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RISK ABSORPTION WHILE PROVIDING HEALTH BENEFITS

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MR. PAUL R. FLEISCHACKER: Our panel members will discuss risk, risk sharing and risk management while providing health benefits. Specifically, they will identify and discuss the various types of risks in health insurance and health care delivery, various types of risk absorption mechanisms for sharing these risks among providers, insurers, employers and employees. In addition,

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the panel will address the management of the risk from a corporate perspective which will include bottom line earnings, and marketing goals and objectives for the corporation.

Over the last 20 to 30 years there have been major shifts relative to who absorbs the risk of cost and utilization increases in health care. Prior to the 1970s, most employers insured their employees with a fully insured program. A fully insured program is the Blue Cross or Blue Shield type of plan, with full risk absorption by the insurer. During the 1970s, many employers shifted their programs to some form of self-insurance due to high inflation, and thus became the primary absorbers of these risks. In the 1980s, we have observed major growth in alternative delivery systems, HMOs and PPOs, and the resulting shifts of risk to either the providers or the plan sponsors, depending on the particular provider mechanism.

MR. RANDALL PAUL HERMAN: I am going to discuss trends in risk transfer in the insurance industry and the HMO industry. I will also address the antiselection risk and the ways employers are trying to alleviate or reduce it.

First, the parties involved in group health care financing must be identified. I am going to focus on group rather than individual products, although many of my comments will be applicable to individual products. I am also going to focus on risk transferred from the insuring entity, such as an HMO, or from an insurance company or a self-funded employer, to either the employer, the employees and dependents, or the healthcare providers.

There are a number of different ways that the transferable risks may be defined. One of the most familiar ways it can be defined is the healthcare or claims cost risk. This risk can be considered in terms of severity and frequency, in terms of the utilization of specific services and the cost per service, and also in terms of catastrophic claims. These are all risks related to the provision of healthcare services.

Another type of risk relates to the attributes of a particular group. Specifically, this risk is the age and sex distribution and underlying health status of a group. Insurance companies are accustomed to rating on age and sex using some kind of experience rating. It is expected that the insurance

company will pass this risk on to the employer. Traditionally, HMOs have used a rating approach which does not transfer any of the age/sex mix and have charged all employers with a single community rate. This rating approach is changing today.

Finally, there is the antiselection risk which appears when a multiple choice option is available.

When considering risk transfer, it is useful to keep in mind that it is important to transfer risks that are controllable. To the extent that one party can control the risk, it is good to transfer that risk. If a risk isn't controllable, then there must be other reasons for transferring that risk, such as a reason based on the marketplace or general terms of equity.

I want to present a simplified comparison of HMOs and group insurance. Traditionally, in the group insurance market, risks have been transferred to employers and to employees and dependents through the premium rating mechanism and the benefit design.

In the HMO market, risks have traditionally been transferred to providers, through financial incentives and/or disincentives built into the contracts.

The group insurer, for example, will pass the demographic risk to the employer through an age/sex manual rating technique, and prospective or retrospective experience rating. Risks are transferred to the employees and dependents through deductibles and coinsurance, and also through cost containment mechanisms, such as preadmission certification programs required to receive full benefits. Risks are not traditionally passed to the providers. Typically, there are no contracts between the group insurer and the provider and payment is often fee-for-service.

On the HMO side, risk transfer is traditionally between the HMO and the provider through the different contracting mechanisms. Types of risk transfers include a fee-for-service payment made with a withhold returned to the providers subject to favorable financial results, a capitation mechanism in which the providers receive a fixed per-member per-month capitation regardless of the

services rendered, and contractual penalties for noncompliance with utilization review programs.

HMOs have traditionally used some sort of community rating wherein the rate does not vary by the employer. HMOs are now increasingly using a community rating by class mechanism. This is probably the predominant method of rating right now. However, because some of the larger well-established HMOs are still using community rating, most lives are still covered under community rated contracts. Also traditional in HMO contracts is very comprehensive coverage with no deductibles or coinsurance and, therefore, little transfer of the financial risk to the employees or dependents.

I would like to discuss what has been happening on the HMO side in terms of risk transfer. HMOs are moving toward the transfer of risk both to employers and to employees and dependents. Focusing on rating practices, HMOs are increasingly incorporating age/sex and industry factors to their rating practices, which is allowable under federal qualification guidelines. They are also moving toward experience rated programs.

A federally qualified HMO has certain limitations on rating methodology. These HMOs may have only a community rate or a community rate by class using age/sex and industry. I have heard of some cases where plans are using smoker/nonsmoker as a class distinction. Federally qualified HMOs theoretically cannot experience rate, but it isn't really a hard and fast rule.

Many HMOs do experience rate and are not in compliance with the federal qualification guidelines. Many of these plans are federally qualified HMOs and many of these plans obtained four-year exemptions from community rating guidelines when they became federally qualified. Recently in Minneapolis, Physicians Health Plan, which is a large IPA, dropped its federal qualification in order to continue to experience rate after its four-year exemption ended.

HMOs are also getting around the federal qualification limitations and using experience rating or other noncomplying forms of rating by forming sister HMOs which are not federally qualified and writing business in these nonfederally qualified HMOs. In this situation, the sister HMOs are subject only to applicable state restrictions on their rating methodology.

The third way plans are avoiding the federal guidelines, and which may be the most common way, is noncompliance. I have seen a high level of noncompliance to the federally qualified guidelines and much federal indifference to it. In recent years there has been a great deal of speculation that the whole community rating system will soon go by the wayside. Senator Henry Waxman has introduced a bill which would accomplish this.

Many people wonder how HMOs can experience rate and pay a capitation to their providers. HMOs are beginning to divorce the concept of the dollars coming in the door from the dollars going out the door. In the past, I have worked with many HMOs where the rate is passed directly to the provider based on the negotiated provider contract. The capitation rate paid to the provider will form the basis of the premium rate charged to every group. HMOs considering experience rating are willing to risk that their premium inflow on a group-by-group basis will be adjusted for experience, even though the associated capitation outflow is going to be on a per-member per-month basis. The HMO must be careful to design an experience rating mechanism which will produce enough revenue to pay those capitations. This represents a large amount of risk for the HMO.

With respect to transfer of risk to employees and dependents, there is increasing use of low option plans, deductibles, and coinsurance mechanisms. Occasionally, the HMO will be competing directly with a Blue Cross type contract, and the employer will request a benefit that mimics the Blue Cross contract. We had one client who wanted to drop preventive care because the group insurers didn't cover it. The important point is that HMOs want to look more like indemnity carriers, particularly as they enter the small group market and as they are faced with double digit rate increases. They want to offer low option benefit plans to help reduce the rate increases certain groups might otherwise experience. On the contracting side, many of the same types of provider contracts that have always existed are still in place. It is not often that an HMO is still using the same types of contracts that it used three or four years ago. A great deal of evolution has occurred in contracting as the relationships between plans and providers have become more and more adversarial. HMOs need to have items in their contracts to use in the negotiation process. Plans enter the contracting process with certain points they are willing to bargain. They aren't entering the negotiations with a "take it or leave it approach."

Many group insurers are beginning to contract with providers either directly or through PPO type mechanisms. These contracts may look like HMO contracts, but they are often discounted fee contracts, some kind of fee maximum, or a Diagnosis Related Group (DRG) contract, in the case of hospitals. An extreme case is the exclusive provider organization where, at open enrollment, the employee who elects the PPO agrees only to use that group of preferred providers. This situation allows the PPO to use a capitation type of contract.

The key to this trend among group insurers is that the medicine is increasingly becoming contract medicine, the provider's reimbursement is based on a contract and the provider must follow utilization review guidelines. Utilization review guidelines are specified in the contract and there may be penalties involved. Through the contracting mechanism, which creates a direct link to the provider, greater utilization controls can be maintained. An insurance company should consider several issues when contracting with PPOs. I have helped a couple of insurers evaluate their PPO contracts. I have also helped some PPOs by analyzing their discounts based on community average fees and have provided some insurers with an analysis of the way they can fit a PPO into their organization's operations.

One of the most important questions to insurers is: "How will this PPO impact healthcare costs?" This is difficult to judge. At best, a ball park estimate can be made. A mechanism that will permit retrospective contract evaluation is desirable for determining the way contracts the PPO has with health providers will impact health costs.

The providers the insurers are contracting with must be identified. For example, are they the high cost providers in the community? Are they already the low cost providers in the community? Are they the providers that your insureds have been using? The insurer's own claim system and database may permit evaluation of what provider-specific charges are, and can help evaluate both the acceptance of the PPO and the amount of discount the insurer will be receiving. This is not always possible. The insurer may not have enough business in a particular area, or the PPO may be a new venture. If the insurer has no business in the area, then local health planning agencies, federal data such as Medicare cost reports, or a consultant may help determine what the discount will be.

The PPO should be able to logically demonstrate the amount of discount expected by the insurer. This research should have been done by the PPO, and should enter into the negotiation process. For example, ask the PPO what they have done to determine how much discount they are receiving from the community average, and what is known about the community averages.

Provider support of the PPO is also important. I have seen physicians with eight or more PPO contracts, and hospitals with 20 or more PPO or managed care products. These multiple contracts are particularly prevalent on the West Coast. In a sense, the rates in the PPO contracts are what those providers are charging. Most of their business may be under PPO contracts. As the providers become more sophisticated, the level of discount will vary with the discount they are getting from the PPO. If their connection with the PPO is not strong, they are often reluctant to extend a meaningful discount without volume.

Sometimes a PPO is strongly supported by a provider group, or even sponsored by a provider group. Even without volume, the providers are then willing to extend significant discounts. Since the insurer is entering a long-term relationship, it is important to know if the providers support the PPO or if the PPO is simply acting as a broker/messenger, delivering the contracts to the insurer.

Types of contracts are important and may include a discounted fee arrangement, a maximum fee schedule, or a per diem rate with a hospital. The contracts used will vary by region. In Minneapolis, I worked with a hospital group that recently negotiated a hospital contract of a 15% discount from charges with a new PPO in town. The hospital administrator laughed as the PPO representative left because charges had been raised 25% the previous year and, in fact, only about 10% of their volume is paid on a charge basis.

In many markets, where most medicine is under contract or under Medicare already, there are very little charge-based reimbursements, and fee schedules may not mean a great deal. A discounted charge contract doesn't make sense in this type of environment. It is important to know the local environment, and the PPO should be able to tell the insurer about it.

With respect to utilization review, should the PPO perform it? Many insurers have already established relationships with utilization review firms. When

dealing with a provider sponsored PPO, the insurer must decide if it is appropriate to have this hospital or physician sponsored PPO perform its own utilization review since it may not be in the provider's best interest to control utilization. Another point to consider is whether the fees charged by the PPO are reasonable, which depends totally on the services being offered. In my experience, there has been a fair amount of negotiation on that issue.

Along the same lines, does the PPO fit the insurer's administrative needs? I've seen PPOs whose service is limited to delivery of the provider contracts to the insurer. It is then up to the claims processing staff to review a claim and determine whether it is from a group that has a PPO, or whether it is a provider under contract with the PPO, and then review the list of contracts to find the contractual payment rate. The payment rate may be a conversion factor on the California Relative Value System (CRVS). The claims processor then has to convert the payment rate into a fee screen, and compare the fee screen to the doctor's charge. This is a claims processing nightmare. Other PPOs have total claims processing capabilities, or will have the ability to deal with the insurer's system on either a tape-to-tape basis or on audited wire transfer relationship. It is important to consider how the PPO will fit into the insurer's administrative system. Since most PPOs are generally smaller organizations, it is often easier for the PPO to meet the insurer's needs than vice versa.

In the future, I believe we will see more local or regional provider contracting networks, maybe a hospital- and physician-sponsored network which contracts with multiple HMOs, multiple PPOs and does direct contracting with employers. The provision and control of medical care from the physician community have traditionally been localized. There are very few national group practices. The Mayo Clinic in Rochester is an example of one such practice, and they are making a national movement. The Kaiser Permanente Group could also be considered national. In the immediate future, I think health care is going to remain a localized activity. The concept of local and regional provider contracting networks makes sense and is here to stay. We will see more of these provider entities doing the contracting, the utilization review and contracting with multiple marketing entities.

I also think that national marketing entities make sense. My experience working with HMOs that want to get into the small group market, or the individual direct

response market, has been that, in general, that HMOs are not very sophisticated marketers and have often had financial difficulty. In the insurance industry, there are many national marketing entities that have found a market niche. There are small group companies, such as those selling individual products and those serving the large employer. The marketing savvy those national firms have shown when working in conjunction with the local provider networks will likely be the optimal way of dealing with health care in the future.

A definition is needed as we move on to antiselection issues. By *antiselection*, we mean an insuring entity, either an HMO or indemnity plan, covering a less healthy, more costly group of lives than another insuring entity in the multiple choice environment. There are many reasons for antiselection. One reason is switching providers. Unhealthy lives are less likely to change provider affiliation than healthy lives. Therefore, when an HMO or a PPO is offered to a group, the number of persons required to change their provider affiliations will affect the degree of antiselection.

Another cause of antiselection relates to the level of employee contribution. There is a law that states the employer must contribute the same amount of money toward the HMO as the indemnity plan. Traditionally, employers contribute the same amount of dollars to both plans. Since the premiums charged for both plans differ, unequal employee contributions result. These unequal contributions result in antiselection, with healthier lives choosing the less expensive options. If the indemnity carrier is experience rating, to the extent that the experience deteriorates due to antiselection, an assessment spiral may occur. I have seen a number of employer groups forced to drop their indemnity coverage and offer only HMOs as a result of assessment spirals.

There are some ways of controlling or minimizing antiselection. A partial list of possibilities is below. They are based on work I've done with our benefits consulting staff and also on work done to help HMOs respond to bid specifications received from some of the major consulting firms. The most effective way to control antiselection comes from the employer or other purchaser taking certain actions to control it. Before the employer will take these actions, he must be convinced that the antiselection is happening. One method is to adjust the determination of the employee contributions and adjust the way bids from the HMOs and other providers are received. Many HMOs have their rating practices

down to a science in terms of making optimal use of the employee contribution. Receiving information on the indemnity carriers' past and future rates is an important step in that process. It doesn't necessarily make sense for the employer to disclose that information to the HMO, and employers are becoming increasingly reluctant to give the HMO detailed information on both past costs and bidders. Still, with the equal contribution requirement, the HMOs can often calculate the contribution rate from the employee contribution and the employer's contribution to the HMO. Recently, more and more employers are making age/sex adjusted employee contributions. The contribution level is adjusted to reflect the age and sex of the enrollees opting for a particular choice. The idea is that the equal contribution law is met because the contributions are equal, given the same age and sex makeup. I don't know whether ultimately this will be legal or not. There is definitely speculation that the equal contribution law itself will be dropped. There is an increasing awareness among employers that the contribution levels should, at minimum, be adjusted for the age/sex attributes of the employees opting for it.

One other means of controlling antiselection is to provide uniform coverage among options. For example, in California, HMOs are not required to provide chemical dependency coverage beyond detoxification. There are still employer groups that will have mental health benefits in their indemnity insurance and none through their HMOs. In that situation, the employer will be selected against. For a second example, mandated benefits on the indemnity side may require chiropractic care. An HMO may also have to offer it, but will never refer to chiropractors.

In effect, anyone wanting chiropractic care is forced to choose the indemnity option. We have seen a couple of HMO plans adopt chiropractic benefits with open access to chiropractors, as a result of employer pressure. Often, this is in direct response to antiselection concerns of the employer. Ultimately, a level playing field would be desirable.

As a closing comment, as long as choice is available, there will be antiselection. Even with the changes in rating structures due to copayments and deductibles, and in the contribution methods, I think antiselection will continue to exist. In the future, antiselection may not work in favor of HMOs and against insurers.

Instead, I believe both parties will be in a position to try to manage antiselection or selection.

MS. MARY BRAINERD: Mr. Reinhart has talked about the competitive healthcare marketplace as the site of a brawl. Some of what has been happening in Minnesota illustrates this well in relation to risk assumption and risk transfer.

One plan in Minnesota has been sued by its physicians, primarily because the plan used the physician withholding to offset plan losses. The plan involved is the largest IPA model HMO in the country, and there is much controversy over who will control that organization's board of directors. That is a risk assumption/risk sharing issue which resulted in turmoil.

There is another Minnesota HMO whose physicians are seeking an injunction to prevent the health plan from putting in its January 1, 1988 rate increases. The physicians feel they need a minimum of an 18% increase to their capitation to approach break-even, and the plan's proposed rate increases are 13% in a community rated approach.

I have also recently talked with three large multi-specialty physician clinics facing financial insolvency themselves, primarily because a large percentage of their business is with an HMO that uses a percent of premium approach to capitation. In summary, there has been a dramatic impact on the physician marketplace in Minnesota as a result of risk absorption issues.

What is currently happening is a result of the way physicians are able to assume risk. In our experience, there are some problems in passing risk to physicians. The first and foremost of those issues is that physician entities and clinics' group practices do not maintain reserves. Therefore, in a capitated environment, if the physicians experience a gain one year and the inevitable losses in future years, they have no cash reserves and lack the financial ability to absorb those losses. This circumstance puts the plan in the position of having to bail out the physician practice, causing a loss to the plan, and it means the plan's capitation is only effective in years when there are gains. Those gains go to the physicians, and in years where there are losses, the plan will likely have to step in on the back end and share in those losses.

My company, HMO of Minnesota (HMOM), has about 75,000 members and contracts with independent physician practices. We currently have about 1,300 primary physicians involved in our program. In translation, this means that we have a very small risk pool in place with any given clinic or group of physicians. Problems thus include the lack of cash reserves, generally a small risk pool, an employer and patient environment which believes full capitation may create inappropriate incentives for management of care, and a system that historically has not considered the risk that managed care may attract to a given physician population.

In the past, organizations which experience rated have taken demographics into account when dealing with employers. It is very different when you have not appropriately accounted for demographics or selection in contracting with the physicians. For example, there is one physician in northern Minnesota who contracts with every PPO or HMO entity possible. She is in solo practice and has two office sites. In one of the office sites, she markets herself as a family practitioner (she is actually an internist), while at the other, she markets herself as an oncologist. You can imagine the kind of adverse selection experienced in a primary care system with an oncologist as a primary access point. In our current method of paying for physician services, it is hard to account for the fact that this physician is going to attract a large number of people with cancer. These are the kinds of intricacies on the selection side that we are starting to recognize.

On the employer side in Minnesota, increasing numbers of employers are convinced that selection is occurring in a multiple option environment and don't want to continue to have that problem. More employers are demanding an experience rate from an HMO to demonstrate both accountability and the ability to manage costs. I think HMOs see the self-insured environment of employers as attractive. More employers are interested in offering a self-insured version of an HMO. However, this has not been a legal way to operate under the current federal qualification guidelines. Lastly, employers are very concerned about the administrative problems of multiple plans. Aside from the cost of selection, the cost of administering five or six different programs, which would include renewing each agreement yearly and dealing with the administration from five different plans, is a big problem as far as many employers are concerned.

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Physicians are reluctant to assume full risk or less than adequate reimbursement in a very price competitive market. Physicians are really not economically able to assume risk, and more and more employers want to be experience rated or self-insured in delivering an HMO or PPO plan.

I want to illustrate the way we have responded to some of those market factors. First, HMOM is a primary care physician directed plan. We use a designated hospital network and operate statewide, which means our organization is involved in both rural and metropolitan area markets. Many of the physicians are in solo practice, which makes it hard to transfer much risk.

HMOM is an affiliate of Blue Cross and Blue Shield of Minnesota and that dictates much of the plan's organization. We have a combined sales staff; the same sales people are responsible for selling both the HMO and fee-for-service products. This means our organization must be able to make a plan viable while offering a dual option approach. We have spent a great deal of time working on the risk and selection issues in our plan in order to do this. The market is demanding both affordable and predictable rates.

Employers want to know what you can do in utilization management. They are demanding utilization reporting from HMOs. Many HMOs, even in the relatively sophisticated Minnesota market, do not have information to give employers. Employers want flexible benefit designs. They are not content to live with benefits dictated by state or federal law, and they want either a single carrier or coordinator who will offer their specific plan benefits. The ways that health plans are circumventing federal qualification were addressed earlier; our plan is probably doing all three. We have a waiver which will soon be exhausted. We are continuing to experience rate and have formed a state certified subsidiary where business may be transferred if necessary.

The years of an HMO as an HMO are gone. HMOM has quite an array of plans available. The traditional HMO plan has comprehensive basic and well baby care with some coinsurance on specialty services and hospital care. HMO Gold is a PPO product offered by HMOM. It is sold through our HMO corporation, but it is a triple option plan. HMOM also offers a self-insured program called Preferred Gold. The HMO core of physicians serves as the preferred network for the PPO programs.

We also have a TEFRA risk plan and a newly introduced Medicare supplement plan. Our TEFRA risk plan is not financially viable in rural communities, and therefore, we are replacing it with a pure Medicare supplement option that maintains many of the advantages of a traditional HMO, such as no paperwork and comprehensive benefits.

Things have changed from a product design standpoint. Our sales are occurring in HMO Gold. Traditional plans and the limited network plans are not selling well in our marketplace. Our fee-for-service HMO look-a-like is selling well, and the very broad panel IPA model HMO in our market is selling well. Those plans that are either group or staff model based are not very successful in terms of the enrollment of new accounts. Almost all of the HMOs are moving to a PPO design, offering some out-of-plan benefit on a limited basis.

HMOM has moved from a designated primary care physician paid on a capitated basis to a fee-for-service system with a withhold. The fee-for-service payment is based on our fee schedule which is a conversion factor and unit value based fee schedule. We withhold 20% from the physicians. Their future withholding is based on their past performance, so we may vary withholds from 10% to 30% based on how the clinic has done historically, starting at the 20% level. The return of withhold is based on clinic performance in comparison to utilization targets.

The utilization targets look just like a capitation. They are a cost per-member per-month, include the cost and use of hospitalization as well as all medical care, and incorporate the use and cost of out-of-plan services for the HMO Gold product. The physicians are responsible not only for their own use but also for specialty and hospital use, for achieving hospitalization targets, and for out-of-plan use by individual members. About 70% of the physicians in our plan have achieved their goals and received all or part of their withhold in each of the last two years, the two years in which the system has been used.

A concern is that the target system and withhold not be interpreted as a discount by the physicians. We want to maintain its role as an incentive rather than have it considered an automatic discount.

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Our hospital payment system incorporates per diem payments along with days per thousand targets. If actual utilization experience is better than expected, we share some of our savings with the hospitals. It is no longer acceptable in our marketplace to simply use a per diem approach where the hospital has no possible gain to be achieved in the plan.

We do a couple of things that are a little bit unique. We have introduced a mini-capitation. When I say mini, it is obvious that it is very small. I'm talking about a payment of 50 cents per-member per-month to the clinic specifically for the cost of case management. We recognize that we ask our clinics to use specific hospitals and to refer patients only to our participating specialists. We have a fairly intensive preadmission certification with concurrent utilization management reporting; we also provide our clinics with monthly use reports which identify the services received by the members who use their clinics primarily. These requirements take time and effort for the physician, and we think it is appropriate to start reimbursing clinics for that time and effort.

Targeting this mini-capitation has also allowed us to focus all of our reimbursement increase to primary physicians. By not increasing our fee schedule, we have avoided passing on payment increases to the specialist. We are currently most concerned in our marketplace with appropriate and adequate reimbursement of primary physicians and cognitive medical services, as opposed to increasing reimbursement for procedural services. This mini-capitation has allowed us to do this. All of our payment increase for the upcoming year will be targeted to primary physicians.

Another unique feature to our program is another mini-capitation applying to quality assurance. In our market, there is an increasing demand for accountability in quality assurance. We have many large employers specifically asking for information about our quality assurance system and the ways we can demonstrate the system's success. The mini-capitation allows us to tell physicians we are actually reimbursing them for the time and effort spent on quality assurance.

We feel HMOM offers some advantages to the physician. The first is that because we are a primary care directed plan, we don't use the word *gatekeeper*, which is considered a negative term in our marketplace. There is the

committed patient population. We feel we offer an arrangement that incorporates limited risk to the provider. We are probably the only Minnesota HMO that is able to actively expand its physician base because capitated plans are simply not being accepted as an initial starting place for new physicians. Physicians are not willing to get into more capitated arrangements. As a fee-for-service based plan, we are able to expand while some of our competitors are not.

There is an opportunity to share in gains in addition to just return of withhold; physicians are able to share in some of the gains that are generated. We have case management and quality assurance programs. We are involved in state and national markets through the Blue plans on a national basis; other health plans in our marketplace are not able to offer that kind of an advantage.

Lastly, two HMOs became insolvent this summer in Minnesota. In both cases, the business was moved to Blue Cross and HMO of Minnesota. The issue of financial stability is increasingly important in our market. There is concern over the financial stability of a couple of the remaining Minnesota plans; there will probably be some legislation passed to increase the reserve requirements for the state's existing HMOs.

HMOM is part of a complex group of corporations. We are an affiliate of Blue Cross and Blue Shield of Minnesota. HMOM is our federally qualified HMO plan. Minnesota Health Plans, Inc. is our state certified subsidiary and is actually a subsidiary to HMOM. We use this subsidiary for small group and individual product business because some of the underwriting regulations available to us as a state certified plan allow use of certain health screens not permitted for federally qualified plans. Employer Provider Network, Inc. is the home of our PPO, which is yet another corporation. HMO Midwest is used for business in some of our boarder areas. To be responsive to the marketplace and to write business with very active health underwriting, we feel we have to go to these lengths to put that kind of program in place.

Catastrophic care can be a problem and is a problem for me right now. Our little Midwest affiliate in Wisconsin currently has about 6,000 members. It is still in start-up and had a $200,000 claim. Since Blue Cross would cover the cost of that claim anyway, we had not put in a separate stop-loss arrangement,

forgetting the problem potential with the Insurance Commissioner in Wisconsin. We need stop-loss insurance at that level and also at the physician level.

The cost of a catastrophic claim can ruin any opportunity a physician group might have for achieving its cost-per-member objectives. Even in a fee-for-service environment, there is a need for stop-loss arrangements. We currently use an individual stop-loss approach, because on an aggregate level, the minimum the physician will be paid is 80% of the fee schedule, in effect serving as our aggregate stop-loss.

In summary, there are some unique market characteristics in Minnesota. Similar characteristics will likely emerge in other areas as HMO penetration increases, as employers, and physicians and hospitals become more sophisticated in contractual negotiations with HMOs.

MR. KEVIN M. DOLSKY: I am going to discuss risk from the insurer's point of view. My premise is that the cyclical nature of the health insurance market represents a substantial risk to those who participate in that business. The focus of my remarks is on risk in the context of the cyclical nature of the market.

I will only refer to the fact that the valuation committee which has worked with the C-1, C-2, and C-3 risk has also addressed the cyclical risk in relation to health insurance. Rather than discussing risk from a valuation perspective, I am going to talk about the nature of the risk and what actuaries can do in response to this risk.

The actuarial response may be broken into two categories. First, there is the response as a business person; by that I mean a member of the management team making decisions on planning and strategy and the company's future, and so forth. Second, there is the response needed as a technician; by this I mean the type of analytical work needed for actuaries to effectively handle the situation.

In regard to the business environment, we say that the health insurance business is cyclical by nature. It is cyclical in terms of inflation. Market competition is also cyclical, tending to be more or less intense at different times. The results that companies achieve are also cyclical.

I am going to present a model to describe the cyclical nature of the insurance business. We will consider the current position of insurance companies, other entities in the health market and appropriate responses to their positions.

To build the model, I am going to start by depicting the cyclical nature of gains from underwriting (see Exhibit 1). The straight center line indicates an average underwriting gain. The waving line shows the fluctuation of the actual underwriting gain over time. The material I reviewed, in which a substantial part of the market is represented, indicates the time period from peak to peak has been about six years for the last twenty years.

The other component to combine with underwriting gain is also cyclical and is the real rate of growth (see Exhibit 2). Real growth means growth in the number of exposures, rather than inflation which causes a revenue growth, and so on. Again, the straight line indicates the average rate of growth, rather than a level at which losses begin to occur. The waving line shows fluctuation around the average rate of growth.

I chose these two measures because, in the long term, the objectives of an insurance company are to produce both underwriting gains and real growth, or to both produce profit and gain market share. In the short term, these goals appear to be almost always in conflict. For example, as more aggressive actions are taken to increase market share, bottom line profits decrease and vice versa.

In the long term, these goals are not in conflict, but are complimentary and interdependent. That's why I am relating these two goals in my discussion of the business cycle risk.

Now, consider the two cycles together (see Exhibit 3). One waving line is gain; the other waving line is growth. The straight line is the average of the two. The way the cycles fit together is dependent on a particular company's response to this situation. A company could have different levels of growth or different gains at different times. Also, particularly with the growth line and its relation to the bottom line profit cycle, I think Exhibit 3 presents the most desirable way to have the cycles relate. I also think it is the natural way to proceed because it is the time when the market is the most and least competitive.

RISK ABSORPTION WHILE PROVIDING HEALTH BENEFITS

EXHIBIT 1

UNDERWRITING GAIN

PANEL DISCUSSION

EXHIBIT 2

RATE OF REAL GROWTH

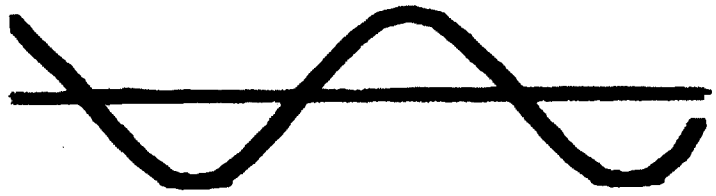
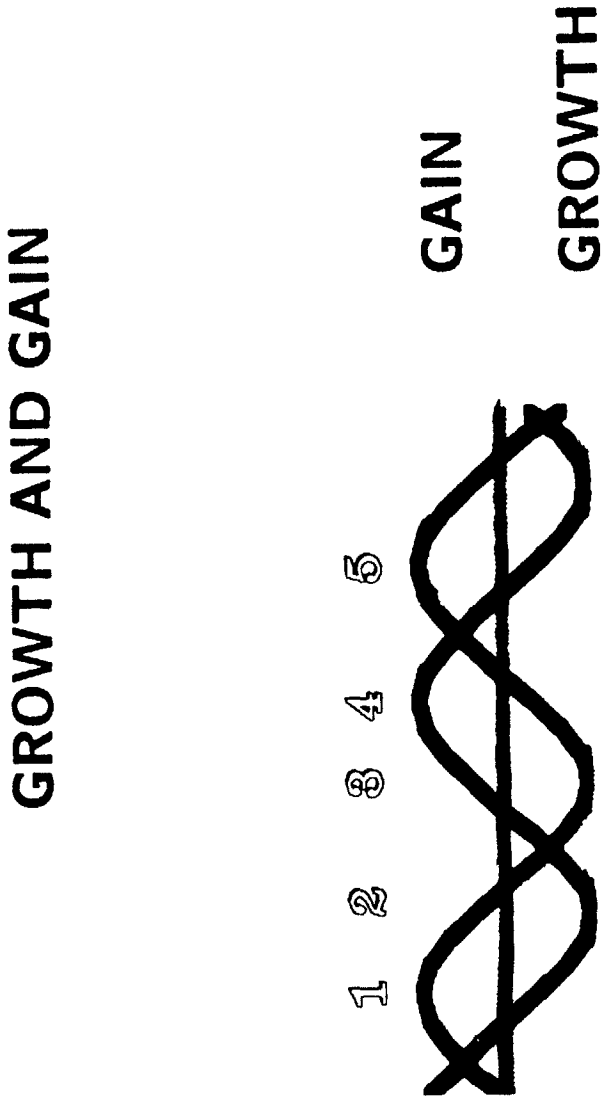


EXHIBIT 3



The numbers on Exhibit 3 indicate the peaks and troughs of the cycle. Number 1 is the peak of the underwriting gain, and at this point practically everyone is making money. Number 2 is the bottom of the growth or the potential for growth; at this point, the market is most competitive. As the gain increases, the growth potential begins to decline. Growth potential reaches bottom sometime after the underwriting gain reaches its maximum level. Number 3 follows the most competitive market; the gain reaches bottom, and as the gain begins to go down, the potential for growth increases. Shortly after the gain reaches the bottom, the maximum point of losses is the maximum potential for growth in the market. Many people are overly conservative and are responding to the problems that caused the losses, and there is maximum potential for growth. Finally, the whole cycle starts over.

Currently, I think we are somewhere between number 2 and number 3; that is, we have had a very good period of gain, we have been in a competitive market, and now our underwriting results are beginning to decline. I don't think they have hit bottom yet, and the market is beginning to loosen up. I don't think the market is yet in a position to be an average market. I still think the market is below average in terms of opportunity for growth.

I'm now going to talk about some external factors influencing the position we are in now. Keeping Exhibit 3 in mind, we are in a position of both below average growth and below average gain. Considering each cycle retrospectively, there are unique characteristics to each top and each bottom.

There are several external factors unique to the current situation. First is the current multiple option environment. Multiple options break down the principles of group underwriting which would prohibit individuals in the group from selecting amounts and types of coverage, and so on. Another external factor characteristic of the current situation is soft market prices. Earlier, some comments were made about physicians losing money while being paid capitations based on a percentage of premium. This may be the result of a situation where the controlling parties chose to use the soft market prices and transfer the risk to someone who perhaps didn't understand the risk as well, or perhaps neither party realized the capitation was less than adequate. Another characteristic of this cycle is the integration of financing and delivery systems. The underwriting gains which have brought new capital into the market have also

introduced new players into financing that formerly were only involved in delivery of care. These new players are now part of the insurance business. This has also contributed to the competitive nature of the market and soft prices. Another unique characteristic is non-level reimbursement whereby some people pay more than others for the same care. This has created some incentives in the current market, causing it to be more competitive and also causing the current gain situation.

Internal actions are needed to effectively deal with the current environment. First, quantifiable measures of claim costs and other costs are needed. For example, considering multiple choice as a characteristic of our environment, measurement systems to monitor age and sex demographics within a group from year to year and project the effect of current circumstances on the demographics would be desirable.

Health status of members should also be considered. Broad studies have been done, but companies probably should do their own independent studies, considering their own marketing efforts and the health status of the people selecting among available options.

This data would help predict what health status is going to be and how products should be priced in the future.

Another internal factor is conflicts of interest. The soft market prices are going to cause conflicts between sales and financial functions. These conflicts must be dealt with effectively to flow through the cycles and handle the cyclical risk in an effective manner.

Given the current situation, there are both business and technical responses. I think technical actuarial responses revolve around measuring medical costs. There are also responses to other expense components, and so forth, that I am not going to explore. The first thing the actuary needs is the ability to effectively measure medical costs. We need to know the costs and exposures on a reasonably up-to-date basis by area and by other pertinent factors. Without this ability, there is little chance of having any advantage over the competition. The ability to measure medical costs enhances a company's ability to direct its future actions.

Once medical costs can be measured, a method to project future differences is needed. We need to incorporate assumptions about dynamic relationships, making assumptions on how the future is going to be different from the past. If we do not assume the future will be different, then we are not assuming a cyclical pattern. We need to look at these elements of change and incorporate them into our projections of future medical costs.

Cost containment programs are another technical response to the current situation. For example, consider a program for precertified hospital care and length of stay, and assume the program reduces hospital costs 10%. Assume further that the medical trend on a group or several groups is 5%. Should we assume the medical trend will be 5% again next year? Is the decrease in utilization experienced the first year the program was in effect going to be repeated in the next year? If we assume the trend is only 5%, we are likely to lose money with the average of the market.

Antiselection is another example of the technical response to the current situation. If antiselection has occurred and resulted in inflation being 20%, and if we lost some money and then saw these high trends, we are going to say inflation is 20%. One has to ask, "Am I looking backward too much and not forward enough? Will the antiselection from this year to next year be as significant as from last year to this year?" If we assume 20%, for example, we probably are not going to be competitive in the period following a loss, because we will be retracing what happened.

There are also managerial actuarial responses to the current situation, namely, the responses the actuary makes as a member of the management team and as a decision maker. First, it is important to keep a long-term time frame. We have to convince ourselves and our management to operate within in a long-term time frame and make our decisions on a long-term basis. Returning to the growth and gain cycle, which has averaged six years, the proper action may only be determined in the context of the current situation. Also, the interpretation of results can only be properly addressed in the context of the current situation.

Our company has made efforts to focus everyone on the idea that growth and profit are inseparable in the long term. Once efforts are focused on the long

range cycle, the next step is to consider the growth and profit to be on equal footing.

Let me describe what we at Blue Cross/Blue Shield of Nebraska did. First, let me point out that, in the Blue Cross system, what other companies call surplus or net worth is called a reserve or contingency reserve. One way to measure financial stability is to relate revenue or premium to net worth. We relate claims and expenses to our net worth or surplus. This measures our net worth exclusive of premium. Our annual claims and expenses are around $250 million; monthly claims and expenses are $20.8 million. We have a net worth or surplus reserve of $90 million. We relate the reserve and claims and expenses, and we express the relationship as a number of months. The resulting figure is something that people can easily understand. Our months in reserve are 4.32.

We then asked our management to consider growth potential over the long term given the available funds. If 10% inflation and a 4% average rate of growth is assumed for five years, the company would roughly double. A total of $500 million of annual claims and expenses would be reached; months in reserve would drop to 2.16. This simple example related to management that funds are needed for successful long-term growth.

Once this point is made, management can address the optimum time for expansion. The best time is when gains are maximized and growth is maximized over the long run.

Consider a competitive market example (see Exhibit 4). The proper price is $1.00 and the competitive market price is $.90, meaning the market price is below what is needed for claims and expenses. New products are needed for growth, but that is considered a separate issue. We assumed that $.05 was lost on the market price to have an advantage in the market and still achieve growth. We said the growth price was $.85. We lost $.15 to growth in a competitive market per $1.00 unit of risk added. In the $1.00 surplus we had at the top, divided by $.15, we picked up 6.7 units in this market.

In a firm market (see Exhibit 5), surplus would remain at $1.00, the proper price is $1.00 and the firm market price is also $1.00. Often market prices will exceed $1.00. Companies are overly conservative. As the result indicates on

EXHIBIT 4

COMPETITIVE MARKET

Surplus		$ 1.00
Proper Price		1.00
Competitive Market Price		.90
Growth		.85
Loss to Grow		.15
Number Units of Growth	1.00/.15	6.70

EXHIBIT 5

FIRM MARKET

Surplus		$ 1.00
Proper Price		1.00
Firm Market Price		1.00
Growth		.95
Loss to Grow		.05
Number Units of Growth	1.00/.05	20.00

the bottom, we lose $.05 with each added unit of risk and are able to add 20 units of growth with our $1.00 of surplus. The bottom line is that we are much better off if we have the ability to determine when we can grow relatively more or be relatively more competitive in the market.

The last managerial type of issue I have identified is market segmenting. For example, if a company has only rather ordinary products, it will likely have best results in areas where there is little control. We need to look for particular areas where we have some reason to target a product when the product has some advantage.

Historically, in regard to market segmenting, some portions of the market have fluctuated more than the others. Most notable is the small group market. In order to be in the small group market at the last market downturn, most companies had significant losses. This may not be the case this time, but the idea is to focus efforts on the current situation.

Returning one more time to Exhibit 3, I believe we are somewhere between numbers 2 and 3, with both results below average. If we make a nonbalanced reaction at this time, the result will be failure; that is, the desired results will not be achieved. For example, we do not have the gains we had a couple of years ago. If we try to force that issue in this market, we are going to pay a significant market price because the market is competitive. On the other hand, trying to grow too quickly through rating strategies, and so on, in this market will require large capital outlays as in our example. The cost per unit of risk added will be high in terms of surplus. I would also consider this to be an unbalanced action.

Ideally, I think every company would like to be in a position that allows the two lines to fit together, being in a position where your maximum rate of growth is at number 4. Trying to grow before the bottom of the cycle will maximize losses; trying to grow before the top of the cycle will maximize gains.

In conclusion, my remarks have been on risk in the context of the business cycle. I contend there are risks other than medical claim risks, although that is the primary risk. In life insurance, mortality risks and investment risks are more critical. The nature of the health business causes the risks associated

with the business cycle. Premiums may become inadequate for reasons other than an inability to project medical claims. Some of this is due to a particular management's viewpoint. I believe the primary reasons are attempts to address inadequate volume. One additional point about this is a number of people have suggested they are not going to do very well because they do not understand the insurance business. Understanding the cyclical nature of the health insurance business would increase their knowledge of the insurance industry a great deal. I think this knowledge is a substantial part of the ability to succeed in the market. It will prove difficult for them; it has proven difficult for some of us who have done this as our main business for many years.

MR. DAVID A. SHEA, JR.: My question is about the HMOM triple option program. We also market a triple option program, namely, a comprehensive, a PPO, and a nonfederally qualified HMO. Sales have been good. We originally designed the products to be actuarially equivalent so that a person pays the same premium no matter what plan was chosen. After a few months of sales, we found that 97% of the subscribers enrolled under the PPO or the HMO and that very few people chose the comprehensive program. How has enrollment been split for the HMOM triple option program? Have you noticed skewed enrollment?

MS. BRAINERD: One way the plans may differ is that people are not locked into any portion of the triple option for any significant period of time. They can choose to go to their primary physician and always have 100% coverage. At any point, they can move to the lesser benefits associated with the second level of coverage. We had assumed that somewhere around 10% of our care would be outside of the primary network and that is proving to be accurate, although it is weighted in some unusual ways. We have more use outside the primary network for chiropractic, mental health and chemical dependency services and little use outside the network for medical services. Our theory now is people want to know that they can go outside the network to see a specialist if they have an acute problem. For areas where the member generates his own demand for services -- namely, chiropractic and mental health -- he is less willing to be locked into a provider network if given a choice.

MR. DAVID V. AXENE: Ms. Brainerd mentioned the potential lawsuits of some Minneapolis IPAs. Because of those issues and some others over the past few years, the health actuaries within Milliman and Robertson are going to start

putting in an exclusion in our statement of opinion this year. Basically, the exclusion will add a disclaimer about the liabilities not reviewed such as the assets or the liabilities of the physician groups. We see a concern over this potential liability. Other actuaries might want to consider this because it is a serious third-party liability for either a consultant or a staff actuary signing a statement for a Blue Cross or other plan.

I would like to learn more about the ways HMOM is measuring the experience of solo practitioners. We have found that, unless they are grouped together and a critical mass of maybe 800 or 1,000 bodies per group of physicians is developed, in trying to analyze incentives, and so forth, whether the physicians had poor experience is basically a matter of luck. How do you cope with that for your solo practitioners?

Also, is the only reason you are using the case management fee that you are on the fee-for-service? We try to avoid paying case management fees. I can understand your rationale because of your fee-for-service reimbursement, but did you consider increasing the budgets for your primary care physicians instead? After all, the case management fee is really just compensation.

MS. BRAINERD: We do pool the experience for all physicians that have less than 250 enrollees working with them. That may not even be a high enough level, but most of our physicians exceed that level fairly quickly.

With regard to case management fees, we pay the mini-capitation because we are fee-for-service. Part of the difficulty we have is that, while physicians do not have reserves, those that have performed well with us in a capitated environment are cash flow dependent on capitation. We have tried to build in some things that would give at least some token amount of money to them to help with the cash flow issue. Secondly, even if the reimbursement for office visits and consultations is increased, a fair number of those services still are referred to specialists. We really wanted to make sure every dollar of increase we put into the plan this year went to the primary physicians. The case management capitation accomplished both objectives.

MR. ROBERT C. BENEDICT: Ms. Brainerd, do you believe there are any utilization changes between the preferred and nonpreferred providers?

MS. BRAINERD: Our Blue Cross plan has a very open model fee-for-service HMO look-a-like benefit kind of system. We call this product AWARE Gold. The physicians are paid on a fee-for-service basis with a 10% withhold. We are seeing significantly higher use from that panel of physicians than in our HMO panel of physicians. In any case, we think our primary physician panel is effective at managing care from the data we have seen.

MR. HERMAN: I would like to answer that with a firm "it depends." I think it depends a lot on the PPO and the providers. My feeling is if the contract has some kind of provision to force the provider to participate in the utilization review program, then, if not in the short term, eventually in the long term, you have increased control over utilization. In practice, there are many plans that either do not have those things in place or are not using the existing utilization controls. Frequently, no savings are generated from utilization controls.

MR. BENEDICT: I was really focusing on your opinion of whether, under either a PPO or new utilization controls, the physician reaction is to shuttle a patient among several different physicians and make four fees out of three at the reduced price.

MS. BRAINERD: That was a big concern for HMOM in moving from capitation to a discounted fee-for-service system. We do not have a firm answer yet. We know our physicians managed care well in the capitated environment. How quickly and to what extent that incentive might change is unknown.

MR. HERMAN: That has been a concern of IPA model HMOs paying on a fee-for-service basis for a long time. A comparison of fee-for-service and capitated plan data indicates slightly higher usage of office visit services under the fee-for-service model. I think a good medical director and provider support for the plan.