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THE SMALL EMPLOYER'S CONCERNS IN CHOOSING A HEALTH BENEFITS PROGRAM

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- What factors affect the small employer's choice of programs?
- How may the small employer capitalize on recent developments in managed health care?
- What problems do insurance companies have in marketing and communicating their plans to small employers?
- Are partially self-insured benefits a threat or an opportunity for carriers in this market?

MR. HENRY ESSERT: Peter Drucker states that "marketing is so basic that it cannot be considered a separate function. . . It is the whole business seen from the point of view of its final result, that is, from the customer's point of view."

My presentation looks at our business from the customer's point of view. With respect to finding out what customers think, there is no substitute for actually asking them. More frequently, however, the information used by insurance

carriers comes from a secondary source -- from people in your organization that have direct customer contact, such as those in sales, service, or administration. The problem with information from these sources is that it may be biased. It is generally unorganized and does not cover the universe of all potential customers.

Market research is an efficient process for organizing data about the whole universe of your potential customers. It is objective, primary, and with proper design, it is unbiased. The information that I'm going to present comes from a market research study called the Group Insurance Strategic Issues Study. Our study is the result of 1,000 telephone interviews with the person in the organization identified as most responsible for decisions regarding group employee benefits. The study is national in scope, with proportional representation from each state. Interviews were conducted from March to May in 1985. The sample was restricted to groups between 2 and 99 lives. The emphasis of the study was primarily on major medical.

A couple of general observations are noteworthy before we look at some of the detailed findings. Variations in attitudes and behavior based on employer size were much less significant than expected. There was some variation, of course, but not enough to generate meaningful segments based on group size. However, there was significant variation among different geographic regions. The variation by geographic region was larger than expected, but not so large that we will need to make this segmentation to get an accurate overall picture. The data that follow are based on the entire national sample.

Let's have a look then at the factors that employers consider in selecting a benefit program, specifically how they select a carrier.

Employers were asked to rate the importance of 13 different factors on a numerical scale. The order of the factors is based on the accumulation of these numerical values. The top five all rank very closely in value. The claim and service reputation of the carrier ranks first, followed by the general reputation of the carrier. Price ranks high, as does design of benefit program. Cost containment features rank fifth.

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Some factors that didn't make the top of the list are employee communication materials, a high Best's rating, the recommendation of an acquaintance or business associate, and the sales presentation of the carrier. Of all 13 items, the availability of a preferred provider organization (PPO) was lowest on the list.

To get more information on the importance of the factors, we forced the respondents into choosing only one of the 13 as the single most important. The results were interesting.

30% picked price as the single most important factor. Claim and service reputation and the design of the benefit program were each picked first by 20%. Only 3% picked cost containment as the most important feature, and less than 1% picked PPO availability.

While it's almost impossible to look at price in absolute terms, we can look at it in relative terms. In other words, relative to an employer's current premium, what renewal rate increase would cause an employer to change carriers? Later we'll also look at what premium savings a new carrier must offer in order to cause the employer to change.

The study develops a whole range of lapse rates. 11% of the respondents indicated they would be very likely to change carriers if their next renewal rate increase is 5%. With a 10% renewal rate increase, 29% would change carriers. In actual fact, the average rate increase of all respondents at their last renewal was 7.7%, and 19% changed carriers. This is very close to what our lapse table would predict if we interpolate between the 5% and 10% value. Another way of looking at price elasticity is to ask: What rate reduction would a new carrier have to offer in order for the employer to change carriers? Some examples from an extensive lapse table developed are as follows. A rate reduction of 5% would cause only a small number to move, 6% to be exact. A 10% savings would cause 26% to change. A 15% reduction is enough to move 41%. You must agree that price is a significant factor in selecting a carrier and a benefit program, but it is by no means the only significant factor.

Claim and service reputation ranked highly. It was the single most important factor for 20% of the respondents. While it is a little harder to put numbers around this factor, dissatisfaction with service does have a measurable impact.

In terms of satisfaction with the respondents' present carrier, 60% are very satisfied, 30% only somewhat satisfied, and 10% are dissatisfied. By correlating satisfaction with specific attributes with overall satisfaction, we found that dissatisfaction with claim turnaround time specifically was the major predictor of overall dissatisfaction.

When we looked at price elasticity segmented by level of satisfaction, we found, as expected, that dissatisfied employers are much more likely to lapse. For example, when faced with a 5% renewal rate increase, 33% of the dissatisfied respondents will lapse, compared to 11% for the sample average. Clearly, claim service is a factor of some importance.

Before we talk about benefit design, and cost containment and managed health care in particular, we'll look at another carrier selection factor of a somewhat different nature.

The broker or agent plays a major role. When employers change carriers, they frequently change brokers as well. And when they change brokers, they almost always change carriers. Of all respondents who have been with their current carrier less than one year, 33% also changed brokers in that year. Of all respondents who changed brokers in the past year, 85% also changed carriers.

Respondents were asked about the role that brokers played in selecting a carrier. 28% accepted the brokers recommendation of a single carrier. 40% accepted his recommendation as the best from a short list. In other words, almost 70% followed the brokers recommendation as to the carrier they should select. For a further 9%, the broker at least selects the final list. Only a small number, 17%, make their carrier selection without a broker or agent.

80% of the respondents have one or more cost containment features. Voluntary second opinion is the most popular feature, in place for more than half of the sample. Preadmission testing and home health care are less popular but have

more than 30% penetration. Mandatory second opinion, employee assistance programs, precertification, and hospice care have a moderate popularity. Subsidized access to fitness facilities and a requirement that only certain doctors or hospitals can be used are less popular but are more popular than wellness programs and rewards for detecting hospital billing errors.

It is interesting to note that from the total list of eleven items, 31% have four or more items included in their plan. 10% might be called "heavy users," with six or more features in their plan. This concept of a heavy user becomes important when we look at plans to add cost containment features in the coming year.

We were surprised to find that only 12% of the respondents have plans to add more cost containment features. But the willingness to add more features is higher among already heavy users. For those that have four or five items now in their plan, 14% have plans to add more. For those with six or more now, the heavy users, 19% plan to add more.

Let's look at two more cost containment items, which are better referred to as managed health care delivery. Of the total sample, 9% have a PPO option in place and 12% have some employees enrolled in an health maintenance organization (HMO). Of greater interest though is the customer's perception of these two forms of managed care. Only 24% of the sample believes PPOs reduce costs, compared to 41% who believe HMOs reduce costs. Among PPO users, only 34% think PPOs reduce costs, while 58% of HMO users see a cost savings from HMOs.

As expected, HMOs have the edge with respect to a perception of improved quality of care. 17% believe PPOs improve the quality of care. This percentage increases only modestly among PPO users, to 22%. Twice as many, 34%, think HMOs improve the quality of care. This increases significantly to 50% of HMO users.

Overall, the respondents definitely had a better perception of HMOs than PPOs. Perhaps it's not surprising then that only 3% of the employers sampled plan to add a PPO in the next 12 months.

I'd like to summarize these findings, with an emphasis on what the customer's point of view means as far as future marketing directions in the small group market.

Our first conclusion is that service must reach what we might call a threshold level. The employer has a sense of cost and value and the trade off between cost and value; but service, particularly claim service, must reach a certain level before the product has any value, regardless of cost. Once this service threshold has been reached, the employer is very cost sensitive. If we put these two ideas together, it would appear that efforts to improve service after a threshold has been reached would be counterproductive. In other words, the buyer is generally not willing to pay for a lot of "bells and whistles." Carriers that are not providing service at the threshold level should devote their efforts to reaching this level. Those that are already there would be wasting their time trying to improve service, if this improvement means an increase in cost.

The third point is that cost containment is cost/value driven. It appears to me that employers generally have a different view of cost containment than we do. Except for a handful of heavy users, employers don't distinguish between the benefit features that we call cost containment features and all the other restrictions, exclusions, and definitions that make up a group health plan. Small employers look at cost containment as a cost/value issue. Unlike large employers that include features based on whether or not they see them as reducing their own claims, small employers compare different plans offered by different carriers, some with and some without cost containment. Their choice will still be the most cost-efficient plan, assuming threshold requirements are met, generally regardless of the specific features that this plan includes.

The fourth point is that HMOs are well regarded, better than PPOs. PPOs generally fit into the list of other cost containment items, but HMOs are perceived as a different entity. This is not to say that HMOs are not without their own set of problems, but all things considered, it would seem their long-term future is brighter than the PPO movements.

The final point is the broker's influence in this entire selection process. We have seen that his influence is substantial but also somewhat complex.

The broker is a filter between the customer and the carrier. To assume that the broker is the only force in the carrier selection process is a dangerous oversimplification. The broker's business survival depends on his ability to understand, interpret, and react to his client's needs. The action of the broker is primarily driven by his needs and your customer. However, he is also driven by other forces, among them his commission and other remuneration.

A strong conclusion from our study was that this issue, of the broker's influence, is an important one that needs further study. We are at the present time conducting a nationwide survey of independent brokers which we expect will provide some significant insights into this entire issue.

MR. HOWARD J. BOLNICK: Celtic Life is a small group specialist. Our Horizon product, for groups of 1 to 25 lives has become an industry leader since its introduction in 1981. We have developed innovative approaches to underwriting, claims, and product features. With our administrator, Dun & Bradstreet Plan Service, we have constantly improved the administrative service offered our producers and insureds. Being "innovative" and "easy to do business with" are the bases of our business.

My presentation concerns a most important topic: Can we provide cost containment to small employers? The topic is important since there has been a *revolution* in health care delivery systems. The revolution arose mainly from cost containment concerns of business and government. We are asking whether small businesses can participate in the now well-established cost containment revolution or, because of their small buying power, will small businesses be passed by and left only with increasingly expensive alternatives to their medical expense insurance needs?

I believe that small businesses *can* participate in the cost containment revolution. However, their form of participation is not as simple, nor perhaps as effective as the strategies devised for large groups. Once again, small business insurance programs are different from those for larger groups.

At Celtic Life we have spent the last two years studying cost containment and devising strategies and products for the small group marketplace. We presently have two PPOs, one in southern Florida and another in southern California. We also are very excited about the introduction last month of our Hospital Certification Program option to our standard Horizon benefit package.

Part of our thinking at Celtic has been that companies compete on the basis of business strategies as much as specific products. I will talk about the strategy Celtic has developed for introducing a product for small groups. Basically, I will describe a few key characteristics which show that our current product is an indemnity product, which is going to evolve into three different types of products. Over the next five years, we see the current indemnity product offered by all insurers, evolving into a three-tier product market.

The first tier is our current *indemnity product.* This product is characterized by complete freedom of choice of medical care provider by each insured with no control by the insurance company over the medical appropriateness of care given to insureds.

The second tier is a *utilization management product.* This product features freedom of choice of medical care providers by each insured, with the insurance company screening the medical appropriateness of care. Screening can involve prior authorization of hospitalizations (precertification programs), second surgical opinions, mandatory outpatient surgical procedures, concurrent hospital stay reviews, and case management of large claims. The most visible and important of these options is the hospital precertification program.

The third tier is a *managed care product.* This product uses doctors and hospitals contracted by the insurance company to provide medical care to insureds. All medical care is also carefully screened by the providers for medical appropriateness. Managed care products include PPOs, exclusive provider organizations (EPOs), and HMOs.

All three tiers currently exist in some form. We feel that all three tiers will continue to exist, although insurers' product mix among the tiers will change with time and the products within each tier will evolve.

Let's look at each of these three tiers and examine the special problems small group insurers encounter in developing effective programs.

Indemnity products pose no special cost containment problems, nor any special opportunities. As with larger group products, benefit changes and voluntary cost containment programs simply do not work.

For example, paying greater benefits for outpatient preadmission testing or voluntary second surgical opinions may even result in a net increase in claims. Even mandatory second surgical opinion programs on selected procedures not tied to a thorough utilization management program have reported only a modest effect.

In contrast, cutting first dollar benefits by increasing deductibles and coinsurance have some cost containment effect beyond merely reducing benefits. However, these tactics are not well appreciated since they smack of simply cutting benefits and not encouraging more careful use of medical care services. This is not real cost containment.

We feel that trying cost containment without using Utilization Management or Managed Care Products is ineffective. This is because voluntary incentives for cost containment do not change physician or insured behavior. To be effective, cost containment features must change the way medical care resources are used.

Indemnity products, though, retain great favor with producers and small businesses. They simply will not vanish as some observers predict. They will, though, become a less important part of the insurance industry's product portfolio. The cost of maintaining freedom of choice and avoiding a review by the insurer of medical appropriateness will increase relative to other products.

Utilization management products, which feature freedom of choice and review of medical appropriateness, in our opinion quickly will become the standard small group product, because these products offer a real premium savings of 5% to 15% without asking insureds to choose to use a limited number of medical care providers. This happens because a review of medical appropriateness does change physician behavior. In addition, producers do not have to involve

themselves in the choice of medical care providers in order to make the sale. Utilization Management Products also work anywhere and everywhere. Most feature a phone call to a precertification administrator who then determines medical appropriateness. Anyone, anywhere can use this system. This means national distribution of a Utilization Management Product is possible.

Utilization Management Products are quite attractive. However, there are a number of significant problems that need to be addressed when designing them for small businesses. I am going to focus my discussion of problems on hospital precertification programs.

Small group insurers who hire one of the many free-standing precertification services to handle their medical appropriateness reviews will have serious difficulties administering their program. The high turnover in small business pools makes it very difficult to maintain two sets of accurate in-force records -- one with the plan administrator and another with the precertification administrator. If the precertification vendor does not access the plan administrator's computer files, there will be a significant number of precertification encounters on insureds whose coverage is not in force.

Precertification programs affect claim payment practices. It is easy to understand that a precertification encounter, which is approved by the precertification administrator followed a few weeks later by the claim being denied by the benefit administrator, has the potential for causing serious producer and insured relationship problems, and even serious legal problems.

Small group programs usually have preexisting condition limitations, a number of limitations and exclusions, and rescission rights if underwritten. The chances of an approved precertification encounter being denied for benefits, then, is much more than theoretical. A method for handling those problems needs to be given careful consideration.

Large employers choosing precertification programs for their employees usually have their own benefit department to educate employees and help them cope with administration of the program. Small businesses are usually not prepared to provide this type of employee support. No one other than the insurance

company, then, is in the position to install and explain the precertification program to employees. This places a great burden on the insurer. Unfortunately, many insurers are not up to solving this problem.

These are examples of serious problems that an insurer must face in developing a Utilization Management Product in the small business market. There are others. In fact, precertification programs in general have been criticized for their bureaucratic methods, their intrusion into the care of sick insureds, and their lack of uniformity and uneven quality. Smart producers must be careful in choosing a product to offer their clients.

Managed care products offer advantages to insurers not offered by Utilization Management Products. In addition to cost containment from medical appropriateness reviews, most Managed Care Products feature discounts from providers. These discounts can be passed along to the insureds through higher benefits or lower premiums. These products work because physician behavior is changed, and the physician gives you a discount for the privilege. Further, to the extent that the contracted providers have a local reputation for excellence, this reputation can be used in a focused marketing program aimed at the local service area. This is, of course, a departure from the national marketing approach used with the two other product tiers.

Managed Care Products present most of the same problems as the Utilization Management Products. This is because these products always include some type of review of the medical appropriateness of care. But in a well-conceived PPO, a precertification program is "invisible" to participating insureds. This happens because the physicians become responsible for triggering precertification, and not the insured.

One of the most difficult problems facing insurers is choosing Managed Care Product partners. It has been said that when you've seen one PPO, you have seen one PPO. This is true. Each new partner does business differently, wants different products, provides different data to its insurance company partners, and requires different administrative interfaces. You can easily imagine what a mess this is for insurers.

In addition, Managed Care Products create other problems caused by the restricted provider network. Small employers do not have the luxury of buying more than one medical care program for their employees. All of their needs must be fulfilled in a single insurance program. Thus, they are quite sensitive to the restrictions in a provider network, particularly if the purchaser's own physicians are not members of the network. For small businesses, the broadest provider network is the best network. However, the broadest network is usually the least effective network.

Because of this, producers seem to focus their sales efforts on the benefits and rates for those insureds not using the contracted providers. But the existence of two benefit plans, one for PPO participants and the other for nonparticipants, is in itself a negative. Employers and producers shy away from these programs because they are too complicated.

These problems have hampered the development of small-group Managed Care Products. Many such products are on the street. However, we have not seen any product with significant market penetration. This includes Celtic's own products. We think that we now understand how to package a product that will appeal to this market. But until we see solid results, we remain skeptical over the attractiveness of these products in the small business market.

I have only scratched the surface of the issues involved in developing Utilization Management and Managed Care Products. Despite significant problems, these alternatives to Indemnity Products will grow. In fact, we expect our Utilization Management Product to be about 50% of our in-force business and Managed Care Products to be about 20% of our in-force business in five years.

Mr. Essert mentioned the 13 possible reasons for selecting a small group carrier. As you'll remember, the top reason was price, which was about 30% of the respondents. This was followed by design of benefit programs and the claim and service reputation of the carriers right at 20% of the respondents. The general reputation of the carrier was most important to 10%. Finally, cost containment features were most important to 3%, and a PPO was most important to less than 1% of the respondents.

This is not a very encouraging degree of sophistication and understanding of true cost containment within the small employer market. That, of course, contrasts significantly with studies that are done in the larger group market. In 1984, TPF&C asked these same types of questions of larger employers. With larger employers, there was a great deal more interest and feeling that PPOs were a very important part of their cost containment package. There is a real contrast there between small and large employers.

We've got a problem, and to reach our goals means that insurers will be spending a great deal of time in the next few years developing and refining cost containment products. The winners will be those insurers who understand the problems and continue to refine their approach. Those will be the industry innovators.

So, we do see a future for small businesses to participate in the health care revolution. But this future is not without traps for you, the producer, and your small group clients. Poorly planned programs will be commonplace. Selling them may entail the risk of being embarrassed.

MR. THOMAS R. CASNER: What types of incentives are you thinking of in plan design that would generate that 10-15% cost savings through precertification? It seems that you've got to have some kind of incentive with someone to realize those savings. In other words, if you're saying that the physician is the gatekeeper, which I somewhat agree with, you still have to have some kind of incentive for that physician to do something, somewhere in your plan design. If you do that, then you've got the PPO. In your second level where you have the opportunity to go to any provider, how are you encouraging that person to follow what the certification says to do?

MR. BOLNICK: First, there is the matter of communicating to them what the rules of the game are, that there is a program to go through. This is not so easy because there's nobody to help you, and we don't have a direct relationship with the employer. Second, there's a penalty, and the design of the penalty itself is a kind of an art rather than a science, because if it's too large you can run some legal risks, and if it's too small, you're not going to get anybody's attention. There have been some programs in the small group area

that offer greater benefits for precertification. I don't see quite how it's going to work. In the small group area, virtually all the programs have a disincentive as a penalty-type approach. What we do is a little bit less than what many do. We normally see a 50% coinsurance factor if it is not certified. We knock 20% of the charges off the top and throw them out as ineligible expenses and then adjudicate the claim on the remaining 80% of the charges. This is subject to a minimum penalty of $300.

MR. ROBERT A. ALEXANDER, JR.: The small case market for group health benefits is important. According to the *Statistical Abstract of the United States*, 55% of all working Americans worked for companies or other establishments with less than 100 employees in 1982. In the United States today, there are some 14 million small businesses. The potential for sales in this market is large; at Transamerica Occidental, we anticipate that about half of our new group premiums will come from groups of less than 100 lives this year. At the same time, the need for more insurance in this market is also large. A study by the American Hospital Association indicates that about 9 million Americans were employed but uninsured in 1983, and most of them were employees of firms employing less than 100 people. When you take the dependents of these people into account, there were about 21 million people without health insurance in 1983. Creating health insurance plans that would make insuring possible for the employers of these people has a vast potential, not only for increasing sales but for providing a vital service to a large segment of the population.

I will define small groups as cases with under 100 employees. The market for such small groups is far from homogeneous, so any generalization which I can make about the marketing and communication problems involved in selling to such groups will necessarily be limited. My comments also may be biased by my method of research, which involved interviewing various home office personnel and field marketing managers using a list of questions which I developed. All of the regional managers to whom I spoke were eager to help provide a field perspective on the problems they face in marketing. On the whole, the input I had from them was very informative, and I would recommend an occasional talk with the field as useful to any actuary to get a marketing perspective.

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One of the primary characteristics of the small case market is its volatility. One might suppose that small employers would develop loyalties to insurers who had served them well over the years, even in cases where larger corporations might change carriers for a marginal price advantage. In fact, large corporations seem much slower to change insurers than small companies. When a big firm changes insurance carriers, detailed negotiations, lengthy internal discussion, and large amounts of paperwork are required. In changes of that magnitude, sometimes the professional lives of employee benefit managers are on the line. This introduces an understandable element of conservatism into a big firm's willingness to change insurers. In small firms, the employee benefits department is often limited to the boss's secretary, who spends a few hours every other week filling out insurance forms. Such firms have nothing to lose by changing their insurer as frequently as they find what they believe to be a better deal.

What constitutes such a better deal seems to be primarily one thing -- price. When I suggested "reliability," "reputation," or "service" as a selling point, the reaction of our marketing people was that yes, insurers have to satisfy certain minimum standards for dependability, but the other admirable character traits of the insurance company were fairly old hat and, therefore, relatively unimportant. On the other hand, a "ten point" price difference could often be a sufficient incentive to get a small employer to change carriers. And prices do vary. A Small Group Competitive Survey compiled by a consulting firm shows up to 70% differentials in major medical rates for roughly equivalent coverage of the same group in the same area. However, the survey uses a definition of "roughly equivalent coverage" which places plans with deductibles differing by up to $250 in the same category and therefore may be misleading.

Important plan features other than price vary by area. In most areas a first-day hospital copayment was unacceptable to many employers. In some areas small ancillary benefits like nursery care, well baby care, and first-dollar accident coverage were very important marketing tools, especially when trying to introduce a product with cost containment features such as hospital precertification into an area for the first time. Only in one region in my survey did a marketing person cite having a large preferred provider network as something critical to successful selling.

The price-consciousness of small employers might lead one to believe that cost containment features such as utilization review programs would be extremely popular with them. In fact, small employers tend to be either indifferent or unfavorably disposed toward such programs per se. Lacking the concern that an experience-rated or administrative services only (ASO) policyholder would have with his actual level of incurred claims, the small employer is not as concerned with the success of cost containment programs. For the small employer purchasing a pooled product, health insurance is a "black box"; a defined amount of money goes in, and services of a defined scope and desired quality come out. A utilization review program or a PPO are things that a small employer may agree to put up with in exchange for an up-front reduction in rates, but the ultimate success of such programs in producing savings for his specific group is largely a matter of indifference to him. In this sense, small employers may be involved with managed health care, but only large employers and insurance companies will ever have a real commitment to it. An analogy could be made to a breakfast of bacon and eggs -- the chicken is involved in producing your breakfast, but the pig is committed to it.

Small employers may also lack the employee benefits sophistication to cope with managed health care programs. Several of the marketing people I interviewed said that small employers especially tended to shy away from utilization review programs, although they could usually be convinced of the value of such programs if adequate time was available to explain the program to them. Also, the lack of an in-house employee benefits staff in small firms often makes providing information on hospital precertification and other requirements to employees very difficult. Typically, a fairly good effort is made to inform employees of any preauthorization or other requirements in their plan at the time of installation, although even this depends on the diligence of the agent or broker. However, as time passes and new employees join the firm, there are frequent failures to communicate the requirements to them. This can result in denied claims and ill will towards the insurance company. Our company's benefits office manager in Orange County, California, reports that, in general, small groups seem to generate more difficulties for his staff than larger groups. In addition, he noted that insufficient understanding of precertification requirements was a principal problem. He suggested that one approach to assuring better understanding of utilization review programs in southern

California would be to publish the requirements of such programs in Spanish, although he also noted that a significant portion of the employees we insure in his area are illiterate in both English and Spanish. Another consideration would be to install an 800 toll-free number staffed properly.

It was the impression of the marketing people to whom I spoke that the majority of insurers offer some type of utilization review program, either as an option, or as a standard part of all plans, as is the case with my own company. The industry standard seems to be a simple telephone precertification for hospital admissions, with a coinsurance penalty for noncompliance. Mandatory second surgical opinion programs are much less common, as are concurrent review, discharge planning, and other more complicated utilization review features. Many insurers use outside vendors for their utilization review programs, although some large firms, such as the Prudential, have developed their own programs in house. Typically, utilization review programs are not terribly sophisticated. Usually, precertified lengths of stay are based on the Professional Activity Study statistics of the Commission on Professional and Hospital Activities. The programs are staffed by clerks and a few registered nurses. However, a few vendors seem to have significantly more sophisticated programs, involving telephone consultations with their own staff physicians and complex tracking and analysis of utilization on an electronic database.

To the small employer, however, these details are unimportant. As far as he or she is concerned, the credit that the pricing actuary gives for various utilization review features in a plan is the absolute, bottom-line value of those features. The size of such credits, balanced against the perceived difficulties or problems with a managed health care program form the basis for a small employer's choice of plan. In fact, from the employee's standpoint, there may be a two-pronged problem -- he may perceive the lesser benefits to make a second class program, while the employer is enjoying a premium reduction.

After conversing with consultants and our staff at Transamerica Occidental, I have a feel for what the approximate magnitude of savings that various cost-containment features are assumed to generate in the industry in general. A utilization review program, involving preadmission certification and some kind

of punitive decrease in benefits for noncompliance, is often credited with generating gross savings in the range of 8 to 12% of claims, offset by the cost of such programs, which comes in at 1 to 5%. These figures are obviously dependent on the insurer's choice of utilization review vendor and also on the underlying benefits. High deductible plans, particularly those with hospital admission copayments, are much less likely to benefit from a utilization review program than more liberal plans.

It was also the opinion of some of the actuaries to whom I spoke that additional utilization review features beyond precertification may sometimes not generate sufficient savings to justify themselves. More aggressive utilization review programs involving greater intervention on the part of the insurer or higher penalties for noncompliance may also have adverse legal implications. In California, at least, legal precedent exists for viewing the employer as an agent of the insurer in informing employees about benefit plan provisions. Thus, if the employer fails in his communication duties, as is frequently the case with small groups, the insurance company is legally at fault. Also, having more input into actual patient care decisions puts the insurer on the edge of legality with regard to statutes forbidding the corporate practice of medicine which have been adopted in many states.

Regional differences play an important part in determining the marketing problems which insurance companies in the small group market face. Vast regional differences exist in the availability of managed health care alternatives; the relative position of private insurers and the Blues in the competitive pecking order; the sophistication of small employers with regard to health care alternatives; and even the basic expectations of employers regarding their health plans. For example, in St. Louis and Chicago I was told that Blue Cross was the major force in the group market and could routinely offer rates 15 "points" below those of private insurers. In Albuquerque, however, Blue Cross was said to get only the kind of business that other insurers would refuse, while in San Diego I heard that they had lost most of their business several years before during a period of severe problems with their claims system. Having a good PPO network which included certain key tertiary-care hospitals was presented to me as an absolute necessity for success in San Diego. But in St. Louis, PPOs were only beginning to emerge as an important

selling point. Our person in Phoenix indicated that ancillary benefits seemed relatively unimportant in his area, but in St. Louis not having first-dollar accident coverage was cited as something that could routinely lose cases to other insurers.

In general, the direction of change seems to be uniformly toward greater insurer involvement with health care providers and greater availability of health care options. However, various regional markets vary greatly in their progress toward such change. Our Rocky Mountain Regional Group Manager described Denver as a progressive health care market, with high HMO and PPO penetration but characterized Albuquerque as "lagging five years behind" in this type of development. Thus, the interest in and acceptance of new types of health benefits can vary greatly by region. This is especially true of small employers, who lack that broader perspective of a large, national corporation. In addition, patterns of medical practice also vary significantly by area and may impact the willingness of providers to contract with insurers. A representative of a free-standing PPO described his involvement in physician contracting to me in this regard. In some areas, like Los Angeles, he was accepted and even welcomed by local doctors, but in smaller communities, he often felt that he was likely to be run out of town.

The importance of PPOs in the small group market is, naturally, one of the factors most highly subject to regional differences. In general, PPOs have been more often the domain of large employers who have access to such arrangements not only through their insurers but also frequently through preferred provider networks established by employer health care coalitions or through independent contracting with physician- or hospital-sponsored networks. However, small groups are gaining importance as a target for PPO expansion. A recent article in *Hospitals Magazine* cites the success of Celtic Life, a Chicago-based specialty carrier for employers with 25 or fewer employees, in marketing a PPO product. Similarly, an article in *Modern Healthcare* reports that the Baptist Health System has sponsored a PPO designed to meet the needs of small businesses. Insurer-sponsored PPOs will probably enjoy a slight advantage in the small group market, because of the insurance company's ability to offer complete health benefit packages of which a preferred provider network is just a part and because of the insurance company's ability, as a large

purchaser of medical services, to negotiate the best possible rate with providers.

A good network of preferred providers does seem to be an important marketing tool in a few, relatively progressive health care markets. As with utilization review programs, however, the PPO concept probably initially will be viewed by small employers as something to put up with in exchange for an up-front reduction in rates. The magnitude of this reduction seems, in the market in general, to be on the order of 10%, based on negotiated physicians' discounts of from 5 to 10% and hospital discounts of from 10 to 20%. The incentives for using PPO providers built into the benefit structure are also significant both in pricing and marketing. A survey of 14 insurance carriers showed that coinsurance differentials of from 10 to 20% seemed to be the standard incentive for PPO utilization. This survey also showed that, at present, few insurers have been willing to take a stronger, more punitive approach to encouraging PPO provider use. This attitude was echoed by the marketing people to whom I spoke, who felt that an incentive approach to PPO was the preferred approach; e.g., 100/80% coinsurance, rather than 80/50%. Transamerica Occidental has enjoyed good sales of its Equal Benefits plans, which offer employers not participating in our regular PPO program to receive a small rate discount for encouraging their employees to use our preferred providers -- the benefit to the employee being lower coinsurance obligations on account of our negotiated rates.

It is possible to isolate two other, seemingly contradictory trends in the small group market. The first of these is a trend towards simpler, more standardized products. At Transamerica Occidental, we have recently expanded our 2 to 9 life product to include cases up to 24 lives, while preserving the product's basic simplicity. We have minimized the need for underwriting intervention at issue, while simplifying marketing and administration by centering plan design on a few standard options. Having such a plan allows us to use the general agent and branch office marketing network of our individual line to take our product to a larger portion of the group market. This type of simplified, standardized product can be sold very effectively by agents without the specialized knowledge of group representatives and puts our foot in the door with a lot of potential customers who might not have heard of us otherwise. To draw

an analogy to individual insurance, we might compare this to the success of companies like Massachusetts Indemnity and Life with simple term life products marketed through extremely large agency forces with relatively low insurance background. We have designed a product not only to suit the market but also to suit the strengths of the sales force.

Running counter to this trend toward simplicity is a trend toward greater flexibility and complexity. Large segments of the under-100 life market now have access to alternative funding mechanisms previously available only to larger employers. Some competitors are now offering minimum premium plans, experience rating or stop-loss ASO on cases as small as 50 lives. In San Diego, our Regional Group Manager says that some brokers were inquiring about high-deductible plans which their clients could use as specific stop-loss coverage for partial self-funding. The marketing people expressed concern with the economic viability of such plans -- and marketing people are not noted for their excessive concern with pricing for future solvency. Their concerns are valid, and perhaps for the sake of our reputation as an industry, we need to consider carefully our willingness to share the risks of insuring with smaller employers, even when they believe themselves large enough to assume such risks.

Competition with HMOs is becoming an increasingly important factor in health insurance in general, and this is true as well in the small group market. Here again, regional variations in the market are very pronounced. Nationwide, *Business Insurance* magazine quotes a 6 to 7% penetration of the health insurance market by HMOs.

However, according to the California Hospital Association, 33% of the population of Los Angeles County were already enrolled in HMOs as of 1983, and in the Alameda-Contra Costa area of California, this total was near 100%. From a marketing standpoint, competition with HMOs may be negligible in some areas but insurmountable in others. On the other hand, the presence of a large, established prepaid group practice plan such as V.I.P. of New York or Kaiser Permanente in the West can be an asset to an insurer trying to sell the concept of a PPO or an individual practice association (IPA)-model HMO, inasmuch as these established plans have shown the local community that satisfactory health care can exist outside the context of traditional, fee-for-service practice.

Although many of the older HMOs have their roots in large union-trust cases, the importance of HMOs in the small case market should not be underestimated. A telephone survey of five Los Angeles area HMOs conducted by my staff revealed the following. One HMO (Pacificare) required a minimum of 40 employees in its groups. Three plans (Maxicare, HealthNet and FHP) were willing to quote on groups of as few as 25 employees, while one plan (CIGNA Healthplans) would handle groups as small as 2 employees. In Chicago, our company's group manager reported trying to sell 25-life groups and finding that 10 of the employees were already with HMOs. In Phoenix, I heard reports of a strong HMO presence down to the 10-life case size, and was told that some HMOs offered comprehensive and attractively priced conversion policies for terminating employees.

It is not overstating the case to say that the prosperity and even the bare survival of insurance companies in the group health business depends on our ability to compete in the marketplace with the HMOs. Here in the San Diego-Imperial County area, HMO enrollment increased from 0.4% in 1977 to 5.4% in 1983. This is still a fairly modest market share, but a 1300% increase in anything in six years is something that deserves serious thought. To compete with such growth, insurance companies have a choice of three major strategies.

The first of these is to accentuate and utilize the differences between HMOs and traditional indemnity plans to our advantage. On one hand, traditional comprehensive major medical indemnity coverage may become something of a luxury item in the future. If so, there will always be industries in which generous employee benefit packages are a vital tool in recruiting, and in those markets, the insurance companies will prosper. On the other hand, if the HMO becomes accepted as the standard for health care as it already has in some areas, indemnity plans may come to occupy the "economical alternative" niche which HMOs have traditionally occupied. Historically, HMOs have been forced into community rating schemes, most notably due to requirements for federally qualified status. An insurer offering age step-rating in the context of a cost containment product might be able to provide HMOs with some meaningful price competition for younger employees. In this way, the antiselection problems which HMOs have forced on insurers in the past might be alleviated or even reversed.

A second possible strategy for competing with HMOs is to evolve into something more like them. Group health insurance has evolved from simple hospital insurance to comprehensive major medical coverage; from flat scheduled benefits to usual and customary reimbursement; and more recently from discounted reimbursement to designated preferred providers. At the same time, the HMOs of today are no longer exclusively the actual physical "health care factories" of the past. Today, an IPA model HMO may own no clinic or hospital nor have a single salaried physician. Rather, the HMO may consist almost entirely of contractual agreements to provide for health care needs as they arise -- much like an insurance company. In the past year at Transamerica Occidental, we have been asked to analyze PPO plans with HMO-style low fixed copayment benefits, PPOs with hospital reimbursement based on diagnostic-related groups (DRGs), and plans with arrangements for profit-sharing with hospitals and doctors for reduced utilization, to name just a few. The EPO concept of exclusive providers of medical services is another recent development which further blurs the distinctions between PPO and HMO. This kind of hybridization between HMOs and conventionally insured products is just another response to consumer demands for more flexible and economical health benefits.

A final possible response to competition from HMOs, rather than developing the kind of hybrid PPO-HMO just discussed, is swallowing the HMO concept whole and adding it to your company's product line. The Metropolitan owns its own HMOs through HealthCare Network; Aetna is setting up HMOs through its joint venture with Voluntary Hospitals of Americare; Lincoln National is now working with United States Health Care Systems, an HMO firm, to offer HMO coverage; and Transamerica Occidental's joint venture with Provident and American Healthcare Systems will most likely involve an HMO product. The ability of a single company to offer standard indemnity, PPO, and HMO coverage will be an important advantage in the coming years. Having this ability will alleviate the traditional antiselection problems faced by insurers providing the indemnity plan option to an employer who also offers an HMO. From a marketing standpoint, the ability to satisfy all of an employer's needs for health care options will strengthen an insurer's competitive position, particularly with small firms who lack an in-house benefits staff to line up such options independently.

As an actuary for a large company, we tend to be somewhat compartmentalized at Transamerica Occidental, and it's educational to get out in the field once in awhile and see what goes on. For those of you who are with large insurance companies, I urge you to do the same. It provides a completely different perspective on the situation than you learn from simply staying in-house.

MR. ANTHONY J. HOUGHTON: Are partially self-funded benefits a threat or an opportunity to carriers in this market? I've been involved with these partially self-funded benefits, and I think they represent an opportunity for people selling in small group markets.

In the large group markets, self-funding has become extremely popular, and a large percentage of groups with over 200 lives have some type of risk sharing, whether it's ASO, minimum premium, self-funding, or whatever. For groups, say between 200 and 2,000 lives, most of these groups do obtain excess medical protection, so they do not assume full risk. They assume risk up to $10,000, $20,000, or $50,000 per person, whatever is suitable for their size group. These groups usually have some type of aggregate protection.

Ten to 15 years ago, "partial self-funding," was employers of 100 lives buying $1,000 deductible coverage for 50 to 55% of the cost of a $100 deductible plan, and then supplementing that insured plan with some coverage of their own. On an informal basis, they would pay the difference between a $100 deductible plan and a $1,000 deductible plan, at which point the insurance company's liability would begin. The problem with that approach was that, while they realized there was a limited out-of-pocket of 80% of $900 ($720 per person), they didn't know how to project the probable cost or the worst case. They weren't sure whether that cost was likely to be larger than the 50 or 40% of premium they saved by buying the larger deductible insured plan. What they needed was something that would give them assurance that, if they adopted a higher deductible plan and self-funded the initial costs, the self-funded part would not have an outrageous cost in any one year. And that is when some companies stepped in with a product they called partial self-funding, which was a true insurance contract with a high deductible, such as $1,000, $2,000, or $3,000, and then a separate employer's contract that limited his self funding cost.

Slide 1 shows a fairly typical example of this type of product. Let's take a group of 25 people in a low cost area which has an expected cost for a benefit plan of $35,000 for which a fully-insured premium would be $50,000. If the employer will take the first $2,000 of reimbursement, his cost could be expected to be $20,000; the expected cost for the excess of $2,000 would be $15,000. Assume that studies indicate that the risk charge for putting an attachment point of $25,000 on that employer's out-of-pocket costs, which are expected to be $20,000, would be $756.

Slide 1

Group size 25 low cost area

Expected cost $35,000 Gross Premium Fully Insured Plan $50,000

Partial self funded plan with employer paying up to first $2,000 per person. Expected cost under $2,000 = $20,000, over $2,000 = $15,000

Risk charge for attachment point on employers cost of $25,000 or 125% = .0216 X $35,000 = $756

Let's look at the premiums under the fullly insured plan and its retention components. Then let's look at the premiums under the partially self-funded product. On the fully insured plan (Slide 2), we are saying that $50,000 is composed of $35,000 of expected claims and $15,000 of retention, with administration costing $6,000; profit being $3,000; and commission and taxes, which are a function of the gross rate, being $6,000.

Slide 2

Gross Premium
Fully Insured

Expected Claims	$35,000
Commission & Taxes	6,000
Administration	6,000
Profit	3,000
Subtotal Retention	15,000
Total	$50,000

Let's suppose that the carrier sells that partially self-funded product (Slide 3) and let's assume that he builds into it the $15,000 for the claims in excess of $2,000 and his best estimate of the cost of the attachment point at $25,000 for the employer's share. His commissions and taxes will be somewhat less because his total gross rate is less. But let's say he has the same administrative expense because he is essentially going to do all the same administration for both plans. If he charges $28,000 (I picked that figure arbitrarily and worked backwards), his profits, instead of being $3,000, would be $2,884, a little less in dollars but more in percentage.

Slide 3

Gross Premium
Partial Self Funded

Expected Claim > $2,000	$15,000
Aggregate Stop Loss	756
Subtotal	15,756
Commission & Taxes	3,360
Administration	6,000
Profit	2,884
Subtotal Retention	12,244
Total	$28,000

Let's see how that appears to the employer as a marketing situation (Slide 4). The agent's presentation to him states the insured premium is $50,000, and that is the cost regardless of experience. Alternatively, the partial self-funded program will cost $28,000 in insurance premiums, and in the worst situation, the stop-loss limits the employer's self-funded cost at $25,000. Therefore, the highest possible total cost is $53,000, or 6% more than the employer would have paid for a fully insured program. The *probable* cost for the employer's self-funded share is $20,000, so the total cost with the insured premium will be $48,000 or less in more than half of the situations.

Slide 4

Partial Self Funded

Insurance Premium	$28,000
Maximum Employer's Share	25,000
Total - Maximum Cost	$53,000
Insurance Premium	$28,000
Probable Employer's Share	20,000
Total - Probable Cost	$48,000

The distribution of total costs may be as follows:

Under $48,000	55%
$48,000-$50,000	15%
$50,000-$53,000	15%
$53,000 exactly	15%

This shows that there are more groups gaining an advantage than those that pay more than the fully insured cost. Even those that pay in excess of the insured cost have only a modest disadvantage, not a financial catastrophe.

So by being able to offer the aggregate stop-loss, the product has become viable. The employer can see that he does not have much to lose and a potential for lowering his cost. He will be receiving current information about the employees' claim utilization. Some companies have been successful with this product in both marketing and financial results because it offers an alternative that avoids competition mainly based on lowest premium rates.

MR. JOSEPH W. MORAN: Would you expand on the question of the availability of HMO options to the employees of small business firms? In your survey, Mr. Essert, you didn't mention how many of the employers in the survey had a program under which an HMO option was available to individual employees and how that pattern varied by area, by size of group, or by any other characteristic. Then maybe the company people might want to discuss the question of how they

are approaching the problem of dealing with the availability of HMO coverage as an option to the coverage provided by the insurance companies.

MR. ESSERT: We found a variation in size. The actual size escapes me, but there is a law requiring employers over a certain size to open their doors to HMOs. I think that is 25 lives. We consequently found that there was significantly larger penetration in the smaller sizes. 12% is the overall sample. So, there were more employees in the plan enrolled in the HMO. We didn't get into how many employees were actually enrolled in an HMO. We simply asked the question, do you have the option available for your employees? So, we don't have any statistics with respect to how many employees took up that option. Our assumption essentially is that, for those that have it in place, someone will take up the option.

We also found the variation to be significant by region. I mentioned as a general point a lot of regional variation. This is one area where it was particularly pronounced. We found some states, some locations in the country in terms of census regions, to have a lot of HMO penetration, where others had almost none. But I don't have the actual figures.

What we draw from that is a lot of difficulty of HMOs actually marketing their product. They are not, as we see it, having a successful time at the smaller group end. If they devoted more effort to that, they might be more successful.

MR. BOLNICK: My comments refer to groups of under 15 lives or so. First, we don't see a lot of interest on the part of the HMOs to get in the market. Those that look at it realize that it takes a long time to grow a block of business and make it a big number. They are all in the numbers game of counting how many people they've got under contract, and it is more difficult in the small group area. Second, they don't have the ability to reach the market for two reasons. First, the normal marketing approach that they take using salaried representatives doesn't work well in the small group market. They haven't come to grips with the proper use of brokers, or very few of them have. Second, the small group is different, which is the important theme. Those HMOs that blunder into the small group market are going to have big problems until they realize that small groups have to be approached differently

than the larger group. So as small group carriers, we think we can sit around and ignore them, or, to be more positive, seek out people, and teach them to become partners with the HMOs in the marketplace. I think over the long run we'll see some of that happening.