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IS THERE A FUTURE FOR HMOS?

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o Can HMOs survive the underwriting cycles in health insurance? Speakers representing various segments of the HMO industry -- commercial carriers, large independents, and small independents -- discuss what changes they envision in the HMO industry and their companies, including:
  -- Delivery system restructuring
  -- Product design
  -- Provider relations
  -- Organizational changes to cope with future challenges

MR. KENNETH S. AVNER: First, let me quickly introduce the panel, all three of us will speak. On my far left is Tom Pyle, President and CEO of Harvard Community Health Plan here in Boston; next to him is Harry Sutton, who is a Vice President of Tillinghast, a Towers Perrin Company, in Minneapolis; and I am Ken Avner and I am with Blue Cross and Blue Shield of Illinois.

As an introduction, I want to tell you a little story about my younger brother who is a pediatrician. During one of his medical school interviews not all that long ago, he was sitting at a table across from two or three interviewers and they asked him whether or not the letters HMO meant anything to him. He thought and thought and finally asked, "Does it have anything to do with a laxative?" Now my brother is a bit of a character, I agree. And I asked him afterwards, after I stopped laughing, how he could say something like that. He said the only thing he could think of was Haley's M-O and the "H" fit right in there.

To me that is bothersome, not only because I was working on HMOs at the time, but because we both grew up in New York City, both of our parents were municipal workers, and when we were growing up we enrolled in the Health Insurance Plan of Greater New York, a large, well-established HMO. You think he would have had some idea of what was going on, especially since he planned to enter the medical profession.

I guess what I learned from this is that he and I were not very different from what a number of people who grew up under the Kaiser Plans tell me. If all you have experienced is the medical delivery system of a large HMO, you do not realize that there are other ways to get medical care.

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To me, the surprise was that there really was fee-for-service medicine. I remember the first time I went to a doctor's office and I had to pay a bill for the office visit before I could see the doctor. I never saw that as a child.

The other interesting thing about the story of the interview is the kind of question being asked. Here was somebody who wanted to be a medical student, who was, he thought, dedicating his life helping the sick. The question they asked him concerned his knowledge of the changing structures of American medicine and the financing arrangements that were going to determine much of his life for the following 30 or 40 years.

The title of this session is "Is There a Future for HMOs?" and it seems that whenever I ask the question I get an answer that begins, "Yes, but." What I hope to do here is explore a little of what is behind and beyond that "But." In complete ignorance of the prediction of its demise into Super Meds that seemed so fashionable two or three years ago, the health insurance industry remains tremendously fragmented. In addition to the Blue Cross plans and the commercial carriers, the last decade has added HMOs, PPOs, and a whole bunch of new players. What with dual choice and the PPOs and HMOs, even those employers who felt safe behind a self-administered plan, were dragged back into what I call the health insurance arena.

Regardless of the predictions of a more uniform medical system based on strict protocols, computer expert systems for diagnosis, and genuine regional medical centers, we are really far from that now. Even if the infrastructure is being laid for this medical system of the future, there is plenty of movement, at least in the short term, in the other direction.

Also, as health care becomes more and more important economically, it becomes more important politically as it gobbles up more and more of the GNP. In the current American political environment, I believe that this means the fragmentation of the delivery system and the intermediaries, who together are what I call the health care financing and management industry, will be defended if not actually augmented. Do not get me wrong; it is not that I think the economic factors will not eventually be decisive. It is just that in a fragmented system it is hard for economic efficiency to take control.

What a fragmented industry translates to is a lot of niches in which different players can be successful. This means there should be a lot of successful strategies. What a successful player who has not been lucky enough to have inherited a dominant position needs is first, a moderate competitive advantage over the primary market leader, for example if he is better at utilization review; second, flexibility, and that may be because he is relatively smaller or less entrenched or better managed; and third, a low break-even point. If that seems to describe the HMO industry, or at least part of the HMO industry, that is the reason why I think the answer to our basic question today is "Yes." What follows, the "But" that most people add to the "Yes," is how some niche will be identified or filled.

To expound upon the future of HMOs, we have decided to segment the HMO industry into three very broad parts -- large local independent HMOs, small local HMOs, and large regional or national organizations. Tom Pyle, with Harvard Community Health Plan, will discuss the position of the first segment, Harry Sutton will discuss the second, and I will cover the third. I expect each of us will touch on the same issues, but the emphasis and approach should be

different. For example, for a large insurer, access to capital either internally generated or through the capital markets, is different than what a small local HMO expects to find. This obviously affects the corporation's ability to absorb underwriting cycle losses. There are similar considerations for other issues. I expect we will speak on product design, network structure and depth, quality assurance, stability, access to capital, marketing presence, and the changing competitive environment.

So let us start by finding out about the large independent HMOs. Tom Pyle is President and Chief Executive Officer of Harvard Community Health Plan (HCHP), New England's oldest and largest Health Maintenance Organization. HCHP is an independent, federally qualified, not-for-profit HMO, founded in 1969 with the assistance of the Harvard Medical School. The plan currently serves more than 385,000 members, primarily in eastern Massachusetts, through a network of ten staff model health centers and a dozen independent affiliated medical groups. Tom also developed and is Chairman of the Board of the Controlled Risk Insurance Company, a malpractice insurance program covering 12 Harvard-affiliated institutions and 4,500 physicians. He is a past chairman of both national and state HMO trade associations. Tom is active in health policy, legislative and regulatory matters at both the state and federal levels, and was intimately involved in the process leading up to the development of Massachusetts' new Universal Health Care law.

MR. THOMAS O. PYLE: What happened to us on that law involved a form of intimacy that would not be polite to speak about here.

The question, "Is There a Future for HMOs," I think, could be turned around to ask if there is a future for traditional health insurance. I do not think you can separate what is happening in the health insurance and health care market whether you want to talk about HMOs or traditional insurance.

Today, health care in the United States is more than 11% of the GNP. It is growing rapidly in excess of the rate that our economy is growing. I used to be able to talk about it being about as big as defense, but now it is almost twice the defense budget. It has some striking resemblances to defense. They are both very emotional issues. If you are against health care for people who are insured, you are some kind of a monster. If you are against buying more armaments, you are some kind of a traitor. Health care is about as measurable as defense. Can anybody prove what all those weapons and silos really do? Can you quantify their deterrent effect? Of course not. It is strictly a matter of opinion and that is also true for most of the procedures in health care. We do not have accurate analyses of the value of most of health care. This lack of information serves to feed the emotionalism.

As a result of this lack of measurement, both health care and defense are dominated by professionals. The idea in both is that the professional knows best, be he a general or doctor. Therefore, we are left without any really satisfying way of measuring these industries. Health care, at this point, being close to two times defense and about two times as important to our economy, does become, a big political issue. In many towns around the country, the hospital may be the principal employer. Remember health care is much more decentralized than defense, so it is harder to get your arms around.

Health care is extraordinarily costly. Here, in Massachusetts, it can easily cost, depending on what the experience of a group is, $4,800 a year for family

coverage under Blue Cross Blue Shield. That is a major part of any family budget, unless you are talking about people with incomes over $100,000 a year. You can say the employer pays it, but I think we are all wise enough to know that this money could go to the employee, if it were not going for health care.

It is a very wasteful activity. At a meeting I attended last spring convened by Health Care Financing Administration (HCFA), three leading researchers in health care in the country estimated that about 30% of what is done in the health care field is totally without merit. Sitting at this meeting were the heads of many of the principal professional societies, and no one challenged this assessment. This to me is even more extraordinary!

Health care is unscientific. If you really delve into it, you will find that many of the things that are done, including surgical procedures and other remedies, have no proven scientific basis. You find that one doctor does it one way and another does it another way, and there is no way of reconciling those differences.

As already has been suggested, health care is quite fragmented. It is basically a cottage industry, although that is changing. And it is not too surprising, from what I have already said, for me to assert that there are no standards or measures in health care. If you were running HCFA, and you wanted to find out what an institution produced for you last year, there is no measure that you could look at.

Health care is supported today by unrealistic expectations. Last year the Harris Organization did a survey for us. We learned that 90% of the people thought that everyone should get the same care that a millionaire gets. Furthermore, well over half the people who were surveyed thought that you should spend any amount to take care of a person -- even as the actual wording in the question asked, up to $5 million. For those of you who have to do projections in this field, if they are done on the basis of the expectations of individuals and as new technologies come along, it may indeed cost that much. We currently have cases that cost $400,000 or $500,000. You can expect that your clients will want that kind of care. It is questionable whether our economy can support that.

While we are spending that kind of money, which is not terribly different from trying to save those two whales -- any amount of money to save the two whales while you trip over homeless in the streets of our cities -- we see the problem of the distribution of wealth in our society. In health care we have a terrible maldistribution. About 10% of the people simply do not have coverage for very expensive things that others can readily get.

In part, this mess has been created by traditional health insurance, but only in part. I want to make that very clear. The expectation that every medical need should be provided for clearly comes from the very good traditional health insurance coverage that we have had. I would say that the future of traditional health insurance will be inextricably intertwined with its ability to solve these problems. This leaves its future somewhat doubtful, except in some heavily modified form, and I would suggest that the HMO is one of those forms. Not the only one, but one, because there is the possibility for control in an HMO.

Now you might say, "But HMOs are really having a hard time. They are losing money." I think we need to examine why they are losing money. Some HMOs

have expanded too rapidly, especially by merger. Some are simply too small and undercapitalized. Some have a poor strategy; some are in a lousy market; some have bad pricing; and so on. Finally, it may be that the HMO concept is wrong.

I would submit that all but the last reason are not unique to HMOs. Anybody who flew People Express experienced the problem of excessive growth and uncontrolled merger. Small and under capitalized, 50% of all new businesses in the United States fail in the first year, and 50% of those remaining fail in the second year, and 50% of those remaining fail in the third year. So the fact that new HMOs have trouble is not something unique to the HMO field. It is just a factor of new business, and so are market miscalculations.

However, the concept being wrong really has to do directly with HMOs. I would submit that the biggest problem in the HMO field is with the loosely structured Individual Practice Association (IPA) and PPO and not, in general, with the more traditional form of HMO. The more traditional form of HMO, the so-called prepaid group practice, which predated the federal HMO act and the coining of the term HMO, is doing quite well.

One of the ingredients that seems necessary is having a strong regional market share. Health care is, after all, a regional business. This is very different from health insurance which is a national business. You can be weak in a region but be strong nationally in health insurance and do quite well. This is not true in the HMO business. You need regional strength, and this is tied to a good market share. Organizations such as HLHP, HIP in New York, and Group Health of Puget Sound are strong regional businesses. They have developed a network of care providers and put together a production system because it is the production of a service that works.

I believe that loosely structured IPAs and PPOs, which are not HMOs but many people think of them as being HMOs, represent something which is extraordinarily attractive to employers and to employees because they basically offer the promise that you can change everything while changing nothing. Essentially doctors practice in their own offices, and by and large, they do things the way they have always done them. It is very attractive because patients do not have to change physician relationships which generally is difficult to get them to do. But these organizations generally do not reduce costs. Even in a PPO, where a discount is given, the reduction of costs may be only illusory. Doctors are quite shrewd and they rapidly learn how to increase the number of services to bring their revenue up to the same level that it was before. Because these high market share organizations are not strong cost control organizations, I think over the long term, they will not do well. Tightly controlled IPAs with an extensive capitation have the ability to control costs. I think there will be technology in the future which will make it possible to specify care relative to the needs of a patient and therefore control cost in an IPA. But, that software is not here today and the prepaid group practice seems to have a great ability to control cost. Better financial management is a big part of the success of my kind of organization. The rest of it are things you are familiar with: reserves, prudent financial management, etc.

There are some other things that are new in health care with the HMO type of organization. First is the opportunity for quality of care measurement and improvement. This is something which has been getting a good deal of attention. We are just at the beginning of developing techniques for measuring the

quality of care. In almost every industry in this country, the CEO can get a report at the end of the month on the quality of what was produced. This does not exist in health care. There are no quality reports produced as a regular matter. This bothers me a great deal and I want to develop that capability. It means inventing a whole new technology and I will not pretend our reports are terribly sophisticated yet. But we are working on them and trying to improve.

Standards of practice, which are sometimes called algorithms for care, are a related need. How should a certain disease be handled? What are the appropriate treatments? This might result in a level of standardization that some call "cookbook medicine." Others feel it is essential to improving the quality of medicine and also being able to measure quality. If you do not have a standard, what can you measure deviation from? This is what quality is all about.

An advantage of the HMO is its ability to invest in R&D to improve practice. In fact, I would say the most important thing about the marriage of health care financing and health care delivery that exists in an HMO is the creation of a framework within which to manage. To be able to look at tradeoffs, to be able to have incentives, to be able to invest in long-term improvement in the quality of medical practice, I see these as being a great advantage.

There was a lot of pressure against this kind of organization. These pressures came and continue to come from those threatened by HMOs because HMOs tend to redistribute power in health care. They redistribute it away from fee-for-service and solo practice. Even the medical societies are now beginning to recognize the physicians who work in HMOs. This is quite a change because, at one time, they were not even allowed to join in some states.

Furthermore, HMOs represent a move away from third party reimbursement. We would say these HMO-type organizations are not third party organizations, but rather combined third party with provider. They move institutional power in the field away from hospitals, and they move power away from regulators to consumers who can do their selecting of HMOs.

There are barriers to the development of HMO-like organizations besides those mentioned above. Barriers include existing MD relationships. People who have a physician with whom they are happy will probably not join in an HMO such as mine. Thus, the transition to an HMO penetrated health system is a slow process because of relationships which will be maintained. Some people want the freedom to select doctors at all levels. They want to be able to elect Michael DeBakey, in Houston, if they need some kind of cardiac procedure. The MDs, I think, are still uncertain about HMOs because most MDs were trained to be medical soloists. Even though the industry has shifted towards more institutional practice, most MDs are not quite ready for working in large organizations. That MDs have not adjusted has been, I think, a drag on the growth of these kinds of organizations.

I think you probably know what the employers' feelings are. They are determined to contain costs; they are skeptical of HMO savings; they are judging value often on claims experience rather than value. In other words, they are adding up the list of services provided rather than looking at what unnecessary services might have been provided in an alternate setting. There is a need to develop new data sets for HMOs which I do not think has been well done by the industry up to this point. Many employers are looking for a sole source for

administration for reasons that I do not fully understand. They seem to focus more on administration than on total cost of providing care.

There is much uncertainty at the moment created by the 1988 HMO Amendments regarding what their ultimate effect will be. I think a broader uncertainty is what government is going to do with transfer payments. This includes those disguised by other names such as mandated benefits. I see these creating a huge instability in the provision and the financing of health care. The Massachusetts health care bill creates a transfer by mandating employers to provide coverage. There is a lot of talk about a federal health care bill that would similarly mandate coverage by employers. I think we will see mandating of other kinds of benefits by the federal government in an attempt to keep things out of the tax base. I believe this makes the whole health care environment very unstable. It could effect HMOs in a different way than others depending on how the legislation is drawn. Nonetheless, it is my conclusion that the HMO which is a good solid regional business, has a decent market share where it is doing business, and follows sound business practices has a strong and growing future.

MR. AVNER: The next speaker is Harry Sutton of Tillinghast. Harry's experience includes employment with one large insurance company for 20 years and 15 years of consulting with Towers Perrin and Tillinghast. His experience includes all aspects of HMO work. He has done a lot of work in employer provided benefits consulting with emphasis on how HMOs affect the structure of the benefits employers should offer. He has also done some work on Medicare and Medicaid programs.

MR. HARRY L. SUTTON, JR.: Today there are roughly 30 million people enrolled in HMOs providing about $30 billion of revenue. The largest health insurance carrier in the U.S. today is Kaiser. That would be if you counted only revenue where the carrier is at risk, where Kaiser's revenue is $5 billion a year. I think Prudential and Aetna have only about $3 billion each of such revenue although they have $9 billion of ASO (Administrative Service Only) business.

I represent a different kind of HMO than the one Tom spoke of because frequently, in the consulting business, we work for smaller ones. The question is "Is There a Future for HMOs," and for some of you, it might be helpful to run through what is happening in the smaller HMO field. Tom explained some of the problems, I will try to explain some of the results.

During 1986 and 1987, two-thirds of the HMOs in the United States had losses from operations. I would guess that there have been maybe 15 or 20 bankruptcies, some of them involving fraud, and at least a couple of Medicare cases that have created very difficult publicity problems for the industry. The largest proprietary HMO system, including a write off of $100 million of goodwill, has shown operating losses of $100 million in the last two years.

Insurance carriers, while generally reluctant to join the HMO business with a few exceptions which go back to the early 1970s, have all jumped into the business. Many of them bought HMOs and many of these HMOs have deteriorated rapidly. In many cases the management left and the insurance carriers managed to buy a bunch of contracts, a bunch of enrollees, and a health care system. They did not buy the existing management and did not succeed in installing effective replacement management.

Earlier today somebody was talking about second surgical opinions, home care programs, and preadmission certification. All of those are external interferences into the physician functioning the way he is used to. With an HMO, the physicians are frequently the management of the corporation, and are intimately involved in deciding how to practice. They are not interfered with from the outside. They learn how to practice and function efficiently.

Perhaps I am oversimplifying, but the insurance industry and its movement into the HMO business or managed care business, is looking at data and saying what should not have happened and what should happen, sometimes by examining the demographics of the population. If you look at what they are doing, you see them interfering with the normal practice of medicine and trying to change it by dealing with the physician on a case-by-case basis. This is very, very difficult. A competent physician can outsmart you on almost everything on an individual case.

Market prices of HMO stocks, while there are probably still ten or so traded Over The Counter, while up from rock bottom, are still way down. With one exception, the Super-Meds, which were originally the proprietary hospital systems vertically integrating, have closed down. Further, perhaps with the exception of Humana which is buying HMOs consistently and growing, the proprietary hospital systems find their management at odds in trying to run an efficient system. As I see it, the problem is a conflict between their hospital managers wishing to fill beds and the HMO trying to keep patients out of the hospital.

Perhaps the kiss of death on the tremendous growth in the HMO industry is that major capitalists no longer want to lend money to HMOs. Wall Street gurus say that the HMOs are now a mature industry, like the health insurance industry, with no reason for further investment. Instead, they are investing money in niches like mental health care, prescription drugs, mail order drugs, and things of this sort. Perhaps those are niches that have not been controlled yet, and if they are uncontrolled, a lot of money can be made until somebody figures out how to get them under control.

The HMO industry has had some dark moments in the last several years. But consider that the health insurance industry has not been all that bright in the aggregate. Last year, the Blue Cross plans lost around $1.9 billion. Insurance carriers, including the ones that own HMOs, lost at least as much as the Blues, before any tax offsets. A number of carriers have sold off their group health business. We are talking about fairly large companies with premium revenues or equivalents of several hundred million to nearly a billion dollars per year!

In looking at where the HMO industry is today and how it got there, everyone has his own idea. The HMO industry really started coming into its own in the late 1970s. The government financed start-ups of 100 to 150 HMOs which coincided with a very bad cycle in the health industry. The health insurance industry had terrible losses in 1981. At the same time, the HMOs were just starting in the marketplace. At that point, insurers' trend factors typically were as high as 15% to 30%, and in 1981, 1982, and 1983, their premium rate increases were substantial. Now the HMOs that were forming at the time did not have underlying trend factors of that size. Further, they knew what all their costs were and they did not have deductibles to get leveraged over, etc. This type of pricing in the market in the early 1980s sheltered the rapid enrollment growth of the early HMOs including the ones that converted to for-profit in the early 1980s.

Because HMOs had been above the market price prior to 1980, the hugh inflation and indemnity premium increases resulting from the high trend factors used by insurance companies sheltered them and permitted them to raise their prices to where they could produce rather substantial profits into the middle 1980s. By then, the insurance companies recognized that the inflationary trend was only 7% or 8% instead of 20%. Therefore, they got aggressive in the market, cutting prices to expand business and expand market share. The HMO internal inflation trends were 6% to 8% continuously during this period, but they could raise their rates faster at the beginning and slower at the end.

Minnesota is a very interesting state in that for three straight years, 1984 to 1986, the average increase in the HMO premiums in the Twin Cities was about 1.59% to 2%. By the end of that time, they were all losing money. The insurance carriers, which had been going up 12% to 15% prior to that time, had produced rates that were very easy for the HMOs to live with. Yet, when the carriers stopped inflating rates to seek new business, maybe because of their cycle, the HMOs felt that they could not raise premium rates because it would make them uncompetitive with the market.

I think the same thing is happening now as happened back in 1981. We now see in insurance companies trend factors of 20% and higher and for small groups, in excess of 30%. Therefore, the HMOs which were squeezed to the point of losing money in 1985, 1986, and 1987 now have a tremendous insurance carrier relief potential.

In Minnesota in 1987, all the HMOs but one lost money. As we work with a lot of HMO clients, we find them afraid to raise premium rates. This goes for Kaiser also. They perceive that their premium rates cannot exceed the indemnity rates or at least not by very much. Therefore, if indemnity rates do not go up, their premium rates do not increase either. This squeezes them and lowers profit levels. However, it does not necessarily bankrupt them. After three years of HMO rate increases below 3% in Minneapolis, the average rate increase was 17% in 1988. It will probably be 18% or 19% in 1989. But the carrier rate increases are generally still higher because they have been losing money and the trend factors are higher. Self-insured employer trend factors are not as high as the carriers'. They do not always budget the carrier trend factor, because they are never sure if it is catching up losses or something else that is not applicable to them.

Another interesting thing in Minnesota, which points to political problems, is it has the largest catastrophic health plan. In 1987, it ran a $12 million deficit. The legislature neatly passed most of that cost onto the HMOs. Thus, several of the HMOs that would otherwise have broken even, or made a small profit, had to pay $1-2 million in taxes to cover the deficit in the state catastrophic pool. The catastrophic pool has 11,500 members. They charge roughly 115% of normal small group premium rates with a $500 to $1,000 deductible, and they have a loss ratio of around 200%. Essentially, the legislature saw fit to tax insurance carriers and HMOs, but most carriers and the big employers are ASOs which cannot be taxed. Small groups were taxed, Blue Cross paid about 30% of the tax, HMOs paid half the tax, and insurance companies paid the rest. That also tells you where the health insurance market is in the Twin Cities.

I would like to talk about the real world of employers and why I think the carriers, employers, and IPA model HMOs are somewhat in a mess. I think the IPAs, and the medical societies that frequently sponsor them, were attractive to

the employer from the standpoint of mega-physician, mega-hospital availability, and the least possible harm or pain, if I can use the term pain, to the employees of the employer. Carriers, including my old company, who started out with group practices, have essentially converted to PPOs or IPAs. I think this is a mistake.

In our community, Physicians Health Plan with 400,000 members is an IPA and is the largest HMO in the state. They have done an excellent job of controlling costs in certain areas. Their hospital utilization has been down around 300 days per 1,000 member years which is certainly highly acceptable. What they have been unable to control is the ambulatory physician and outpatient physician services and ancillary testing. Essentially they are being nickelled and dimed to death in an area of primary services which they cannot control. They have been better than average negotiators with hospitals. However, with participation of 3,000 or 4,000 physicians out of the 5,000 in our metropolitan area, they have been unable to force the physicians to use the hospitals where they can get the best contracts. Since every physician participates, and each wants to use his own hospital, it is hard to channel hospital patients. That is the structural problem of the global fee-for-service IPA model. It is very painful to disrupt the physician by telling him which hospital he is going to practice at.

We have done some real changing in our community. You might read that Alain Enthoven in his new book says that we should have competing health care systems rather than just competing plans overlapping doctors and hospitals. Five Twin Cities hospitals are closing because they are essentially bankrupt. We now have four hospital systems covering the metropolitan area which is down from about 40 independent hospitals 15 years ago. These are multi-hospital systems and all of them are not-for-profit. They are using their amalgamation to close some facilities, but not closing as many as they should. It really is developing a constriction in the supply of services for the hospital side of the business. All of these four systems are high quality care. I do not think we have any really dismal hospitals in our area.

We are creating major changes in the environment. Most of the changes are very unfortunate for the physicians. They may have to change hospitals. They are probably getting less than 50 cents on the dollar in our biggest HMO program which is even less than what they get from Medicaid in our state. This is an HMO problem because even if the HMO is not at risk financially, it has the risk that the physicians will not be financially able to survive in a competitive environment.

In the short to intermediate term, I believe the HMO losses will drop, and profits will reappear mostly because the HMOs are sheltered by the rapid indemnity increases that when missing in the past, have kept the HMOs from raising rates. I believe the emphasis on gaining market share, at least in our community, has been changed to maintaining solvency.

There are a number of problems, some of which Tom alluded to, which will cause problems in the next few years. One, for a lot of insurance carriers who started their own HMOs, is that to me it appears they are pulling in their horns and shutting down HMOs that are losing money. While the large carriers have a lot of money available, how long they will be willing to invest it in the HMO business is a different question. There are some big insurance carriers (top 20) who are losing $50 -- $100 million a year in their HMO business. How long are they going to be willing to lose that amount of money to try to be a national

force in the HMO business? I can only guess at their "staying power." The proprietary hospital systems only lasted a couple years before deciding that the losses were more than they wanted to take, as long as they could still make money in their regular hospital business.

The start rate of new HMOs is way down. I doubt if there will be more than 20 or 30 starts this year. This compares with 75 to 100 a year over the past two or three years. Certain cities like Chicago had over 30 HMOs and that will be down to maybe ten.

HMOs are trying to package their services on a regional-wide or national basis, which is difficult at best. By and large, except possibly for Humana which seems to be doing well, our experience is that a hospital-sponsored small local HMO has been the most difficult to manage. This is because the hospital is really thinking about trying to fill its beds and gaining market share rather than having someone run the HMO who understands the management of health care in total and not just the hospital portion of it.

A couple of final points. There are ways that IPA models can control their costs. I am not sure that many of them have the guts to do it because they are controlled by organized medicine. They can control referrals although generally they do not like to do it. They can have gatekeepers -- Physicians Health Plan, the global IPA I mentioned before, still uses a butterfly to show their enrollees are free to go anywhere. I just do not think business as usual with cut-rate fees can make it in the long run. You need to do something to control the costs of primary care.

Employers will be a problem. Many of the big carriers, who incidentally often own HMOs and big HMO networks, are telling the employers how anti-selective the HMOs are to their indemnity plans. The HMO Amendments will permit employers to change the way they contribute to HMOs. Now they will be able to contribute equal percentages of the premium rather than equal dollar amounts as they have done in the past. They can adjust the contribution rates by age and sex. The result is that the playing field might tilt a little bit because you could have younger, more utilizing, employees joining HMOs. Coupled with this, the contribution may be less. Many people in the HMO industry realize it is a problem and are looking for means of risk adjusting the contributions that the employer makes. Employers should be trying to get their sicker employees and those who need well managed care into the HMO, but to pay for those employees fairly.

For those HMOs with Medicare contracts, Medicare is probably the area where it can get either a super selection or a very negative selection into the HMO. No one has solved that problem yet. HMOs are being pushed by the government to take Medicaid contracts, and many of them have lost money doing that in states like Massachusetts which are almost forcing the HMOs into the Medicaid business. Governor Dukakis' bill, according to my interpretation, says that by 1992, all the state welfare recipients are to be in a managed health care system. I am not sure what that is supposed to mean. Certainly it would include HMOs, but what else?

It is my feeling that governmental agencies that like the HMO concept overestimate the capability of an HMO to manage at a cost that the state seems to be willing to pay. If they are only paying 50 cents on the dollar or less, it is pretty hard to run a managed health care plan with salaried physicians. You

cannot hire a physician at half a salary. The government has big expectations of managed health care to lower the cost of their programs, both state and federal, and their expectations may not be realistic. The result is that they frequently reduce their reimbursement to where the managed health care systems really cannot live with what is being provided.

In conclusion, I think HMOs will survive and employers will be more willing to push their employees into better managed plans rather than into easy access, no copay, predicted savings plans as they have done in the last two or three years. National networks are extremely expensive and I do not think we are going to see any Super-Meds with large market shares.

MR. AVNER: I will speak on the future for HMOs for large regional and national organizations. What types of organizations are these? They are large Blue Cross Plans, commercial carriers, companies such as Partners and Equicor, and maybe even to some extent the large national chains, such as Maxicare. I am tempted to say that Maxicare is not the example I want you to think of, but on second thought, I think it is a good example even if it might show how things can go wrong.

The first thing to consider is what distinguishes these kinds of organizations and what distinguishes the way they approach the market. First, what distinguishes them is that they are large. What the largeness gives them immediately is access to capital. Capital is either generated internally, raised through these organizations' knowledge of how to tap the national capital markets, or they generate it from non-health business. But usually capital is not a problem.

The second distinguishing characteristic, and I say this somewhat tongue in cheek, is knowledge of the health care market. I have a friend who is a strategic management consultant. He did a large strategic positioning project for a company with a very large block of health business. Soon after the assignment ended we got together one evening. I suppose it was after a couple of beers, he paused and asked me, "What is going on in your business? I just do not understand it. What would you guys do if you were competing with the Japanese? They would bury you. They would move the whole business offshore. I do not understand how a large industry can be so poorly managed." So I say with trepidation, the large carriers bring with them their extensive knowledge of the health care market.

Having said that the management is not as strong as maybe it should be, on the other hand, the management at least understands what the industry is about. The management understands that there is an underwriting cycle. I fear that what happened with many of the small independent HMOs is the first time they got caught in the cycle, they bailed out. They were not ready for it. They had not built the reserves. They had not even worried about where the capital was going to come from.

After having gone through an underwriting cycle once or twice, you understand that a short term outlook is not going to work. Eventually, almost everybody is going to lose money and you cannot keep planning figuring that you will be profitable year after year. You have got to look beyond the short term and realize that there is a point in the cycle when it is time to get rid of the dogs and a point when it is time to build market share.

One of the interesting things about working for a Blue Cross Plan is that you know that the company is going to make it on health insurance if it is going to make it at all. I say that because I am from Chicago and Allstate, headquartered in one of the suburbs, recently announced that they were withdrawing from the group health business. There is a certain management staying power that comes from working for a company that must be committed to making health insurance work.

I would like to add a comment to something Harry mentioned. I had a very interesting discussion with the controller of a hospital corporation which has HMOs competing directly with us. He expressed anger, getting livid about how, after getting his hospital controllers to control costs wherever they could and turn a profit on the hospital side, the jerks over in the HMO managed to lose so much money that they made the whole bottom line look terrible.

The third characteristic is an availability and commitment, even going so far as to call it a corporate culture, to non-HMO options. Even if they think HMOs are the wave of the future and the only thing that will exist five years from now, these large players usually still have a significant enrollment in traditional business. It may be that the traditional business is not strictly traditional such as when somebody else is doing the managed care part of their programs. But the carriers still have the responsibility for paying the claims. Perhaps, they also have PPOs, point-of-service triple option plans, and all the other wonderful cutting-edge stuff we read about.

Finally, the large players have an orientation that spans geographic markets. I guess that is what always distinguishes them from Tom's kind of plan. They feel they have to be active in more than one market. I agree with Harry that this means they will have to have significant market share in more than one market. If I were running a large commercial carrier, I would say that this means I better have capacity where it makes sense to have it. I would pick large metropolitan areas and see how many of those I can establish and ignore the rest. The problem, and this was mentioned in my introduction, is that health care is fragmented. If you are trying to be a large player in different markets, you are going to find that the same approach will not work every place you are. It may be that in one market an IPA is appropriate. It may be in another market that to really compete as an HMO you are going to have to use a group or a staff model. The proper HMO structure need not be the same in every market.

Personally, I believe there is an HMO structure appropriate to almost every significant market. It may happen that somebody has gotten into the market with this structure before you, making it hard for you to penetrate.

So, for me, those are the distinguishing features of these organizations. They are large. They have knowledge of the health care market. There is an availability and commitment to non-HMO options. There is an orientation that spans geographic markets.

Now for the question of what the future portends? This is where I want to discuss my major theme of what this type of company needs to do with HMOs. They must view the HMO as a product. They need to integrate the HMO into their portfolio. My thinking is that an HMO is not the delivery system answer for every person, at least not yet. What any effective provider, and in this sense I am talking about the health insurance carrier as a provider of service to

employers, has to do is find out what the customers' needs are and fill them. HMOs based on IPAs are having tremendous growth now because there is a perceived need for them. Strategically, if you think that the need is flawed, you might position yourself so that you can survive beyond the market's realization of the flaw. But certainly, if your customers are willing to pay for it, you ought to be willing to provide it. This assumes the product is not too disruptive to your long term strategy.

I had a very interesting experience a couple of years ago when we were considering our HMO strategy for the Chicago market. At that time there were 35 HMOs in Chicago. Now Chicago is a big city, but it is not that big a city. There were clearly too many HMOs.

As our little group sat at a table, we took turns talking about what we thought was going to happen. We discussed what could be done to control utilization. We discussed what effect our pricing strategy was likely to have in dual choice situations, especially if we did not have the traditional part. What was particularly enlightening was that after going around the table three or four times an exhausted sales vice president said, "I give up. We are never going to see rational pricing in Chicago for HMOs in the next couple of years. It is not going to happen in the short term." He felt there were just too many players and too much capital still coming into that market. He said the people who owned too many of those HMOs were not yet convinced that it was time to get out of them. His conclusion was there would not be rational pricing in the HMO market in Chicago for at least a couple of years.

Finally he recommended, and this is the telling thing, that even though it was his fastest growing block of business, he should shift his sales resources away from the HMO. Under his conclusion that he could not help but lose money in HMO for the next couple of years, it was appropriate to move the emphasis somewhere else. And the fact that makes this strategic decision so important is he had other places to move it. He had a PPO product. He had a traditional product. He had a managed care overlay to his traditional program. He had options.

How many HMO managements do not have those options? Without them, they are so committed to the HMO idea that even if they feel it is uncompetitive, there is nowhere else to go. They are stuck fighting a losing game. That was what the VP did not want when he said the market would be irrationally priced for the next couple of years. Until enough of those players went bankrupt and got out of that market, he did not see a way we could help but lose money in it.

If my main theme is "view HMO as a product, and try to integrate it into your portfolio," I think that leads naturally to evolutions in benefit design. By this I mean a number of different things you are probably all familiar with: copays and deductibles, shifting blocks of business, etc. By shifting I mean things like giving up the Federal Qualification or shifting business out of a Federally Qualified program so that pre-existing condition exclusions can be added. Even if they do not allow an exclusion, most state rules allow inclusion of deductibles that are more substantial than are allowed for Federally Qualified programs.

Other evolutions include out-of-network access, and triple option products. Again, I would expect the same approach not to be appropriate for every market. A successful national carrier must look at things differently for each market because what you have to work with may be different in each market.

There is a marketing problem that results when a company tries to treat HMO as a product and integrate it into the portfolio. The HMO marketing force culture is often different from the traditional business marketing culture. Many of the traditional agents do not really understand HMOs and do not want to have anything to do with them. Even agents with substantial HMO experience are often uncomfortable with the HMO concept as opposed to selling a traditional plan. I think this is because there is an unseen partner present when they are trying to sell an HMO group. They may have to consider the provider relations effects of their sale.

That is something that first, they do not like because it takes control away from them, and second, it is something they do not really understand. Hence, they are not really comfortable. It is just a tremendous additional complication.

Let me give an example of what can happen. There are some physician group contracts where the physician compensation is based on a percent of premium. What that means is when a sales person sells a group and varies the premium from the standard premium, he is also affecting physician compensation. If he shaves rates, presumably to build market share, he may also be driving the physicians into bankruptcy. Or if he thinks he is making a couple of extra bucks per member per month by adding a couple of extra bucks onto a rate, he is not going to keep it all. The company is not getting to keep it all because a certain percent of the increase will go directly to the physician.

Continuing in what I see as a natural progression here, I have started with the product and then talked about evolutions of product design. Another thing my scenario portends is the increasing importance of underwriting. Underwriting is always very important in the health insurance business. The saying is: "A good underwriter and a bad actuary means you make money. Maybe not as much as you wanted or should have, but you still make money. A good actuary and a bad underwriter means you are out of business." In a dual choice environment, underwriting is even more important.

HMOs can no longer take the view of membership at any cost. The margins that allow profitability are no longer there. I would say that some of those margins were due to anti-selection which no longer occurs. This ties back to the distinguishing characteristics of the large companies. In my opinion they are more comfortable with doing serious underwriting. I am not saying they always do a better job of it, but I think they are more comfortable in doing that kind of job. Presumably, on the traditional side, they have bottom lines for their lines of business. They know where they make money and where they do not make money. I am not sure that a lot of HMOs have that kind of information system.

I cannot stress enough the importance of knowing where you are making money and where you are losing money. To go back to that story of the strategic management consultant, he said when he analyzed a company, that was basically what he did. He took the business apart. He said group health insurance is no different from other businesses he analyzes, but the senior management in group health did not know where they were making money and where they were losing it. And he said that he just could not believe that senior management would get to that level and not have asked and seriously tried to answer that kind of question.

Another thing I see coming, related to underwriting, is participation requirements. I believe that the dual choice environment violates the basic principles

of group insurance. I think everybody agrees with that. But the way you would combat it, if you had a choice, would be to exclude other carriers. And what happened was because we had the HMO Law and because a lot of employers did not really understand what it said. They let just about any HMO in and created a fragmented environment within the group. In truth, unless they were mandated, this response was not necessary, and there was very little mandating going on.

Because of the new HMO Amendments, the whole mandating problem should evaporate. Then the selection within a group will no longer have this artificial barrier. If you are a major carrier, if you are trying to build market presence, it seems an effective strategy would be to exclude other carriers. You might agree to participate in a group only if you are the only carrier. Your position is that you must see everybody in the group because that is the only way to do effective underwriting.

Finally, in terms of the future, there is one more problem on which I would like to comment. There are the cultural differences that result when an HMO is part of a large national or regional firm. Usually these large firms developed an HMO operation separate from the non-HMO operation. The two operations frequently had very different cultures. The HMO was part of a very fast growing industry that was worrying about providers, etc. and the traditional business was a much more mature industry. And when management tried to merge the two, there were all kinds of fireworks. I think the time has come, if a company is going to be successful, to force the two operations to integrate. It is the only way to get the HMO to work as part of your portfolio.

I wonder when you are a national carrier and you put your HMO operation on the West Coast and your traditional operation on the East Coast, whether or not you have any chance of ever getting those two to work together. There really was a national carrier that was particularly proud of having the entire country separate its ADS (Alternate Delivery Systems) and traditional operations a few years back. To me, they were out of step with what was going on. Maybe, at the beginning of the decade when the game was growth, they had to get that operation in a different place. They had to get it insulated so it would not get contaminated by the traditional group insurance culture. But it seems if you are going to survive in the next decade, you are going to have to get those operations together and get them working together. And regardless of the technology, I do not believe you can get them working together if they are in two different cities. There is just too much interaction that has to occur between the two parts.

An interesting side note might be to take a look at joint ventures. I guess that is really what you create when the HMO and traditional business operations are in different cities. It is a joint venture within a single company. Maybe we have proven that in the health industry in general, joint ventures are very hard to make work.

Let me make a few comments about network structure. I completely agree with what Harry and Tom have said. IPAs are very hard to work with. They have a lot of advantages in terms of marketability but it is very hard to get them to really give you what you need in terms of efficient care. We do have one very well managed IPA, not in Chicago but in a downstate area. I think that the reason it is well managed is because its Medical Director seems almost driven to make that IPA work. Oddly enough, he is not driven primarily by money,

although he is happy to have more of that every time we sit down for contract negotiations, but in working with him you really get the feeling that he thinks this is something that needs to be done. It is something he is bringing to his community and he also gets something out of it. He gets a larger more powerful organization that he is a part of, but he has a real commitment to making it work.

I would propose the thesis that we are not completely out of the age of entrepreneurs in HMOs. I do think it has become a lot harder to be a successful one. I think they have to be willing to do a lot of work and it would help if they are effective Medical Directors.

But in some of the backwaters, the smaller cities, where there still are three or four hospitals and most of the services are local, there is room for HMO formation. Of course, the HMO opportunities are not as they used to be.

Continuing with networks, there are other opportunities for improvements and Harry mentioned some of them. There is a carving up of health management responsibilities. I do not know any medical groups where the majority of the physicians are really comfortable handling substance abuse cases or most other mental health cases. There are organizations that will contract to handle these problem cases. Some of them are quite effective. There are others. Prescription drugs, allergies especially, present an opportunity. We see various approaches to get pharmacists to shift people to generic drugs instead of brand name drugs.

What comes to mind is the exhibit hall at GHAA's last Group Health Institute. There were all kinds of fancy equipment and vendors who were peddling to the HMOs that they could pick off little portions of HMO risk and manage it better.

Whether or not that strategy pays administratively is another issue. It is pretty hard for an HMO management to spend a lot of time working on something that ends up being 3% or 4% of its cost. Even if the risk is cut in half, or cut out completely, it might take a massive effort and only cut 3% or 4% of the premium cost. On the other hand, it is true most companies' profit margins in this business are smaller than 3% or 4% of their premiums!

Nonstandard physician contracting presents some unusual problems for large carriers. I mentioned before the special risks that come with physician contracts based on a percent of premium. This kind of risk is not something physicians really understand. For awhile, it was very fashionable for physician groups. The argument was it protected them from duplicity by large, impersonal insurance organizations. I do not think there was real understanding of the implications of the contract. Should it turn out that premiums were insufficient, there was sure to be yelling and screaming about how anyone could sell a rate so low. It would make no difference that the insurer was losing money also.

I remember negotiating with a physician who was starting an IPA in a rural area, who said under absolutely no scenario would he accept a contract provision for reinsurance of physician risk. He said that the physician risk was the IPAs completely, and he wanted no part of any stop loss protection.

Now frequently, a large HMO contracting with an IPA provides stop loss insurance of $5,000 or $8,000 per person per year. This prevents the claims from a single member bankrupting the organization or causing substantial financial

damage to it. When we proposed this, and I actually was quite adamant that he have such protection, he would not budge. He said that it was just another way that the large insurance company was trying to nickel and dime him, getting some more of what was his money back to us.

Even when we said he could purchase it from someone else, he would not agree. He was going to accept risk. Actually, it turns out to be a very smart move for him. I pointed this out to our management at the time. He does not really have any risk of going bankrupt. If he gets in trouble, we would have to bail him out. The reason we want the provision in the contract is so that contractually, we get paid for providing the "lender of last resort" protection to him. Otherwise he gets the reinsurance for free!

There is one final issue that I think pertains to national carriers. That concerns exclusivity and network differentiation. This can be a problem for national carriers especially in major metropolitan areas. And remember that my view is that the national carriers have to concentrate in these areas, because it is the only place where it pays for them to try to succeed. The problem they typically have is that they invariably contract with entities that also contract with other HMOs. The question is how can they get network differentiation?

Another HMO can put together essentially the same network relatively easily. A related question concerns exclusivity. Its implications, both positive and negative, is something that national carriers worry about. At HCHP, Tom does not worry about exclusivity. Nobody else has got his network. But in a lot of places where we operate, it is something that we are very worried about. There are three or four HMOs that all look the same as ours from the network point of view. So the question is, how do we distinguish ourselves?

One way might be to study your providers and learn who are efficient and who are not. But because a provider is bad does not mean you will be able to throw him out of your network easily. The marketing people will yell and scream that he is essential for marketability. I have seen it happen a number of times.

I would also submit that exclusivity is not always what it seems. First of all it cuts both ways. You may get locked into a provider and then find out they are not the ones you want to be locked into. If the contract is tight, it can be pretty tricky getting out of such contracts. And if the contract is loose, it may be too easy to get out. Periodically, say once a year, you are going to negotiate within this exclusive arrangement. You will negotiate with the provider for what level of payments you as the insurance carrier/HMO are going to make. It seems that if things do not go very well in that negotiation, it can be easy to find an out to the exclusive arrangement.

I recently had an opportunity to see the way the HMO for which I am the actuary operates, up close, from the other side. A member of my family needed surgery. Because of my knowledge of the system, I was confident that everything would be handled very well. The mother of this poor child was not so confident.

Nothing I could do would calm her down. I watched the way the whole process worked itself out. What came across to me was how well the pediatrician was able to handle her and calm her down and lead her through the system. What I saw is what I think is the ideal way for an effective managed care program to work. It was not some nurse, contacted for the first time, at the other end of

the phone who was her primary contact. It was somebody she was used to dealing with, taking her step-by-step through the referral process, explaining what was involved, what the risks were, generally being the coordinator. This was the person she could call up and ask her questions and express her fears to. He was the one who taught her how to manage the system.

I guess what I saw was a return, at least for me, to the original concept of HMOs. The physician's role as medical advisor is retained and reinforced at the same time the "perverse economic incentives" within the fee for service system are removed, to use Elwood's term. I think we need to return to an HMO viewing health care delivery not so much as insurance, like an indemnity plan, as a framework to purchase health services. And I think that is why things like well baby care and preventive care, and I would submit even mental health care, need to be included. If people are going to use these services, then the best way to do efficient management is to get a good physician on your side with the perverse incentives removed. Unfortunately, I think we once used to do this and then forgot how and why.

That is the end of my presentation. I promised at the beginning that we would leave sufficient time for questions, comments, and discussion. The outline prepared for distribution before this session mentioned that there were a number of wild cards in terms of the future for HMOs. These might include things like Section 89, the HMO Act Amendments of 1988, maybe picking up on what Tom said, universal coverage, and the transfer payments. Harry, I wonder if you could start by commenting on what effect you think Internal Revenue Code Section 89 will have on HMO participation.

MR. SUTTON: Like many of you in the group health business I have diddled around with Section 89. The HMOs are afraid that the complexity of Section 89 will be an excuse for an employer to cancel out a bunch of HMOs. That way the employer will not have to go through the calculation of the actuarial value for each HMO plan he offers. Alternatively, the problem could be solved by letting the HMO come up with what its actuarial value is according to the IRS factors and furnishing it to the employer.

Section 89 is a mess, and we all wish it would go away. As somebody was saying this morning, if Congress wants to tax health benefits, why don't they just do it directly instead of causing a mass of confusion to employers. It has little effect on HMOs because, by and large, the HMO benefits are substantially higher than any of the indemnity plans -- even flexible benefit options. Since the executives are those who want to use Dr. DeBakey in Houston and are less likely to sign up for the HMO, the fact that the HMOs have such high actuarial values makes it easier to avoid discrimination.

MR. PYLE: I would just like to say that I am happy to see that something has been done for this profession that had previously been done by lawyers and accountants.

MR. SUTTON: I would like to make a comment on increasing regulation of HMOs. Because of the difficult situation of HMOs financially, the National Association of Insurance Commissioners has been rewriting the HMO statutes. The capital requirements are going to be greatly increased. Insurance commissioners do not want any insolvencies and the best way to assure that is to require HMOs to have so much capital they could not possibly go under, let alone start! We will be facing much increased regulation as a result of these difficult financial

situations. Maybe Tom will not have a problem with it, but a lot of smaller HMOs will have to spend a lot of money and raise capital in some cases.

MR. DALE C. GRIFFIN: I would like to have your comments on the part of the new HMO law that deals with experience rating. Do you have any thoughts on whether experience rating will have a big impact on the viability of HMOs, particularly the IPA HMOs?

MR. PYLE: I do not think it is going to affect Harvard's viability. As I understand it, the new law does not allow true experience rating. It is different in that you are not allowed to retrospectively adjust the rate. I think the market is moving to a point where that is going to have to be allowed or employers are going to find some way to get around it.

MR. SUTTON: The new law allows what we call prospective experience rating. It can cause technical problems for HMOs if they capitulate a medical group and have a community rated capitation, even an age/sex community rated capitation, and now have experience rated premiums. There is a large potential for disturbing the contractual relationship with the medical groups.

In fact, I would not be surprised if some HMOs will have as much trouble making money on an experience rated basis as insurance carriers do. Perhaps, they will find themselves faced with the same insurer problem of all raising rates together or lowering them together depending on the competitive nature of the market.

It is also not strictly accurate that a Federally Qualified HMO could not experience rate before. If the group consisted of state employees, you could base your rates on the cost of that group. So at least for governmental agencies, which are a big part of the enrollment of many HMOs, you could experience rate or have separate rates. Unfortunately many HMOs, in order to get market share, cut their rates and typically lose money on either Federal employees or state employees.

I do not think most HMOs will have a serious problem with the new ability to experience rate, but they will have to learn a new method of business for larger groups. One last thing to remember is that since the HMOs are in a dual choice situation in the employer market, their employer group enrollment is only a subset of the total employer's size. If the average group is 500 lives, an HMO may find its average size is 100 lives. Many of our HMOs really have a very small average group size -- the size you almost could not experience rate in any event.

MR. PYLE: The practical problems of experience rating are great. I have not found a salesman yet who did not have all his groups below average in experience, and I have not found an employer yet that did not expect to realize significant savings as a result of this. So trying to implement is clearly going to have a lot of problems.

MR. AVNER: My experience is that a lot of HMOs not only were not community rating but had no intention of community rating. They were doing this legally; they had waivers from community rating at the time they became Federally Qualified. At least one, in Minnesota, as soon as the waiver expired gave up the Federal Qualification. Harry is signalling that two did. Big ones too. So maybe experience rating will not be that big a change after all.

A second point is the acceptable deviation from community rates allowed for small groups. I believe 10% above the community rate is the way the amendments finally read. I went over to our small group business and saw what kind of variation we had in the rates and it was a lot larger. So if the HMO is Federally Qualified and going to operate under those statutes, there are still significant restrictions on the rating that is allowed.

MR. MARK R. WHITE: It seems to me there is a question with the whole level of competition in the HMO market. For a number of years the HMO market has been more or less insulated from the kind of competition that the general group insurance market has faced. You can argue about how much profit the insurance companies make on their indemnity plans, but by and large, you would have to agree that the insurance carriers are in a saturated environment. In contrast, the HMOs have been in a growing type of environment for the last few years being able to pick up a lot of people by taking them away from the indemnity plans. A question that comes up is, "Do you think we are getting close to the point where it is a zero-sum game?" Now, the HMOs are going to be competing with each other for a relatively stable group of people who have already indicated that they are the type of people who will accept HMO restrictions. If that is the case, when you superimpose upon that the changes in the law and regulations, are we entering in the next couple of years, a critical shake out period? I am talking about a situation much worse than just ten or 15 bankruptcies a year.

MR. SUTTON: Without a doubt I think we are entering a shake out period in a number of metropolitan areas. Let me describe a couple of situations to show that the market is not static.

I have talked to the Kaiser people for many years. They used to feel that the breakpoint was 50%. Once 50% of the employees were in an HMO, it could not go any higher. And it stayed that way for many years. But then with the cost movement in the last decade, they broke through that barrier and got up as high as 75%.

When you look at the indemnity market, the assumption usually made is that the indemnity plans have a big chunk of the people in each individual group. But now we have groups talking to us about eliminating the indemnity plan completely. Employers could just make available a certain sum of money, maybe related to the lowest cost HMO in a given metropolitan area and eliminate the indemnity.

The other solution is one Ken alluded to. The new law -- and the Minnesota statute except it was never implemented -- permits an HMO to write indemnity coverage as long as it is a limited part of its business, say 10%. This means that the HMO can write what we call a combo or an opt-out option. Then it could write the whole group and provide accompanying Major Medical benefit coverage alongside the HMO benefit. Presumably, the out-of-network benefits would be so skinny that not many people would go outside the HMO. This would at least give the employer an escape valve to say that if an employee does not want to use the HMO he can go outside.

With small groups I expect this will become a popular benefit design. Why should a 50 life employer really have more than one option in the first place? Maybe you could call this a double or triple option already. The idea is that the HMO will now compete for the total business rather than a dual choice.

I think difficult times lie ahead for some HMOs. You are correct in the sense that if you go back to the late 70s, in many metropolitan areas there were only one or two or three HMOs. Then the same area had 30. Some of the 30 will go under. The rest will somehow combine or pick off the enrollment from the ones that go under. Maybe the big carriers will dominate an area again and the independents will not.

My rule is that an HMO really has to get 10% of the area market to be in a position where it would be hard to dislodge them from the market. This size gives them an economy of scale to build more clinics or to expand into the suburban areas less populated or growing suburban areas that need physicians or whatever.

MR. PYLE: I would like to note a fundamental disagreement with a premise of your question. I think the times ahead are going to be difficult and the competitive environment is going to change, but this has been a competitive business for a long time. Most of the HMO business has been written after all large employers in the market were already offering health insurance. It has never been a noncompetitive market for HMOs. We have always had to take business away from health insurers. Just going back in my own experience to the Harvard Plan in 1972, trying to get the large employers in Massachusetts to offer HMO coverage was not an easy thing to do. I think that it has been a competitive market for a long time, but it is becoming competitive in a more sophisticated way. It is becoming competitive around data, around combining risk pools, this sort of thing. I do not think it will have a higher intensity of fire to it than it has had at times in the past.

MR. CHARLES J. PAYDOS: Mr. Sutton talked a bit about Minnesota. I get the impression that some of the more inefficient hospitals have been put out of business. Minnesota seems to be doing some things right and I contrast that with my home state of Connecticut where we have a DRG system in, I think, its third year. We have seen some pretty good sized DRG increases, a lack of consensus among providers, hospitals, the insurers and the HMOs and of course, the regulators. I wonder if you could comment a bit about what is happening in Minnesota?

MR. SUTTON: Whether it is Paul Elwood or Walt McClure or whoever, the Health Department and the regulators, over their dead bodies, went with competition as a solution to trying to control health care costs rather than regulation. We got rid of Certificates of Need. We stopped regulating hospital rates. Interestingly, the Health Department is now looking at regulating physician fees or salaries in some legal suits; they are concerned about the people who fall through the cracks.

First of all, Minnesota is different from Connecticut in the sense that we are dominated by group practice. We have almost no solo practicing physicians in the whole state. We have clinics with 1,000 physicians, with 300 physicians, and clinics of 20 to 50 physicians are common all over the state. Since they are mostly multispecialty groups, it is easy to capitulate them for services. The physicians can control their own members in most cases. Clearly, not every medical group is efficient.

I think one of the reasons HMOs have had difficulties and why the carriers overestimated costs, is the U.S. has experienced, for the under age 65 population, a drop of 25% in hospital utilization over the past five or six years. In

Minnesota the drop was 50% over ten years. In Minnesota we went in 15 years from almost the highest hospital utilizing state in the U.S. to one of the lowest. Consequently, utilization of hospitals in the Twin Cities is only 47%. If you look at areas like Cleveland and Toledo, you see they are still at 80%. They have not succeeded in cutting the supply of hospitals or reducing utilization.

We tend to have a socialistic government. We have a very cooperative business community. The regulators did not interfere with anything very much once the program got started. However, now that institutions have gotten close to bankruptcy, we are seeing an attempt to overpopulate. There is a requirement of 8.3% surplus without limit for all HMOs. This essentially means HMOs are going to have to add 2% to 4% surplus margin to premium rates forever in order to meet the surplus requirements.

I think we have a medical community that is essentially innovative and, while they get dragged kicking and screaming at times and they dislike this interference (private review systems and all that), they, by and large, changed the whole character of the way they practice medicine over a ten-year period. Consequently, even Blue Cross' utilization, as anti-selective as it may be, is only half of what it was in the mid-1970s. It dropped from 850 hospital days per thousand members per year to the low 400s.

Essentially, there has been a monumental change in the way medicine is practiced in our state. The HMOs forced that on the fee-for-service community but everybody has been affected. The hospitals were empty and finally recognized that there is no way they can exist with 20% or 30% occupancy. So they agreed to close down and the state was convinced that nobody in his right mind would build a new hospital. There are no proprietary hospitals; the two little ones went bankrupt.

Physicians are moving out of the state. That may be a negative. Physicians find it very hard to survive financially with everybody and his brother looking over their shoulders and having to join two or three HMO networks in order to get enough patients. They are all moving to North Dakota. I expect they will greatly increase the cost of health care in North Dakota.

FROM THE FLOOR: For quite awhile I have noticed that HMOs have some information that it appears to me other carriers or forms of plan such as PPOs do not have. One thing is an HMO knows all the members of its plan. It knows who they are. It usually knows, in another place, what their medical history is, at least from after the point when the person comes in for care. It would seem as if the HMO is in the unique position to adopt some kind of really protractive preventive care program but I have not seen any. Would you care to comment on that?

MR. PYLE: I assume you mean me. We have some in our plan. We have, what I am told, is the world's largest computerized medical records system and we have a variety of things that kick out and serve as reminders and so on. One statistic that comes to mind is I think we are getting a rate of mammograms in the neighborhood of 80% in contrast to the general population's of around 50%. That, at least, is the right order of magnitude.

But when you start talking broadly about prevention, there are several problems. One is that most things that are preventive in nature have very little to do with what a physician does. They are things we have to do for ourselves.

Medicine in the preventive sense is not a spectator sport. It is fastening seat belts; it is controlling weight; it is controlling the intake of alcohol; it is not smoking; and so on. It is very, very discouraging to think that a physician cannot do those things for you. Most Americans would like to think that it can work another way. One of the technologies that we do not have is an effective technology of behavior modification. So I think that many of the preventive things are beyond the pale of the HMO.

I think it is particularly unfortunate that many HMOs have been sold on the basis of preventive medicine. Ours has not, except when other people have sold it that way. There are people running around Boston telling you that we are successful because we practice preventive medicine. You do not hear us saying that because we do not think it is true.

Now what I have said is dangerous to say. I said it to a group of people from the Massachusetts Business Round Table and several of them had just invested all sorts of money in prevention programs and they were very upset with me. But there is less to prevention than meets the eye, and it is an area where we need to do a lot of work to really find out what is effective prevention and how we can get people to practice it.

MR. SUTTON: I tend to agree. There are certain areas, like prenatal care, immunizations, and tracking the development of small children, and a few others, where there is a big payback for the amount invested. These are essentially part of the primary care of the HMO. In a lot of the other areas, such as weight control, companies have spent millions and have never been able to talk people into controlling their weight. There is an insurer program that the insurance industry has been financing which shows some health gains associated with not smoking and periodic meetings with individuals and physicians to measure their risk factors and try to talk them into changing. They make some changes. They particularly do not mention a net savings. It adds something like 4% or 5% to the cost of a health benefits program to add this program. Interestingly enough, there was not one word about whether there was any reduction in the cost of the health care program to offset that. My point of view is that all these programs are great as long as you do not expect them to reduce your claim costs, because it really does not affect it, except maybe in the very, very long run where you would be hard pressed to measure it.

MR. AVNER: In response to your questions, may I disabuse you of a notion. We use the same membership system for HMO and for our traditional coverage. And it is true that our statistics from the membership system are best for the HMO. That is where we know the age of everybody enrolled. We even have the name of everybody who is covered because they have to show up on capitation or enrollment lists that we give to our physicians so they know there is coverage. But what was very interesting was when we found, in the course of doing longitudinal studies, that although we had a fast growing HMO we had a tremendous amount of disenrollment. We had much more enrollment, but we had a tremendous amount of disenrollment. Year-to-year we were seeing tremendous shifts of who was enrolled and who was not. Maybe people were gaming in the system. It is not as clear cut that you have as much quality information as you might think.