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HOSPITAL ENTRY INTO HEALTH CARE FINANCING

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- o Hospitals and hospital management companies are increasingly entering traditional indemnity insurance markets.
- o Hospital representatives will address health care financing from the hospital perspective.
- o What are the risks and financial incentives from the hospital's perspective?
- o Are hospitals marginally pricing their health insurance products?

MR. JOHN F. FRITZ: As I'm sure we're all aware, there has been a great deal of interest in the indemnity insurance market on the part of hospitals and hospital groups. But not only are hospitals interested in the indemnity side of things, they are also quite involved in other financing alternatives such as HMOs and PPOs. It's interesting that we should be meeting right now when just about a month ago one of the top for-profit, hospital holding companies, AMI, made the announcement that it decided to get out of the insurance indemnity field. We have as our panelist someone who's with a for-profit group as well as Ron Osborne, who's with a non-profit group, so we'll get those two perspectives. I guess it would have been ideal to get a balanced view and invite someone here from an entity that decided to get out of the insurance business. Unfortunately, the news about AMI broke a little bit too late to arrange that so I did the next best thing and discussed the issues with several of the

* Mr. Osborne, not a member of the Society, is Vice President of St. Joseph Health System in Orange, California.

AMI people and I'll be happy to share some thoughts on that later on. First let me introduce our first panelist. Clifford (Keith) Powell is with Humana Inc. He's the actuary with Humana's group health division and supervisor of the actuarial staff with the responsibility for financial reporting, rate filings, capitations and experience studies. Prior to that Keith was with Blue Cross of Kentucky. Humana has probably made the biggest splash in the indemnity insurance field on the part of any of the hospital groups thus far. To date, Keith tells me there are roughly 200,000 employees covered under their indemnity insurance programs with roughly $350 million of annualized premiums. In a three-year period that's quite an accomplishment.

MR. CLIFFORD K. POWELL: I should start by saying that my comments reflect my own opinion and not necessarily those of Humana. I should also advise you that you may have some questions about Humana that I will not be able to answer, at least right now, due to confidentiality.

Over the past two or three years, a number of hospitals and hospital companies have entered the health insurance business and several others have such moves either under way or under serious consideration at this time. The big names have received the attention, with AMI, The Hospital Corporation of America, Humana and the Voluntary Hospital Association getting lots of press. Smaller hospital groups and even individual hospitals have been making similar but less visible moves. Many Blue Cross plans, insurance companies and agencies of the federal government have seen increasingly aggressive pitches by hospitals to the effect that they are willing to take on an insurance risk-bearing role in return for being the primary hospital care provider under some sort of insured arrangement. Some of these arrangements are well along the continuum towards the hospitals actually being small insurers. Some surprisingly small hospitals have taken the leap and are now offering insurance benefits on their own with no insurance company involvement. This new interest in becoming actively involved in the insurance business has come about because of changes in the environment and prospects of the hospital business. Ten years ago, the hospital business was very profitable and the future was bright. There were a large number of friendly, unquestioning third-party payors and hospitals had every reason to concentrate on their own high margin business and leave low profit gains to the less fortunate of the world. Of course, times have changed. New

players came into the hospital business. There was a great deal of internal expansion and in many cases the new facilities and services simply were not needed. With rapidly increasing cost, previously friendly payors became more hostile and started finding ways to use their collective buying power to control their cost in the health care area. As a result of these changes, the hospital business has become a rougher game today. It isn't easy to continue the profit growth of the past. In fact, there are widely quoted estimates that up to one-third of present hospitals may be out of business within ten years. In such an environment survival is the issue from the hospital's perspective. Because the hospital industry generally shows low variable costs, survival is usually seen in terms of protecting the patient base. One way to protect the patient base is to participate in a health insurance program that requires or strongly encourages insureds to use your hospital. From this point it is a small conceptual jump to taking control of your own destiny and actually running the insurance program. So from the hospital perspective there is certainly business risk in getting involved in the day-to-day details of the insurance business. But many are taking this risk because the alternative may well be loss of the patient base to such a degree that the hospital will not survive.

Are hospitals marginally pricing their health insurance products? I will try to answer this question as asked but there is a risk the question is missing the point. I'd like to suggest that the important marginal pricing question has less to do with the price of the health insurance product than with the price of hospital services as delivered by the hospital company. To answer the question for better or for worse, the pricing model most frequently used today by Humana's health insurance operations looks very much like that of many Blue Cross plans. The hospital discount that our insurance operation negotiates with the hospital division is fed almost mechanically into a rating process. Since our discounts are there up front, we really have no reason to do what many people call marginal pricing and I suspect that many hospital-linked insurers which price the way we do actually use less marginal pricing than most health insurers, again because the discounts are there up front and they are very sizable discounts. Under this pricing approach, the issue of marginal pricing centers not on the health insurance rates but on the negotiation of the discounts with the hospital providers. This is where the really interesting

issues are and I'd like to suggest there are two or three issues that are at the heart of this whole question. One is: What is the marginal cost to the hospital of an additional patient day? Given that the bricks and mortar are there in place, what does it really cost the hospital to take care of one additional patient? The second question is: How many hospital days delivered by the insurer would have gone to that hospital anyway, absent such a special insurance arrangement and hence absent the special discount? These two questions are very difficult to answer but I think they are critical to trying to understand the economics of hospital entry into the insurance business. The third question is: To what extent is the parent company's hospital just another provider to be judged on the same basis as any other hospital willing to give a certain set of services for a certain discount? Clearly it is possible to have a rating model that takes in an undiscounted or a minimally discounted hospital component and somehow tries to deal with discounts and the setting of the aggregate rate. Under these conditions the marginal pricing issues could be taken into account at the point of pricing the health insurance product. This approach would present serious difficulties in that the rating process would become very slow and the various components of health care cost would not be as clear as under the more traditional rating methods. It is important that the buildup and premium clearly reflect the various components of cost because even for a hospital-linked insurer, these costs are real. For this reason, I think that hospital-linked insurers should price their products using methods close to traditional rating methods and leave the marginal pricing issues to their dealings with providers including their parent.

MR. FRITZ: Our next panelist, Ron Osborne, is the Vice President of St. Joseph Health System in Orange, California. Ron's responsibilities are varied. He has the responsibility for insurance company relations, PPO and HMO contracting, and the wellness program. Prior to joining the St. Joseph Health System, Ron was right here in Chicago with Blue Cross/Blue Shield as Vice President in charge of cost containment.

MR. RONALD D. OSBORNE: First I'd like to tell you a little bit about the St. Joseph Health System. The St. Joseph Health System is a multi-hospital system. We own eight hospitals. We own an HMO, Health Plan of America, which is a state-wide HMO in California. Within that HMO we have about 70 hospitals

under contract, and approximately 5,600 physicians. Most of the hospitals are full service hospitals. In addition, there are a myriad of business ventures in which we are involved, most having to do with the running of each of the institutions that we own. We also own a malpractice insurance company which is located in Bermuda and therefore we are underwriting the malpractice experience of our hospitals. If we look at the question of hospital entry into financing I think we should realize very quickly that there are some people in health care today who believe that entry is essential. The hospital is not prepared to defend itself against an onslaught of attacking organizations, the list of which includes of employers, insurance companies, the general public, and community coalitions. The hospital must be prepared to protect its own patient base.

If we look at the rationale for entry, we really see that there are three basic reasons. The first is offensive. A hospital needs to be in the insurance business basically to go after new market penetration. When we think of the offensive rationale, we're thinking about channeling patients. In other words, we need to go into the market, find patients who are using other hospitals through an insurance program because of the benefit provisions that attract the patient to use the preferred providers, we then bring more patients into our hospitals.

The second reason is defensive. In this case we are trying to prevent erosion. We're aware that there are HMOs out there taking in new members every day and when they do, because of their very strong capability to channel, they are in essence taking patients away from our hospitals. So in other words, largely because of HMO and PPO contracting where patients are being attracted away, we have to be in the business of attracting them back, and not just attracting them but keeping them once we have them. The defensive reason then is to prevent erosion. The third one is entrepreneurial. There are many associated products to the basic indemnity insurance program that can only be sold through an insurance company. As a consequence we have to have an insurance company to assure delivery of those products. Despite the experience of AMI and the recent article about Humana in the *Wall Street Journal*, we have underscored our need to be in the insurance business. If we look at the experience of hospitals as contracting originated and as contracting has matured, particularly in

California where contracting is the way of doing business today for hospitals as well as insurers, you'll see that the hospital has not looked kindly at the intrusion. Government, of course, through Medicare, did provide and has for many years provided a means of security for financing of the hospital business. However, what the government has felt free to do because of its "license" and its underwriting of a large segment of the population has been to hamstring the ability of the hospital to do business the way it wants to do business. As we've looked to Blue Cross, we originally saw it as a friend, as an ally. It was an organization that hospitals developed, but Blue Cross over the years has become, like many of the other insurers, a contractor. That contractor needs a discount. With the discount as with the Medicare program we see that costs have to be shifted, prices have to be adjusted, so that others pay a part of the bill for both Medicare and Blue Cross. HMOs were not a big threat initially but in California in the last three years HMOs have moved into most of the metropolitan areas and they are cleaning up in the marketplace. Any wise indemnity insurer would realize that its competitor down the street selling indemnity insurance is not really its biggest competitor. It's the HMO down the street. The HMOs are indeed the biggest competitor for the indemnity insurers in California, and PPOs as well. We find that in our hospitals, a very high percentage of our admissions are contract admissions. The next wave is the triple option or managed care networks. With the triple option; indemnity, PPO, and HMO offered under one program with a single aggregate rate which is experience rated, mean that one single entity will control a great deal of the destiny of a hospital. When that happens, hospitals get in trouble. As a consequence, we look at government and we attribute about 55% of our revenues to them. We look at Blue Cross and in California we attribute about 8% to them. We look at Blue Shield, and about 6% is attributed to them. All of that's contract business. We then look at the plethora of employer-based PPOs in California (currently our hospitals have about 200), and just our 7 hospitals in California have about 260 PPO and HMO contracts. You can begin to see that we have a great deal of reliance on those who finance care. We have no choice. We must be in that business. Moving on, if we take a look at our strategy, you'll see how we're going to do that. We've completed some of it -- much has to be done. First of all, for general contracting we are seeking every possible contract that we can, providing the contractor with which we contract understands that there is an obligation to give us something in

return for the discount. We want to make sure that the contractor does have benefit provisions that include at least a 30% penalty for the patient that does not use the preferred provider. We're looking for as many contracts as possible so that we don't allow any one contractor to have too much. We have an HMO, Health Plan of America, which we purchased about two years ago. We've increased that organization from 28,000 enrollees to about 72,000 enrollees today. We expect to achieve the 100,000 mark in a matter of months. We, of course, are in the PPO business. Believe it or not, much of the work that I personally do has to do with assembling PPO networks for employers or for insurance companies. I will customize those and, of course, include our hospitals in those networks and in the process. I play the role of the consultant, so I am able to work with the insurance company or the employer to get them to include appropriate benefit construction so that there will be channeling.

We are currently looking at buying an insurance company. The reason or rationale for that should be obvious from the remarks I've made, but more pressing at the moment is that we see an opportunity for the purchase of an insurance company that no one else knows is in the market to be purchased. It is a good insurance company, is about to get probably a B or B+ rating from Best Guide. It's very young and has very good market penetration in California.

Once we buy that insurance company, it will be our strategy to nurture the company as a separate business. We will not make the mistake of assuming that the insurance company exists for the betterment of our hospitals. We simply will be a very good owner, meaning that we want the insurance company to manage itself. We want it to mature. We want it to grow its own business and to thrive economically. We believe that we are about four or five years away in our affiliations with insurance companies and other contractors from seeing another wave of assault in which we will then be able to rely on our insurance company to underwrite a lot of the business that we will have developed in other relationships.

We're also developing a small employer insurance program and utilizing the name of our hospitals to capture what we believe will be a large percentage of the

small employer market. Small employers are not getting the benefit of cost containment that large employers do. Very recently at a gathering in Orange County in California, I presented to large employers the message that we believe that a lot more needs to be done for small employers because the large employers basically have been shifting cost to the small employers, because they've been effective in cost containment, because they've been effective in contracting so the small employer is paying a much greater price. As a consequence, this small employer insurance program will be designed, not only to provide the kind of underwriting and cost containment provisions typically afforded to large employers but also will include a coalition that will allow the small employers to meet on a regular basis with hospital administrators and will provide data reporting and analysis. The small employers will be able to interface and have impact on many of the decisions made by hospitals pertaining to how they do business.

Finally I should mention that we have recently developed a wellness program which we are marketing nationally. The wellness program is actually an insurance product and is designed to work with the actuaries and underwriters within the insurance company. We sell directly to an insurance company and ask the insurance company then to sell to its group insurers. Because we work with the actuaries and because we work closely with the marketing departments of the insurance companies to whom we sell this product, we can integrate this into the cost containment portfolio of the insurance company, and we can enable the insurance companies to measure the effect of the program and in essence develop a new database.

There are some new concepts of underwriting that we expect will become important in about two years. They are going to be based upon a new generation of data and that data will be coming from diagnostic screening, which is the first component of a wellness program. This is a very comprehensive physical that includes blood workup. It enables anyone conducting the diagnostic screen to assess the relative health of an employee population. As this data matures, we are going to be able to see that there are significant improvements in corporate employee health and we're going to be able to see that there are opportunities to give special rates to those employers which seem to have healthier employees. As a consequence we have interested a number of actuaries from

large insurance companies in working with us not only to sell our program but to implement it so that they can benefit from this new generation of data. That data then will be used effectively in pricing more competitively in what will become a much more competitive insurance industry. That means then, in essence, there will be greater emphasis on preventative care.

I'll leave you with one last message. Last Christmastime I was having lunch with an individual who we refer to as a futurist. He lives up in the mountains in California and about every 3 or 4 months he comes down out of the hills and shares with us some of his projections for the future. This fellow has done a lot of work along the futurist line for many years and has done it for many large corporations. He shared with me the fact that we are within ten years of seeing a virtual elimination of invasive surgery. He shared with me that we are within five years of seeing the average consumer walk into the local drug-store, purchase a battery of tests, take them home, and self-administer in the bathroom. Not only will he self-administer but self-diagnose, which means that the average consumer who does this at least once a year (for a nominal amount, perhaps $25) will be going to the doctor with a different request. Instead of saying "Doctor, I don't feel well. Tell me what's wrong," the patient's going to say to the doctor, "I feel fine but my tests don't indicate that I'm going to feel fine in the future. What can you prescribe for me?" And the doctor's going to be prescribing wellness or lifestyle interventions. Knowing this, we realize that in health care we're not going to be in the business of providing a great deal of acute care. And if we're not, what does that portend for insurance companies? What does that portend for your business?

You are not going to be underwriting acute care. You're going to be underwriting wellness -- wellness which should be an integral part of the insurance package and is an integral part of ours. With that I think I will conclude. If there are questions the three of us would be happy to respond.

MR. FRITZ: At the beginning I promised I would make some observations about what happened with AMI and what I perceive to be some of the reasons as to why that program did not succeed. If you read the press on the AMI decision, according to the news release, the insurance program which had been in existence for roughly a year to a year and a half had lost about $25

million. The comment in the news release also said it was projected that another $100 million would be lost in the following year if AMI had not made the decision to get out of the business. When I discussed these issues with some of the people at AMI I started to see a common thread of what I think happened. The $25 million, a figure that is probably accurate, did not all come from claims. There's a large amount of overhead involved in that. The $100 million seemed overstated and probably didn't relate only to the insurance operation. Probably less than half was anticipated to be lost in the following year due to the insurance operation and again some of that would have been due to the overhead. My observations and conclusions were that there are probably four reasons that that operation didn't succeed other than the obvious one, which was that they didn't stay in the business long enough. Other than that, probably the most important reason was the tremendous cultural difference between the hospital side of the house and the insurance side of the house. That difference was never really properly addressed within the AMI environment. There also seemed to be a lack of commitment and long-term support from top management at AMI to the insurance operation.

Also, it appeared to me that there was a lack of a coordinated effort between the hospital side and the insurance side, which is absolutely essential to make the operation work. Lastly, and I hinted at this before, I feel they geared up too quickly with too much, too fast, resulting in tremendous overhead costs that helped sink the ship.

Those are my observations after talking to a number of people. Those are not necessarily the exact words that anybody told me, so I take the blame for anything that I've said here. With that I'd like to open the floor to questions.

MR. SCHUYLER W. TOMPSON: Mr. Osborne, I believe you said an insurance company does not exist for the benefit of the hospitals. It seems to me that there is quite a problem here; in fact there are quite a few problems. One of the problems would be retaining independence. Maybe I'm thinking of it from the point of view of the actuary and maybe I'm trying to place myself as the actuary in the insurance operation just seeing what kinds of problems he might be faced with. It strikes me that there could be conflict of interests that the actuary might face as to which is more important; the hospital's finances

or the insurance company's? I think there is a potential conflict there. Then the marginal pricing gets in here, and I believe Keith was saying that the marginal pricing is left to the parent, which is fine -- although -- as an actuary I have a little bit of a problem with that. Buying an insurance company sounds real good to me, although I wonder, how large an insurance company could this be? What degree or what magnitude of marketing and underwriting capability do you have? You touched on certain underwriting ideas that you have selecting the better quality risks and that sort of thing. We've been attempting to select better quality risk but the marketing people don't really understand that. They want to get out there and sell because their compensation depends on that. So it strikes me that there's all sorts of problems and I'm sure you thought about them and dealt with them. Would you share some of your thoughts on this conflict?

MR. OSBORNE: The first question has to do with the potential conflict of interest, particularly for the actuary. We've been very entrepreneurial for a number of years and we're very accustomed to starting new businesses. For example, Perfect Fit is the name of our wellness product. We started that as a separate for-profit company. It has a separate management structure, separate board and the board does not feel beholden at all to the bottom line of the St. Joseph Health System. As a consequence it functions as a separate business. That's our management philosophy. I suppose we might change our minds if we reach the point where the parent corporation was in financial jeopardy. That's when you batten down the hatches and you look for money and help in any direction. That is not our case. We don't expect that to be the case. We're a very profitable entity and so we see no reason why there should be a conflict of interest. With Health Plan of America, our HMO, that has not been the case. Our HMO is one of the toughest contractors that our hospitals face and our hospitals happen to be the toughest hospitals to contract with for Health Plan of America. Each entity looks out for its own best interests.

MR. FRITZ: Those were my questions when I first started doing work for hospital entities -- what is the potential conflict of interest, and, how do you get the message across to the marketplace that that is really in their best interest? When you really think about it, though, there are only so many premium dollars that are going to come in. Competition that's out there is

going to dictate how much you can charge for that product and you must be competitive in terms of that dollar of premium that is being charged. Within that restriction you've got some leeway, and depending on the strategy that one takes as the overall hospital group, do you subsidize the insurance operation by giving deep discounts or do you let the insurance operation be unprofitable by not giving them as big a discount? Top management understands that they're going to be looking unprofitable as long as you play those kind of games. I think the approach Ron is outlining at Health System is the one that I feel will work the best, where you kind of isolate that operation and let that management group work toward a profitable enterprise.

MR. POWELL: There certainly is potential for a conflict of interest. I think so far that we have dealt with it fairly well. I guess that we have taken the attitude, as kind of a hybrid, of running an insurance company like an insurance company and a hospital like a hospital but we always try to do it with the understanding that we're playing with the same people, the same stockholders and vested monies. As nice as it might be if you could really operate totally at arm's length, I think there are times when you could sub-optimize by doing that. You do have to take into account that there are times when the hospital has a greater need or the insurance company has a greater need. I'd suggest for people who are coming into this position, being actuaries with insurance companies owned by hospitals, that you try not to lock yourself into one preconceived notion or the other. I found most of the issues can be resolved -- certainly the ethical issues -- even the business ones if you keep an open mind. The dominant fact (at least for us) is that it is one set of stockholders and we do have to pay that single set of stockholders a reasonable rate of return. I think that they would justifiably be rather intolerant if we played some savage game with their rate of return on the grounds that we are the hospital company or those guys are the insurance company, or vice versa.

MR. JAMES K. HUTCHISON: A question for Keith; Have you been able to measure your success in directing or redirecting traffic and if so could you share the results with us?

MR. POWELL: That's an excellent question and I think that's one of the points I mentioned as critical to this whole idea. I can answer about half your question. We have tried to measure it. We've not been able to put fixed numbers on it but we are absolutely convinced that we are directing traffic. I don't have numbers. I guess there might be some people within Humana who do have numbers but I wouldn't believe them. We're doing surveys, we're trying to be sensitive to customers' comments on this issue and we have a very strong feeling shared by just about everyone, including the people who were initially skeptical, that we are directing traffic toward the Humana hospital.

MR. FRITZ: As a subset to that question, Keith, are the hospitals satisfied with their perception of the channeling that's going on?

MR. POWELL: Well, that's a little hard to answer. Humana as a hospital company, is one of the most successful companies in the recent history of American business. Some of the hospital people feel they could have done a much better job without us, but I feel there is a shared perception that we're doing something positive for them.

MR. JAMES P. HILFERTY*: There's an old expression in marketing that, "I'd rather own a market than own a factory." I think the movement into insurance gets hospitals closer to the consumer and yet I feel in attending some of these meetings that there's a perception that the insurance part and the hospital part of the entire spectrum are not the places to be. I see more and more insurance companies trying to lay off the risk to providers by capitating. It makes me wonder -- you talked about futurism before -- how do you see the future? Do you try to get close to the customer to get market control and then survive while there's a shakeout in the hospital industry and hope that things get better in the future?

MR. OSBORNE: I believe that there are going to be far fewer hospitals. I do think we all need to hang on as best we can for a few years until the shakeout occurs, but for those remaining institutions, life should be much brighter. When that occurs, I would expect that the job of the hospital

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

administrator is going to be one that's highly sought after, particularly if the hospitals that survive, will be the ones that have insurance affiliations. I would agree that getting closer to the customer can be achieved through ownership of insurance. I would agree that by working with employers through coalitions, by contracting and so forth, that we have a better opportunity of assuring our economic destiny. My feeling is that the future is bright. My feeling is that health care will thrive but that we are going to have about 3 to 5 years of some trauma.

MR. POWELL: If I'm understanding this question properly I would say that at least the present thinking at Humana is survival. I don't know that there's a lot of theorizing about what hospitals will be doing 10 years from now although it's entirely possible that there is. The idea that everyone has caught on to and seems to be holding on to very tightly is that we may lose about 1/3 of the hospitals out there in the next 10 years and we have to survive. Survival and getting through this period of difficulty are certainly very heavy issues.

MR. OSBORNE: One of the previous questions that really didn't get completely answered also pertains to this. In the St. Joseph Health System hospitals, we do not use marginal costing in contracting or for anything. We did consider doing that, of course, because we've been approached by so many contractors who said that they wanted a 40 - 45% discount. If you're not familiar with the contracting environment in California those numbers may surprise you. But that sort of discounting is going on every day in California. We don't do it. As a consequence, we know that we're not only getting a marginal profit, but we're getting real profit when we discount for contracting. If a contractor says to us "we want 40% discount or forget it" we generally say "forget it." Because we're not marginally costing in pricing, we think our future is going to be brighter than for most.

MR. POWELL: I hope what I said was that the marginal pricing issues are at the hospital level and I didn't mean to imply that that is how Humana sets its discounts. The issues are there. I wasn't speaking of their actual conduct.

MR. THOMPSON: Part of that last question touched on capitation of hospital benefits. I'm familiar with the fact that many plans have capitation of the physician costs but I thought, and I may be incorrect, that it's rather rare where the hospital does accept a capitation. Of course when they do they will be on the risk. How widespread is the use of capitation with hospitals? I thought it was very, very rare.

MR. POWELL: My experience is that it is rare. I agree with you on that and that is not the way we started. Our initial capitation arrangements were more with physicians where we used them at all.

MR. OSBORNE: I would agree it's rare but in California we are now moving both hospitals and physicians into capitation relationships with HBA. In other words, I think within the next couple of years you'll see a lot of it.

MR. HILFERTY: Could I ask another question about marginal pricing? In California, Kaiser is a very big HMO and very often it has services for which it doesn't have adequate capacity. It seems to be me that strategically it has started to aim that undercapacity -- instead of contracting or even not contracting, it sends patients to 15 or 20 hospitals. Kaiser has, I think, begun to strategize or concentrate those referrals so you can end up with maybe 500 or 1,000 referrals. In many cases business that a given hospital had very little of or none of before, in that situation where it's all or none, with a fair amount of referrals involved, would you consider marginal pricing?

MR. OSBORNE: It is unlikely, but, again, it would depend on the size of the hospital. The minute you start dismembering your financial structure in that manner, you're bargaining with the future and I don't like the odds. If we're talking about a lot of new patients for the hospital, not just existing business or a small increase but a lot of new patients, I might consider it. But I'd also want to know what my relationship with Kaiser was, I'd want to know that it was a long term relationship and I'd also want to know that I had a chance to develop an insurance program that could perhaps pull those people away from Kaiser. If I knew those things were all working in my behalf I might do it.

MR. FRITZ: You probably touched on an important reason why marginal pricing might exist within a hospital group: What is the occupancy rate of the hospital entities? My understanding is that the occupancy rate at St. Joseph's is very, very high, unlike others in the not-for-profit areas where the occupancy rates may be below 50%.

MR. DAVID V. AXENE: Over the past several years we have had the opportunity to work with quite a few hospital groups, and a few years ago I thought it was a tremendous business boon. But I found out during the past couple years that when the hospital started to realize that there is only so much money out there to pay for the health care and that the insurance companies have been playing with that risk for a long time, they would rather contract for services rather than to learn to be an insurance company. A few like St. Joseph's are willing to actually become and manage risk like an insurance company would. The rest have become AMIs or NMEs or some of these other ones that are basically pulling out of the market. What was the main reason that you decided to become an insurance company? Is it because you don't think you can do it without that internal capacity or did you completely give up on the idea of joint ventures with insurance companies?

MR. OSBORNE: No. We're doing everything. We're joint ventures, contracting, buying an insurance company. We have to maximize our economic leverage in the market and the statement that you'd rather be a market than a factory is very true. The issue is really having a strong hold on the market and whatever it takes to do that is what we intend to do. The fact that we are taking that bold step, the fact that we purchased an HMO, and the fact that we are now about to purchase an insurance company is because we recognize that once an entity, whether it's an insurance company or a large employer, is aware that it has leverage in the market, it will find uses for that and it's just a matter of time before some of those uses will appear to be very perverse in our eyes. We don't want that to happen. As a consequence we have to get our hold on the market as well and that can only happen if we are in the financing business.

MR. POWELL: I'm a latecomer to Humana but it's my impression that they went through the same process and reached the same conclusion. There are costs

in becoming an insurance company but the basic reason to do it, at least for Humana, was to control your own destiny.

MR. ROBERT A. SUJECKI: It seems that today, one of the biggest things employers want is information. Have you found you're able, from your diverse operations, to pull together pieces of information that an insurance company alone or a hospital alone wouldn't have and from that extent, through synergy, have you an advantage?

MR. OSBORNE: I found an interesting situation in California. I think John mentioned that I was here at Blue Cross/Blue Shield of Illinois. That was up until two years ago and when I was here my department developed the system called PROBE, Performance Reporting of Blue Cross Experience, which was one of the original big health services utilization reporting systems. I found that I had to work with employers extensively with data. Data became the basis of almost every cost containment program that an employer would develop. In California my experience has been the reverse. Though there are many employers who want data, it's as if they jumped over a lot of the cost containment programs that were developed in the Midwest in the last few years to begin contracting. Everyone's relying on contracting for cost containment and there's much less interest in the data. When I work with employers I help them develop a health services utilization reporting system. If they're self-insured I will identify the data elements they ought to collect off of UB82. If they are insured I will work with the insurance company to develop that. In the hospitals that we own we have developed a DRG reporting system so that we can report on a DRG basis on employers utilization. But the problem is that not all the hospitals in the networks that we use for contracting are ours and we don't have the data reporting capability in many cases. I really believe that data reporting is absolutely essential and we have even built it into our wellness product. When we work with an employer to develop a wellness program we provide them with a consultant who will assist the employer in developing a health services utilization reporting system to measure the effect of the wellness program. Once they have it they can use it for other cost containment programs.

MR. POWELL: I'm sure some people at Humana would disagree with me but my secondhand impression is, we do not have a distinctive edge in this area for a couple of reason: (1) we're still growing, still trying to decide what we can deliver and (2) fact that our contracts tend to be fully insured. I think that over the long-term we could do as well as anyone else and presumably a little bit better because of the data available from the Humana system.

MR. FRITZ: It seems to me that the issue of discounting is really only a short-term solution. Eventually that discount just becomes another definition for "usual and customary" and you really need the data to understand what's happening, and to determine the areas of cost savings and cost containment and so forth.

MR. RONALD I. BECKER: Since hospitals are getting some marketing, are they going to get sophisticated about it? For instance, I know Humana has a number of maternity hospitals because that's a profitable market. Have you thought about market segmentation and how this is going to affect what you are going to be doing?

MR. POWELL: I don't know. I haven't been involved in it.

MR. OSBORNE: Absolutely. I have recently talked with a large insurance company in the Midwest that has decided that the way insurance is delivered today is inappropriate for the future. But they don't really know what kind of insurance product is needed in the future and you may probably recognize who I'm talking about when I make the next comment. They've gone out to the public and they've said, tell us what your perspective is, what you believe insurance ought to do. Behind all this is the general concept that insurance probably needs to be a product that encompasses a full life span, so that when you walk away from one employer you don't lose your insurance, and you don't lose your benefits. All of this is encompassed in a full life concept. If you then jump back to health care and what that means, you begin to realize that we're talking about a degree of vertical integration that heretofore we have not thought about. We need truly womb-to-tomb capability to provide care. Within that spectrum is an opportunity for identifying all sorts of market segments. We're going after each one systematically. They give us the ability to respond

in the future and they become very profitable very quickly. Yes, we're using a great deal of segmentation in our market planning.

MR. LEONARD KOLOMS: Could the panel discuss the conflict that I see between an insurance company and a hospital when the objective of a hospital is to increase the beds and the objective of the insurance company is to keep down the price by keeping the people out of the hospital?

MR. OSBORNE: The objective of the hospital is not to fill the beds. The objective of the hospital is to make money. As we move into a more capitated environment we find that the insurance companies and the hospitals, if you pardon the pun, are in bed together. In other words, they believe that keeping people out of the hospital is the way to make money. I happen to believe that we're going to see financing moving much more to a capitated basis and as that happens, then the differences will be minimized.

MR. POWELL: That's very well said. Our purpose is to increase profits for Humana stockholders. People from the different divisions of the company, hospital and insurance, come at this from different directions and they are going to find they have to change a little with time. It is tough for people who are used to selling hospital beds to understand the need for pre-admission review but I think we are taking steps and I hope we'll get there.

MR. KOLOMS: In order to attract the customers you have to keep your rates down and one of the ways to do that is to select out the better risks. By selecting out the better risks doesn't that end up in a conflict with the hospital side of it? Isn't that one reason why they have lost the money, that they have abandoned the practices of group underwriting principals?

MR. OSBORNE: In St. Joseph Health System the answer to that question lies basically in charity care, uncompensated care. Last year we gave probably millions in care free of cost. We don't believe that you sacrifice good business principals in order to be in the market. On the other hand, a great deal of compassion is required to be a good hospital. We do not want the degree of compassion that we expressed through our employees and our hospitals to be harmed in any way by our business ventures. As a consequence, you'll

find that people don't get turned away from our hospitals. You'll find that when they can't pay they get the care anyway and you'll find that our rates are low. It is possible to do all those things. You just have to know what you are doing and understand the impact of what you do and make certain that you keep your practices clean.

MR. POWELL: Again this has been hard. Humana has gone through some rather difficult times in this very short three year period trying to get people to think insurance and at least to some extent wanting good risk versus hospital people who have a somewhat different bias on this. This is just something we've had to learn to work on and try to develop the right incentives to maximize profits overall. I would just remind you that the group health division of Humana is a fairly small operation in a very big hospital company. So to a great extent the hospital business goes on as usual with many other insurers and payers.

MR. DARRELL KNAPP: In talking about the triple option plan you mentioned having all three options experience rated. I guess that seemed to be in conflict with the community rating concept on the HMOs and I was wondering how you were going to deal with that. I guess the second part of the question is, would that also include a variable capitation for the providers going out?

MR. OSBORNE: Under the triple option the way most of the insurance companies are envisioning it, they need all three components to be experience rated. It is impossible to provide a single aggregate rate unless all three components are in fact experience rated. The way we deal with that is to simply recontract with our HMO network and we set up an EPO (Exclusive Provider Organization) which is basically a nonqualified HMO so we can experience rate. No, I wouldn't say that we would use variable capitation rates, in fact, capitation, particularly for the hospitals, is a fearsome thing and I have a feeling that we will be lucky if we can simply get capitation for all of our hospitals under our HMO. But once it happens I have the feeling that we're all going to get to like it. There are advantages for all concerned and as we begin to see that not all beds are going to be filled, you begin to feel a little more security when you realize that you get paid more and make more when the beds aren't filled under a capitated program.

MR. POWELL: We're just beginning our work on triple option so I really don't know if I can answer the questions. I'll just give you some impressions. We are not just an HMO but also an insurer to many people so we don't quite have the constraint of the old style community rating. In any case that constraint is going out the window with this new idea of community rating by class, so I don't think we're going to be badly handicapped on that. As for variable capitation levels, I suspect we will have them simply because the different benefit designs and the triple option, to us at least, will call for it. If we use capitation to any extent as an inducement, a softer kind of capitation than you'd expect with a really serious HMO for the middle level of the triple option, there's a good chance that it will be different than what we get for the HMO wing.

MR. AXENE: I think that it's very important to realize that when you introduce capitation contracts, a significant part of the capitation is an incentive to the providers to operate cost-effectively. When you move into an experience-rated environment you are essentially wanting to share that again with a third party called the employer. There is only so much money to share and you've got to make sure you don't disrupt the provider system just to keep the employers happy yet disrupt the employers to keep the providers happy. It's a three-way balancing act that we've found very difficult to do, but we've found some solutions that work very well.

MR. POWELL: Experience rating means different things to different people. We might well want to take a group's experience into account in studying the rate prospectively but we are and probably will remain a company interested mainly in fully insured products, not retrospective dividends.

MR. OSBORNE: You provoked my thinking on that last comment and I'd like to make a point that I think a lot of us overlook. That's the observation that contracting will inevitably lead to the point where we have to get rid of it. You can only contract so much and then your average rate in the hospital goes up tremendously and so you end up having to stop contracting or hold your contracts at a certain level. When you do that then you risk your relationships in the market and that's a problem for hospitals. But also, if you look at it from a standpoint of the employer or the payor, in California hospital

rates are probably higher than they are anywhere else in the country and yet we have more contracting going on in California than in any other state. That really speaks to the point that contracting is not really a cost containment program. It's simply everybody grabbing for what he or she can get to make certain that he doesn't get left behind. Meanwhile, hospital prices continue to go up. The inevitable solution is that we've got to figure out a way to get hospitals to compete on the basis of average price not based on the biggest discount. To do that, we have to have ways to channel patients without contracting and that really goes back to the insurance company. The insurance company has the ability. I know it can be done because we did it at Blue Cross/Blue Shield of Illinois through a program that we developed called the Medical Services Advisory Program. We set up a program for Zenith Radio Corporation, featured in the June issue of *Chicago Magazine*, where we were actually getting people to select hospitals based upon average price. Once they do that, they get incentive in the benefit program to do that, and then you'll see hospitals unable to adjust their prices. They're going to have to bring them down in order to survive. That won't happen, by the way, with capitation, either.