RECORD OF SOCIETY OF ACTUARIES
1988 VOL. 14 NO. 1

STRATEGIES FOR SURVIVAL IN THE GROUP HEALTH INSURANCE MARKET

Moderator: STEPHEN D. BRINK
Panelists: TED L. DUNN
ALLEN P. MALTZ
J. L. MCCALLEN
Recorder: AUDREY L. HALVORSON

- The purpose of this session is to discuss strategies used by health insuring organizations and their likelihood for success. Over the last five years many organizations have made significant changes in their strategic directions in response to the changing health care market. Specific items to be included are:
  - -- Specific strategies for success
  - -- Super-meds -- What went wrong?
  - -- Impact of alternate delivery systems
  - -- Role of managed care
  - -- Specialty niche players

MR. STEPHEN D. BRINK: I think it is appropriate that we are talking about survival these days; 1987 results were poor, very poor. Many people expected 1987 to be a turnaround year. A few companies made money, but they did it through heroic effort. The *Health Market Survey* reported that the Blues collectively lost $1 billion last year; Lincoln National lost $74 million in health, $51 million of which was related to HMO operations. They also reported that Cigna lost $79 million on their HMOs, and Travelers lost $55 million. I'm sure you know how much your company lost.

The red ink, though, has not been confined just to the insurance carriers. Most of the freestanding HMOs also lost money in 1987. Many HMOs have not been through a typical insurance company underwriting cycle, and were slow to increase rates, focusing instead on maintaining market share.

While there are many factors affecting trends, the major culprit seems to be price increases. Providers are rapidly increasing charges for the fee-for-service market to counteract Medicaid and Medicare shortfalls and price discounts granted to alternate health care delivery systems.

More carriers are moving into managed care, through Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), utilization review services (UR), and multiple option products. Many carriers have gotten out of the health insurance market; during 1987, few entered the market. Large blocks of business have changed hands.

HMOs have changed some of their strategies as well, moving to point-of-service plans, or swing plans, and developing PPO products. They are also expanding their market share to include Multiple Employer Trust (MET) groups.

We are still seeing some joint ventures taking place. Many of the earlier ventures failed, although some are still operating. The pace seems to be slowing as more organizations are attempting to improve the performance of the joint ventures that are currently in place.

Rather than starting new ones, the main point is that many carriers are redefining their strategies. We are talking about survival. We are talking about short-term profitability. We are also talking about long-term organizational structures.

The first speaker will be Mr. Jim McCallen. Jim is a Canadian who, after two years at Canada Life, joined Great-West Life in Winnipeg in 1974. His areas of responsibility included product development, pricing, financial analysis, and underwriting. He moved to Denver with Great-West Life in 1981 and became responsible for the large group operations including underwriting, administration, accounting, pricing, and product development. Just recently Jim has been made responsible for all home office functions to support the New England group operation, which is going to be effective later in 1988.

MR. J. L. MCCALLEN: In my opinion our topic, Strategies for Survival in the Group Insurance Market, is very appropriate in that it is in the beautiful setting of Disneyland. It seems that these take on a special meaning in the world within Disneyland.

I think Adventureland symbolizes all the exciting and challenging things that are going on in the insurance business today; Frontierland is akin to all the work many of us are entering into in the alternate delivery systems and managed care settings. Fantasyland is where many of us will be if we do not turn around the 1987 earnings. And of course, Adventureland is where we all want to be a couple of years from now -- in a very successful setting.

In group insurance, the health market has undergone a tremendous change in the 1980s. Nontraditional players such as HMOs have accomplished significant increases in market share. The investment required to be successful seems to become larger and larger every year. Many references have been made during the conference that 1987 saw what was probably the worst financial year in the history of insurance for both indemnity plans and HMOs.

There is plenty of evidence and rumors that many companies are deciding to get out of all or part of the group health market. Yet, fundamentally, I believe the health care industry is one of the more positive environments. There is little or no foreign competition, and coming from Canada, I do not include Canadians as foreign competition, even though their way of doing business is pretty foreign to me. There are very few examples where other industries have to deal with foreign competition. Second, there always will be a need for our product -- health care. It will depend upon the perception of the public as to whether this product should be delivered in the private enterprise or in the public arena. And the consumption has been increasing on a constant basis. This is evidenced by the growth in US health care expenditures from 9.1% in 1980 to 10.9% in 1986. And with each of these changes in our environment are created many opportunities to differentiate our products. Some examples would include Section 125, under the heading of Managed Care.

In this session I will touch briefly on how my company, Great-West Life, is approaching the health care market with an objective of being successful on a

consistent long-term basis. First, I will discuss what I think are the key issues involved in general business strategy in order to accomplish this advantage. Then, I will present a simple way that we have used at our company to present our business and environment. Third, I will discuss what needs to be done to gain this competitive advantage. Finally, I will review some of the tactics that Great-West Life is using.

Business strategy involves questions like, where to compete? This includes different market segments, customer segments and different product segments. Second, how to compete? How do we differentiate ourselves? An example of this is, "At Ford, Quality is Job 1!" That is definitely how they want to differentiate themselves, and success depends on how the customer feels about Ford's quality. And most importantly, when to compete? When do we enter or withdraw from a market? When do we introduce a new product? Timing is absolutely everything to success. As an example, in my opinion it would be fairly futile to enter into the arena of managed care networks at this point in time.

Developing a business strategy requires an understanding of the environment and the business from an economic, legal and competitive point of view, and, importantly, how each of them are changing. We need to understand the decisive things to do to gain competitive advantage. We have identified what we feel is a simple way to present our business and our environment. We tend to look at eras. An era is a time period defined by the single decisive initiative which is successful and allows us to gain competitive advantage. If it is done well it will leave us well positioned. What is the one decisive thing that really counts when all the shouting is over? We have identified four eras. In the 1974-79 period, the decisive initiative was self-funded business. In the early 1980s the decisive initiative was claim processing. Currently, we are in the managed care era. In the 1990s we are going into the distribution era.

Before 1974 the decisive initiative was benefits. And it was during this era that companies first introduced things like dental and vision benefits and focused on comprehensive plans. Some of the key attributes regarding eras, including the continuance into the next era, are no longer decisive. So, for an example, it still is very important to have a self-funded product, but that alone does not differentiate one carrier from another. A fully automated comprehensive claim processing system that handles all the plan options and recognizes prior provider contracts internally is important to a managed care program, but it is really the managed care program itself which is most decisive today.

A second attribute would be that factors in the current era help trigger the next. There are many external factors that also help or lead to changing the eras, such as government policy and economic conditions. What we will see is how each era itself leads to the next one. Third, eras contribute to the financial cycle. Companies typically make a big investment to get into the next era at the peak of the financial cycle, and each year seems to require a bigger financial investment. And most importantly, planning for the next era must start in the current one; otherwise there is a great danger that by the time we introduce a product to compete in the era, it becomes a commodity and there is no longer a competitive advantage.

In the late 1970s there was the introduction of many alternate funding products such as Administrative Services Only (ASOs) and Minimum Premium Plans (MPPs). This is really the first time that the industry has unbundled its services for the customer. This in turn led to the demand for lower retention and data

concerning the claims which are now representing 90% of the costs. This helped lead to the widespread introduction of the computerized claim system in the early 1980s. There was a need to reduce costs through higher productivity and to provide the data for management review and reports.

Once we had the data, this led us to the demands to do something about the claims costs, which led to many claims control programs. Initially, it was retrospective, after the treatment was rendered. Examples of this would be a hospital audit and the increased focus on duplicate bills and eligibility, etc. Plan design change is another example, and this led to more employee cost sharing. Finally this led to the demands to intervene before the treatment was received. This has led to the current era of managed care including UR, PPOs and the rapid growth of HMOs.

Managed care is starting to put some real dimensions on what I will loosely label as distribution. Investment in managed care is so significant that there is pressure to joint venture during increased business volume. The result is multiple distribution outlets for the same managed care products. Examples of some of the joint ventures would be under the heading of managed care networks. I think all three panelists represent different approaches. In some other areas, examples of joint venture would be between Pacific Mutual and MONY in a claims processing joint venture. We are also currently involved in one with The New England which is a joint venture of all administration, underwriting and pricing functions. Provident Life & Accident has another type of joint venture which is requiring the business transmittal of Transamerica/ Occidental.

This is leading to other creative ways to reduce distribution costs. Distribution becomes the battleground, but the base product stays the same. For example, we and a number of other companies are experimenting with direct marketing to employees. Finally, with managed care and multioption plans, along with the general trend in flexible benefits, we are being pushed more into marketing to the employee, and enrolling him into our plan. This is something that Great-West has not historically paid a lot of attention to. So we think that distribution is likely to be the decisive factor in the 1990s, and those companies that respond creatively will have a competitive advantage.

Regarding financial cycles, the earning troughs were 1975, 1981 and 1987, followed by peaks in 1978-79, 1984-85, and I certainly hope in 1988-89. In part this was caused by a change in eras. One reason is just the capitol investment itself and probably more importantly is the desire for business volume driving down prices; e.g., during the last era there was a rationalization of impact of managed care.

Finally, another aspect of eras is that one needs to plan for the next era in the current era. At Great-West Life in 1972 we first introduced our ASO product; 1978 was when we purchased a claims system from Advanced Systems Applications (ASA); 1984 was when we started the Private Health Care system to approach the managed care era; and at this point in time starting last year, we started exploring Alternate Delivery Systems (ADS). One such example is the joint venture with The New England Life.

Let us review some of the tactics we have used at Great-West. In the self-funded era we promoted transferring more risk to the customer. Great-West is predominantly a group company with a major shareholder; therefore, it was

essential that we avoid widely fluctuating business cycles. So we have concentrated on self-funded products, and we have come at it from the point of view of endorsing the principles of an ASO to immunize the company from accelerating trends in health care. This leads to a focus on retention, so we needed to position our products with low net cost and guaranteed retention. This, of course, required effective expense management and sacrificing some profits in peak years of financial cycles.

In the claims processing era, we devoted much of our time and money to enhancing our claims system with the objectives of higher productivity and a flexible reporting system. We have also introduced products providing customers access to our claims systems, which we call BEN. One such product, BENLink, allows the customer to manage eligibility as well as access information on claims processed. We like to think of this as a competitive advantage; however, providing several customers with free hardware resembles more of a commodity approach. Another example is BENShare, whereby we lease our claims systems to large customers and support them just like a benefit payment office. Here again this proved not to be a perfect strategy, as we found out that our distribution system is not accustomed to working in this market.

In the managed care era, we wanted to be integrally involved in the development of managed care systems. The reasons for this were that we would have hands-on assurance that it works for the customer and consistency with Great-West Life markets and systems allowed us the ability to differentiate and maintain control of our customers. After our initial survey of third-party vendors, we decided to work with the Health Data Institute and develop our own UR program and preferred provider programs. We ended up as the managing general partner with 17 companies participating in Private Healthcare Systems. This has allowed us to continue working directly in developing enhancements to the managed care contracting process.

Right from the outset, there has been a significant emphasis on quality. This is a hard thing to put your hands on, but in the area of UR we focused on seeking agreements with the physician community on the most cost effective quality care. In the area of PPOs, specifically on the hospital side, we have identified more than 20 quantifiable criteria on quality of care.

In the distribution era, some of the tactics we have used include using plan design, which is really quite similar to the managed care programs, where the richer plans typically are coupled with less freedom of access to health care. We have also tried to focus on the issue of control. We want to have control over the enrollment process so that we can direct the employees' choices to the maximum extent possible.

Some of the other Great-West Life tactics include a very heavy preference for a full package. We have a strong preference for writing all of the coverages because we feel we end up with a stronger tie to the customer. Similarly with claim service, we feel we can manage that process and that it would be hard to replace. With ancillary services, we want to provide services we created ourselves; e.g., BENLink and managed care. With respect to LTD, we do not have a very large block of LTD-only business. However, we did reenter the market last year with the primary purpose of positioning our products to sell in conjunction with our other services. In our financial results, we found that we made a major share of the earnings on life insurance business, particularly when

we have also sold medical. We are at best breaking even on life business where it is sold in isolation.

We have also had an emphasis on a diversified product mix. We have four mainstream benefits, two in group life and health, and two in the group pension arena. We feel that by diversification we are better immunized by the market, and it alleviates some of the price pressure. We have tended to use our compensation formulas as a means of focusing on our objectives. We have a general field office where the sales representatives deal with life, health and pensions, and we feel that we need compensation to be structured in such a way to focus them on our objectives. Some examples are that we paid our sales representatives to convert cases from wholly insured to alternate funding methods some six or seven years ago when that was the main part of our strategy. We paid more on a full package of benefits than we would have if they were to write the coverages individually. Any ancillary service generates additional compensation, and the managers are paid based on the business mix amongst the four product lines.

Another one of our tactics has been to focus on integrated service. We have started a program which we refer to as a VIP program, where we have the sales offices identify peak cases in the marketplace which are more visibly important than their overall persistence. What this entails is the formal discipline process, complete with the business plan and its schedule of activities which are monitored throughout the year. It involves coordinators in the home office and in the field offices to be responsible for the services delivered. This recently has been expanded to other parts of our business and coordinates our service program, all of which is a more formal way of delivering service.

Under the heading of internal communication, we dedicated our entire group conference a couple of years ago to the theme of "Winning Combination." Our objective was to get all employees in the company focused on the item of delivering service to the customers. We started off by including all middle management personnel, stating our mission statement and values, rolling out a highly visible program for the employees, and then summarizing it in quarterly communications meetings where every single employee was in attendance.

So to summarize, I would like to leave you with three points:

1. It is important to understand the decisive things that we need to do in order to gain a competitive advantage. Currently this is with respect to managed care; soon this will be with respect to distribution.

2. It is important to plan for the next era in the current era. It is too late to launch into managed care at this point in time.

3. The 1990s will see the emergence of the distribution era and planning for this should start now. The investment to successfully enter into the distribution era will be very significant, but in my opinion the cost of avoiding this investment will be greater.

MR. BRINK: As you were discussing the various eras, I could not help but think about the apparent strategies used by many companies. Companies seem to respond to the eras at different rates. A number of companies are still in the claim processing era, while others have moved into the managed care era.

Our next speaker is Mr. Allen Maltz. Allen is now the Senior Vice President and Chief Financial Officer for Partners National Health Plan. He is responsible for the accounting, reporting, cash management, finance budgeting, planning, risk management and actuarial services. Prior to 1985 Allen was with Aetna as an Actuary in the Employee Benefits Division, where he was responsible for fund and reserve management, manual rate development, and development of special financial arrangements for large groups. Prior to 1982 Allen was at Travelers for 10 years in the Group Division.

MR. ALLEN P. MALTZ: I am going to spend a few minutes talking about the Partner's strategy for success in the Alternate Delivery System (ADS) arena. I will start off by talking a little bit about my company so you can get an idea of where I am coming from. I will go on to talk about our outlook on the environment and what we believe the marketplace is telling us. Then I will finish up by talking about our strategies for success.

Partner's was formed May 23, 1985. Partner's is a joint venture of Aetna Life Insurance Company and the Voluntary Hospitals of America (VHA). Aetna is the largest shareholder-owned insurance company in the world with more than $8 billion of annual group health insurance premium equivalents. VHA is the largest national network of associated hospitals, made up of more than 790 shareholders and affiliated hospitals in 48 states, which comprises approximately 20% of all community hospital revenues in the country. Approximately one out of every four U.S. physicians are affiliated with VHA hospitals.

Just to give you some war stories, I started out with Partners on September 4, 1985; I was the 44th company employee at the time. When I joined the company, we had no markets, no products and no members. We sold our first case in December, 1985. Our first market was Louisville, Kentucky, with a PPO on a 10-life group called "Big O Tire," and it cancelled before it became effective. Just to give you an idea of how far we have come, as of December 31, 1987, we have 22 operational HMOs throughout the country, 72 PPO markets under contract, and we have a national third-party claim administration system as well. We have 1,450 employees and over a million members in our ADS products. Since December 31 this number has increased, because effective February 1, 1988, Partners became a subcontractor under the CHAMPUS contract in Southern California and that includes 430,000 covered lives in Southern California and another 115,000 covered lives in Arizona. It is a five-year contract with a total premium of over $1.8 billion, and it will make Partners one of the top five companies in the HMO industry in less than three years of existence. So we have come a long way since "Big O Tire," but I've been there for the pain and hopefully for the glory.

I would like to take a few moments now and talk about our general outlook on the environment. I started out by saying that we are beginning to see a lot of consolidation in the health insurance industry and among ADS companies. The marketplace, in our opinion, is moving away from straight indemnity toward managed care. Small indemnity companies will find it difficult to move into managed care, because network development is expensive, and the small volume which the smaller company is likely to bring to a provider is not likely to get that provider's attention. So they are less likely to get the largest discount and the most favorable reimbursement the provider might give.

The recent shift in health care trends has also greatly increased loss ratios causing "bottom line" losses. Companies can no longer focus on other lines of

business and treat health care as an accommodation line on the side, to keep their agents in business. If you try to make health care an accommodation line, we feel that you will likely run substantial, consistent losses. In today's environment, either a company commits the resources necessary to be a serious player in the marketplace, or you just will not make it.

Some companies, not just small ones, are refusing to write new business. That is particularly true in the small case market where loss ratios tend to grow substantially faster than in the large case market. In fact, I have recently become aware of a few small companies who are taking steps to discontinue their group health line completely. It is our belief that the well-managed health insurance and HMO companies continue to remain profitable even in this tough environment, although there are fewer of them and the profits are somewhat smaller. We still believe you can be successful in this market if you make it your primary line of business.

We believe that the healthcare trends will continue to outpace overall inflation in the next year or two. Also, after several years of slow growth or no growth in utilization, the utilization growth rates have returned with a vengeance.

Here are some possible reasons for the continued Medicare cost shifting or the push by the government to reduce spending. The aging of the population could potentially create some utilization. Epidemics, such as AIDS, are sort of a wild card in today's environment (nobody can accurately predict how fast that epidemic will spread). Costs in the neighborhood of $40,000 or $50,000 or more for AIDS patients is a scary phenomenon and has already had an impact on plans in New York, San Francisco and some of the other larger cities. We have seen a strong increase in utilization in outpatient care. Another cause for trend increases is new medical technology, such as a tissue plasminogen activator (TPA) drug to treat blood clots in heart attack patients which costs about $2,500 per treatment and is likely to become used on the majority of heart patients. There also seems to be a trend toward a more rapid approval of "experimental drugs" and "experimental treatments" which has also increased costs.

Insurers, HMOs and other ADS companies have reacted to these trends on a lag basis, but they have reacted with "catch up" kinds of health increases. We are seeing indemnity market rate increases in the range of 30% to 50%. On the HMO side, we are seeing in the market somewhat more moderate increases in the 10% to 25% range. Those of us in the ADS field would like to believe this lower rate of increase is because we are doing a better job of managing care and keeping control of those kinds of trends.

I now want to talk a little bit about health care providers and our outlook on what's going on in that part of the world. The increase in volume of discounted patients who are coming to providers by the form of HMOs and PPOs is creating a new cost shift of its own, whereby providers are increasing their overall fee level and then discounting them when they go to HMOs and PPOs. The net result for the HMOs and PPOs is that there is more moderate inflation put into the indemnity arena, which tends to increase the price inflation. Physicians have also begun to organize a little more effectively, particularly in Minnesota and Southern California, where we are seeing almost a union mentality of physicians -- a get tough "sue the company" mentality.

Physicians are also learning how to work the system. Most UR programs are focused on inpatient care and precertification and in-hospital types of review.

In the recent period, outpatient costs, which have been subject to less review, have really taken off. The recent increase in medical malpractice insurance has also found its way into physician fees and has again renewed the use of defensive medicine, which tends to increase utilization rates.

Looking at health care competition, we find that price competitors still exist in the marketplace. And some companies still seem to be looking to buy market share, although it has become more and more expensive to do so. Most ADS companies have chosen to get on the "quality of care" bandwagon, but there are still few statistics available for anyone to demonstrate that the managed care system has quality providers. HMOs have moved towards "swing out" options which are plans that provide out of network benefits rather than have a strict lock-in. These HMO plans are designed to compete more effectively with PPOs and indemnity programs. All in all, competitors seem to be moving closer to one another, with the distinctions between an HMO and a PPO and an indemnity program and a multiple option program getting less and less clear. The ultimate winners in the marketplace, we believe, are the companies which provide efficient quality service and efficient managed quality care.

In developing an ADS product, we feel that there are three major constituencies that must be pleased by the product. The three constituencies, in our opinion, are employers, employees and the providers of the care.

Looking at ADS products and the health care arena in general from the employers' needs, our belief is that if the employers had their wishes fully granted, there would be products that gave them complete control over their benefits programs, including benefits' flexibility and detailed reports, and they would be asked to buy only those products they need. They would be looking for high quality of care, low cost, maximum cost predictability in the form of budgeted costs and smoothing of their financial terms. They would be looking for the plan to be accountable through refunds and reports back to them and perhaps through provider risk sharing. They would be looking for ease of administration, which in their jargon would mean that rather than having 50 or 60 HMOs to deal with for a multisite employer, they could deal with one entity and package their product and pay a single rate to one entity that took control over their entire program. They would be looking for the widest possible choice of providers for the employees, and for provider accountability or risk in the bottom line result. As you will see later, some of these employer demands are somewhat incompatible with the provider demands, which is the art of our business.

What the employees would be looking for is the widest possible choice of providers, low out-of-pocket cost, and low monthly contribution. They would also be looking for high quality of care, which means the best that health care has to offer in times that they are sick. They would be looking for ease of administration, but to them, ease of administration would be no claim forms. And they would be looking for free choice of programs, so that they could make either a point-of-service selection or at the very least a selection annually in an open enrollment environment.

The third constituency is the provider. What is it the providers are looking for? Well, in today's environment the provider is looking for patient flow. They are also looking for high reimbursement, which is somewhat incompatible with low costs on the employer side. They are looking for administrative convenience, which to them means informative ID cards containing understandable

benefits plans and explanations of payment. They would be able to take the right amount of money from patients while they are in their office. They would also like to maintain their professional independence. They would love it if some of these HMOs got out of their hair and let them practice medicine the way they feel they know how to do it. And they are also looking for protection of their professional reputation, which means dealing with HMO companies which provide a quality image.

In looking at the products that our industry has to offer, in my view indemnity companies have tended to go after the employer marketplace and they tend to be employer friendly. They tend to offer freedom of choice to employers in choice of benefit design, and freedom of choice to employees in terms of choosing a provider. The employer has control over an indemnity program in terms of establishing what they want to pay for the plan, and they also get a fair measure for plan accountability. On the other side of the coin, that comes at a price, and indemnity plans on a benefit adjusted basis tend to be more costly than managed care.

Indemnity plans, on the other hand, have traditionally been provider-unfriendly. They offer no steering of patients to a provider, and they have coinsurance and deductibles which are unintelligible to the average provider. The average provider has no idea how much money to collect from patients when they are in their office, and they offer uninformative ID cards which do not even necessarily guarantee that the individual is covered. On the other hand, providers like the high reimbursement that indemnity programs offer.

HMOs in contrast have tended to be employer-unfriendly and provider-friendly. When I say HMOs have tended to be employer-unfriendly, they tend to offer restrictive choice in terms of the networks the patients can go to. They tend to have little employer control. An HMO will often come with a fixed plan of benefits or a limited choice of benefits plans. And until the very recent past, HMOs have offered very limited accountability to the employer, as if the population was kept in a black box where nobody could see it. However, as a saving grace, they have tended to be somewhat lower in cost on a benefit adjusted basis. HMOs have on the other hand tended to be provider-friendly. They typically use co-pays rather than coinsurance and deductibles and have informative ID cards so that a provider knows what to take from a patient when they are in their office. Offsetting that, they offer somewhat reduced reimbursement and somewhat reduced independence because of the use of UR in the program.

PPOs have tried to walk the middle ground by being a little bit of this and a little bit of that. I guess you could say the cup is either half full or half empty, and that they do a good job going after both constituencies. Another way of looking at PPOs is that neither buyers nor providers are completely satisfied by that product.

Let me talk a few moments about Partner's strategy given the environment, and our outlook on the competition and what the marketplace is demanding of us. A spectrum of products is more likely to meet the marketplace demand than any single product, and that means there will be some buyers out there looking for indemnity plans, HMOs, PPOs, and third-party claim payment systems and multiple options. Our company believes that we need to be in a position through our family of companies to provide that. Partner's has chosen to play on the strengths of its parents. In creating ADS products, Partners will be using the existing Aetna claims systems, their rating techniques and technical expertise to

assist us, in addition to our own sales force. Many of Partner's products are sold under the Aetna name using the Aetna sales force, which means we tend to have a large company multisite focus on our customers. We tend to focus on the large metropolitan areas. We look for markets because of our other parent, which has strong VHA hospital presence and a strong network of providers. And we try to sell the Aetna/VHA reputation for quality in the marketplace.

Once we have identified a market we are interested in, we typically go through a build-versus-buy analysis to determine which approach is best for market entry. A market which has several existing HMOs in a typically large metropolitan area may not be the best marketplace to build a new plan. A buy approach might be best in that kind of a market. Our belief is that the ability to deliver service as efficiently as possible is critical. Partner's growth has allowed us to spread the fixed expenses and those developmental costs of the company over an ever broadening book of business and thereby cut the cost per member. We also believe that effective UR and management has become increasingly important, and as the trend rates have increased and as time moves on, that will be one of the distinguishing characteristics of the winners and losers.

I would like to leave you with some thoughts on our pricing strategies. We feel that it is important to maintain pricing discipline. Our approach has been not to lower our prices even if it means losing a customer, and I have tried to instill in my staff and those that I work with that we should never give away something of value for nothing.

MR. BRINK: I think you are right, you cannot make it up on volume. Our next speaker is Mr. Ted Dunn from Provident Life & Accident. Ted joined Provident in 1951 as an Actuarial Trainee. He served in many different positions within Provident. In 1972 he became the Group Actuarial Underwriting Vice President. Recently he has been named Chief Operating Officer for the Western Home Office of Provident in Los Angeles following their acquisition of the Transamerica/Occidental block of business.

MR. TED L. DUNN: I have been at Provident since 1951. Somebody asked me what I did before that, and I said that I was a small boy. It has befallen me a number of times over the years to be the last speaker at the end of a day, and I do very much remember one such occasion five years ago in Melbourne, Australia. It was a long three-day meeting, and I was the last speaker on the third day. By actual count, there had been 36 people that day get up and speak before me, and I knew I was in trouble. So I decided to tell them I felt like Elizabeth Taylor's eighth husband on his wedding night. I know what I'm supposed to do, but how do I make it interesting?

The session is aptly named Strategies for Survival in the Group Health Insurance Market. The key word, in my opinion, is *survival.* It is not just by happenstance that I wear a red tie these days. This is a result of the underwriting results we are having.

Effective May 1, 1987, Provident Life and Accident acquired the group life and health business of Transamerica Occidental Life Insurance Company in Los Angeles. At that time Provident did truly become a national company in scope, and it is of interest that the state with the largest amount of premium and premium equivalents for us is now California. Our current size is $3.4 billion annually of group premium and premium equivalents.

In February 1986, Provident became part of a joint venture established at that time with Transamerica/Occidental and American Healthcare Plans, Inc., a subsidiary of American Healthcare Systems (AmHS). AmHS is the largest not-for-profit hospital organization, comprising over 1,000 hospitals. In order to avoid the antitrust implications of having two insurance companies as part of the same joint venture, a rather formal organization was established. With our later acquisition of the Transamerica/Occidental group business, the antitrust problems evaporated and we have now instituted a much more cost-effective arrangement with AmHS, in which each partner will focus on its own area of expertise in managed health care.

At the present time, Provident has 25 PPOs and has arrangements with ten other PPOs. There are approximately 600,000 persons, including employees and dependents, insured under our plans with PPO arrangements. Currently, we are redirecting our efforts in the managed health care area toward improving performance of our existing PPOs, rather than rapidly expanding into new markets. During 1987, we phased out the rate discounts used to stimulate market penetration in our PPO markets, and we have modified our pricing to reflect the actual experience in claims savings associated with the PPO. During 1988, we will place major emphasis on improving our UR capabilities and on evaluating the performance of each individual PPO.

Provident presently has UR capabilities in both the Chattanooga and Los Angeles home offices and has about 1.5 million persons covered under such plans in all 50 states. This number of persons includes both employees and dependents.

A significant part of Provident's approach to managed health care is its Patient Care Services area, which has two purposes. The first is to ensure appropriate utilization and delivery of quality health care while monitoring and controlling costs. The second is to reduce claim costs associated with health care.

Patient Care Services are provided in two main categories. The first is medical care coordination for acutely ill patients. They have multiple medical confinement within a year and costly procedures. The second is medical case management of catastrophically ill and injured patients.

Perhaps the most visible part of Patient Care Services is the large loss case management activities. The total savings from these activities are running about $16 million per year. We believe that the ratio of savings to costs is in the area of 14 to 1. I wish we had comparable statistics for a lot of other activities. This is one that really does seem to be working. Since both our UR and the large loss case management activities are an integral part of our computer claim payment system, occasionally activity with respect to a large loss case management will start even prior to the patient's admission to a hospital.

A significant challenge to the group insurance industry is that, to my knowledge, no company has truly continued to be successful in every part of the marketplace at the same time. That is, some companies are quite successful in the baby group market, some are successful in the large case market and some are successful in special niches such as group long-term disability. Some companies have even been successful at more than one category of the marketplace, but not necessarily in the same time frame. I think that the opposite has been true for Provident in 1987. We were not successful in any category of the marketplace, other than in perhaps group long-term disability. We hired a

person from Union Mutual who told us that we did not know what we were talking about, but that he did -- and he was right.

In an effort to address this challenge, Provident has structured its group department into five distinct operating areas. Each of these areas have their own separate administrative, claim and underwriting staffs, which are self-contained. Generally, the marketing support and actuarial support are centralized and support all of the five operating areas, which for Provident are: (1) Baby group, 2-19 lives; (2) Nonretention area, 20-150 lives; (3) Retention groups, 150 lives and over; (4) Long-term disability which is a separate product for us; and (5) Mass marketing including group universal life products.

Provident, as an insurance company, is very heavily weighted in the direction of group business and employee benefits in general. In fact, more than 80% of the revenues generated for the entire company arise from the employee benefits arena. As a result, we get a lot of top management attention and rightly so. We are getting it in spades right now.

Provident has only a few specified corporate strategies. Some of these strategies would be nice to achieve, but there is only one strategy which our Board of Directors has told us must be achieved, and that one is to continue to be a viable player in the employee benefits arena. We must win there.

Allen stated that the ultimate winners will be the companies that provide efficient, quality service and efficient, quality managed medical care. I agree with him completely.

To be a winner today in managed health care, I believe three things are needed. The first is that one must have people on board who can talk with the medical care purveyors in their own language such that these purveyors understand what is really being said. The second is to have the capacity to appropriately massage large amounts of data to effectively produce the types of management reports which consultants, brokers and large clients demand, while at the same time provide the data necessary to affect the behavior of purveyors of medical care in a significant way. The third and last is to be able to prove that the care that is being provided is truly quality care. At the present time, no one really seems to be able to give a complete definition of what constitutes quality care. However, I believe we are moving down the road to achieve that definition, and that this will be a very important parameter in the near future.

MR. BRINK: As you said, there is plenty of room for winners but there is also plenty of room for losers.

MR. EARL L. HOFFMAN: Mr. Dunn, you mentioned that you modified pricing in 1987 to reflect actual PPO savings. What are the key indicators you are looking at on PPO versus non-PPO experience to determine the actual savings?

MR. DUNN: Perhaps Steve Carter, Vice President and Group Actuary at Provident Life can help us with this question.

MR. STEPHEN T. CARTER: We have done several things. We tried to look at studies of the number of physician visits, how they changed, things of that nature -- experience of PPO plans versus non-PPO plans. And we tried to take all of those into account. You always learn something. When I first came into this business, people used to tell me that the more you saw a doctor, the

more bills you would have. With these $10 co-pay approaches, our physician visits have increased by 225%, and this does not just stop there. This increases all the way up, so that hospital charges go up 14% and so forth. So we have tried to look at a number of things, taking this into account.

MR. ALAN N. FERGUSON: Ted, you said that it is difficult to measure quality care. Would you care to speculate on the elements you might be looking at?

MR. DUNN: When I say quality care and it being a significant element in the future, we go back to the eras where retention costs were a factor in the financing arrangements. What I am saying is that employers and other clients want to know whether or not the coverage that is being provided for them does in fact constitute quality care. Is it the right kind of treatment? As to what the actual elements are going to be made up of, I do not know.

MR. FERGUSON: Are you looking at the kinds of treatments provided by different types of providers -- cesareans, for example, or readmission rates?

MR. DUNN: I would say all of the above.

MR. FERGUSON: If you offer a large customer a choice between a traditional plan and a PPO, and they want to know how things will work and how they will compare, how do you explain that? Do you have any problems with that?

MR. DUNN: I think we have made a lot of strides in being able to come up with the figures to in fact differentiate between them. And I think we have gone a long way down that road in massaging the data efficiently to produce those kinds of answers. We used to blow a lot of smoke, but I think we are really coming up with some answers in that area.

MR. HARRY L. SUTTON, JR.: Partner's is a joint venture indirectly of Aetna and VHA, and Provident has at least been connected with AmHS, which are systems and not-for-profit hospitals. In our experience, using a hospital as a base for an HMO, because of their conflict of trying to fill the hospital and at the same time control the cost, has been very difficult to run with. Could you discuss your problems in dealing with hospitals and controlling the cost of your healthcare plans?

MR. MALTZ: I think that the point you are making is something that we are very cognizant of. We have been very careful to segregate the ownership of the hospital from the management of Partner's national health plan for just that very reason; so the way that we have managed the health care business is to include the VHA as a basis for our PPOs and HMOs. We include other hospitals, in addition to those, to round out our network, our range of service coverage, and our geographic coverage. We manage the healthcare business as we believe the healthcare business should be managed. If a question comes down to, should we create a program that will increase hospital enrollment, the answer is no, we're looking to manage care.

MR. DUNN: I might make a similar comment to add to that. You are quite right, Harry. When we sat down with the hospital people, we found out that some of the same words meant different things to different people and we needed to make it perfectly clear from the insurance company's viewpoint and from our policyholder's viewpoint, that what we were interested in was getting people out of the hospital. What the hospital people are interested in is getting people in.

It takes a lot of dialogue to develop a level of trust between what you are saying to each other.

MR. HARVEY SOBEL: I have a follow-up question for Allen on what Harry was talking about. Is Partner's able to negotiate independently with each of the VHAs? I would also like you to clarify the relationship between Partner's and some of the other parents, including Aetna and the Aetna HMOs.

MR. MALTZ: Partner's does negotiate independently with each provider, be it VHA or non-VHA, as well as the physicians affiliated with those hospitals. So, in that regard, our approach is that we include the VHA hospitals in our network. We do not use only the VHA hospitals. In dealing with them, we look to get competitive advantage, and that is because of their ownership status of one of our parents. But we are in many ways an independent entity from VHA. Essentially the only rule is that we include them. In terms of the question of how should the ownership work in our relationship, Partner's is by its name a partnership; we are a 50/50 partnership of a company called VHA Enterprises, which is a for-profit subsidiary of VHA and the Aetna Life Insurance Company, and we have joint ownership of two equal parents.

MR. SOBEL: You mentioned that you wanted to capitalize on the strengths of your parent, and that would include the pricing. How does that work when you do triple-option pricing? I assume you have your Aetna marketing force and perhaps your own independent sales force trying to market rates that, if you were a separate entity, you would want priced to be adequate for each component rather than in the aggregate.

MR. MALTZ: Our approach is to price each component on a stand alone basis within the family on an adequate basis. When we go to the customer, though, we are looking to go with a single blended rate, regardless of choice. And, what happens under the covers, and how we divide up the money is really among ourselves.

MR. BRINK: I have one question for the panel. Several years ago we were all concerned about Humana and some of the other hospital corporations and the gloom and doom. What lessons can we learn from the hospital entry into the health insurance market and their ultimate withdrawal?

MR. MALTZ: I think that the major problem that Humana faced was that they broke some of the cardinal rules that were tried and true in the insurance industry. They went in there and tried to buy market share for low prices, which in our view has never worked. And they went in and tried multiyear guarantees, with caps on rate increases, which we were foolish enough to try to match for a short period of time. Fortunately, that period is behind us. I think that what they did wrong was that they had the belief that getting into the indemnity side of the business was easy and that you do not really need to know much to be in this business. If anything, within our company we have a good healthy fear of what it takes to be successful in the market, and we believe strongly that it is very easy to do poorly, very difficult to do well. And you have to have discipline to do well in pricing and underwriting, etc.

MR. DUNN: I would agree with that. I had a very interesting meeting, a number of years ago now, in Nashville with the Hospital Corporation of America (HCA) people. They are well connected, at very high levels, with the people who own Provident, and they were nice enough, in a gentlemanly way, to let us

know ahead of time that they were going to take over our business. We met with them all day and wished them well. It did not happen. I think one of the reasons is because to a great extent on the very large group cases, the service you provide to your client is one of the most important things they are looking for. And it takes a long time to develop that service, to deliver that service and to do it well. This meeting did take place prior to the culmination of Equitable and HCA.

MR. FERGUSON: On this question of survival, Ted, what is the rationale for the merger or takeover of the Transamerica business by Provident? What are the pros and cons for each of the parties?

MR. DUNN: I believe I can speak for the Transamerica people. From what we were told and what we have subsequently heard, the Transamerica people, I think, had decided that they were not big enough to be a viable player as they perceived it. They went out and tried to buy some other group companies. I believe they did. They were not successful in buying some, so they came to the conclusion that they were going to sell their group line. In my opinion, this decision was not made by the group people at Transamerica. They, in fact, did not know they were being sold until the day it was announced; it was quite a surprise to them.

So far as Provident was concerned, we were in a sense protecting our seat in the partnership with the hospital people. We had found that they had been a very good fit between Provident, Transamerica and the hospital people. It would have taken a very significant investment by Provident to develop enough business in the west for Provident to be a national player, and we felt that we had to be a national player if we were going to continue to be a viable participant in employee benefits. Those were the driving forces that led us to go ahead and do the merger and acquisition.

MR. MICHAEL D. SYDLASKE: My question is for Allen and for Ted. Do you think that the employers and consultants know how to judge the relative merits of managed care programs? Are there suggestions you would offer as to which ones are better than others?

MR. MALTZ: I guess I would leave that to the consultants to figure out. I would hate to step on that part of the marketplace. We are seeing so many crosscurrents among what different consultants are counseling their clients to do and what the different clients are asking them to do. And it is not at all clear what the marketplace wants right now. That was one of my points on why we needed a spectrum of products, because I do not know that we believe that we have the perfect product yet that the marketplace is looking for, if that product exists. In many ways it depends on the philosophy of the company. Our belief is that there is a need to have a spectrum of products so that we can be flexible enough to tailor a product to meet the larger employer. In terms of measuring one program against another, I think you would want to look at the quality of the people who built it, and the quality of the data that they used to build the system. How did they know they got a good deal or not? What were they looking at to determine whether they negotiated a good reimbursement? Do they have a good geographic coverage for the community so they can truly provide what they say they can provide? Do they cover all the ranges of service? When you get beyond that, in many ways reputation is important because some companies routinely make a point to deliver what they say they will deliver, and that is probably as important as anything in the industry.

MR. BRINK: It seems like there is an undercurrent here with some of the larger employers across the country. A healthcare providers' group was formed in San Diego. Another buyers' group was established in the Denver area. And these are employer coalition organizations. They are putting together their own PPOs, and they are strictly going after discounts. The reason they are doing that is that they are disenchanted with the insurance industry, and with the HMO products as well. They feel like they have to do that themselves. I think these are a small number of employers, but it is an undercurrent that seems to be happening at the current time.

MR. DUNN: I do agree with Allen on his point that each marketplace is separate. You have to look at each marketplace as a separate entity, because there is no one thing that will work in all marketplaces that I know of.

MR. JOSHUA JACOBS: I would like to ask Mr. Maltz and Mr. Dunn if they think there is room for survival of small companies who work on a regional basis. They spoke about national players, and now I hear Ted Dunn saying you have to adapt yourself to each individual marketplace. Do you think that a smaller company could be successful if it confined itself to certain limited regions?

MR. DUNN: Let me address that, because that was one of the alternatives Provident, in fact, looked at before we went out and bet the form on this acquisition. What would happen, if in fact we did not? And we came to the conclusion that we would be nowhere near as large in the future, but that in fact we would still grow -- but not to the extent that our management had told us they expected us to grow. We ran that scenario out for about 50 years and then came to the conclusion to go ahead and pursue the acquisition, which we did.

MR. MALTZ: I believe that if you are a strong player in a single market, or a small number of markets, there is a possibility of survival with that strategy. My belief is that there is not very much possibility of survival if you are a small player in a lot of markets. So, you should pick your markets well and try to be successful in those that you are in. That is one possible strategy. In dealing with the providers, in many ways volume is the name of the game. And if you can deliver what a group of providers believe is a fair amount of volume in their market, you can be a strong player. But if you try to be a small player in every market, you just will not have the power to get the kind of reimbursement rates you need in order to make it.

MR. SUTTON: I would like to pursue this national network. I think you said, Allen, Partner's has 22 HMO divisions and Ted had 35 PPO locations. While that is a sizeable network, if you are looking at large national accounts, it does not come close to matching the likely plant locations where that national account is. The investment in setting up in most major metropolitan areas must be rather immense, whether you are buying something or starting from scratch, which is slower. I guess I am interested in whether you really think you could get your money back from doing it. I guess you must or you would not be doing it. I sense the networking of the big carriers opening in more and more cities has slowed down dramatically in the last couple of years. Maybe they are looking more in a buying mode than a starting mode since so many areas are overbuilt in terms of independent systems. Along with this national network, Allen raised the question about a major national account contracting with one carrier or provider to provide managed health care in most of the plant locations. The only major example that we have really seen is Cigna with the Allied Signal

Corporation, which cancelled out all of their HMOs and offered to their employees whatever Cigna HMOs happened to have available at their major location. Could you discuss this national presence in covering so many areas, and do you think that national presence can, in fact, capture 100% of a large national account?

MR. MALTZ: I mentioned that we had 22 HMOs, and we have actually better than 70 PPOs. I think that in a PPO product, for many larger employers we can provide coverage to a large majority of their groups. We did what we like to call critical mass at this point. There are several major accounts where we are able to provide coverage for 70% to 80% of their employee base. I do not think we will ever hit 100%. Our goal is to be in the larger metropolitan areas, which also tends to improve the hit rates that we have. So I think that the answer is yes, a company can do that. I do not think that the 70 sites that we have now are enough. You have indicated that maybe some of the other competitors are not growing the PPOs as rapidly as in the past. That is not the case with us. We are continuing to follow that strategy. To take on the second point where you talked about the Cigna Allied Signal approach, they replaced existing plans in exchange for a very favorable deal. You are talking our kind of language when you say that.

MR. DUNN: We at Provident had set out with our partner to establish a number of PPOs. Our strategy now would be more toward "Rent a PPO." We are not going to set up another 20 or 30 PPOs. It is too expensive to do it by yourself. There are not enough people in this country that are skilled in doing this sort of thing -- people who go around and set up PPOs. So, we have changed our strategy very considerably, in that regard.