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THE FUTURE OF HMOS

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- Marketplace
  - -- Current industry trends
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- Physician structures
- Capital needs

MR. DAVID E. HARRELL: In 1929, the first HMO prototype, Ross Loos Clinic in Los Angeles, was formed. In 1945, the Kaiser Permanente medical care program was established in northern and southern California. If you follow the continuum to 1970, these HMOs served three million enrollees.

In 1971, the Presidential health message proposing an HMO initiative to combat rising health care costs was introduced. In 1973, passage of the Health Maintenance Organization Act made federal funds available for plan development. The total investment was $364 million over ten years. Moving on to 1976, the HMO Act Amendments liberalized requirements creating widespread industry acceptance for federal qualification. Federal qualification became a precursor to the so-called mandate for employers with whom you may work.

The National Labor Industry Council for HMO Development was formed in 1979 following the Fortune 500 HMO Conference sponsored by the Secretary of the Department of Health, Education and Welfare.

In 1980, there were 236 HMOs serving 9.1 million members. It is important to get a feel for this time line with the establishment of the first HMO in 1929, the second major HMO in 1945, and the existence of 236 HMOs with 9.1 million members just 35 years later.

In 1981, the federal financial assistance program to promote HMO growth achieved its objective and was terminated, and the federal effort to encourage private investment in HMOs was a success.

In 1983, a public offering craze went on in the HMO market and the accompanying deals abounded in the stock market.

If the historical development and trends are any indicator of where we've been, then they are surely somewhat indicative of what we can anticipate by the turn of the century in the development of HMOs. My theory is based on available historic data.

The number of HMOs grew from 175 in 1976 to 648 in March of 1988. Keep in mind that in 1980 there were just 236 HMOs. From 1976-1988, that represented a 370% growth rate in the absolute number of HMOs, or 14% per year. We can also examine the growth of enrollment and market

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share. HMO membership has grown from 6 million in 1976 to 31 million in 1988 for a gross rate of approximately 16% per year, certainly one measure of success.

The most recent data indicate a slowing of the rate of growth in both the number of HMOs and in HMO membership. The industry is currently going through some consolidation, and there has been a slowing of new starts. Similarly, at the turn of the century, the life insurance industry experienced a major craze for new development and new entrants into the market, and then there was a consolidation and an expansion. In my opinion, that is what we are about to see in the HMO industry over the next twenty to thirty years.

The second measure of the success of HMOs has to be physician satisfaction. Many of us hear about physicians being totally dissatisfied with HMO activity. I suggest that this is not true when you consider that most HMOs are enjoying high levels of physician participation and/or satisfaction.

The reason we hear about physician dissatisfaction is that many physicians participate in HMOs as a defensive measure, to avoid losing their patient market share. Clearly, many physicians participate in HMOs in order to stabilize an existing practice and to avoid a migration of their existing patients. The strategy of some physicians reflects that some participation may be driven more by the economy than a buy-in into managed care.

HMOs with plans in multiple states increased physician participation 7.9% from 1987 to 1988, while independent HMOs increased physician participation by 28% for the same period. There are a lot of physicians participating in managed care programs and specifically in HMOs. My company's plan covers a population of approximately 4 million people in southeastern Florida. I personally contract with 47 hospitals and 1,800 physicians, and I know there are physicians participating in HMOs who are pleased with that relationship and participation.

The third measure of the success of HMOs is employers' acceptance. According to a *Health Market Survey* of January 15, 1989, approximately two-thirds of all employers surveyed felt that HMOs either saved them money or had no effect on costs. According to a recent Group Health Association Of America (GHAA) report, one in ten Americans is enrolled in an HMO, and this number could grow considerably within ten years. Actual enrollment percentages vary widely by geographic area. There are difficulties in projecting future growth trends, and different estimates have been made. In January 1988, Ken Abramowitz of Sanford C. Bernstein & Co. estimated that 30% of the private pay population would be enrolled in HMOs by 1992. In a presentation to the Health Care Council of the U.S. Chamber of Commerce in 1989, he estimated that if trends are extended another five years, 50% of the working population of the United States will be enrolled in HMOs by 1997.

When analyzing the market for HMOs, we must not forget the public sector as a payor. Specifically, the federal government consumes (or pays out) approximately 50% of the health care dollar in this country. How does the government react to HMOs? The Medicare program enrollment in HMOs continues to rise, even though there has been a cutback in the absolute number of HMOs participating in the Medicare program. The Medicare and Medicaid enrollment in HMOs grew about 16.19% in 1985 and 13.9% in 1986.

Now, if we are to address the future of HMOs, I think we have to determine:

- What is the marketplace?
- Who are the players?
- What are the trends?

I've tried to provide you with some historical data to illustrate that there is real growth and involvement in HMOs in the United States. The marketplace for HMOs is clearly the under-65 working population and the over-65 Medicare population. This marketplace has several players, and I've attempted to place them into four groups: the traditional or indemnity market; the preferred provider organization (PPO) market; the HMO market; and the employer market, which

is either self-funded, self-insured, or involves some third-party administration or self-funding activity.

The trends show that traditional indemnity insurance carriers are losing market share to managed care programs such as HMOs and PPOs. Many traditional carriers are implementing some aspects of managed care in their products such as precertification requirements. PPOs have had an effect on HMO growth, and in my opinion, this activity will diminish with flexible HMO development and as members become accustomed to managed care.

I am not a proponent of PPOs. My position as a managed care executive is that open-ended PPOs do not control costs at the level that employers are going to require in order to hold down costs as an absolute percentage of GNP. If the purchasers of health services care about costs, they must measure the value of HMO managed care in utilization terms to determine its current success and the potential to continue that success.

Based on 1986 data, the number of HMO inpatient days per thousand for the under-65 population was 351 as compared to 606 days per thousand for the under-65 population in the nation as a whole. These numbers reflect a 72% increase in the utilization rate for the nation as compared to that of the HMO industry. For the over-65 population, the days per thousand for the HMO industry was 1,835 as compared to 3,121 days per thousand for the nation as a whole. Again, this is a 70% difference in total days per thousand.

Let's take a look at discharge rates. The HMOs had 81 discharges per thousand for the under-65 population as compared to 112 discharges per thousand for the nation as a whole. The over-65 population had 262 discharges per thousand in the HMOs as compared to 367 discharges for the national population. When you look at these data in percentage terms, the HMOs performed 38.27% better than the nation as a whole in managing the discharge and/or admission rates of the patients and/or members and/or employees of the employers that we serve. For the over-65 population, this means real dollar savings to the economy and the national budget process since there is a 40% variance between the HMO statistics and those of the nation as a whole.

Now let's consider length of stay. For the under-65 population, the average length of stay was 4.4 days for the HMO managed care population and 5.2 days for the population at large. As you actuaries know, an 18% savings in days means a lot in terms of cost. One of the great salesman of our times, Zig Ziegler, once said, "Don't confuse price and cost." Price is what you pay today, and it's a one-time thing. Cost is a lifetime thing. When you consider an 18% longer stay per patient/per member/per employee and the downtime that the hospitalization represents to the employer for every admission, it translates into real dollars. This amount must be added into cost savings over and above premium. This is often overlooked in the managed care industry.

Consider the over-65 population; the average length of stay for this population in HMOs is 7.1 days as compared to 8.5 days for the nation as a whole. That is a difference of 19.72%.

I've extrapolated these data, assumed an average hospital reimbursement rate of $700/day, and extended these data for a population of 31 million commercial HMO enrollees. If there were 31 million commercial members covered in 1988, and if we could save $700/day for every day we save in hospitalization costs, what would be the result? It equals $5,533,500,000 just for the under-65 segment of the population. There is a bright future for managed care HMO programs with a $5 billion savings on such a small market share.

Comparing these data for Medicare makes an even more significant statement. The plan that I operate in South Florida has about 110,000 members. Of those 110,000 members, approximately 13,000 are Medicare members. If I extrapolate the data that we just reviewed of 1,835 days per thousand and apply the data to my operation in south Florida, one HMO, the savings for one year would be $11,702,600. This amount is a savings to the economy, which is a savings to the federal budget, which is a savings for the Medicare contribution, which comes out of your revenue.

Most employers given the opportunity will offer HMOs as a cost-saving measure. Now I'd like to share something with those of you in the traditional indemnity market who feel that all of the healthy folks are going to the HMOs and leaving all of the adverse selections to the traditional plans. Consider the age/sex mix of the entire United States population, 38.4% of the population falls into the 0-24 age bracket, compared to 36.8% of the HMO population. My point is that those

age brackets clearly are not migrating to the HMOs as a percentage of the population. Also, the male/female mix for the HMO population is 47.9%/52.1% compared to the total U.S. population male/female mix of 48.6%/51.4%. There is not a clear movement of the young, healthy population to the HMOs to the detriment of the traditional programs.

The final point I want to make on utilization in this regard is that those employers who have self-funded plans and think that HMOs are causing adverse selection on self-funded plans don't understand actuarial math. This is because the employer's cost for a self-funded plan is 100% of the health claims plus other components such as administration. If the HMO comes in and picks up all the healthy members from that self-funded plan, has it deteriorated or adversely affected the employer? No, it saved him a lot of money because he shifted the risk for the bulk of his population. The employer retained risk that he already had. But he's shifted the balance of his risk, improved his days per thousand, improved his average length of stay, and reduced his cost because he's getting his employees back to work faster.

The federal government has a commitment to HMO growth. Physicians and hospitals participate in HMOs, although sometimes reluctantly. We can determine from the marketplace trend that HMOs will be a viable alternate health care payer for the foreseeable future.

The next issue on our agenda is product design. The basic HMO product provides 100% of health care cost to the member after a specific deductible or copayment. The copayment is usually in the area of $5-$10 per office visit, $25-$50 for an emergency room visit, and $0-$100 per day for an inpatient hospital stay with an absolute maximum limit. Some plans do allow the members to go out-of-panel, and in so doing, the member generally incurs an increased copayment or deductible. This latter approach is really a modified PPO. It has a tendency to dilute the effectiveness of the HMO managed care program since the nonparticipating physician has no incentive to respond to the request of the HMO to reduce utilization and length of stay. My position is that for HMOs to be successful in the next ten to twenty years, they must be flexible in order to achieve a greater market share. However, this flexibility must not minimize the importance of the primary care physician in the delivery system. Otherwise, managed care will fall into the pit of open-ended, open-cost, nonmanaged health care previously enjoyed by the traditional indemnity carriers. In my opinion, flexibility will mean prospective and retrospective experience rating, risk sharing between the HMO and the large employer, and modifying member copayments as long as they don't unduly confuse the provider panel.

Physician structures have changed substantially over the last several years. The basic structure has evolved to include the staff model, the group model, the network model, and the individual practice association. In my opinion, the network and individual practice association (IPA) model physician structures will continue to grow. These models tend to offer a broader choice of physicians, which tends to appeal to new enrollees. Clearly the staff model plans have shown a greater ability to manage care and control cost and utilization. In order for the IPA and the network models to continue to expand their market share, they must have the physicians and hospitals participate in risk. This is called risk sharing with a provider in order to make viable plans work prospectively. This can be accomplished through physician and hospital capitation, which will occur as the providers struggle to maintain revenue and patients. The HMO must force the issue in order to maintain price advantage over the traditional carriers.

In my opinion, capital needs will decrease except for acquisition needs. This is because I believe that start-up HMOs or HMOs expanding into new markets will evolve from existing successful HMOs that will generate cash internally. The bloom is off the roses for the "get-rich-quick HMO," and the future of managed care will rest with a well-run, well-managed, cost-effective HMO.

I'd like to close by sharing something that appeared in the December 12, 1988 issue of *Health Week*. James F. Dougherty said:

> "Due to the slowing of the growth rate in membership in HMOs and the reduction in the number of HMOs due to consolidation, there are those who feel HMOs cannot survive in the long run. This position is faulty when the comments are taken into focus. Critics and doom-sayers uniformly forget that HMOs' basic underlying principles carry overwhelming business and social logic. Combining health care services into a single purchase at an appropriate price and organizing human and physical resources in a way

that assures quality, cost-effective care is a simple concept which many feel should have been adopted 50 years ago."

I agree with our initial prognosticator that the market share will grow to 30% and then to 50% of total market. My further prediction is that HMOs and the traditional carriers will not be as we know them today. We will see the evolution that started in 1945 with the phase-out of traditional insurance into managed care programs.

DR. THOMAS P. O'BRIEN: It's good to see that medicine is not the only group that is undergoing massive changes. The March 6, 1989, issue of *Medical Economics* includes an article that fits in well with our subject titled, "Did a Guy with the World's Best Job Shape Your Pension Plan?" Then the subhead reads, "He's an actuary and a survey ranks his occupation as the best there is." Later on the article mentions how one actuary came to choose such a rare field. I'm glad to be speaking to a group of people who must be perfectly happy and content in their jobs. My presentation emphasizes the increasingly important role that actuaries are going to have in making specific recommendations about the directions that health care is going to go in the future.

My background includes thirteen years of private practice as a physician. In the course of that time, I feel that I made almost every business mistake a physician can make in private practice and practice management. I hope I learned from these mistakes. My current role with EQUICOR, although my title indicates responsibility for market entry and market expansion, is that of a mechanic. We inherited several HMOs from Hospital Corporation of America (HCA), and it is my job to go in and "fix" these HMOs and literally stay on site until the management or medical direction portion of the HMO is fixed and back on track. This has given me a relatively critical perspective, not on the HMO concept, but on how an HMO functions in real life. It is my opinion that HMO management requires a level of sophistication to perform a very strong juggling act between marketing, financial realities, and above all, managing physicians and medical costs. Any one of these three responsibilities is really a full-time job. To have a chief executive officer (CEO) who is interested in all three of these and who can make his plan grow, as AV-MED has grown, is very unusual.

There are four questions being asked over and over again by employers and individuals throughout the country: How much care? What kind of care? How do we pay? Who do we pay? Against this background of consumerism and benefit plan management, the medical profession ends up asking the same four questions: How much care? What kind of care? How do we get paid? Who will pay us?

The reasons these questions are being increasingly asked by physicians are relatively simple in terms of historical background. We all know that there is an oversupply and a maldistribution of physicians in this country. The physician misallocation continues. There are incentives for this misallocation built into the system, such as the geographic differentials for Medicare Part B that allow differential payments for physicians who are not in rural areas. There are also other kinds of inducements such as practicing in large medical centers and enjoying the cultural privileges of big cities. All of these things have increased the competition among physicians in big cities. There is also the factor of increasing group activism among physician groups. Recently the American Academy of Family Practice sued the Health and Human Services Department to require Health Care Finance Administration (HCFA) to comply in Tennessee with a Sixth Circuit Court of Appeals ruling that overturned the specialty screens in Michigan. This establishes a level playing field between the internists and the family practitioners in the four states of Michigan, Tennessee, Kentucky, and Ohio. There are bills in other legislatures to increase the number of states where this will be applicable.

In addition, there is increased documentation of the differences in pay scales and in charges between internists and family practitioners. Hospitalization costs are greater with internists. The average hospitalization cost charged by an internist during a 3.4-year study was $7,193, whereas the family practitioner charged only $5,764. The length of stay was also greater with the internist. His length of stay was 7.5 days, while the length of stay for the family practitioner was 6.3 days. Internists' fees averaged $913, while the family practitioners fees averaged $629. I'm not saying that there isn't a preselection factor operating here that allows sicker patients to go to the internal medicine specialists. I'm saying that within the medical community, there is an increased amount of attention being paid to who is getting paid what and whether or not it is justified. There are medical specialty groups, such as the American Academy of Family Practice,

that are actively working to get these pay differentials broken down no matter what the mix of patients.

What has been physician response to this increase in competition? First of all, physicians have raised their fees. There was a 7.8% increase in physician fees last year. There has also been an increase in the frequency of physician/patient visits as physicians now have more time in their practice. As physicians have excess capacity in their offices, they tend to see patients for more follow-ups. In addition, there has been an upsurge in the use of technology that has brought about an increase of services. This is more prominent in the outpatient area. There has also been a marked increase in the number of claims over $20,000, and an increase in the number of psychiatric claims being provided under preestablished programs. These programs have 30-day inpatient or outpatient stays, and are of the type for which a diagnostic-related group (DRG) is automatically paid once a patient is admitted. In the largely unregulated psychiatric area, hospitals have embarked on developing these programs as a strategy.

In addition, we see that X-ray and lab costs have gone up 20%. As the physicians are seeing patients more, they are ordering more tests and lab examinations. As a result, there has been a drive to avoid physicians also having an economic interest in those lab and X-ray facilities.

The advantages of shifting to the outpatient population for the physician relate to the preservation of autonomy. Those advantages also relate to the physician's appreciation of the fact that there is less utilization control. He is free to prescribe what he wants. He is free to perform techniques that would be much more carefully checked if he were performing them in the hospital. As a result, his income is maintained at the levels of a few years ago.

The Blues did a study with 77 million subscribers regarding the number of outpatient visits per thousand people. From 1981 through 1987, the Blues found that there was a 26% increase in the number of outpatient visits. The cost per visit went up 88%. When patients were seen an increased number of times, the lab and X-ray costs, which weren't previously associated with an outpatient visit, were multiplied in a marked way. We all know the story that you can expect outpatient charges to go up when the inpatient charges go down. The Blues found that the inpatient days dropped 26%, but the net cost per case still went up 77%. Even when we consider the shift from the inpatient hospital setting, we find that there are defensive strategies that physicians are using to maintain their autonomy; to practice medicine the way they feel is right; and to maintain their incomes. This may not be a conscious desire, but it certainly is an effect.

Where does all this lead us? One east central state has a state employee health care cost of $30 million per year. The insurance company that runs this health plan estimates that next year, the health costs will be approximately $37 million. This is despite marked improvements in the claims processing system and almost no increase in charges for claims processing and management of this state insurance plan. To get this $37 million premium from the state is impossible; it does not have that kind of money. This increase in the cost for the state's multioption insurance plan can be broken down. There are increases in premiums from 1987 to 1988 in the following ranges:

- Indemnity premiums went up an average of 11%.
- IPA HMOs went up 10%.
- Staff and group HMOs went up 8%.
- PPOs went up 17%.

These figures are astounding when you consider how many of the pricing strategies used in the HMO and PPO market were really based on a relative lack of good data and were the best judgments that underwriters and actuaries had available to them. So in many cases, these are catch-up figures allowing for the increases. Nonetheless, we have a problem. Large state health plans do not have the money and are not able to get it. Legislators are under increasing pressure from the people not to appropriate more money for health care. I think this problem is going to become more severe, and the only way out of it is to use strict managed care principles through HMOs.

Another factor affecting the future of HMOs is the change in the Financial Accounting Standards Board (FASB) ruling, which requires that retiree health benefit costs be carried as a liability. The only way to account for that has to be through the use of strict managed care principles.

THE FUTURE OF HMOS

So let us turn now to what I see coming down the road for physicians and consumers of health care. First, we need to look at the near-term and long-term views of Representative Pete Stark, the Chairman of the House Ways and Means Committee. His primary goal is to tend to problems in health care. This Democrat from California feels that there are two immediate issues that he must take care of this year. First, he must drive down Medicare payments to physicians and hospitals. Second, he must decrease physician referrals to facilities that these physicians own or have a direct financial interest in. Just to give you some idea of the amount of ownership that physicians have, the American Medical Association (AMA) says that this decrease in referrals will affect approximately 10% of physicians. There are other industry estimates that would indicate that this number is closer to 20% of physicians. The 20% figure is developed by considering indirect techniques of ownership through other corporations, through family members, etc.

Over the long term, Fortney "Pete" Stark, U.S. Representative of the 9th district, says that he feels we will be directing aggregate amounts of money to state and regional medical societies by the turn of the century. These societies will distribute these aggregate amounts of money to staff model HMOs or capitated payment systems. We already see this happening in various subspecialty areas. Medicare now has a participating heart bypass demonstration center where the people are trying to drive down the cost for this very expensive procedure.

The federal government has always led the way in developing the way health care is paid for and the way people become accustomed to looking at it. We see that there is a real interest in managing health care through strict managed care principles because of accounting problems, because of legislators' views of the need to maintain costs, and because the money just isn't there to pay for the increase in medical cost.

What is the solution? The solution on a short-term basis has to be increased managed care. On a longer-term basis, there will be a continuing need for some products that allow an opt-out option, especially in the commercial market. The problem is pricing. The problem is knowing how to put the physicians at risk so that we end up having a provider community in which hospitals, outpatient physicians, ancillary suppliers -- everyone who is involved in the provision of medical services -- are as much at risk as they are with a standard HMO model. We need close control of costs while allowing people the freedom of choice to make moves outside the system, controlling those moves very accurately by benefit plan design.

In the near term on a commercial basis, we have two immediate problems that we must solve. The first is the problem of medical "waste." This can be helped in a small way by adding appropriate utilization review monitoring tools for our medical directors. Many plans with more than 50,000 enrollees have no effective way of comparing one physician with his peers in the community. This needs to be resolved. The second issue with medical waste is the fact that most of our medical directors are very poorly trained. Their medical knowledge is good, but their ability to manage other physicians is relatively poor. Psychologically, many of them have not made the leap to the necessity of managed care, and many of their CEOs do not know how to effectively manage their medical directors. The CEOs don't know the questions to ask to find out if the medical directors are doing their jobs, are calling physicians, and are making interventions that will direct patients proactively to less costly sites of care.

The other immediate problem is how we will deal with the medically underinsured population. I'm not just talking about the medically needy, or medically indigent. I'm talking about the working poor that do not have adequate funds, who cannot afford appropriate levels of insurance. These near-term problems are significant.

As the systems grow and develop, we are going to have a much greater focus on freedom of choice and better pricing strategies. Of course, that must be why actuaries have the happiest profession, because there is going to be a lot of work for you. I also think that as benefits are more well-defined, there will be an increased push towards catastrophic coverage for health care.

Let me make one final point. Oregon doesn't have the money to increase the amount of funding for its medical benefits. The solution that has been considered there resembles the following scenario. Let us say that we have a $30 million fund for payment of health bills within the state. A decision is going to have to be made on how that money is spent. Oregon is taking the first 500 most common procedures, paying those out of the $30 million, and then not covering anything less common. The problem with this kind of thinking is, what if the number 600 most common

procedures actually can save an immense amount of dollars if it is allowed to be covered. For instance, the procedure may save money on long-term disability. It makes economic sense to cover, but we still have our $30 million limit. So, we end up having to take out something from the top 500?

An example of this is already present in the use of intensive care unit (ICU) beds. As you know, the 14 to 17% of hospital inpatient cost is from ICU use. An ICU bed costs three to four times as much as a regular hospital bed, and the annual total tab for ICU beds is about $15 billion in the United States.

The issue is that there aren't enough ICU beds the way they are currently being used. We have to look at how we are going to tighten the criteria for admission. As we do this, we need to examine the cost implications for a state that has fixed amounts of money available to pay for health care costs and has to take something out of the top 500 procedures to allow something else to go in. The decision on what is taken out or restricted is going to require precise actuarial numbers. We will need to know not just the cost of various diagnoses, but the specific financial impact of various treatment techniques that might be used or eliminated. For instance, let us look at some of the criteria that we might use to develop numbers, which may help us to decide whether or not people should get into ICUs. How many dollars can be saved by eliminating brain dead individuals from ICUs? What would be the financial implication of eliminating patients from the ICUs who have metastatic cancer? What about eliminating people with poorly responsive diseases, the category of diseases where medical care leaves no clear differential of improvement? Should we make a decision that will allow patients in ICUs if they have a failure of two organ systems, but not a failure of three?

These decisions are not going to be made by actuaries. They are not going to be made by the individual practicing physician. They are going to be made by society with input from both the medical community and the voting community. How we shall do this is going to require immense sophistication of systems in which hospitals, physicians, and payers, such as HMO or managed care groups, are able to define accurately what their cost structure is so that they know the effect of various discounts or payment capitation models.

From the other side, the insurers are going to have to understand clearly that, in order to control costs effectively for their own company, they must have a clear understanding of what the financial implications of various treatment styles will be. Finally, as a former practicing physician, may I presume to talk for my colleagues and say, "Yes, we are being carried kicking and screaming into the twenty-first century. As a group, we still are very vocal in our hostility toward HMOs, but we are signing up. We are participating, and we see the handwriting on the wall."

MR. FREDRIC L. SATTLER: The most difficult thing about this talk is to typify an HMO. There are no typical HMOs. They vary dramatically in their make-up, their construct, their cultures, how they operate, where they are, the attitude of physicians, and the attitude of enrollees. All of these factors are going to have a very significant bearing on the future. One thing about the future of HMOs is clear: the HMO is going to be on the cutting edge of the medical/legal/ethical argument. Many critical issues concerning the way health care is delivered and allocated will be debated in the HMO arena.

We are going to see great product diversity among HMOs. The standard HMO is going to be very different in the future. HMOs will offer several products. There will be cost-sharing, opt-out options, various benefit packages, and some experience rating. I am going to talk about HMOs in the context of what I foresee as the future of the health care delivery system, and I will try to point out how HMOs fit into that particular context.

Let me begin with the evolution of managed care. We started out years ago with a dominant form of care called fee-for-service, which is now a dying animal. In some parts of the country, it is virtually reaching extinction. In other parts of the country, it's dead and doesn't know it. In still other parts of the country, it is on track and could become extinct. Fee-for-service care is moving into what we call managed care. Managed care, in its broadest context, really means some form of cost control or direct intervention into the delivery of health care by an outside force.

The first step in moving into managed care is what we call managed fee-for-service. There are no contracts between payers and providers, and providers are not necessarily working together any more than they did in the past. There is no formal arrangement, but there are a lot of informal arrangements. There is usually some payer such as an insurer or an employer paying the bills. In this phase of managed care, the way hospital care is being used is examined and some sort of hospital utilization review program, such as a second surgical opinion, may be implemented.

The next phase includes the development of PPOs. It is here that you get into alternative delivery systems, which are highly organized in some respects and loosely organized in others. There are contractual relationships between payers and providers. These contracts may discuss only price or may even outline how physicians and providers will behave in certain situations.

HMOs are at the far end of the managed care spectrum. As I pointed out, HMOs are not all the same. Some HMOs are more loosely organized and resemble PPOs, while other HMOs are very tightly managed, integrated organizations with an internal culture and a consistent set of incentives.

Over the years, this form of tightly managed, well-integrated HMO has grown in importance. These HMOs are largely group practice and staff models. I think that these models will continue to grow in importance because they probably have the best chance of delivering real cost control in the long run. Other models will exist; they will find niches in the market. Some of us will be willing to pay more to have more freedom. In this context, freedom really does have its price.

That is how managed care is going to evolve, but it will evolve differently in different regions of the country. If you really want to know what the future of HMOs looks like, go west and a little south. When you get to Los Angeles, San Diego, or San Francisco, look around. That's what the future of HMOs will look like.

When is the future going to occur in Chicago, New York, Miami or Dallas? That depends on how quickly this trend is picked up on. The one thing I do know is that the future is getting here more and more quickly. There are providers in the country who used to look at California and say, "We've got six or seven years until that happens to us." Now they are saying it's about two years. California is a good place to look for what will happen in the future.

Let me tell you a little about what I call the bottom line. First, there will be a high degree of consolidation within the health care industry and also within HMOs. There will be fewer and more powerful decision makers. This is going to occur because of the need for the delivery system to organize around HMO/managed care entities. That organization process will very naturally weed out many of the decision makers. Quality will become an explicitly bargained for and sought after feature on the part of buyers, and HMOs are going to have to deal with that straight up. We will have to begin to talk about the quality of those products and services and begin to measure them.

Data and information will be a more critical resource. This is true both internally and externally. Within the delivery system, this information will be used to make a lot of the decisions that we talked about earlier. Right now, management information systems are probably a major weakness for most managed delivery systems not only in terms of capturing the data, but in analyzing the data and acting on that data. From what I see, most HMOs and delivery systems don't want to spend the money to put those systems up or to capture the data. That is going to be critical. Also, employers as well as actuaries want that information to determine if there is good value. This notion of value is one that has become very important.

In addition, the way in which payers and providers interact will become more sophisticated and critical. Speaking from the employer perspective: How are we paying providers? What is the basis? How are we paying HMOs? How are HMOs paying their providers including physicians, hospitals, and allied health professionals? This whole notion of shared risk will become more sophisticated.

There is also that old issue about adverse selection and who goes where. That playing field is going to become more level and better understood, particularly on the part of employers.

There will be increasing control and assessment of technology and its uses. Again, I think one of the cutting edge areas is going to be HMOs. HMOs, to be cost effective, are going to have to deal with these issues in a straight-forward manner. HMOs are a good form of managed care to deal with these issues because of the relatively closed nature of the HMO system. Decisions can be made in the HMO system the way decisions were made years ago by the medical profession: extra care just wasn't given to someone if the family physician didn't feel the patient would respond well. Because of today's legal environment in an open system, every physician has someone looking over his shoulder. The HMO can establish the guidelines and the protocol that will allow a little more flexibility in the way that physicians handle the spread of technology.

Individuals who utilize heavily will gain a lot more attention than they have in the past. I've heard this whole issue of adverse selection characterized by one HMO manager as "people aren't sicker or healthier -- they just utilize more or less." Utilization issues can be dealt with much more favorably and forthrightly in the HMO setting than in the non-HMO setting.

There will be an ever-widening difference between well-managed, highly cost-effective HMOs and the other HMOs. We will see a well-defined market niche and highly segmented markets for those well-managed HMOs. The problem with those kinds of organizations is that they take a lot of capital to grow. For the most part, Wall Street is not going to be a happy provider of capital to the HMO industry. Money is going to have to be generated internally or the HMO is going to have to be part of a larger corporate organization that can provide capital.

Finally, let me talk about some of the major trends. At this point, cost is still the bottom line. All employers are interested in the entire cost equation. I think the challenge for the health care delivery system is to come to grips with that as opposed to creating some additional forms of national health insurance. We are going to begin to see Medicare broadening or new programs coming on stream in the next four to six years, particularly to deal with the uninsured or the underinsured. The temptation is going to be to upgrade those programs by increments. When you look at social programs, most of the administrations now don't want to put any more money into them, but must maintain the programs because anything else looks like a take-away. Health care is still an area that has a lot of political clout. So unless corporate America feels like it is getting its value, it may finally just say to Uncle Sam, "Take it. We don't want it anymore. We can't deal with it." That is really as much out of frustration and lack of predictability as it is with the magnitude of the dollars that the corporation are spending. It's an embarrassment when you budget an 8% increase for health care, and it, actually comes in at 22%. No good line manager can get away with that for very long. I think that HMOs are far better at predicting what is going to happen next year because, in effect, they have a lot more control over the production function than fee-for-service plans.

I'll go out on a limb here and give you some estimates. In the year 2000, there will only be about 10% of employees in the United States who will be operating in a health care environment, which is entirely fee-for-service. Employee enrollment in HMOs will grow from about 16% of the work force in 1987 to about 26-27% in 1995. Again, I'm talking about the more tightly managed HMOs. Employers will continually cut the number of plans that they are offering to employees. Many employers now offer from two to four HMOs plus an indemnity plan, and the indemnity plan may have a PPO option. I think this situation is going to change dramatically. It just doesn't make any sense anymore. Employers are going to find the plan that satisfies their needs, and tell employees to take it or go out on their own.

By the year 2000, only about 5% of physician and hospital payment will be unilaterally determined. This means the contracts are going to be that prevalent between payers and providers. There will be an increasing focus on managing costs associated with ambulatory care. It is interesting to note that most of Dave Herrell's emphasis was on the inpatient side when he was quoting numbers. There is a reason for that. Those data are all we have in the way of statistics on good management. But outpatient services are where the action is today. Eight years ago when I started at Northwestern National Life (NWNL), roughly 55-60% of our book of business was inpatient. Today that number is down to about 43%. The outpatient side has grown commensurately. The nice thing about a hospital is that there are only 5,000 of them, and you basically have a good sense of what is going on in those hospitals. It is relatively easy to get your hands around the action in a hospital.

Selection of physicians is going to become more important and more possible. We have a glut of physicians, so we can afford to be choosy. The question is, what makes a good physician? What makes a physician right for a given plan? I had a discussion with a physician at the Mayo Clinic not too long ago. He said that the Clinic has trained a fair number of doctors over the years, and after awhile those doctors either like it and fit into the environment or move someplace else. The whole process of getting good, cost-effective physicians in your plan is difficult. It is going to require a great deal of work.

The final major trend is that you'll see a real division along the lines of well-managed, tightly run, highly cost-effective HMOs and those that aren't. Don't confuse an HMO with an HMO.

MR. HARRELL: The outpatient issue is catastrophic. In my company's plan, we are currently doing an analysis by diagnosis of cost trends for outpatient procedures over the last five years. It will just blow your mind. With the escalating costs, one of the questions to be addressed is not just the cost shift from the government to the private pay employer, but the charge shift from the hospital to the payment system. With the decrease in bed days, are hospitals making up for it by increasing the arthroscopic and obstetrical/gynecological (OB/GYN) procedures in the outpatient setting?

In response to comments on the employers that are cutting down on the number of HMOs, that time is here. Major employers are drastically cutting back to offer one IPA model HMO, one network model HMO, or one staff model HMO. This impacts the premium and decreases the cost of administration to the employer. The final thing is that plans should develop out-of-system options. Plans clearly have to do that to develop flexibility. The big issue is going to be whether the government is going to allow the federally qualified plans to do that. There are some people who believe that the 1988 amendments allowed for some flexibility, but the regulations haven't been written on that little caveat of the 10% out-of-plan. Unless the federal government does something aggressively on that, a plan is going to have to make a decision whether or not it is going to be federally qualified, nonfederally qualified, or set up a new line of business.

MR. SATTLER: One thing that I didn't mention is that the out-of-system option, which allows HMOs flexibility in product design, will place a financial burden on HMOs. This is because the amount of risk that can be shared among plan hospitals and physicians is decreased with the addition of nonplan providers. HMOs will have to look more like insurance companies and have the financial resources to deal with the kinds of things that insurance companies deal with. I'm not that sure that all HMOs are ready for that since that financial ability requires a very large amount of capital. However, the future does seem bright. Growth will certainly occur, and HMOs are going to be a force to be reckoned with.

MR. HERMAN: Dave, you provided some numbers which indicated that physician networks have been expanding at a greater rate for independent HMOs than for multistate, national HMOs. Does that mean the physicians find independent HMOs more acceptable, or does it mean that the multistate, national HMOs are more selective when choosing physicians? Or, does it mean something else?

DR. O'BRIEN: Have you ever seen a huge dragon try to react quickly? It is difficult for us to go into a market, respond to a need, or react to physician interest. An entrepreneurial hospital can set up a PPO or an HMO in a relatively short period. Those groups don't have a national product development or a strategic planning committee to work through. When we enter a market, we are players for the long term, but it takes a long time for the two synapses at the head of the dragon to get down to the tail.

MR. HARRELL: I would agree with that somewhat. The difference I see is that an independent HMO is an HMO operating within a specific geographic market. That market may be a multi-county or a state market, but it is not multistate such as EQUICOR. I think that there is flexibility in local plan operation and faster response time due to the absence of a large bureaucracy. I also think that local plan managers are more sensitive to the perceived needs of the community on the part of purchasers. For instance in a small plan, if a marketing representative is calling on a large employer and that employer requests that certain doctors participate in the plan, the marketing representative can contact the medical director immediately to start the process. It's that kind of response that can take place on a local level.

DR. O'BRIEN: I also think that presently there is an "identity crisis" in the HMO field. Locally, many of the hospitals, state medical societies, and county medical societies enter the market for defensive or marketing purposes. It's easy to do. Usually in a multistate operation, the HMO is a business. I think that it is easier to get them going as a defensive or a marketing mechanism, but much harder to sustain. That identity crisis is going to have to be dealt with, because eventually the notion of risk runs head to head with the notion of provider income. Those folks have to start thinking alike. The group or the staff models have a better shot of dealing with that, while the hospitals think more about filling beds. That's fine if you have enough money to keep pumping into your HMO to keep it alive. However, if you want the HMO to succeed, you don't want to keep beds filled unnecessarily. This is going to be a large change in philosophy for some providers.

MR. HARRELL: Every HMO sponsored by a medical society will go out of existence within the next five years. I don't see any of them being able to survive because they don't have the utilization or peer review capacity. The politics within a medical society are too great. When a physician is not credentialed, the next person elected president of the local medical society will be under pressure. Medical societies have a difficult time controlling reimbursement rates. When peer sanctions are imposed for lengths of stay, practice referral patterns suddenly dry up for the chairman of the peer review committee. This does happen, so I don't know how the medical-society-sponsored HMOs will survive.

DR. O'BRIEN: The problem in these provider-based HMOs is that the decision on benefit allowance is made on the basis of good medical practice, not on the basis of the benefit plan terminology of "life-threatening" for emergencies and "medical necessity" for routine hospital and office practice. Medical necessity and life threatening emergencies are light years away from the traditional practice of medicine. They are much more sophisticated criteria and require more thinking than ordering extra tests or doing extra follow-up visits. This is the difference that the provider-operated HMOs have not resolved yet.

FROM THE FLOOR: How do you feel about hospital-based HMOs?

DR. O'BRIEN: A hospital with which I'm acquainted can provide a good example. The hospital agreed to capitate laboratory services. The cap rate for commercial labs was about $.64 per member per month. The hospital submitted a bid of $1.10 since a board member, who was also chairman of the hospital, said, "After we put all the money into building this thing, we're going to get it out." As you can see, there is a real conflict of interest. I think that it's to the credit of HCA that it realizes this conflict of interest. This caused HCA to be half-owner in the formation of EQUICOR.

MR. HARRELL: Let me give you an expert position. I was CEO of an HMO that was owned by three hospitals. It was interesting to see that the hospital that was the majority stockholder also had the highest utilization rate and demanded the highest reimbursement rate. The other hospitals didn't appreciate this situation too much, and it caused a bit of dissension. The HMO was eventually purchased by AV-MED, which is also ultimately owned by a hospital. The brilliance of this bifurcation within AV-MED and the Santa Fe holding company is that no one from the hospital side sits on the HMO board. If the hospital cannot deliver a high-quality, cost-effective product, it doesn't participate in a particular level of service. This differs from the circumstances of the former entity in which the hospital was always trying to bring in revenue and an extra $100 per day didn't bother that board. That board wanted that revenue to flow back to it. If the entities within the HMO have divergent interests, that HMO is bound to fail.