RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 1

HMOs: MYTH VERSUS REALITY

Moderator: DENNIS J. HULET
Panelists: HERBERT A. FRITCH
J. CALVEN HOWELL*
SCOTT C. THORNTON
Recorder: DENNIS J. HULET

This session will explore often asked questions about the value and effectiveness of managed health care delivery systems (i.e., HMOs):

- Do HMO providers "manage" health care better?
- Do provider financial incentives reduce quality?
- Do HMOs profit from shadow pricing or managing health care?
- Do HMOs attract a better risk pool?

MR. DENNIS J. HULET: The topic of this session is, "HMOs: Myth Versus Reality." Anyone who's been conscious in recent years has heard HMO advocates say that HMOs are the solution to the health care crisis that our nation is experiencing. At the same time we have those who come from an indemnity background that say managed care has not really done the job it is saying it is trying to do. There are questions such as, will HMOs survive? and will indemnity carriers be able to stay in the health care business? that have been subjects of hot debate the past couple of years. The position that you take on these particular issues will probably depend largely on your experience and background and your exposure to the managed care environment.

I am a consulting actuary with Milliman & Robertson in our Seattle office. I specialize in managed care issues and have worked almost exclusively in the managed care consulting area for the past six years. Prior to joining Milliman & Robertson I worked for an indemnity carrier and was involved in its efforts to start contracting with providers and setting up arrangements that more directly tied them to health care providers.

As a special guest we have Calven Howell who is HMO/PPO programs coordinator for J.C. Penney Company. He is based in Dallas. He is currently responsible for the general management and administration for the 170 HMOs and the two PPO benefit programs which J.C. Penney offers to its associates nationally. Prior to joining J.C. Penney Company, Calven was involved in benefits consulting with two prominent Big Six accounting firms, Coopers and Lybrand and Ernst and Young. Calven began his career at Kraft Inc. in personnel and later joined Litton Corporation Labs in corporate benefits administration. Calven holds a bachelor of science degree and an MBA degree from Louisiana Tech University. He's been with J.C. Penney long enough to be well immersed in the employee benefits issues that face the employer, and in particular, how to deal with the managed care plans that J.C. Penney offers throughout the country.

* Mr. Howell, not a member of the sponsoring organizations, is with J.C. Penney Company, Inc. in Dallas, Texas.

We also have with us on the panel two actuaries who work in the managed care area. Scott Thornton is the chief actuary for Deseret Mutual Benefit Association in Salt Lake City. Deseret Mutual underwrites and administers the employee benefits program for the employees of the Church of Jesus Christ of Latter Day Saints and related organizations. The benefits program includes self-administered HMO and indemnity plans, both offered to closed groups since 1981. Deseret Mutual also contracts with several independent HMOs and PPOs to provide other managed care plans for church employees. Scott manages both the group insurance and pension actuarial functions within his company. He's worked at Deseret Mutual for the last 11 years. Scott coauthored a study which analyzes adverse selection and relative performance between the HMO and indemnity plans. This study was published by the Group Health Association of America (GHAA) in 1989, and I'm sure he can help you get a copy of that if you're interested in the results.

We also have with us Herb Fritch, who is an actuary with the Partners Health Plan. Herb is Vice President of the southern region of Partners. He is responsible for five HMO and PPO networks in a six-state area. He performs a management role rather than a direct actuarial role, but he certainly has to deal with the actuarial issues in his management role. Partners is a 50/50 joint venture between the Voluntary Hospital Association and Aetna. And if you kept up with the media in the managed care world lately you know that Aetna's currently trying to acquire VHAs interest in that venture. Previously, Herb was a cofounder of SANUS Corporation Health Systems, a national managed care company. Also, Herb was a consulting actuary who specialized in HMO consulting.

Hopefully, with the different perspectives and backgrounds represented by our panelists, we'll be able to stimulate a little bit of discussion on our topic, "HMOs: Myth or Reality." In the Society format, a panel discussion generally means that panelists take turns giving a 15-20 minute speech and then allow you to ask questions at the end. Because of our topic, I thought a question-and-answer format would be better. Therefore, we have identified several questions we believe get right to the heart of the issue. We will give our responses to those questions, and then as we finish with our responses we invite the audience to ask more detailed questions on the same issues or add comments. We would like to see this be a discussion and not just a one-way rhetoric.

As I go through the questions I will give each of the panelists a chance to give their response and hopefully the panelists will also have some additional discussion.

Let's begin with questions about risk selection. Do HMOs attract a better pool of risk? Some maintain that HMOs enroll the best health risk and are charging too much for that risk. Is adverse selection a serious problem when HMOs or other managed care options are offered in the employee benefit setting? If so, for whom is it a problem? And if not, why isn't it a problem? Can these selection problems be effectively managed to the satisfaction of all parties?

MR. SCOTT C. THORNTON: Over the years in our company we have done several actuarial analyses of the adverse selection present in our plans. The main HMO plan

that we offer began in 1981. It was our first venture into the HMO area, and it was offered in the Salt Lake City area. That plan surprisingly enrolled about 75% or 85% of the eligible employees in the first year -- an extremely high penetration. It was offered in connection with another staff model HMO which picked up around 5% or 10%, so the indemnity plan had very few people left in it.

The first couple of years we experienced relatively poor results with the HMO -- we lost quite a bit of money. That prompted an investigation as to why that was happened. We suspected there may be some adverse selection against the HMO in our situation, so we started analyzing that. We tried to do quite a detailed analysis where we would adjust out the impact of the age/sex mix or demographic variables. We wanted to specifically investigate whether the health status of those that was in the HMO was any different than the ones that chose to stay with the indemnity plan. Our study, as published, shows the result that our HMO definitely attracted a sicker group of employees. This was based on the finding that the prevalence of disease in the HMO, after adjusting for the age/sex mix, was about 35% higher then was present in the indemnity plan in that same area. We had some particular selection problems with the OB/GYN area and a much higher maternity rate in the HMO than in the indemnity plan. Another notable area was psychiatric. Part of the reason for the differential in psychiatric was that the benefits in the HMO are substantially better then the benefits in the indemnity plan.

Since that time we have offered probably half a dozen or dozen other HMOs. We've tried to manage them, since they, in essence, are competing with our indemnity plan. In certain geographic areas, we have tried to do strictly demographic analyses of the enrollees in those particular plans. In some cases the results were surprising, in that we had thought the HMO was attracting the better risks, but we found they were not. We found the demographic selection was almost neutral between the two plans. In another case we found the HMO did attract the lower-cost participants. We were actually able to quantify how much adverse selection occurred. The expected claims, due to the particular mix of employees there, were about 9% lower in the HMO than for the average employees in that geographic area.

It's hard to generalize from these results. I am simply reporting what we found in our own experience. And I think the conclusion there really is mixed. Sometimes HMOs do attract a better pool and sometimes they don't.

With regard to the problems that adverse selection causes, there are the obvious problems of the assessment-type spiral which are well known. I'd like to comment on a hidden problem here, too. Adverse selection makes it difficult for the employer or the purchaser to evaluate the true efficiency of the HMO.

I found that generally the employer groups we were covering judged the cost savings (or the lack of cost savings) with the HMO strictly on the basis of the premium rates. They're saying, "Okay, if the premium rates for the HMO are lower that must mean the HMO is saving money. And if the premium rates are higher (which was the case in our situation) that must mean the HMO is not saving money, that it's not an efficient mechanism." I think that the problem arises from the fact that if the premium rate charged for each option is a self-supporting premium rate, and if you do get into a

situation where you have substantial selection, then the underlying efficiencies or inefficiencies are obscured. Currently, we're seriously investigating different ways to adjust for that adverse selection so that the premium rates would reflect only the differential between the benefits and the differential in efficiency. This is similar to the approach described by Professor Enthoven. I think it is quite possible to manage this effectively, at least with large groups (I'm approaching this from a large-group standpoint, where the employer is very involved in the management of the benefits program).

I believe there are three conditions that must be present to effectively manage selection. Number one is to have data available and do proper analysis. To elaborate on that, we need detailed data that is consistent among the different competing plans regarding the enrollment demographics and the extent of illness that is present in those plans. That would include such things as prevalence of psychiatric cases. We're trying to get this type of information from the outside HMOs. Sometimes we're successful, sometimes we're not. With this data it is possible, through actuarial techniques, to create an index of the relative expected claims for each plan.

The second criterion that needs to be present to manage this is there needs to be an adjustment mechanism, or some way to transfer money from one plan to another, in order to compensate for the adverse selection. Another approach is to adjust the employer contribution to the plan for the adverse selection.

The third condition is willingness to be flexible. The HMOs you offer and the indemnity plans need to be willing to work together and be flexible in allowing a more scientifically determined adjustment for adverse selection to occur. Such an adjustment is going to benefit one party and harm another party, but we've been able to successfully manage the adverse selection with this approach. We first determine the adverse selection index. So far we've only done that based on the enrollment mix in the plan; we haven't really gotten into determining the difference in the health status. Next we adjust the premium rates for each plan up or down in accordance with that index. Then we use our company as a sort of clearing house for the premiums, so that we match the total incoming premium from the employer groups to the required outgoing premium needs of the individual plans. Each of the individual plans needs the required amount of money to pay for the claims. We cannot change that. This approach could probably be best used when all the plans are offered by the same carrier, for instance, a triple-option plan. It would be much easier for a single carrier to make those adjustments and modify the prices of those plans.

MR. HERBERT A. FRITCH: I come from the HMO side of the industry and the question, do HMOs create adverse selection? is a confusing issue. You can point to studies in both directions. I know I've seen some studies from Aetna that are pretty convincing that the indemnity plans are getting badly selected against. I have heard of summaries of others that show just the opposite results. I believe there are two counteracting forces at work in the selection issue. I think it's more instructive to talk about each of those forces to understand them a little bit.

In the HMO's favor, you potentially have a requirement that a member switches physicians and other health care providers in order to get HMO benefits. That definitely

tends to work in the HMO's favor. The people who are the most chronic users of medical care are the least likely to change providers. It is likely the older people in a group have the strongest ties to current providers. If they are required to change physicians, hospitals, whatever, they're less likely to do it. That works far more to the benefit of staff model HMOs, where almost everybody has to switch, a little less to the benefit of a group model HMO, and probably doesn't have too much impact if you've got a broadly based individual practice model (IPA) HMO, where you may have 60%, 70%, 80% of the physicians in a community participating.

On the other hand, working against HMOs is benefit selection. Traditionally, the HMOs offer the highest level of benefits. And in that regard, when you offer higher levels of benefits, naturally the people who are going to use the most benefits are the ones most willing to pay the additional amounts, if required, to get the higher level of benefits.

Historically, from an HMO's perspective, benefit selection has impacted most dramatically in the areas of maternity and psychiatric care. Offering a significantly higher level of benefits in those two areas will almost certainly lead to adverse selection against the HMO. The key determining factor we have found is the out-of-pocket difference in premium that you ask a member to pay in order to join the plan. We in the HMO area pay very close attention to this differential. Where we're coming in with the highest level of benefits, the one underwriting guideline that we're very strict about is limiting the amount of premium differential that we will allow compared to the other options. We have found the HMOs will get adversely selected against if you're asking people to pay a significant amount out of their pocket to get higher levels of coverage. In general, the HMO industry is getting more and more sophisticated in that regard. Part of what you're seeing in a response to this concern is an effort by HMOs to offer more and more low-option products.

If there is selection going on, and if the HMOs do get positive selection, do they charge too much for it? I'd say categorically no. Just look at their financial results -- they haven't been charging too much compared to their cost anyway. A lot of that has been just the nature of the industry. It's been so competitive in the last couple of years, with too many players coming into a given market quoting low rates to get established in that market. Very few HMOs in any kind of competitive area have been able to competitively charge adequate premiums. In fact, in most cases it's driven the prices of HMOs down below what the costs really have been. That's starting to change again with the consolidation going on in the industry, but by and large, I do not think you could make a very strong case that HMOs, even if they are getting positive selection, are charging too much for the risks they are enrolling.

I think it's a manageable problem from the HMO perspective, largely because of out-of-pocket difference. I can appreciate Scott's comment that it gets very confusing for an employer to try and identify who are or are not efficient providers or efficient HMO or managed care options. It certainly clouds that issue and makes it a difficult one for an employer to evaluate.

MR. J. CALVEN HOWELL: I would agree with Herb that it's very difficult for an employer to determine efficiency. We at Penney's are struggling with that right now

since we offer 170 managed care plans and we want to pare that down somewhat in the future, as most employers are wanting to do. In the past, with the Penney Company, HMOs did attract a better risk. That differential has been decreasing, though. We received an actuarial study by TPF&C giving us that information, so we can look at it. It helps us in determining our contribution level to the HMOs. I do not know that the report is sophisticated from the standpoint of getting into some of the issues that were discussed. But I would agree to some extent with Herb that HMOs now are becoming more concerned with adverse selection, or maybe they've always been concerned with it, but their concern is becoming more prevalent, especially with some of the diagnoses, such as pregnancy and mental and nervous types of conditions. I know we have a high female population, and one of the benefits they use quite a bit is the pregnancy benefit. HMOs provide a lot more first-dollar coverage than our self-insured indemnity product does.

I know that a lot of employers have put in cost containment provisions and mandatory precertification programs for their own standard indemnity program. It's not the total freedom that we once had with straight fee-for-service plans. You get to pick your own doctor, but with URC cutbacks, deductibles, coinsurance, and cost containment measures, the employers have put a lot of restrictions on their indemnity programs. The HMOs don't seem to be restricting freedoms quite as much, relative to the indemnity plan, as they did when HMOs first became prevalent. Therefore, employees may say, "If we're going to have restrictions, we might as well get better benefits," and so they're jumping into the HMO.

I think J.C. Penney believes selection can be managed, but only, as Scott and Herb mentioned, through cooperation. There cannot be an adversarial role between employers and HMOs or managed care. Right now at the Penney Company, our managed care program is our HMOs (other than cost-containment provisions in our indemnity plan). So we really believe there is a partnership between J.C. Penney and our HMOs. I do not think that was once true. Initially there was a fear of adverse selection against the indemnity program, especially since it was self-insured. But I think now we realize that the HMO industry is maturing somewhat and selection against the indemnity plan is less of a threat, especially in some markets more than others; and with cooperation and exchanging data, we would feel more comfortable working with the HMOs.

An issue that we've discussed with most of our HMOs is the reluctance or the incapability of providing data. Some HMOs have indicated to us in the last 12 months that they're going to be providing or they're willing to provide us with utilization data so we can look at that information. We get tons of data from our carrier on the indemnity side so that we can manage that program, but we currently don't get any data from any of the HMOs. Now when we ask them, HMOs do say, "Yes, we can provide data." In some cases they just can't; they haven't been collecting the data, or the data is less than a year old. They don't have enough information to provide us with. So, as Scott mentioned, if we can get data from the HMOs, we would be more than willing to work in cooperation with them to make sure the pricing and plan design issues are ironed out. We can try to eliminate the selection issue as much as possible, and then the choice is made based on premium and on what benefits are selected.

MR. HULET: I think we could begin by paraphrasing a bumper sticker you have probably seen: selection happens. If there is a choice given to employees, or to employers, selection happens. The indemnity insurance industry was really based on the premise that there would be risk selection, and that if we have individuals who have the right background and training, and hone their skills, they'll be able to evaluate that risk, and therefore be able to put a price on it that will allow a carrier to make money.

Contrast that with the level of rating sophistication in the history of HMO development -- many of the HMOs were initially community rated. This meant there was not a lot of sophisticated rating analysis done. Perhaps their analysis was no more sophisticated than taking total cost divided by total members and adding a little bit for their administration. Then their rates would vary only by the kind of family structure that was being insured. When you compare this level of rating sophistication with the level which insurance carriers have developed for their health benefit coverage, it's very easy to see why shadow pricing (which I will define as setting a price that is based on what somebody else is doing rather than your own evaluation of the risk) has been a problem for some marketplaces. There are HMOs that lack the sophistication to evaluate the risk and therefore felt that an insurance carrier, who had the expertise to do that evaluation, was setting a price that would be able to make money. So, by matching that price, HMOs would do what they have to do to deliver the care within the fixed-dollar amount they are collecting through their premium rates.

I think most people will agree that selection happens. And then the question that has to be addressed is, what are risk-takers doing to evaluate that selection and set their prices in accordance with the selection they are accepting as part of their business?

There are a number of things that can be done to evaluate the selection. We've already mentioned things like looking at demographics (i.e., age, sex, family mix) and trying to identify how they are impacting the total requirement for dollars to cover the risk. There are also advocates of looking at and trying to evaluate health status. There have been a number of studies done that have tried to identify variables that can be used to measure health status and to assess the relative effect on health claim cost of those variables. As we get more sophisticated about that part of the business, we will be able to do a better job of identifying the degree of adverse selection that takes place. But even if we get very sophisticated in our techniques, I do not think we'll be able to have a true measure of adverse selection because of the individual variation that happens in claim costs from year to year. Until we master time travel we'll never be able to tell what would have happened if the circumstances had been different. And that's what we have to deal with on selection issues.

There are a number of things that carriers and HMOs have done to respond to the adverse selection question. They have tried to respond through benefit design, and we'll try to deal a little bit more with that in a later question. They've tried to do it with the type of groups they underwrite and with the contribution structure, as Herb mentioned. And I think all these things are items that need to be considered in setting the strategy to deal with adverse selection. The combining of the product back under one carrier is really what needs to be done in the long term to be able to control the adverse spiral that is likely to happen when products compete against one another. Until you combine

the risk back into a single package, it's very difficult to assure that you'll be able to price prospectively in order to cover the risk that you're accepting. As many insurance carriers have found out, even though you deal with products that are experience-rated or even self-funded, you're always playing a catch-up game. There's only so much money to go around, and at some point there won't be enough money to catch up.

I'd like to open the discussion up to the floor for comments and further questions about the adverse selection issue.

MR. JEFFREY L. SMITH: One of the issues for public policymakers to deal with, which Mr. Howell identified as being difficult both from the HMO's perspective and the employer's perspective, is where coverage is provided to a publicly funded entity, particularly state and multicounty agencies. Is there a concept of different compensation that exists, either by statute or by policy, that makes the limitation of employer funding versus employee funding, as Mr. Fritch mentioned, almost impossible? We all know health care is a localized issue, and HMO service areas are specifically defined in a multiarea where there's a great degree of difference in health costs in rural versus urban, or even one urban area versus another. If the publicly funded entity has a price that spans the area, it's very difficult to manage selection purely based on price. I would certainly solicit any comments from the panel to address that issue from a public perspective, so that contributions to a health plan can reverse any refund difference back to the employee is not interpreted as differentiating compensation within a class of employees. That certainly is an issue we have to deal with.

MR. HULET: That's an issue that any multisite employer has to deal with. Since Milliman and Robertson has locations in several different cities, the indemnity side of the plan is blended for all cities in setting the cost for the health benefit program. With our HMO product, we have to deal with whatever price the HMO has established for that particular marketplace. And so the differentials in out-of-pocket cost sometimes do not represent the differential between what an indemnity product would cost in that area, and what the HMO price is for that area. That makes it very difficult to have the right incentives working to encourage use of the most cost-effective plan.

MR. FRITCH: In our situation where we do have employees across the country similar to what I was mentioning before, we do have a very similar problem. We have the indemnity plan that does operate nationally. The premium rate is developed using national experience. And then we do have the HMO operating within that geographic area. The ideal way, from a theoretical perspective, to handle that would be to differentiate your premium rate for your indemnity plan by geographic area. So, in essence, you have a set of competing rates within each geographic area, where the indemnity plan is priced specifically for that area, and the HMO, obviously, is priced for that area since it's operating there.

As we've discussed, within our organization that may be good theoretically, but it does create other types of problems. One is simply an administrative problem. If you had 20 different premium rates for your indemnity plan as opposed to what we have right now -- one premium rate -- then that creates an administrative problem. There is also this equity question. If our employer wants to keep the compensation the same basically

across the nation, and the premium rate for the particular insurance plan that they have is considered as part of compensation (or the employer contribution is considered part of the compensation), you do potentially introduce an equity problem by differing the contributions. I'm not sure what the solution is. One other factor to consider is the size of the risk unit. As you start to split up your plan into smaller and smaller geographic areas, it becomes more difficult for us as actuaries to predict what the cost will be. Instead of working with 8,000 employees, you're working with a 500-employee group in a particular area, or 100 employees; it's really difficult to accurately price. It's a lot more work for the actuaries.

MR. HOWELL: You couldn't be more right, and I was hoping maybe somebody here would help us, because we're struggling with this as a national employer. At Penney we have 100,000 associates, or employees in the medical option plans; a third of those are in HMOs. And we have, obviously, all the major metropolitan cities covered, but then we also have Pocatello, Idaho; Kemmerer, Wyoming; and Dunkirk, New York, where there is no managed care. We are struggling with that very issue of trying to be equitable with our indemnity program as well as the HMOs. You have to realize there are price differentials on a local basis. It's not something we can come up with on a national scale. The advantage of using an indemnity program is you can pool your population and level out some of the price increases or jumps to make it more equitable. But it is an issue we are dealing and struggling with.

FROM THE FLOOR: Are HMOs doing what insurance companies used to do years ago, which is look at the average and cancel everybody above the average?

MR. FRITCH: I have accused our actuaries of that recently, but being responsible for the membership numbers too, I don't propose to do that. I think we are moving more and more in the direction of, not so much retrospective experience rating, but prospective experience rating on at least large-size accounts. You have to understand, though, from an HMO's perspective, it's traditionally been offered as an option. The average size of our employer groups, even if we wanted to, given any kind of normal actuarial rules as to the credibility of the experience by size of the group, does not allow us to experience rate the majority of our groups. Perhaps half your membership may be in the largest accounts. But, depending on the regulations and all kinds of other factors that are state-specific, experience rating may not be allowed. In general we are moving more and more to prospective experience rating and paying a lot more attention to the experience a group has had with us in setting renewal rates.

MR HULET: Any time there's more than one HMO competing for the managed care business and one HMO moves to the prospective experience rating or any more detailed recognition of rating variable than their competitor, then the second HMO will likely end up at a disadvantage. The HMO that is recognizing rating variables, if they're evaluated correctly, will have a lower price for the good risks, and have a higher price for the poor risks. Therefore, the competitor will suffer from the adverse selection.

I think there will be a lot more true experience rating, true self-funding using the managed care mechanism as part of the product that's offered. As more of the national carriers get involved in managed care, there will be more of the products that

incorporate managed care as just one feature of the program. And there will be the internal incentives that try to get people to use that managed care portion of the delivery system. Experience results will be combined for purposes of evaluating what the next year's price ought to be. That will eliminate some of the adverse selection discussion that is going on right now. However, for small employers it still is not going to be a solution, because they're going to eventually have to choose one option: either the managed care option or a traditional option.

In the Southern California marketplace, where the market is very mature as far as managed care goes, there is tremendous adverse selection that indemnity carriers seem to be suffering anytime they write a group that has an HMO option offered; part of that results from the price differential. The employees are being asked to contribute a large amount to belong to the traditional plan, and therefore, only those that are real users of the system are going to be willing to pay the price. As other markets mature, there's going to be more and more of them that are forced into recognizing as many rating variables as they can get their hands on. And if that means experience rating, then they'll have to do that just to stay competitive.

MR. THORNTON: We have experimented a little bit with self-funding in some of our HMO options. If there's an HMO offered in a particular area, and we have determined from our experience analysis that our claims cost was relatively low (we're having good experience in that area), then sometimes we have chosen to work out a self-funding arrangement with that HMO. We use their provider network and all of their utilization management controls, but we just pay them the claims plus an administrative services fee. It's worked out relatively well. We may find quite a bit more of that in the future, especially for large employers.

MR. CHARLES S. FUHRER: I have three comments about what was just said. First of all, Mr. Fritch said that although HMOs are moving in a direction of doing prospective experience rating, he felt the size of group involvement is too low to give any significant credibility to the HMO's experience. I disagree with that. I think even the smallest groups have credibility. My reasons for that are relatively complicated. You can read either my paper that was in the *Transactions,* Volume 40 or the short paper I've prepared for the Health Section newsletter that's going out in April.

The second thing I wanted to address was Mr. Hulet's comment about the fact that if we don't have time travel then we can't possibly know what might have occurred. That probably is a true fact, but we could estimate what could have occurred. When you're talking about the expectation of how much adverse selection would have probably occurred, you can estimate a lot of things. We can even estimate how much standard deviation there is in those estimates. So we're not quite as lost as that comment would maintain.

My third comment is just general. We in the health insurance element in talking about adverse selection, in and out of HMOs, hear about the so-called positive selection, healthier and younger risks who don't like HMOs. Yet I have seen very little data of any kind that anybody's collected to either show this is happening or not happening. It

seems we talk about it, but we don't really substitute facts or demonstrations for impressions. I would like to see somebody collect some data, even in their own company, and maybe we would get a little better answer to these things instead of just talking about it.

MR HULET: I think the reason we have actuaries is because we don't have time travel, and therefore I agree with your comments about our ability to estimate and make projections based on what we do know and to analyze variables that are available to us.

MR. HARRY L. SUTTON, JR.: A couple of comments. One, certainly there is demographic selection and probably some other selection apart from that. I believe much of the underwriting selection wears off in two or three years, and then you're left with the demographic selection, assuming there's no more shift. If eventually 95% of your employees are in the HMO and the rest cost $1,000 a month per employee, I don't know if it costs the employer money or not. The HMO has really lowered the cost of the 95% even though the cost of the 5% is leveraged way up. Since those are the executives of the company and those who do not join the HMO, I'm not sure it's all that bad. Except, maybe, they shouldn't charge that person $1,000 a month to join or to stay in the indemnity.

I don't feel that the big insurance companies are so competent at controlling health care costs. We just look at the losses in their HMOs, generally speaking. And I'm not sure that their prices are very good either, speaking on the HMO side of it. In Minnesota we have a statute that prevents any HMO from writing indemnity business. And I like to at least throw out for your consideration that, in certain metropolitan areas, you have a good health care provider system which may be independent of the big carrier. Most of them are. In that, a big national account should look for that good health care provider. You will see those HMOs willing to take the indemnity risk and take the whole local client, rather than being with one of the big five, if I could use that term, as their only alternative. I'd like the reaction to whether you think HMOs could, in effect, go under the indemnity plan and protect the share in the market and use their local advantage to do that as opposed to the big national carrier you are talking about.

MR. HULET: I have certainly seen, in my consulting work, a number of managed care organizations that are making moves to capture that indemnity portion of the market. Southern California is one example. There are many indemnity carriers that, once the HMO penetration gets to a certain level, will not write the risk at all. That leaves the employer with a choice of either having no out-of-plan option, or finding an HMO that will underwrite that nonnetwork risk. I am an HMO advocate myself. I believe that is the way we have of producing a more efficient health care system. And as such I believe employers that are really searching for a way to reduce their costs have got to look first at finding that very efficient delivery system and then try to build the incentives into their program to get people to try it. And, hopefully, when they try it they'll find it's not such a bad deal after all. Those plans that have the capacity of underwriting the full risk by offering more than just the lock-in option to a single delivery system have an advantage. The traditional carriers that are doing the same or offering the same kind of product but not building that product off of a truly well-managed delivery system will find themselves

out of the marketplace when we get right down to the stiff competition that will surely come.

We've seen a number of carriers that have taken the approach that they will offer that kind of a product by either building an HMO or buying an HMO, and haven't done their homework in evaluating the HMO they are aligning themselves with. Therefore, when they get their product all built, they find they cannot offer it at a competitive price.

MR. FRITCH: I think there's clearly a movement, on the HMO's part, to try and develop things like open-ended products that do have some out-of-network benefits and can be replacement products for entire groups. If what you're talking about would be products where the HMO had 30% of an employer's membership and will go on risk for the other 70% and put in some medical management, probably not. To the extent that an HMO would work with an employer to design contribution differences, benefit differences, or have an open-ended product that had a 25% or 30% benefit difference between in network and out of network, such that 75-80% of the care could be expected to be delivered in the network, then the HMOs, I think, would be pretty interested in trying to take on the full risk of both the network and nonnetwork services or members. Other than some innovative ways to do open-ended products, most states aren't quite as liberal in a regulatory sense as Minnesota is. We've run into significant regulatory problems trying to integrate financial results.

MR. HULET: Having adequate surplus would certainly be a big consideration for those HMOs that want to write that other portion. Therefore, the significance of that other portion becomes a key issue, and as Herb mentioned, if you're talking about 5% of the risk, then it's probably manageable. If you're talking about 50% or greater it's probably not manageable.

MR. HOWELL: Our Minneapolis HMOs that we offer are, as far as pricing, probably the best in the country. I attribute a lot of that to the location and to the health care delivery system in that city. What we've run into, as far as a concern of the J.C. Penney Company, is that we realize that none of the national carriers have the answers. We've just had all the national carriers come in and give their managed care pitch to us. None of them has been able to provide what we really would like. So the issue we have been struggling with is that it's already an administrative burden to manage the 170 HMOs that we offer and just the one indemnity plan. To carve up the country into small segments, even beyond four geographic regions, is going to be administratively difficult for any national employer to do. So we're still trying to work through what we can do, or define what else is out there. It's got to be a national program to some degree, but managed or administered on a local level. We know Dallas and New York, but beyond that, we're really not familiar with the local health care delivery system in each of the areas where we're located. So I agree with you to some degree that working with the best health care provider in a local area would be nice, but I think we're struggling with the administration side of it.

MR. THEODORE LOUIS JUERGENS: Could you elaborate just a little more about the experience-rating HMOs, and in particular Mr. Fuhrer's comments about the

credibility in smaller HMOs and, on one of the panelist's comments that there wasn't any credibility to that? Or maybe I'm misinterpreting what the panelists said.

MR. HULET: I didn't make either of the comments about the credibility; however, when I did work for an insurance carrier we did a statistical study to try to see whether there was any predictability between experience in year one and experience in year two and year three. We found that for groups with fewer than 2,000 employee lives (so you're talking about probably two and half times that for total enrolled members), there really wasn't any pattern that was statistically valid. The experience-rating philosophy that has developed in the marketplace has been more a reaction to marketing pressure than anything else. I do not think a 200-life group is statistically credible. Yet 200-life groups usually can be fully experience rated on their own experience. I don't know about the study to which Mr. Fuhrer referred. The number of events that have to take place, particularly when you're talking about one segment of care (in other words, you're not just grouping it all together for total claims costs) becomes very large before any significant degree of credibility exists. Providers have to be very careful when they're working with capitated agreements that they don't try to capitate something without having a large enough number of events taking place to assure that there's some consistency in the risk that they're accepting. I'm sure Herb has a comment there since he introduced it.

MR. FRITCH: Let me clarify a little bit. I think what we're talking about is to say that until you have a year's worth of experience with an employer that has at least 200 to 250 employees, which might equate to 500-600 members, we don't believe the experience has much credibility to it. Now that may be a valid difference in actuarial opinion. I can accept that. Within an HMO setting, maybe the average group we have has 20-30% penetration into that group in option-type sales. For the majority of our groups, we don't even have 200 employees. If you look at probably the top 10 or 15 groups that a mature HMO has, they may account for 40% or 50% of that HMOs membership. We will give them credibility and many of those top 10 or 15 groups probably deserve full credibility by our credibility factors. I think the credibility factors we use are the same factors that Aetna applies within some of its experience rating formulas. So I don't think we've developed anything unique to the HMO industry in this respect. We don't have that many groups with more than a couple hundred employees if you look at almost any of our HMO plans.

MR. HULET: One other comment on the credibility of HMO experience: One of the theories of managed care is that HMOs are able to control the risk better and get rid of some of the things that are discretionary that would cause the fluctuation in a traditional indemnity plan. To the extent that HMOs can minimize the fluctuation because of the way they manage the delivery of health care, that should make the credibility higher for a lower number of exposed members. I haven't seen any statistical studies that would show where that credibility level moves to when you're talking about an efficiently run HMO. But I do believe there should be greater credibility at a lower member count than there would be when you're talking about a traditional indemnity product.

MR. ALLEN P. MALTZ: Talking about credibility and just to add some more thoughts to the mix, we do use credibility factors which, for a given group, are quite comparable

to what our indemnity side uses. This is really a marketplace issue. In the indemnity program, they're looking at the entire size of the group nationwide. So if you take a group like J.C. Penney, that's literally thousands of lives. When you get over to the HMO side of the house, we might write 25 lives or so of a J.C. Penney in one location and 300 lives in another. To date, we use different credibility factors for each location. What the marketplace seems to be demanding is that we look at the entire group, across locations, and give credibility based on that. If we write a particular national employer, and we have 1,000 lives in 20 cities, the marketplace seems to be demanding that we look at that as a 1,000-life group as far as credibility factors. Unfortunately, the theory behind whether it deserves full credibility begins to get a little hazy. I'd like to get your comments about giving credibility across all locations for a single-employer group. Let's talk about the theoretical side rather than the practical side.

MR. HULET: If you're going to combine the membership in different sites for purposes of a credibility formula, you also have to combine financial results for those different locations. If you try to make the argument that you can't combine the sites because perhaps their managed care system is not identical, that is a fairly weak argument. If you look at the traditional indemnity plan you can definitely say that the management represented in different geographical areas certainly was not the same in the prior use of credibility formulas. But certainly, unless you're going to combine financial results, either at the corporate level, like Partners, or by having the ability to somehow share savings that one HMO experiences in one location with an HMO in another location that happens to have a bad year, it's pretty difficult to justify combining the membership for purposes of applying a credibility formula.

MR. FRITCH: I agree with Dennis. I think theoretically it's a great idea. If we've got 1,000 lives across the country and an employer says, "Let's do it," even within Partners, we don't have common ownership of all the health plans. Some we only manage and don't own, some we manage and own part of, and some we own outright. To share the financial results from both a regulatory standpoint and an equity or an ownership standpoint is a very real, practical problem for us. And I think most of the national HMO companies that have a significant number of sites have the same problem. Theoretically, I don't see any real problem with it.

MR. HOWELL: We're probably one of the national employers that are pushing for funding in that arena. The issue that we're dealing with is from a practical side. We're not actuaries so we may not be as technical, but when we have a carrier come in, with either a regional or a national HMO program, that wants to expand coverage in California and at the same time they're canceling us in Florida, that's really kind of weird. We're a national employer. Where's our leverage? We have none. We have no leverage at all. So it's hard for us to deal with a national account representative who is sending us a proposal to expand in one site, and on the other hand they're canceling us in other places. That's why we've been pushing this issue to at least allow us more leverage. We have associates throughout the country, and we're paying the company contribution to the premium; so whether it's feasible or not, we feel it is practical. We hope you all can work on that. There should be some answer so that we don't have an HMO canceling because of high utilization in Boca Raton, and then in Los Angeles having great experience and the Los Angeles HMO pocketing the money while Boca

Raton is getting burned. We actually have had one national carrier tell us that it can do this. Now, I don't know if it's just blowing smoke or what.

FROM THE FLOOR: I think when you talk about what can be done, Herb mentioned the issue of ownership. But I think another issue is the providers themselves. You've got groups of providers in one location that are getting burned and in other locations doing well. What national carriers are beginning to wrestle and grapple with is the concern of breakage. Can there be a separate accounting of the breakage which the carrier takes on and breakage from one company to another? When you get into situations where employers are looking for full refunds, and what have you, in an expected setting, breakage becomes more difficult. Because then it's really the providers that get left with the poor experience rather than the employer which has it combined with sites with favorable experience, or the company that covers that deficit or returns surpluses.

MR. J. PAUL AUSTIN: I want to get a reaction to see whether we have a unique problem in Michigan or whether it's shared in other areas. We own four HMOs and have a traditional program. What we've been seeing is that the managed care feature of the HMOs clearly saves in inpatient dollars -- maybe 20% or 30% or more (usually more in the 20% range when you've adjusted out demographic differences). What we're finding is that the benefit plans of the HMOs tend to be broader, and their overhead costs tend to be a little higher. The reimbursement arrangements with hospitals occasionally tend to be not as good as the traditional program. And so when we're all done, and you look at the very bottom line adjusting out as more sophisticated companies do for demographic differences, the cost savings isn't there. I just wondered if others had seen a problem or maybe what they've experienced is different than what we have.

MR. FRITCH: I'd say this is typical of the first stage of an HMO's maturity or development. You are offering a 100% outpatient coverage, with a $5 office copay, so you not only have to overcome the 25% increase in benefits but you're also going to get increased utilization of those services because of lower copayments. In order to control that and end up with a net cost-effective system, I think you have to get into very sophisticated data on physician profiling. Identify which gatekeepers are the most effective. Begin to trim the panels down using specialty profiling to determine which specialists are cost-effective. The appropriate use of meaningful financial incentives for the primary care physicians and others, and/or a fully capitated arrangement are very advantageous. I think you have to go to another level of sophistication within the managed care industry to overcome that cost disadvantage. I'm not going to tell you the industry as a whole is anywhere close to being there. At Partners, over the last two years, we have made tremendous strides and are a lot better equipped to do that. We are not there by any means across the board in every one of our health plans, but I'd say we're probably getting there in the majority of them right now, but there's still a ways to go. I think that's just a matter of the maturing of the individual HMO and developing the tools that we have to deal with. You can cut the hospital use by 30%, but all the other things cost so much that there is still a net premium increase, and you probably have a higher premium than you do under a typical indemnity benefit level.

MR. THORNTON: Perhaps I could respond by sharing some information in a study that we did and published last year. We were actually trying to compare the indemnity plan versus the HMO plan on a total cost basis, as opposed to just looking at the change in hospital utilization.

Just a preliminary comment: I believe HMOs do have a handicap going in because of the higher administrative expenses to run the HMO. We found that with our group it costs about 1.5% more in premiums to administer the HMO plan than the indemnity plan. I'm not sure if that's typical within the industry.

We made an extensive study trying to compare the relative performance of the two plans over a seven-year period (not just a one- or two-year period). We studied employees in the same geographic area, so geography wouldn't have any effect on our results. We adjusted for the different age/sex demographic mix between the two plans. We looked at employees by medical diagnoses. We had about 13 broad diagnosis categories.

We found that in an employee who had the same medical diagnosis, the annual claims cost (actual dollars paid out) per person was about 11% lower in the HMO. This occurred despite the fact the outpatient benefits for the HMO were higher (we were paying 100% of office visits with a copay versus 80% in the indemnity plan). That would seem to indicate the HMO actually did save money relative to the indemnity plan.

There were certain benefits we could not measure specifically because they were not comparable between the two plans. For instance, if the HMO offered well-baby visits and preventive care, and the indemnity plan didn't, then we excluded that benefit in the analysis. Also it was very difficult to make a drug comparison because we could not link the diagnosis to the actual drug that was prescribed. So, I think some of that 11% net savings was eaten up because of the additional benefits that the HMO provided, which included a much more liberal benefit on drugs. (I think the percentage of premium that was going to drugs was roughly 4% or 5% higher in the HMO as compared with the other plan.)

Perhaps the future direction for the HMOs will be to offer more plans that are not the 100% plans, where the benefit levels between the HMO and the indemnity plans will come closer together. In that circumstance, the employer will start to realize more of the savings from the HMO delivery mechanism.

MR. HULET: The managed care progression has taken place first in inpatient care. We have seen this impact the nonmanaged care segment of the business, because providers have learned more efficient ways to take care of their patients. I would estimate that the progress that they've made in controlling the outpatient expenses is probably five or more years behind the progress they've made on the inpatient side. There are a lot of things that I believe can be done to better control the costs of the outpatient care and what has happened in many plans is, although they've saved on the inpatient care, some of that cost has been shifted to outpatient care.

We're working closely with some physicians who have been looking at that issue, and trying to identify efficient processes for physicians. The goal is that the information they

gain on efficiently treating patients can be transferred to those that have not developed the same kind of efficiency in their own practice patterns. I think as we learn more and more about what is an efficient practice pattern for particular conditions or particular procedures, we'll be able to find mechanisms that will allow us to control those costs more effectively.

The intensive nature of management that's required in a managed care system will always mean the administrative cost has got to be higher. That becomes a problem when you start experience rating, because many of the employers don't understand why they have to spend more to be able to save that money. This sometimes causes a conflict to convince them they ought to be paying extra for that management rather than just reaping the rewards of that management.

MR. AUSTIN: One other item in the administrative cost difference is the insurance charge. We price our risk or insurance charge higher in the HMO partially because they're so small. Traditional programs are 20 times bigger than the HMO program. You can afford to have a much smaller provision in there for profit on large groups. That could wipe out the 11% difference if you start with a large group and whittle it down to a pretty small number.

We have a PPO. We have talked about the HMO. We talked about the indemnity program. I wonder if you could tell us about the PPO and whether that's something that's going to continue to take on more members or whether it's reached it's maturity at this point and is going to be reduced?

MR. HULET: A PPO has traditionally represented just discount medicine. There has been very little health care delivery management put into place for most PPOs. The advantage that HMOs have, over and above their favorable payment rates with providers, is the fact that they are managing care. I believe it's going to become more a point of whether or not the care is managed effectively, rather than what kind of discount arrangement you have. If we use the definition that a PPO is essentially a discount arrangement, I don't think PPOs will continue, because in many marketplaces, the discount really does not mean much. Hardly anybody pays full price.

MR. FRITCH: I think there's still a lot of a business that is converting from an indemnity to a PPO setting. PPOs will continue to gain membership at least in the short term while a conversion to more managed care is going on. But, as HMOs get more sophisticated and joint products are more highly structured and highly managed (a point-of-service product, gatekeepers, financial incentives, capitated systems, etc.), it's going to be hard, in the longer term, to get away from gatekeepers, financial risk for the providers and primary care physicians. I think in the longer term, managed care systems will end up with the majority of the market share, at least in urban areas. I don't think this will be feasible in the rural areas very often.

FROM THE FLOOR: Do you believe HMOs will continue to have favorable selection?

MR. HULET: The marketplace right now seems to have so much churning of members because the employer keeps changing benefits and the HMOs they affiliate with, I'm not

sure we have enough data to make that assessment. But reason would say that initial selection, which would happen because people know what kind of health problems they do or don't have, would wear off because medical problems increase with aging. Those things that they can identify when they enroll to therefore make a positive selection won't be evident to them three years in advance. And so, that is likely to happen. I don't know what effect that has on the pricing structure or how we ought to be evaluating it. But I think we can certainly say that it is logical that would happen.

MR. THORNTON: We made our initial enrollment of the entire group back in 1981 and found that there was a tremendous amount of adverse selection that occurred at the beginning. After about three years the effects of that initial enrollment had worn off quite a bit (i.e., the hospital utilization rates were a lot closer together). I'm not sure we specifically looked at selection since that time, but I believe there is still some residual effect. I don't think that it all wears off, but I think quite a bit of it does. If they are selecting based on benefits, once they get the medical care taken care of (i.e., once the pregnancy ends, or once they have the surgery) then they're not as likely to select for that reason in future years.

MR. SUTTON: Just another comment and another look at selection. Recently I have seen a fairly large case that was ASO. In the first couple of years of being ASO with a new carrier, experience looked really good because the old carrier had the runoff. The very first year the clinic expenses were extremely low, so the employer didn't think anything about adverse selection. The second year, the HMO enrollment was about 40% of the group. Now since then costs were being measured on cash claims only; they were using the number of employees they had in the ASO plan, and measured that against the cash claims. The result would be that you would obviously look at your indemnity costs and cash claims for one year divided by the number of employees for each month. But obviously it looked as if you would experience that immediate high level of selection, because nobody had bothered to look at claim liabilities and whether in fact they had all the claim liabilities on 40% of the employee group in the HMO. I really think some of this has been very superficial on selection. Not that it doesn't exist but that when you have a big drop in enrollment or a big shift in enrollment, it looks as if you have a big selection change because claims don't drop for another three or four months. But today we're running into a lot of problems comparing cash flow results against accrual results. There are consultants that try to convince people you can save a lot of money by going self-insured because the claims will drop by 25%.

MR. HULET: I'm sure there are no actuaries in the crowd that would try to do their analysis based on the cash rather than incurred basis. But that can certainly be a problem, for instance, if a health plan is relying on somebody who has an accounting background and who doesn't have the same understanding that an actuary gets from the training he goes through, there may be problems. Accountants may be concerned more with the cash flow aspects than with the true long-term cost.

I would like to move on to a different portion of this topic and talk more about the provider side. Panel, please address this question, do contractual arrangements between managed care plans and providers produce a better delivery system? I will leave the term "better" open to interpretation, and they can describe what they view as "better."

Do the financial incentives of providers affect the quality of care delivered by managed care providers? And if so, what structure seems to be most effective? What structure seems to be least effective?

MR. FRITCH: To take it perfectly literally, I don't think the contractual arrangements do a whole lot. I think they create a locked-in delivery system, a group of physicians and a network. This gives you the potential, I think, to begin, through data analysis, to look at both the cost and the quality of your provider network and begin to whittle down the panel and have a more effective result. I don't think I'd necessarily leap to the conclusion that most or even half of the HMOs in the country have achieved that desired potential yet. I certainly think it's there, and I think we're making a lot of progress in moving along that line, in both the cost and quality aspects.

The financial incentive piece has been a particular area I've focused on over the years. The first thing I start with is the fact I think the financial incentives in the existing indemnity system lead to a lot of overuse, a lot of excessive surgery, and a lot of poor-quality medicine. So I think that from a pure cost and quality standpoint, the current financial incentives in the indemnity system are a pretty low benchmark from which to start. What I've seen happen is, as you create meaningful financial incentives in an HMO, a lot of the same physicians who overutilize and, over operate, over hospitalize, whatever you want to say, are also the ones that potentially can be impacted negatively with financial incentives that go too far in the other direction.

I have come to the conclusion that high-quality medical care isn't necessarily costly. High-quality medical care can be very cost-effective if it's done in the right manner and if the doctors are ethical and competent providers. To make an appropriate diagnosis and treat a problem effectively is both the highest quality and the least costly. If the doctors misdiagnose and over refer, because they're not sure of their own diagnosis, or if they make treatment decisions that are inappropriate and aren't really addressing the patient's need, that's very costly medicine. I don't really separate the financial incentives ith both the cost and the quality of the outcome. I think you really have to get down to individual doctor practice patterns and evaluate those in light of appropriate financial incentives. And I think combined, they give you the potential to have a very cost--effective and high-quality delivery system.

MR. THORNTON: I'd agree with you, Herb. I would like to approach this question more from a value standpoint as opposed to the quality standpoint. The "value" meaning that you're getting the most out of your benefit plan. I believe the medical delivery system in general can be improved by more specifically defining what medical care ought to be provided for an individual diagnosis. By doing that, you're maximizing the value, and I would say also the quality of the plan by eliminating the inefficient or relatively ineffective care. You are putting more resources into effective care.

I'd briefly like to describe a technique we've used mainly in the benefit design area, which I think has a lot of application in improving the quality and the value. We call that technique "value analysis." We are using it to decide whether or not to include or exclude a specific new type of treatment within our plans. For instance, if a new

technology or procedure comes along, then we specifically exclude it from our plans until we decide to include it. That's actually written into the contract language.

What we do is score that procedure on criteria such as, what is the rate of success with that technology? Is it a life-saving item versus a convenience item? How prevalent is the disease that's being treated? What is its cost and so on? We take into account about five or 10 different variables in the analysis. We actually come up with a numeric score so that we can compare one procedure versus another procedure.

This is very useful to us in deciding whether to include or exclude the specific procedure in the plans. I think it does give us a good, objective way to decide on incorporation of new technology. I believe this same approach has quite a bit of potential, although we haven't used it fully yet. It does have potential if we extend it to actually reviewing more established types of treatment. Right now we've only been using it to look at new technology, but if we were to go back and look at some of these things that have been accepted for years and years and put them through the scoring system, we may find that some things do not score very well.

I believe, applying this specifically to the HMO versus indemnity setting, that this approach is much easier to implement within an HMO. For one thing, in our plan we do have regular meetings of the provider panels, and that gives a very good forum to discuss some of these medical issues. One other thing we are starting to do with our plan is starting to do a lot more intensive analysis using the claims data on the HMO, trying to identify physicians by specialty who have unusual practice patterns, who are outliers (either very high cost or very low cost). We are getting into a lot more detail to see exactly why that is happening. Are they doing two knee operations instead of one? And so on. Then we're trying to discuss those findings in somewhat of a nonthreatening way with the provider panels. We then try to reach a consensus within that panel in a local area as to what the most appropriate treatment is. I think that approach does have a lot of potential in changing the practice patterns.

My conclusion to the question would be that I think there is a lot more potential to increase quality and maximize the value of the plan in an HMO setting, where you have a much closer relationship with your providers than you do in an indemnity plan. You're also dealing with a much smaller set of providers as opposed to doing things nationally for all indemnity plan participants.

MR. HOWELL: When we talk about the type of contractual arrangements and whether or not they're cost-efficient and provide quality, we've been told by every vendor out there that their program has both. So I probably agree with Herb that I don't think the contract itself would necessarily dictate that it's going to be more efficient or you're going to get great quality care. Efficiency and quality would obviously depend on the type of organization you're using, whether it's an IPA group, and the kind of financial arrangements you've established in that agreement. Theoretically, if you've worked through a lot of those issues, and you've met your goals, then I would think the result should be more efficiency. I probably would agree too that in the fee-for-service arena there is probably a lot of abuse and poor quality. But from an employer's standpoint, the employee has selected that physician or that provider of service for whatever reason.

When you start restricting an employee's choice based on financial incentives, you've encouraged them to use an HMO or PPO or this provider over that provider. We have a problem with the liability that is accruing to that provider of service. The HMO's liability, as has been suggested now in several *Wall Street Journal* articles and other articles, could accrue at some point to the employer for poor quality of care. I think that's where we have a large concern over restricting choices. We probably believe that managed care is where we're going, and that it is what is going to be needed; but we do have to really keep an eye out on the quality of care delivered, because if that liability does accrue to the employer, beyond the HMO or other managed care product, then what's scary is the effect on the bottom line. It's just really scary for an employer from that perspective.

MR. HULET: I attended a conference, either GHAA or American Medical Care Review Association (AMCRA), and there was a physician on the panel who was talking about managed care and the ability to teach doctors to be doctors who have efficient practice patterns. His conclusion was that you can't teach effective health care delivery to physicians. Either they are good health care managers or they're not.

I guess I come from a different school of thought. I think we can teach providers to manage care better than they have in the past. But right now we lack a mechanism for finding out which practices are efficient and still provide the quality of care that's necessary. We do not know how to convey that information from one provider to the next once we do find it. We have been trying to do some of this as health actuaries at Milliman & Robertson, but, we certainly can't do it as actuaries. We have to call on medical professionals to help us understand what's going on and what is and is not appropriate.

As we learn more about how to change practice patterns by reeducating the providers of care so that they understand that they're not compromising the quality of care delivered by changing their delivery, then I think we'll see more and more effective managed care systems.

The contractual arrangement that HMOs have with the providers give them an advantage in trying to implement that education system. And some of the financial incentives that are built into contracts have various useful lifetimes as far as convincing providers to go out of their way to learn how to deliver care differently. I think one of the main concerns that many in the public domain and many in the provider domain have is that the financial incentives will be structured to encourage inadequate care. And I think there are certainly many examples of inadequate care that were delivered. Maybe one of the reasons for that was a financial arrangement that encouraged the physician to take the money and then not deliver any care.

But I think by and large the contractual arrangements that HMOs have with providers are a mechanism that can be used to strengthen the educational responsibility that providers have. And if the managed care organizations will use it effectively, then I believe that many different financial structures can still provide a worthwhile system.

I do believe we have to change from a financial structure that encourages physicians to do more to get paid more. In the opening session it was pointed out that this is not an effective economic system when the providers increase their income by providing more care, whether it's needed or not.

MR. ANTHONY J. HOUGHTON: My opinion is that most of the managed care programs, including HMO's precertification programs and the like, in general are helpful to OB patients; they really have better care. Nevertheless, I'm seeing more articles in newspapers and other sources where physicians are complaining that certain bureaucratic requirements are unwise in particular instances. The people who seem to be complaining don't seem to be the original doctors who, when managed care first came out, felt it was equivalent to communism. These doctors seem to be fairly scarce practitioners these days. What I'm asking is, do you sense that attitude is about the same as it was, or is it actually diminishing right now?

MR. HULET: From what I've seen the hassle factor has been increasing. And to the extent that providers feel they're being hassled by people who don't really know how to deliver care themselves and are going by a book somewhere, I think you can say that the physician resistance is growing.

However, I think there are those systems that, rather than having practitioners who are not professionally qualified do the peer review, are using a medical director more often. They use someone who really understands care because he's been out there delivering it. He can look at the practice pattern of particular physicians and then sit down and talk with them to explain why he feels they're not being as efficient as they could be in their practice. The resistance to this kind of an arrangement is not growing. This is the kind of arrangement that I think is more effective and in place in many of the better managed HMOs.

I think Herb can probably relate some of the experiences he's seen at Partners. I think the hassle that has come from many of the utilization review (UR) programs that traditional insurance carriers have put into place has been the source of a lot of the complaints that you hear from the provider segment. The HMOs that have a physician peer there to help physicians understand what maybe they could do differently seem to have very little resistance to their programs.

MR. FRITCH: I think any time an outside party questions a doctor's judgment in terms of what kind of treatment, or where it's going to happen, or how long the patient's going to be hospitalized, they're not going to like it. That's pretty obvious to start with. I haven't seen, within a particular geographical area, that kind of resistance has changed. What's happening though is we are taking a much more hands-on and much more aggressive approach with physicians. As you begin to impose that in areas where it hasn't been imposed before upon physicians, hospital administrators, etc., there's always a negative reaction to it. I don't think that in Los Angeles or Minneapolis, where managed care has been going on and been a way of life for a long time, there is an increased amount of resistance. As we get into new areas that haven't been as competitive, there's always an initial negative reaction.

I know our goal within Partners is to deal with providers in such a way that, once they've established a track record with us, they are cost-effective and good managers. Our goal is to try and ease up on any overbearing kinds of second-guessing or second opinions or precertification and give the doctor more direct responsibility. But I think we've begun to take a much harder position until that track record is established. We do have to really put some teeth into precertification and concurrent review, and not just have a data collection mechanism. We must begin to question treatment decisions that we don't think are justified. As this happens I think we are going to get a few negative reactions. We believe, anyway, that the negative reactions are likely to come from the doctors with whom we may not agree. We may disagree with the way they practice and think they're practicing a lower quality of medicine. We are willing to accept the negative reaction in the short term.

MR. THORNTON: I was in a meeting a few months ago with the head of a hospital-based HMO. He was, in this instance, talking more from the perspective of the medical community within the state. He felt that a lot of the hassle the medical system resented was that they had to deal with seven or eight different HMOs, each of which has slightly different criteria on precertification. That was the thing that was bothering him. He was pleading with us to try to get some community effort together where we could bring all of the HMOs together and try to agree on some sort of standard set of procedures in that area. I think if that were to happen locally and then perhaps on a national scale, there would probably be less resistance to the HMO concept.

MR. HOUGHTON: We've seen some surveys of doctors indicating that many of them would not have considered the medical profession if current conditions were prevailing at the time they decided. They spend a greater proportion of their time dealing with forms and not as much dealing with patients. Now that may be a good thing if fewer people go into medicine. But, a lot of the physicians are alienated now with grievance towards medicine as their profession.

MR. HULET: If you look at the medical profession as it stood 10 years ago, and what the expectations were, and compare it with what we're trying to do as far as structuring the profession now, I think you can understand why a lot of physicians would say their decision would be different. I think if we had the same kind of restructuring in what actuaries could and couldn't do, and where they worked, and how they worked and all those other things, I may reconsider my decision to become an actuary.

Just as an example of how severe the reaction can be, in a recent rate hearing in New York, there was a physician who wanted to testify. His interpretation of what he had been put through was that it was a second holocaust. He happened to be a Russian-Jew who had been trying to practice in what he thought was a very good manner -- putting the patient's interest first and everybody else's interests second. Evidently Medicare and all the major carriers had excluded him from practicing and being reimbursed by their systems, so essentially he was put out of practice completely. So he was coming to the rate hearing to make his feelings known. He really felt picked on. I think there are extremes out there and they are trying to be very vocal. There's one segment of physicians that have been organized to protest against health care management and the HMO structures that are being established. I think that's just a fact of life. But it's what

we have to do to identify who the efficient and cooperative providers are, and take advantage of them to help lower the health care cost that we have to deal with in the insurance environment.

MR. FRITCH: I think it depends on which doctors you talk to too. Part of what's going on in managed care is a lot more power is being given to primary care physicians as opposed to specialists. I've observed the specialist clearly will react negatively to having gatekeepers and primary care doctors and going through primary care authorizations. There is a growing number of primary care physicians out there who are understanding that, with the right kinds of financial incentives, they can get reimbursed very well for taking an active role in the management of the patient's care. They are a quiet minority, because they're doing very well right now. But more and more of them are understanding that if they accept the responsibility for managing their patients, they can come out better financially than they ever did before. I think there's a growing number of them that are understanding that and starting to work with the system and not against it.

MR. STEVEN M. HICKMAN: We've done a couple of market surveys across the country. In those, we've talked to groups of randomly selected physicians on the concepts of managed care. And I would recommend this to anyone who hasn't done it. It's quite eyeopening. There is a subset of physicians who are both resentful of managed care and convinced it doesn't work. One of the interesting and optimistic things was that the younger physicians had been educated and accustomed to managed care right away and seemed much more accepting than the others. It is a hopeful sign that a more friendly partnership can occur in the future. Would anyone care to speculate as to how doctors will react to any kind of national physician payment reform, should that happen?

MR. HULET: I suspect they won't like it. I think the physician payment reform that Medicare's imposing is something we've all got to start thinking about regardless of what segment of the industry we work in. It will have an impact. The question is whether or not that impact will be so adverse that we will not be able to control it. I don't think the changes that we saw when they put the Diagnostic Related Group(DRG) system into effect were all predicted before they happened. I think the same will be true when they put in the physician payment reform. Even though we put on our thinking caps, sit down and try to estimate what's going to happen and what effect it will have on the particular segment that we work with, we will find some surprising results when it does take effect. And so, I don't know that I can give you any insight into what is going to happen, because I haven't sat down to consider all the ins and outs. But I do think it will have an impact. And certainly as actuaries we need to start thinking about that. This is particularly important if we're dealing with long-term risks, and somebody's laying money on the line that must be evaluated now rather than a couple years down the road.

MR. THORNTON: From what I've heard, the payment to the primary care physician types, the pediatricians and so on, would be increased. The payment to the surgeons and so on would be decreased. That may have an adverse effect on HMOs relative to indemnity plans, because I think one of the things HMOs are trying to do is to reduce the levels of surgery and increase the primary care that's done. Just looking at the primary care gatekeeper system which encourages more primary care, it's possible that if the HMOs were to adopt this new relative value schedule, that they would experience a

different impact compared to the indemnity plans where probably more of the expense is in the procedures that would be cut back.

FROM THE FLOOR: It's been my experience and kind of looking at this from the other side of the coin, from the HMOs' point of view, such as with physician reimbursement, primary financial incentives, withholds, they don't . . .

MR. HULET: Over the past two or three years, HMO experience would probably dictate that withholds would not be given back. If there was something returned, it was returned out of the goodness of HMO management's heart, rather than because the experience justified it. Therefore, physicians have looked on withholds as an additional discount rather than as some money that's set aside that they'll likely get back if they perform their jobs well. I think withholds can play a very key role in managing the risk.

From an HMO's standpoint it's certainly a real advantage to have the option of paying out only 85% of your dollars. If you're spending at the rate of 85% and you've set your premium rates at a 100% level, then that gives you a higher expectation of favorable results. But the provider perspective and the HMO perspective on that are certainly different. And the employer's perspective is probably different still. If there is any recognition of experience, an employer may feel like it ought to get the same advantage as the HMO with regard to that withhold. I don't necessarily agree with that. It certainly depends on the way it can be passed through to the employer or to the providers, but the financial arrangement with physicians needs to have something that will penalize those who do not perform according to expectations, and reward those that are doing the job that's expected.

On the issue of hospital reimbursement, I think there's been a lot of change in the way people look at it. I don't really know where we're headed on hospital reimbursement in the future, but I think that any arrangement that a managed care organization or an insurance company can put into effect that helps control the price side of the care is worthwhile. Then they have to work particularly with the physicians and the hospitals to control the utilization side so that the price reduction they may receive means something.

MR. FRITCH: I think Dennis makes a couple of good points there. On the withhold issue, I know our withholds can be used for two purposes. One is a pure financial buffer for an IPA or an HMO. The other is to provide meaningful incentives. We are moving more and more toward meaningful incentives. I think that means much more individualized withholds. With primary care physicians, withholds will vary based on which primary care doctors are managing care appropriately and which ones aren't, both up and down. Any time you group a large number of physicians in a risk pool, where any one doctor does not benefit from making a cost-effective decision, you lose the financial impact of a withhold as an incentive. It still works as a buffer. Too often in that case nobody gets any withhold back and it's viewed as a pure discount. There's a clear movement I think across the industry, but it's by no means the majority of the plans right now, to go to more individualized withhold systems and away from large physician group withhold systems, which puts every doctor under the same withhold and adjusts everybody's withhold in the same manner.

As far as the hospital contracting goes, I think we still have a strong preference for per diems. What we're seeing out there are hospitals that are getting a little more sophisticated and understanding their clout in terms of their leverage in the marketplace. I know we're not shifting voluntarily off of per diems to either DRGs or discounts off charges. I think we're starting to see a lot more per diems with stop-loss features included, that under certain outlier situations there is an additional reimbursement over and above the per diem. But basically we continue with per diems as the preferred or standard means of reimbursing a hospital in an HMO setting.