that there are about three thousand doctors in the metropolitan Atlanta area. They have never had trouble getting doctors for group models. One HMO has about nine hundred physicians in it's IPA, and the enrollment at the first of the year was around 55,000 people. So we will be very much interested in seeing what happens with the HMOs. I feel that the HMO is going to take over in the city of Atlanta. Blue Cross/Blue Shield in Georgia is looking very seriously into HMOs and is going to have one, not only in the city of Atlanta but I suspect all over the state.

MR. JOHN F. FRITZ: Mr. Burbank, in the Humana plan, do you use some kind of hospital preauthorization program and if so, who does the preauthorization? Do you do it yourself or contract outside, and if you

do, how is it working?

MR. BURBANK: We have a patient care coordinator that basically manages the patient. As far as the preauthorization, we have put it in two of our markets. It is working, but we don't know how well yet because it hasn't been in there long. We have hired a person that sets up the Professional Standards Review Organization (PSRO) system for the federal government to run our utilization review system. We prepare for the patient's discharge the day they are admitted. It is more a patient management system, and we will have it in all markets once it gets up and running. After all, we have only been in business a year.

MR. CARTER: Suppose a large employer went to a steprated basis and varied between male and female, and then he paid the insurance company those rates although it's a self-insured plan? What would that do to an HMO? Would he have to use an average rate to pay the HMO or could he use a step-rated basis for paying the HMO? And if he could do that, might that really stop the penetration?

MR. SORBO: No doubt it would, if it is a federally qualified HMO. It would be perfectly legitimate to use those step-rates as a mechanism for taking the HMO age/sex composition and come up with an average contribution rate for the HMO. I think that has been tried in a couple of cases.

MR. CHARLES OSTHEIMER: The cost containment features in the plans I've been working on are being installed simultaneously with the offering of HMOs. I've been seeing antiselection against the HMOs. The people going to the HMOs are getting the full benefits. They need the benefits and are using the HMO substantially. Meanwhile, as the plan goes to an 80/20 full comprehensive instead of first dollar coverage, the people who still want that first dollar coverage will shift to the HMOs. One client didn't want HMO penetration just for administrative reasons. Corporate clients pushed for HMOs as a cost containment device.

MR. HERBERT A. FRITCH: American Airlines is self-insured and went to an age-rated contribution toward HMOs. HMOs whether the federal government knows about it or allows it are going to an age-rated premium.

MS. TRASKA: You have been saying there are three major mechanisms in controlling costs in PPOs and HMOs. One of them is utilization review. The second is risk-sharing by providers. The third is selective contracting, which eventually means that not all hospitals will get contracts and not all physicians on the hospital staff or in the neighborhood can be in a PPO or HMO.

MR. MC CASKEY: On a conceptual level, that's basically it.

MR. CARTER: Some of these PPOs are very restrictive. I think the Metropolitan is setting up PPOs which are basically closed, and they will choose the doctor. A lot of these PPOs will use any insurance company, unfortunately, so it is not necessarily that restrictive.

MS. TRASKA: If we are moving towards selective contracting and towards control of utilization in one or more settings, are we not also eventually moving toward capitation and may soon see a day when a standard contract is really the minority among all the different contracts the insurer might have?

MR. BURBANK: I see people in either PPOs or HMOs or some such type. Blue Cross of Chicago has sixty-two hospitals signed up in their PPO. We've got our own hospitals that have contracted with our competitors through a PPO system, giving them more discounts than they give us. Louisville, Kentucky with twelve has four with Humana, four with Blue Cross, and four with Preferred Health Plan. Everyone has taken sides, we now have three major factions in the city. Doctors in California sign up with HMOs for a salary of $50,000 to $75,000 a year as long as their malpractice insurance is paid for. That's going to continue throughout the country.

MR. MCCASKEY: Humana is part of the Blue Cross preferred provider network. We just made a bid on our state employees' group. Humana was, of course, a part of the preferred provider network that Blue Cross bid, and I understand Humana also put in an independent bid along with about forty some other institutions. All I can do is wish the consulting actuaries well.