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JOINT VENTURES IN HEALTH CARE FINANCING

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Panelists: STEPHEN H. BERKEY
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- o Joint ventures between Health Maintenance Organizations (HMOs) and insurance companies
- o Dual or triple option rating strategies
- o How are these ventures structured from a financial standpoint?
- o How are separate organizational objectives met?

MR. GREGORY N. HERRLE: As most of you already know, we are going through a very significant change in the financing and delivery of health care, probably the biggest change in the history of the United States. This change has led to a rapid rise in the growth of HMOs, PPOs, IPAs and CMPs and other forms of alternate delivery systems. It has led to a rapid increase in managed care products. As a result, employers have had to deal with a number of multiple options; a number of health care providers, adding to their administrative cost; and confusion they have with respect to what plans to offer to their employees.

Another question that has been raised is the question of adverse selection in a multiple choice environment. It is certainly a significant question for all of

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us as actuaries. There is an ongoing controversy as to who gets selected against in a multiple choice environment. Is it the HMO or is it the indemnity program? The result has been a frantic increase in the activity of joint ventures, associations among insurance companies, insurance companies with HMOs, insurance companies with hospitals, HMOs with hospitals and various other combinations. These have been some of the types of joint ventures to date. A number of companies have gone to a new approach -- the product strategy of triple option rating. The reason for starting some of the joint ventures has been to introduce triple option products, three products under one roof for an employer to ease some of the administrative burdens.

The first speaker on our panel is Bob Jackson. He is the president of Jackson & Associates, a consulting firm based in Atlanta, Georgia. He has been involved in the health care business for about 15 years and during that time has represented most of the major health care companies. Since 1981, Bob has participated in creating a number of the joint ventures of the type being discussed. Bob will talk about some of the general issues and questions that we may all have had to date.

Following Bob will be Stephen Berkey. He became an FSA in 1970, and a member of the Academy in 1971. He has been employed with Lincoln National for his entire career, beginning in 1965. He spent six years as actuary of Lincoln of New York. He returned to Fort Wayne in 1976 as Second Vice President in the Employee Benefits Division. He is currently a Senior Vice President in Lincoln National Life, President of Lincoln National Administrative Services Corporation, and also the President of Lincoln National Alternative Care Technologies. Alternative Care Technologies is the separate division within Lincoln that is responsible for its managed health care ventures. Steve will give us the perspective of an insurance company that has been involved with numerous joint ventures with HMOs and TPAs. He will concentrate on a couple of their ventures and present his reactions to date on those ventures.

The last speaker is Dave McLean. He is Senior Vice President of Corporate Development with American MedCenters in Minneapolis, Minnesota. He has been with American MedCenters and its predecessor organization for 10 years. He has over 15 years' experience in the health care field. Over the ten years with

MedCenters, Dave has had experience with and responsibility for strategic planning; product development; management information systems; and actuarial, rating and provider contracting.

MR. ROBERT P. JACKSON III: In 1983 I had an opportunity to address the Group Health Association of America, the largest health maintenance organization association in the country. The meeting, which was held in Dallas, Texas, was very upbeat. At that time, as you may recall, HMOs were really riding the crest of the wave. There were a number of entities being created and going public. There were many millionaires created overnight. The stock market was being very favorable to health maintenance organizations, preferred provider organizations and the whole range of alternative delivery systems. This was a very positive meeting and a time of euphoria in the sense that people were making a lot of money. There was a new idea in the wind. I saw stock multiples in those days as high as 60 times earnings. It was really incredible, but that was then. A great deal has happened in the last three, years and it is interesting that as we look at the same industry, we find that some acquisitions which took place during that time were probably commanding as high as $2,000 per member on acquisition. Now many of those same types of arrangements are down to somewhere around $300 per member. The stock price situation has deteriorated, and many of the HMO companies are under tremendous earning pressures. A number of the start-up entities have made marriages out of necessity with other organizations. It has been said that the only real certainty in business is uncertainty, and that has clearly been true in the case of the HMO and PPO business.

The health care industry is undergoing a mass consolidation, where organizations with a tremendous amount of capital and the capacity to raise large sums of money are beginning to take the forefront. I would like to focus on what that consolidation means from the standpoint of some of these joint ventures and to more specifically share with you some of the types of comments that I hear as I travel around the country.

Where we might begin is by posing the question, What are the objectives of the various types of organizations in developing a joint venture? You will find that each of the participants in these arrangements has its own ideas of what

its objectives are. For example, I was approached by an insurance company several years ago which had a very heavy indemnity health base in a number of major cities. It was concerned because it was concentrated in these urban environments and had been rather slow to embrace prepayment. It felt it was going to lose market share very quickly. This was a real concern to it, and its objective was to try to protect market share. At about the same time in another location, an HMO entity was at a point where it had grown very rapidly and steadily as a federally qualified HMO, but it had reached a point where it began to sense from its employer groups a need for change. The time had come to develop sort of a one stop shop, to be a full service vendor. It was necessary for this particular HMO company to develop a relationship so that it could meet all the needs of its employer groups.

As we begin to look at the joint ventures, we might take a look at some of the different perspectives and objectives that these entities have. I will begin with the insurance company. Insurance companies want increased profits. What we saw happening a few years ago was that suddenly the insurance companies began to realize that HMOs were somehow coming up with better pre-tax margins than they were able to generate themselves. As they began to study the problem and to understand it better, they concluded that many of the mechanisms that they needed in order to compete with this type of arrangement were already in place. If they took the time to learn what it was the HMO business was doing, it was quite possible that they could increase their profits dramatically without an associated increase in expense.

Also, there is the issue of protecting existing businesses and expanding market share. I have alluded already to the case of a carrier that was in 9 or 10 large urban areas. It was very important to protect that market share. Also, insurance companies are interested in controlling health care costs through direct relationships with providers. It is very interesting to see what has taken place in the three years from 1983 with regard to these relationships with providers. Previously, many of the insurance companies were dealing with the health insurance issues in the form of claims after events had already occurred. What the HMOs and the PPOs did was to recognize early on that it was the physicians and the hospitals that really were going to affect the ultimate cost of the health care transaction. And so the HMOs directed a lot of their

efforts towards the physicians. Insurance companies very soon realized that there were great opportunities in establishing physician relationships. They sought, just as the HMOs have done, to develop relationships on a direct basis, and I'm sure that Mr. Berkey and Mr. McLean will talk about that. The idea here is one of trying to deal directly with the people who are providing the services.

Along the way, of course, the market as we know it is changing too. I'm sure most of you have increasingly seen situations where employer groups have come to you and are electing to self-insure or go to some other type of arrangement. Previously, as brokers we didn't suggest self funding until the employer had approximately 1,000 employees or so. Now, through associations and arrangements with reinsurance, the threshold has consistently dropped. In a sense one part of the market disappears, but a new portion of the market has been created by the selling of unbundled services. When these entities go out and become self-insured, there is suddenly an opportunity to sell other services on the part of the insurance company.

The ability to penetrate new markets is important to insurance companies. I've seen as many as 25 new products that different insurance companies have come up with in order to take further advantage of the HMO population and the prepayment concept. Those are some of the objectives from the standpoint of the insurance companies.

Now let's take a look at the HMOs. We all know that the HMOs have enjoyed tremendous growth in revenue over the last several years. I heard numbers the other day of 25% increases in revenue; I know of a number of firms that have enjoyed over 50% in selected markets. There has been a great increase in members and revenues, but that does not necessarily translate into more profits. HMOs are looking to develop new markets too. They might be geographical markets, or different services and products that they can provide. Also they would like to continue the growth rate that they were able to enjoy during the boom years of this business before the consolidation took place. There is also the idea of alignment with a "big brother" in the sense that more and more of the HMOs are realizing that this business requires very large amounts of capitalization. A number of the freestanding and even the regional companies are

increasingly finding that it takes tremendous amounts of money to be able to compete in this business. Therefore, it's comforting to have a joint venture arrangement that can bring the necessary capital and other resources available to assure that the organization is not only surviving, but even expanding its market share.

HMOs see an opportunity to manage all of the health care activity in employer groups. We have done some focus group sessions and met with different employers at the national account level, and what we have found is that more and more employers are saying, "I have 100 different HMOs nationwide, and I want to try to consolidate my volume. I'm using not only a large number of HMOs, but I'm also dealing with a number of traditional indemnity carriers. I want to find some way to simplify my life. Perhaps the joint venture is one way that this can be accomplished." Addressing the employer's request to meet all its needs is an important part of any strategy when you are in a competitive business.

And then there are the providers. They want to improve their financial results. I think we all have read or heard about the increased number of physicians who are available all over the country. My experience would indicate some parts of the country don't have an overabundance of physicians, but generally there are plenty of physicians available to meet most health care needs. Physicians want to maintain and expand their market share. The physicians want to provide more services, they want to try to make more money, and the hospitals are in a position where increasingly their occupancy rates are stabilizing. They are looking for methods by which they can increase market share and profits. These are some of the different types of objectives that some of these entities would have.

I guess the next question would be, What's really happening; what kind of programs are really being put together? The first program we will discuss is what I would call the companion carrier type arrangement. These have been initiated more on the part of the HMO. The HMO knows it needs some help, but it really does not know what kind of help it needs. Somebody has told it about dual choice and triple choice, and all it knows is it is a federally qualified HMO and doesn't have the "new" products. It probably isn't at a point where it is ready to go into a long term type arrangement. This companion carrier

model serves its purposes well in that it's a very easy arrangement to get into. It can be implemented very fast, and there is little financial risk. There are no regulatory problems, because what you basically have is two companies -- the insurance company and the HMO are coming together and agreeing within some parameters to provide some mutual services for one another, but they are still retaining their individuality. I think that's the key point here -- they are maintaining their autonomy. These types of arrangements can be very positively received. Several of the programs that we have put together have been arranged, as much as anything, to try to get an opportunity to learn what it is insurance companies do. If I have learned anything out of the last six years of dealing with HMOs and insurance companies it is that HMOs don't have any understanding at all of what insurance companies do, and I'm not so sure that the insurance companies have understood what it is the HMOs are doing. That's all changing now, but this is one way by which you can come together and create an opportunity to sell some products.

It is not necessarily long term; as I mentioned, it's a short term solution. It is expensive, and you are not really putting anything into it, so you can't expect much out. It is more of a convenience than anything. You do lose some identity, particularly the indemnity carrier. If they are not careful, the HMOs will try to gain the upper hand in that regard. There are some potential problems in marketing -- it may be that the insurance companies will have a group of people in a particular area, and the HMO people want to sell the product instead. It becomes a question of who's going to sell it and what are the licensing problems associated with that decision. This is a very simple, quick and basic program to implement. It does not require a lot of capital. You can get in and out of it pretty fast.

An HMO sponsored fronting arrangement is another program that has been utilized. It is not as popular or prevalent, but it is something that more and more HMOs are examining. In this particular situation, there is not a lot in the works for the insurance company. It gets what in essence is a fronting fee out of it. The HMO will set up the various services, and in many cases it buys them on a unbundled basis, which is to say it can go out and buy a particular function from one organization if it likes it, and if it doesn't, it turns around and hires somebody else. This arrangement has a lot of flexibility from

the standpoint of the HMO. From the perspective of the insurance company, it is a pretty tough deal unless you are in a position as an insurer to provide many of those unbundled services, and then you don't have any guarantee.

A third type of arrangement is the joint venture. I suppose there are all types of permutations in this regard. One is the situation where the insurance company and the HMO come together. In most cases, they contribute capital, put money into the venture; they begin to become partners in the true sense of the word. There is a sharing of risk and profits. There is a process of getting to know one another's business; there is a process of trying to adapt new products and services to meet the needs of that market. The primary characteristic of this type of relationship is that it will be longer in duration. As a result, it will take longer to implement. It usually takes six months or so to get something like this in place. It takes a greater commitment. There's the possibility that the entity created may be an equity situation, which would have to be discussed.

There is better market acceptance, because there are perceptions of greater commitment on both parties' part. There is a genuine long term gain of knowledge, because both parties see that there is a greater commitment, and they are willing to commit more, and can learn more. The disadvantages of this arrangement are: it does require more time; you loose some control; there are problems in coordination. I suppose the biggest problems are loss of control and problems in coordination. We have done a few of these programs, and the mechanics of getting one implemented begin with "who will perform what functions." Each side has an idea that it is bringing more to the table. An example: I had an HMO client that was going to enter into a relationship like this, and it was very adamant that it control the claims. We started posing questions about why it wanted control. As it turned out, the HMO was really not equipped to do the job, but it wanted to have that control. We tried to stand back and look at it objectively. What we found was the insurance company was much more equipped from a systems standpoint to provide the claims service. Because all its costs were fixed and in place, it was willing to perform these services for a very marginal cost. The preconceived notions sometimes get in the way. There are some problems with coordination, and, of course, once you

start a program like this it takes some time to get going. Also, it can be difficult to terminate.

The next type of program is the acquisition or merger. This does not warrant a great deal of time except to say there are some entities that have elected to go out and purchase what they need. We have been involved in situations where you go out and buy a shell charter, and you pay from $50,000-100,000 per state for the license plus the surplus. Probably the most obvious example is Fred Wasserman at Maxicare buying Kansas City Life and renaming it Maxicare Life. This was to facilitate this type of arrangement.

There are also a couple of other types of possibilities where the HMO goes into organizing an employer group. Here one or more large employers might come together and act as sponsors, actually taking the place of the insurance companies. Another alternative is the type where the HMO goes together with a group of hospitals. Increasingly, the hospitals are feeling that the prepayment idea has really come into its own; the HMOs are getting stronger, the occupancy rates with the hospitals are down and they are beginning to think to themselves, Is this a business that we need to get into in order to protect our market share?

What are some of the stumbling blocks to prevent these arrangements from being successful? Here are some of the reasons that I have seen as I have travelled around and that are most often brought up to me. Profit sharing: I have a friend who is president of an HMO, and he says, "The insurance company margins are X; my margins are two X. Why would I want to go into some sort of deal where I have twice as much potential profit as that guy?" That's obviously something you have to work out. The equity question: If you are going into a long term relationship, who will have what percentage of the deal? Who will lead? Who will follow? Many insurance companies and many HMOs feel that they need to have or want to have the dominant position in the relationship. Who's going to take the lead? Something that is seemingly insignificant, at least to me, is the identification of products. How are the names going to be shown? The HMO name up at the top and the insurance company name in real fine print at the bottom, or is it vice versa? Underwriting authority can use several different approaches, and initially it might be that the insurance company can

agree to provide certain products to the HMO. That might evolve into a limited underwriting authority with specialized underwriting manuals, and then if it truly is successful, there might actually be some sort of real underwriting authority. Often the HMOs want to try to position the indemnity product so that there is a natural flow toward the HMO, so the indemnity product designed is the product of last resort. That's only to be expected, but there are some real issues that come about in terms of how the product is designed and priced. Marketing: Who's going to sell the product? Is there territorial overlap, because very often the HMOs have their own marketing staff? The insurance company in most instances has its staff. How are these people going to interact? What roles will they have? How are they going to be compensated? Do the HMO's people have to be licensed? That's not necessarily a given in every jurisdiction. These are some of the stumbling blocks.

As for time requirements, the acquisition or merger takes quite a bit longer because of regulatory approval. We have to understand the HMOs are used to moving very quickly. Many of you with insurance companies have committees; an issue has to be reviewed, and approved and it takes time. HMOs don't feel like they can wait in many cases. Both the insurance company and the HMO see these as opportunities to grow and gain more profit, and have more flexibility than ever before, because until now they couldn't really offer all those products. Utilization review, of course, is one of the HMO's strengths. The weaknesses: HMOs really don't understand insurance companies. That's my opinion, but it's gathered from a great deal of field experience. They just don't understand what it is many of you do. Because it is a new industry, there's not quite the depth of talent that exists in the insurance industry. Also, HMOs have a certain amount of market and financial instability and, of course, a weaker distribution system because it is new. The way to sell the product has not yet been defined.

I'll conclude by looking at the future of these arrangements. As things get aligned, there are going to be fewer joint ventures. There is going to be a significant growth in premium for those ventures that are successful. Just about everybody I talk to is focusing on the national account approach. People want to learn to differentiate the products. We have done a real job in the insurance industry in making our products generic. HMOs have also done this,

and we now have to learn to differentiate. As things evolve, insurance companies will end up with the upper hand, and that will probably mean approved administration.

MR. STEPHEN H. BERKEY: I'll describe the basis of some of our strategy so you can understand what we've done in the last 12-15 months. I think it is important that you understand that the Lincoln views its business to be managed health care and not group life and health business. About March, 1985, we formed an organization called Alternative Care Technologies. It is an entrepreneurial type of organization within Lincoln, and one of the reasons it was formed is the reason that Mr. Jackson referred to -- the question of decision making. We felt we were going to have to make very quick decisions, and we didn't have time to go to boards and committees and task forces. We have authority to make decisions within 48-72 hours. We are also a change agent within the Lincoln. We saw this industry changing dramatically and felt we were going to have to bring our Employee Benefits Division into the 21st Century very quickly. That's what we are helping to accomplish within the organization. In trying to do that, we even moved out of our corporate offices.

Part of what we saw going on in late 1984 and early 1985 was a dramatic change in our business. The market share of the HMO and self-funded organizations has risen quite dramatically, particularly the HMO. The insurance company and Blue Cross market share has been coming down. When we began to realize what was developing, it became very important to us to look at our industry very closely and determine what are position was going to be. Our belief now is that by 1995 only 10-15% of the market will be in the traditional fee for service type of health care that you and I have known for many years. Another thing that we observed was in comparing some figures from 1981 to 1984 for the amount of in-patient days per thousand for non-HMO business compared with HMO business. Although the numbers are not quite apples and oranges because the HMO figures have some over-age-65 statistics in them, there is a dramatic difference. Even though it is improved from 1981 to 1984, it is clear to us that the differential is going to continue for some time. It seems pretty obvious that the HMOs are managing the business, particularly cost, much better than insurance carriers have for a number of years. Therefore, in early 1985, we undertook a

major study within the Lincoln. We hired some outside people to help, and we interviewed over 150 entities and people throughout the industry, including HMOs, hospitals, physicians, employers, and consultants.

In September 1985, we arrived at five major conclusions. The first one was that health care was going to remain a local game. There had been a lot of talk in the press, and a number of people had written articles about how it was going to be a national marketplace. We simply do not believe that. Health care is delivered at the local level. When you go and get the care, the product is provided by the local physician or hospital. In our view it seems like there are few economies of scale. There will be some very large players. We will be a national player, but I think you have to understand that there is a very local focus as to what's now being delivered in this marketplace.

Second, the winning system would be a managed health care system with full benefit flexibility. HMOs specifically have had a very limited product mix. HMOs have one or two versions of a product, and they really do not consider themselves in the employee benefit business, as you and I might. They really have very little flexibility, and from our research it certainly appears that the employer is looking for a lot of benefit flexibility in what it receives from its vendors.

Third, there was no one player or system that has it all. By that we mean that even though there will be some national and large players, to deliver a product that we call managed health care, it requires the providers to come together with the insurers, and the insurers to come together with the payors, and a number of players. It is important that when I say managed health care that you understand I mean bringing together the delivery and the financing of health care. Not everyone who uses that term uses it in that manner.

Fourth, the natural alliance for an insurance company is with a managed health care system. By that I am specifically referring to an HMO or PPO. If you make some comparison of what their strengths are, and our strengths as an insurance company, it is a very good fit. We went into this study thinking that possibly we wanted to align ourselves with the hospital system. Clearly

the results of the study and the follow-up concluded that affiliating with a hospital system was not something that we really should do.

Last, the triple option product would create a differentiated position in the marketplace. I'll talk a little bit more about that as we go along and define what I mean by a triple option. But clearly, the employer was looking for someone to take charge of its plan. A typical employer may have 4, 5 or 6 HMOs in a specific locale; may have a couple of PPOs; and may, in fact, have more than one indemnity plan. They are fighting each other, and the loser in that battle is the employer. It is looking for someone to come in and help it get control over its entire plan. Those are the five conclusions that led to the development of a Lincoln National strategy that indicated that we would pursue a product-led strategy built upon a triple option product created around accessing many health care systems in selected markets.

Alternative Care Technology's responsibility in that strategy statement is accessing the managed health care systems that we want to affiliate with. In implementing that strategy we have looked at a lot of local markets, and we look closely at the local market before we proceed. We basically have two broad options in proceeding with some kind of venture to create a managed health care system. First, we can affiliate with an existing system, or we can build our own. It was very clear to us that in a number of markets we were not going to be able to build our own HMO or PPO or managed health care system. In fact, it was too late. If you look at the Chicago marketplace, for example, there are approximately 30-35 HMOs, and they are simply not all going to survive. There will be a number of failures out of that group, and to come in as a 37th player in this market today is not a very attractive position. Now I will say that earlier on we thought there were a number of markets that we were not going to be able to build. Interestingly enough, some of those markets have turned out in our view to have the possibility of building a system after two or three years of a lot of activity for a lot of different reasons. There are many secondary markets where the possibility of building a system is possible, and in others we look for joint ventures, affiliations, partnerships or whatever to create the system that we want, in order to provide a triple option product. One of the things that we did was look at the skills necessary between an insurer and an HMO in determining who we wanted the

partnership with and what we each should be doing. It is pretty clear that HMOs have some strengths and we have some strengths. They are very good at contracting with providers, managing those partnerships and contracts. We know much more about the actuarial and underwriting side of the business, and are much broader in terms of benefits and benefit design. In most of our arrangements in terms of the marketing side of the business, the HMO has continued to do direct marketing, while the insurance company has done the brokerage marketing. Therefore, we have somewhat stayed out of each other's hair.

In trying to analyze who our partners might be, we did look at hospitals and hospital chains and organizations. We have concluded that most of them had a different strategic outlook than we did. Generally, they were going into the HMO business to fill beds, and I want to unfill beds. They also have, in my view, an unhealthy view of the control issue. They almost always insisted on control, and the reasons in my view were not always in the best interest of what we were trying to put together. They wanted control for their benefit, and in many cases I'm not sure the hospitals understand what business they are in. They read a lot in the press about getting into the insurance business. We talked to a number of them a year or a year and half ago, and many felt it was very easy to start an insurance company. We even had some consultants tell us how easy it was going to be to run an insurance business. Humana has not proved that true.

Why do HMOs work? Obviously, they are involved with a number of areas that we as insurers have not been involved with for any of our past history. HMOs have been very good at controlling cost. They have an organized system. They reduce the duplication of a lot of the services when they can control comprehensive services that are provided to the employee. Oftentimes they get involved with preventive care. In essence what they are doing is attempting to change the behavior of both the employee and the providers. In many cases, the physicians or even the hospitals are on some kind of prepaid basis. In general, we have looked at a number of different models but overall feel that the capitated approach to these arrangements is one that you have to be looking at very closely. The traditional general type of fee for service arrangements can get you into a lot of trouble. That's a little bit of the background of what brought us to September 1985, about 13 months ago. At that point in time,

we undertook the strategy of going out and finding a number of partners and affiliations and trying to validate these conclusions. Were they true, and can you put together an affiliation with these kinds of organizations? Obviously we have been relatively successful to date.

I will describe now the results that we have had to date and describe a couple of our ventures in a little bit of detail -- U.S. Health Care and Peak Health Care. Also, I want to talk a little bit about what we mean by the triple option product and then what the partners in these affiliations are getting out of them.

We are operational in 29 sites today, and we'll be operational in another 21 sites with our existing partners by the end of next year. We expect to make additional affiliations within the next six months, and these will probably open up 15 to 30 more sites before the end of 1987. Generally, we expect to have 65 or 80 sites operational in the next 15 months. When I say operational, in general I'm talking HMO and PPO. Our general strategy is to start with the HMO and move to the PPO. In some cases, however, it may just be the the PPO. I think we have about 13 or maybe 14 or 15 partners by now. The big ones are U.S. Health Care and Peak Health Care, and I'll spend some time talking about those. What we decided was that we could not do it ourselves. We were not health care professionals. So what we did was go out in the marketplace and find health care professionals to associate with -- those people who have proven that they could manage health care cost.

The first major affiliation that we made was with U.S. Health Care. We had to form another insurance company. We used the Lincoln National name, although we are doing business as Health Win. This affiliation is in a very limited geographic area of about 6 or 7 marketplaces. I was thinking as Mr. Jackson was talking that we have 13 different partners, and we have 13 different kinds of joint ventures or arrangements. None of them are the same. In the case of U.S. Health Care, it was a merger. We merged its business with our business in specific locations. The products that we are selling in those areas are the HMO, the PPO and our traditional indemnity insurance. The distribution systems being utilized are the Lincoln National agents in many areas, the brokers that we were utilizing through our employee benefit offices, and the direct selling

that was occurring out of the traditional HMO environment. Because it was a merger, it was necessary for some tax reasons to create another insurance company rather than a general corporation. However, the insurance company is being taxed as a general corporation. All of our employees in these areas in both the Lincoln and U. S. Health Care are in this company. Health Win owns the HMOs that used to belong to U. S. Health Care. It now owns a block of group life and health business that was in the Lincoln prior to merger. Again, the purpose of the merger was to create the ability to sell the triple option product and to better manage health care costs.

The arrangement with Peak Health Care was much different. It was not a merger. Lincoln acquired ownership in Peak HMOs and PPOs. Peak has a holding company, which is a publicly held company, and we bought in at the second level into all of its HMOs and PPOs. We did not acquire any of the publicly traded ownership of Peak Health Care. What we are doing now between our joint venture and the Lincoln is developing a marketing arrangement for the triple option product. That marketing arrangement in the local areas is a very close working relationship because of the agreements we put together. It does differ by geographic area. It is not the same in all areas. If Peak has strong people, we utilize them. Where we have strong people, we are carrying the ball. Peak is now in the process of being bought out by United Health Care. United Health Care out of Minneapolis will be our new partner.

Everybody has his own interests with a triple option product, but we modify them to meet the needs and objectives of the partners. Basically, there are three products. There is an HMO with a limited number of providers, and a PPO that is normally a swing PPO. The PPO may use that same sponsoring network, but you can elect to use providers outside of the network. The third option is the traditional indemnity insurance that you and I know, where you can go to any provider and have traditional deductibles and co-insurances, etc.

Some of the issues that you have to address in these joint ventures and get involved with are how and where you are going to go with a joint venture and whether you should develop an HMO or a PPO. Do you need both? Some of these people have very strong opinions about the marketplace and managed health care and what works and what doesn't work. The local market is the key in our view

as to what you can do. One generalization today is that PPOs are not yet assuming risk and in many states cannot transfer risk to the providers, while the HMO can. It gets down to what you want to do in these local markets and what the contractual arrangements between you and your providers are.

Probably the biggest question, and I don't have any real answers for you today, is how you rate and underwrite when you renew the triple option product. If you think I'm going to be able to answer all those questions, I'll have to back off. We are still working through some of those questions ourselves. Our view is that we think we can work through those issues with someone who's helping us work through them, rather than someone who's a competitor.

What's in it for some of our partners or the partners that are in these ventures? One of the things that the joint venture gave us in terms of our joint venture strategy was that we had very early entry and a significant market presence. It gave us access to some local markets that we were not expecting to be in. The key thing is sustainability. In fact, if we did nothing, our block of business would be about 50% of what it was last year in about ten years. Managed health care is going to take over our marketplace, and you will not be able to sit back and do nothing. I'm using managed health care in a very broad generic definition here. Obviously, it provides a provider link. The Blues have had a lot of advantages over us for a number of years, and now the HMO business allows us to get to a structure which transfers risk to the physicians and hospitals and gain access to a direct marketing operation. Most of the HMOs do direct marketing, and some do sell through brokers, but the largest majority are direct marketing people. What do they gain from us? Capital and product flexibility are probably the biggest gains, along with access to our brokerage marketplace. HMOs typically have not done well in marketing through the brokerage community. Many of them recognize that they are not satisfactorily capitalized. They are usually very thinly capitalized, and when that first big cycle hits -- which I am sure many of you may be praying for out there -- a lot of them are going to be in real trouble. They are not going to have the financial resources to withstand a large cycle. Fortunately or unfortunately, depending on how you look at it, they have some things that they can do about it. What the Lincoln would traditionally have to do is raise prices, but the HMO would go back to providers and cut a new

contractual arrangement to control the costs. In our case we can also bring HMOs reinsurance, because we are a national reinsurer of HMOs, and it gives them access to reinsurance lines of business.

In summary, we are continually assessing the marketplace and our strategies. We feel that the conclusions that we came to a year ago have been borne out during the last 12 to 15 months, and we will continue to look for additional partners over the next 6 to 9 months. We feel very comfortable with our strategy during the last year, and we continue to see a lot of disruptions in the marketplace. I think it is important, from our perspective anyway, that we try to keep our options open. It is not really clear who all the winners and who all the losers are, and we feel we need to be positioned to be able to move in the direction of those winning systems.

MR. DAVID J. MCLEAN: I'm from Minneapolis, and Minneapolis has many times been accused of starting this problem that we are trying to manage ourselves through -- HMOs moving to a more hybridized approach of arrangements with insurance companies. I want to review the experience of American MedCenters in the Minneapolis area and other parts of the country in the last couple of years and then talk about what's ahead for us in the immediate future. After that I want to address some of the topics that Mr. Jackson and Mr. Berkey spoke of, giving you the HMO perspective.

American MedCenters was spun out two years ago from the management of MedCenters Health Plan, which had started in Minneapolis in 1972. The plan has been operational in Minnesota for almost 15 years. It is one of the leading plans in the United States and currently has an enrollment of about 250,000 members in that plan. We set up a management company because of the need for new dollars, expanded product needs, and expanded geographic locations. We took that company public in January 1985 and raised approximately $11 million in a public offering. In the last 9 months we have opened four new HMOs. The management of American MedCenters includes 3 plans in Wisconsin -- the Jackson plan, the Nicolet Health Plan and Midelfort Clinic Health Plan -- in addition to the large MedCenters Health Plan of Minnesota. The new plans that we have opened have been the Fargo Plan in Fargo, North Dakota; the Virginia Mason Hospital and Clinic in Seattle, Washington; and a plan in Atlanta, Georgia.

That effort has consumed a great deal of time. As Mr. Berkey mentioned, the cost of entering new markets and setting up new HMO programs at this stage of the game is quite costly and too time consuming based on the way the needs of the marketplace are moving.

Our own corporate goals have been three-fold. One is to manage and own group practice based HMOs. We started out with a large group practice in Minneapolis, so we have a very dominant physician orientation. Our philosophies basically revolve around this because we think the practice of medicine in a group model is much more efficient and provides some inherent quality control measure. Our efforts were to create a national affiliated association of HMOs that were built around that same philosophy, not necessarily all being group practice, but at least having group practices a central focus. The third major point is to combine the quality control component, which we think is going to be very important in the long term.

The group model advantages: (1) The group practices combine an existing fee for service base with a prepaid component, so they are serving both populations; (2) they deliver integrated primary, secondary and tertiary level care so that it's not only a primary care gatekeeper approach, but you also have the high dollar cases being treated by a common base of providers, which creates economy as well as quality control; (3) it works off a large loyal base. The plans we do operate with are the most prestigious group in each of those marketplaces. There is already a built-in inherent name recognition on the part of the population in those markets.

American MedCenters manages those plans under contract as well as taking an ownership position in some of them. The revenues for 1985 had just under $19 million in management revenue. The contracts are usually written on a percent of revenue basis. American MedCenters shows pretax income of $3.7 million, and net income of $2.2 million. Our earnings per share of $.45 were down about 2% over the previous year. This reflects the large amount of development activity that went on in the last half of 1985, such as the feasibility and development work for new HMOs. We like to think of ourselves as being involved in and focusing on joint ventures for several years -- joint venturing with physician groups. When we go in and analyze the marketplace feasibility of introducing

an alternative delivery system to the marketplace, we focus on those medical groups who we think would deliver care in a way that we think it needs to be delivered.

Under our arrangements American MedCenters assumes no medical risks. As a management company and part owner of those HMOs, it's a guaranteed revenue stream. There are no large facility costs. We think as a result there is a faster return on investment, and we can move more rapidly, since we are building upon the existing physicians in those marketplaces.

The MedCenters Health Plan started in 1972. There are currently 5 major HMOs still in business in Minneapolis. Roughly 50% of the population is enrolled in one of those 5 HMOs, and we are not sure when the growth will stop. I think the one thing that can be said is that what exists as pure HMO business now is not going to be there in the next few years. It will become much more hybridized. Therefore, what people have traditionally tracked as HMO penetration is going to get very difficult to track, because we are going to see managed care systems which will be a combination of what has traditionally been indemnity and HMO. In terms of MedCenters Health Plan enrollment, it ended the year in 1985 with just over 200,000 members. We have added close to 30,000 members already this year and expect to end the year at approximately 255,000 in the Twin Cities.

We think capitation works the best with a group practice model. The monthly premium flows to the HMO. The capitation goes to the medical group, and that covers all physicians services and includes lab and X-ray. In addition, there are dollars set aside to fund the hospital, and the physicians are at full risk for those hospital dollars. American MedCenters is the manager of the whole stream of business and manages that for a percentage of revenue. The monthly capitations less referral expenses are controlled and monitored by the physician group. We manage and negotiate hospital contracts along with the physicians. There are monthly deposits put into the hospital fund for each one of the groups, and claims are paid according to the contracts that are written with those respective hospitals. At the end of the year, if there is a deficit in those funds, the physicians are required to pay the difference. If there is a surplus, the funds are given back to the physicians. They are at full risk

for the hospital care as well as physician care. One of the advantages of a group practice is that because they have a much larger facility base, they have been able to move a number of services out of the hospital environment into an out-patient environment, which has created economies of scale and also incentives to better manage care on an out-patient environment.

How are funds distributed under our model? In our type of HMO model, 30% of a dollar on average goes to fund the hospital costs. Roughly 42.5% goes towards physician services; 12% for operating expenses; 7% for pharmacy expenses; reinsurance or stop-loss coverages are about 3%; out-of-area expenses are roughly 3%; reserve funding is usually about 1%; quality assurance, health education, optical benefits, preventive dental and counsel are about 1.5%. The key difference between our model and a traditional indemnity model is we have a much larger percentage of the dollar going to the physicians. In a group practice model you can deliver many services in an ambulatory environment instead of the hospital setting, using those dollars in a much less intense ambulatory environment. Since doctors decide where 80% of the health care dollars are going to be spent, we think it makes sense to put them at risk for that same appropriate percentage.

In terms of the marketplace, we've been very aggressive since the late 1970s in terms of modifying product mix. Up until 1980 we had been an HMO in the Twin Cities with one product, the same one as everybody else in the United States. Even today, in many cases of selling to groups of over 50 employees, the same product is used. Over the last few years we've diversified significantly. Our Medicare demonstration projects that started in 1980 were one of the first . We currently have about 20,000 members enrolled on a risk contract with HCFA and have been in that business for about 5 years. We have a prepaid dental program. We have in the last 3 years begun to market to small groups, and individuals, and tailored our products in some cases to the out state area in Minnesota with an agricultural product. We have jumped into what has traditionally been indemnity insurance business.

Let me try to give some perspective about what is happening to us now and what we are up against in terms of what our customers are saying. Some of the penetrations that we have achieved over the last 15 years in some of the major

employers in Minneapolis follow. These are the percentages of employees who have selected MedCenters Health Plan as their health alternative: 58% of the employees at Prudential; 56% at Cargill; 53% at Dayton Hudson; 42% at Control Data; 36% of General Mills employees. Obviously, as we talk about national accounts strategizing, being able to service their needs has become very key to us, particularly in the Minnesota area.

The first thing we did in the last 12 or 15 months was look at what we had to do in terms of being able to modify one of our products to a multi-option approach. It is a product we call Medchoice and is similar to what some of our competitors have been doing in Minneapolis. It is basically an HMO product; the people sign up, select physician groups who are available and are covered at 100% if they use those providers. If they choose to go outside of those providers, they are covered at a 75% level coverage with a lesser level of benefits. That particular product has been quite attractive because it allows us to go into accounts and take over the whole book of business. At first we thought it was going to serve us best with small employers and some of the mid-size employers, but we are finding that it is probably going to serve us best based on the penetration, so the penetration in a company is what we believe is the key. A product like Medchoice will give us the ability to service companies that have 100, 200 or 300 employees and where we have penetrated an excess of 50% of that account. However, even that's not enough because of the many things that Mr. Jackson and Mr. Berkey have talked about. The industry challenges ahead of us, whether we traditionally have been in the HMO business or in the insurance business, are costs that are continuing to rise and increased competition.

We have had multiple players get in: hospitals getting into the insurance business, insurance companies getting into the hospital business or the HMO business. We are going to see a mad scrambling for the next couple of years, but there is definitely going to be a further consolidation. Amongst all this the consumers and employers are going to put pressure on us by saying, Wait a minute -- you have to remember who the customers are and what we want. In addition, the government controls are also putting a fair amount of pressure on us, and the business coalitions are speaking for both of those customers.

We signed a letter of intent with Partners National Health Plan in August, and on the night of September 30 we signed a definitive acquisition agreement. Partners National Health Plan is a joint venture between Aetna Life & Casualty and Voluntary Hospitals of America (VHA). It was started in April 1985 as an effort to bring to Aetna the delivery system capabilities and to bring Aetna's insureds to VHA's member hospitals. Since then, the Partners has been attempting to develop HMOs in roughly 40 marketplaces over the next 18 months. It has found this very costly. We have spent a fair amount of time looking at alternatives in terms of potential partners for ourselves and what we needed to move into the future. Even though we were looking at having products like Medchoice, we still don't have the full line capability of doing the benefit consulting work and the other ancillary insurance products. It was becoming quite clear to us that our original objective of achieving roughly 1.2 million members by 1990 on our own was not going to be attainable. The industry consolidated too much. The arrangement with Partners National Health Plan is going to be such that American MedCenters is going to be a wholly-owned subsidiary of Partners National Health Plan. We will continue to operate the American MedCenters base out of Minneapolis, but the thing it gives to the Partners is the ability and experience of working with physicians, and to American MedCenters it gives a much broader base of Aetna's expertise and capabilities. It also brings the VHA hospital system, which currently is 670 hospitals that already have signed contracts to act as PPO providers in a PPO network. We've already begun the motion to be able to do that.

The market changes are such that the following factors have been influential -- large employers are making sure that we keep their interest in the forefront of our thinking and that all these acquisitions, mergers and joint ventures are not going to leave the employers standing without what they need. Increasing penetration within accounts has been a key factor for us where we have had plans that have been in existence for a number of years and have significant penetrations in key accounts. We need to be able to service their needs. The geographic expansion is another factor -- some of our companies we do business with in Minneapolis use 40, 50 or 60 HMOs around the country, and they are saying this has to be more rational. It all leads to better efficiency and better cost control for the employer as our customer.

The multiple option advantages are such that we believe that HMOs offer the insurers the ability of contractually linking themselves with physicians, and I think in the next 5 years that's basically where things are moving. The HMO business is not going to be here in 5 years; it is going to be moving back towards the insurance side. In moving back towards the insurance side, insurance companies will need to pick up the capability of contracting with providers and offering managed care systems. The ability to enhance the business is something that we think the HMO offers. The insurers, on the other hand, provide the enhancement of a provider business base. It really brings a patient population to the provider and provides some stability there, and it brings the ability to further meet the needs of employers and the government and also to expand the managed care business. HMOs have done a lot in the area of utilization control and those types of things, so with a much broader base you can spread that out across it and do some things that are much more sophisticated.

What are those things when we talk about managing the health care dollar? The things that are particularly important to bring to an indemnity fee for service model are provider contracts, health resource management capability, utilization review and reporting, quality assurance, and ancillary service development. These are things that we have been doing for a number of years, and we are now looking at how we integrate these back into an indemnity model. For example, on the provider contract management's being able to assess and target positions: when moving into a marketplace, we don't necessarily want to take all the physicians, and we want to know who the ones are we want to do business with. We know for a fact that most insurance companies are trying to get at that same issue themselves whether or not they have done some sort of arrangement with an HMO, PPO or whatever. Everyone is facing that same issue. Once you have gotten an assessment mechanism set up, there is an evaluation process that has to be established, and it is an ongoing part of the business.

All of these things need to tie to a contractual method of doing business; whether or not it is on a discounted fee for service basis, capitation model or something in between, it needs to relate back to some sort of contract. Since many physicians have not had experience with assuming risks and capitation,

they need a certain amount of support and resources to be able to analyze what their practices are telling them from a financial point of view. Most have never had the opportunity of reviewing the numbers in terms of what it means to be asking the patient to come back so many times for certain conditions or writing out prescriptions that don't make sense in terms of costs or looking at the alternatives that they might have instead of hospitalization. All of these are part of what we refer to as managing the resources of health care, or health resource management.

The things that we traditionally focus on in an HMO environment which are now being molded into a modified indemnity environment would be how medical policies or coverage policies are interpreted and pre-certification, which has been around now for several years under various types of systems. Case management and monitoring high cost cases, hospital concurrent review, pre-admission testing, referral management, and home care alternatives are also used. There has been a big movement towards home care alternatives, and there will continue to be a movement in that direction, as well as outpatient surgery. We use non-acute profile management to put a measurement on physician use of hospital services. Clinical risk management is similar to case management, focusing on the high dollar cases that drive stop loss coverage.

Utilization review and reporting methods tie back to the providers the idea that here is the budget, here are the targets as they relate to the financial numbers and here is how they convert into your hospitalization practices so that you come up with some targets by which you can measure yourselves. Being able to monitor and report this information is important. It has been my experience that if you have good information and present it well, physicians won't have a problem with it. It's when you don't give them any information and all you do is say we are going to cut your cost that they react negatively. They are very open to the behavior modification and incentive systems. We think that's very important in terms of being able to move these things into the future. The quality assurance activities we all need to keep in mind whether or not we are on the insurance side or the HMO side or in between. There is a greater need for outcome base measurement, and customers are demanding it, be they employers or the government. The government is getting very demanding now in terms of the Medicare risk contracts in terms of quality

assurance. These need to be linked back to provider evaluations, how the behavior change incentives are structured, and also reporting systems. In terms of the health care dollar, probably 10 or 11% is focused on other ancillary parts of the business that we have made sure that we control as best as possible. These relate to pharmacy, other insurance products, dental management, workers' compensation, and occupational medicine. All of these are going to be necessary in a managed care environment.

The rating and pricing issues -- nobody has any quick and dirty answers for them, but these issues are going to have to be worked through based on each particular environment or each particular setting. Information systems -- how we all are going to make computers work to our advantage in terms of billing needs, data tracking, reporting and, lastly, provider contracts.

MS. GAIL SUZANNE DUBOIS: Mr. Berkey or Mr. Jackson, two areas I would like to get your comments on: (1) What sort of legal forms do these agreements usually take that you find between insurance companies and HMOs? (2) Could you make some comments on what kinds of profit sharing arrangements you've seen when there is a different profit margin between the indemnity product and the prepaid product?

MR. BERKEY: The legal structure is generally just a stock purchase arrangement or a contract for a marketing arrangement. Mr. Jackson described a marketing arrangement where there really is no capital invested. Depending on how profound an arrangement that is, you may or may not have a contract. If you do, it's just a simple contract. If you are buying into a business, you purchase stock, or if you are going to create a new corporation, you create that corporation and are part owner of it. There is nothing magical about the kind of arrangement that has to be created. The profit sharing situation is one that we simply haven't dealt with a whole lot at this point in time in terms of how we are sharing profits. Our basic strategy is to take an equity position in the entities that we are working with, and that way we get our share of the profit based upon the amount of equity we purchased. The partner may get profits based upon doing administration, providing PPO services, or otherwise, but in particular it has access to our insured lives. The attractive thing to it is the ability to market to those Lincoln clients. We

have not developed any special profit sharing arrangements because of the issue of the HMO business's being more profitable than the traditional indemnity.

MR. JACKSON: My experience has been a companion carrier approach. We have drawn up some of those arrangements with something as simple as a 2 or 3 page letter agreement which basically spells out the various responsibilities of the parties and usually provides for 60 or 90 day termination. Those things are straightforward. The other types of arrangements are more formalized. They involve some sort of issuance of equity when you create a separate entity. On the profit sharing side, we just completed a case where we had two different profit margins; each side agreed to a target profit, and we used that as floor for negotiation. There was some sharing of anything above that target level for each participant. The losses were shared to some extent as well. It is sort of a negotiated settlement, but you can work something out with different margins.

MR. JAMES P. HILFERTY*: I would like to ask Mr. McLean a two part question. In your joint venture up in Seattle, I understand that you need about 40,000 people to have a good HMO, one that can make a profit. I'm wondering whether you can achieve that number of people with what sounds like a fairly small organization. Another part of that question is, What kind of an investment do you make and do the physicians make? What do you bring to the Aetna party? Is it the HMO part of a triple option?

MR. MCLEAN: Let me describe the Seattle marketplace a little bit more. We have invested approximately $1 million to date into that marketplace. The partner that we have there is the Virginia Mason Hospital and Clinic. That particular group is viewed in the Northwest part of the United States as one of the most prestigious medical groups. It has about 170 physicians within its group practice. It owns its own hospital, and it does referral business from all points of Oregon, Montana, Idaho, and Alaska. It is a well-known player in that marketplace. It is an 80% owner of that HMO. American MedCenters owns 20% of the plan, but again, Virginia Mason Hospital and Clinic is the

* Mr. Hilferty, not a member of the Society, is Administrative Director of Sequoia Hospital District in Redwood City, California.

predominant owner. It does not participate in any other HMO plans. In order for people in the Seattle area to go to Virginia Mason Hospital and Clinic on a prepaid basis, they will have to do that through Northwest MedCenters. We believe that this is an inherently tremendous market opportunity. Group Health of Puget Sound is still the only player, although there have been probably at least 15 other HMOs that either have opened or have announced the intent to open in that marketplace. There is no question it is going to be a very competitive marketplace. In terms of the profit margins, it depends on your model. An HMO that may be assuming a fair amount of hospitalization risk, which is traditionally an IPA approach, may need an enrollment base of anywhere from 30,000-40,000 or above in order to break even or to turn a profit. Under our model, where the physicians assume risk up front for up to 75% of the dollar, roughly, from an American MedCenters point of view our profits will come through managing contracts for a fixed price. Again we think that somewhere in the 20,000-30,000 member range will turn a profit for American MedCenters. The HMO itself under our approaches does not generate a whole lot of bottom lines. It generates enough bottom line to be able to assume whatever level of risk it does have in certain areas. Most of those dollars are controlled and managed by the physicians under our approach. Again, you just can't say as a rule of thumb that 40,000 members is basically the break even. That's the Seattle marketplace.

In terms of the question about Aetna, the thing that was attractive to the Aetna VHA Partners people is that since they formed Partners National Health Plan in April or May 1985, they have opened 10 HMOs. It has been very difficult for them to do that, and the industry has continued to move more rapidly. They have about 10,000 members enrolled across all the plans they have started, and most of these plans have just gone operational in the last two months. They needed two things -- an enrollment base to basically launch them off and experienced management people. With the acquisition of American MedCenters they quickly picked up 300,000 members. They have a management structure in place but in order to expand rapidly to service the Aetna market of 11 million people covered under health benefit programs, they needed a lot more help. One thing we brought to the table was the revenue stream in the form of 300,000 members. In addition to that was a management team that has

had a lot of experience in dealing and negotiating and managing arrangements with physicians.

MR. DAVID V. AXENE: Did surplus issues have anything to do with going to the general corporation side of things?

MR. BERKEY: I don't think so. I wasn't part of the legal process that put that company together, and I don't think it had to do with the surplus issues. It was more of a tax issue, and we needed an insurance company there, because we were putting our group business into it, and we couldn't put our group business into a general purpose corporation. To my knowledge there's been no problem relative to surplus requirements in that company, and it certainly wouldn't affect Lincoln's Best rating. It would only affect that particular company; that's the only place where we've done that, and it was only because it was a merger of business.

MR. AXENE: To date you haven't come up with a risk sharing method for transferring money back and forth between the different parts of your joint venture company. Are you working on that, or how are you solving the problem of adverse selection from one line of business to the other?

MR. BERKEY: I'm going to assume that those are not really the same questions. The risk sharing can be part of the negotiations to what you are paying and what you're putting into it, and you have some regulatory problems relative to profit sharing. What you have to be careful of is that you don't put an entity that's not an insurance company into the insurance company business. If you are really taking risk, then you become an HMO or you become an insurance company. That can be a problem depending on how you structure that "profit sharing arrangement." If you're talking about just overrides or something like that or participating on the top side, you can do that. We simply have not done that yet. The problem of anti-selection we have not solved yet. Clearly we are going to have a 100 life case that's going to end up with 75 of them in the HMO and 25 of them in the insurance company. The 25 are going to be the 25 worst health risks, and the price that we really ought to charge the employer for those indemnity lives is going to be extremely high and not very attractive. And if that HMO were not our "partner" we would

probably have a very difficult problem on our hands. On the other hand, because it is, we are convinced that we can work out some kind of a pricing mechanism that will be fair overall, but we do not have a solution for that. Anti-selection in terms of going in up front can be solved more in the plan design and underwriting regulations that you put in place. If you design your plan to move all of the good risks one way and the bad risks the other way, that's where they're going to go -- they're not stupid. What you have to try to do as best you can is balance those issues in terms of the plan design and the pricing so that you get a fair balance. It may not work in all cases, and then the real question is, What are you going to do in a year or two or three, when you've got a real problem in terms of the balance of those plans. I don't have an answer for you now.