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THE DINOSAUR OF HEALTH CARE REFORM—THE SMALL TO MEDIUM SIZED COMPANY

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Will the small to medium-sized company survive health care reform? What can such companies do to survive? What is the impact of reform options such as size of employer groups on alliances and the structure of alliances? What are the managed care options: build versus rent, go-it-alone versus coordinated? Niches such as geographic location, employer size, and nonstandard health plans will be discussed.

MR. WILLIAM R. ELY: I am a health care consultant with Tillinghast in Kansas City. I have the honor of introducing our knowledgeable panel.

First, let me introduce Stephen R. Bosworth. Steve is second vice president and assistant general counsel at Mass Mutual. He has practiced law there since his graduation from Boston University School of Law in 1977. He is a 1974 graduate of Williams College. Heading up a four-year lawyer section that works exclusively on health benefit matters and Mass Mutual's law department, Mr. Bosworth has participated actively in the development of Mass Mutual's managed health care network, Preferred Plus. He has developed a legal structure for the company's minority equity investments and managed care operation, and he provides input to Mass Mutual's employer contract holders on a variety of managed care issues. By working closely with Mass Mutual's health care management client, Mr. Bosworth has helped to formulate company policy on health care reform issues, and he provides technical support to the company's Washington D.C. and state lobbying efforts. He has participated extensively in state and federal level industry groups, including the Health Insurance Association of America (HIAA), and he has chaired several committees for that association.

Our other speaker is Norman E. Hill. Since August 1991, Norm has served as senior vice president, chief actuary, and director of Kanawha Insurance Company and Central Reinsurance Company of Lancaster, South Carolina. Previously, he's been a partner in two Big 8 accounting firms and an executive of two insurance organizations. He has over 30 years of experience in the industry. For both life and health insurance, he has been involved in a broad range of products as well as financial, regulatory, and other types of analysis. He has functioned both as a company executive and as a consultant. Mr. Hill is a Fellow of the Society, an Academy member, and also a certified public accountant (CPA). He currently serves on the Risk-Based Capital (RBC) Technical Resource Group for the National Association of Insurance Commissioners (NAIC) and the Reinsurance Committee of the American Council of Life Insurance (ACLI).

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*Mr. Bosworth, not a member of the sponsoring organizations, is Second Vice President and Associate General Counsel of Massachusetts Mutual Life Insurance Company in Springfield, MA.

MR. STEPHEN R. BOSWORTH: First, let me give you a little background about Mass Mutual. Mass Mutual is a mid-sized carrier and solidly so, with $2.1 billion of group coverage in force, making us 12th or 14th in the commercial industry, depending on the calculation method.

Some of our peer companies are New York Life, Principal Mutual, and Mutual of Omaha. So we're in that range. Clearly, we're much smaller than the Big 5 (or the Big 4 now, as the case may be); but we're certainly larger than a lot of the smaller companies out there. I think this will be an interesting forum because Norm is going to give you the perspective of a much smaller company. You may see that there are a lot of similarities in terms of the way we're thinking, but, at the same time, perhaps different things are influencing us.

Our market concentration is in the 100- to 300-life employer marketplace. We do not have individual health business; we are not a small group carrier. Though we do have some small group business in the 50- to 100-life range, our current marketing focus is 100 lives and above.

We are a national carrier with an East and West Coast emphasis. California is an extremely important market for us, as is the Northeast. We also have significant markets in the Southeast and Texas.

In response to health care reform, we have gone through what I call "forced march strategy sessions," where someone locks the door and says, you guys aren't coming out of this room until you come up with a document that says you either understand situation x, which is happening, or you come up with a strategy for dealing with situation y, which is a development that we see forthcoming. These meetings have been increasingly common at Mass Mutual, and of course, they always involve both market and legislative issues. Right now, federal legislative issues are key. A lot is happening there. But we're not ignoring the state issues either because those are equally important in some respects and may be more so in the future.

We have also worked with third-party consultants to get a reality check and see if we're going in the right direction. We brought in Andersen Consulting, for example, over the last six months to sit with us during these strategy sessions and give us some feedback as to whether we're making any sense. Are our priorities straight? Is our assessment of what's coming accurate? And, I must say, for the most part, I think that our consultants have agreed that we're on the right course as much as anybody can be in a situation that is changing so rapidly.

Another thing that we've been committed to is the establishment of a very active Washington, D.C. office. We have, since 1993, had a full-time health staff person in this office whose job is to be a liaison between our home office in Springfield, MA and the activities in Washington, D.C. She works very hard with staff members on the Hill and coordinates visits by our home office executives and other people with members of Congress.

We also have a number of lobbyists on retainer who have been used for a variety of purposes by the company. Right now they're working almost exclusively on health issues. Our lobbying strategy is to keep these people on retainer. Our lobbyists are

all what you call *access lobbyists*. They are people who know people. They are former Congressional representatives. They are former staffers. So they have the contacts that we need to get in quickly to talk to somebody.

Of course, that does not guarantee that you're going to get the results that you want. But it does give you access, and today access is the key. Also, this is an expensive proposition, as these people do not come cheap. Those who have the kind of contacts that we want to use have a price tag. But I think that you have to consider the importance of the federal developments and what this might mean to the industry when you start weighing the price tag.

In addition to our own home-bred lobbying effort, we participate heavily in trade groups. We're very active participants in the HIAA, contributing much staff time to HIAA measures because we think that it's an important and constructive way to utilize our time.

We also are involved in state trade groups to a certain extent, but not nearly as much as we are involved at the federal level. Obviously, we're very much involved in our home state, Massachusetts, and with the association there, but we are not a member of any other state association. We have retained a lobbyist in California, and we have lobbyists available in New York and New Jersey if matters become pressing there.

Well, again, the emphasis has been on federal issues because experience has shown that if you have a structured federal network, you are able, at times, to influence the process even if it only means a word here or a word there. And, believe me, in these times, when the stuff is churning through the committees the way it is, a word here and word there can be extraordinarily important for your business. Of course, economics are going to dictate how much you can do.

We would recommend that you get involved deeply in that process in Washington—certainly that you work with your own representative very closely and let him or her know what is important to you. Work with your senators. We have talked to our own representative and we're hoping that he understands where we are, what Mass Mutual means to the Springfield area in terms of employment, and what federal reform could mean to a company like Mass Mutual.

Let's look quickly at what federal reform could mean and how we have been approaching it. As I said earlier, we have an extensive federal lobbying effort, and we have tried to focus on two points.

We have made the point that voluntary alliances, as envisioned in the President's proposal back in September (the alliances of 5,000 lives defined as extremely regulatory in nature) are not the way to go. I think we, along with many others who have made the same arguments, have had considerable success here.

I don't think we're going to see Clinton-like alliances. I think if they come about, they're going to be voluntary. Virtually all the bills point in that direction. The big question is, what size are we going to operate at? What size of employer is going to be able to go in there?

Another area where we have gone in deeply is trying to preserve the experience rating for employers with 100 lives or more. Why? Because this is our market. We've made many arguments as to why the 100-life break makes sense. Traditionally, experience rating started at that point. There's a certain amount of credibility at that point, and so forth. I'm not sure that we've been too successful in this. As you know, the figure has varied all over the place, from a range of 58 to 2,000 lives to 5,000 lives, to determine the break between alliance and community rating. I also do not think there's a consensus in the industry as to whether 100 lives really makes sense.

If we get 100 lives, it means that Mass Mutual's business is going to be relatively unscathed in the future, pending insurance reform and other issues, which will obviously have an impact on cases of all sizes.

Other areas of concern that we've thought about and have done some lobbying on are premium caps and cost controls. It's not our fight. Premium caps and cost controls are opposed by a broad coalition of companies, industries, and organizations. The Big 5, of course, have been lobbying extensively against premium caps and cost controls, and doctors have been lobbying against them as well.

A proposal has emerged more recently though that is a constraint to us—the all-markets requirement. Many in Congress, especially the single-payer advocates, Representative James A. McDermott (D-WA) especially, would like to require carriers to operate in all markets. This means that if you're writing a large group, you must also write small-group and individual health coverage. That is not something that we want to see.

We're very pleased, at least, in the Ways and Means Committee draft, that you have, a distinction of five different markets from which a company can pick and choose. The question for us is whether that remains viable if the defined differential for large and small groups is not favorable.

Medicare Part C programs are a big concern. Even if you bring the employer threshold for participation in that down to 50 lives, you have a real problem. I think that the inevitable growth of a federal bureaucratic program similar to Medicare Part C is going to inevitably spell the doom of the private sector. The government will increasingly become a negotiating entity and will have the kind of clout that the private sector is not going to be able to muster.

With all that being said, of course, there are many other issues that face us. I emphasize that our strategy, up to this point, has assumed that federal reform will not affect the 3,000-life marketplace in the near term, and that's over the five-year period. I put question marks after that also.

I offer this to show you that we've made certain operative assumptions that the federal regulatory framework is not our main constraint in the future.

You can't ignore state reform, although we've been able to up to this point. Why? Because as a carrier that's focusing on the larger markets, we really haven't paid much attention to small-group reform efforts in the states. In those states where we

see an onerous situation developing, such as New York, for example, we simply withdraw from the small-group market. And as you know, most of the model bills allow withdrawal with a five-year penalty for reentrance into the market. That has not posed a major obstacle to us.

When we look at our portfolio and see four or five small cases in the state, it just doesn't make any sense to develop the infrastructure necessary for maintaining that business. So we have not felt bad, and we've not been perceived as being a bad company in the marketplace by withdrawing strategically from certain states in a smaller group market. Of course, that's been 50 lives and under. Once we start getting that threshold higher, it's going to be a much more difficult choice.

We have, however, decided to invest in areas that will develop our expertise in living in the new world. Although we're not currently a member of the California Health Insurance Purchasing Cooperation (HIPC) program, we intend to apply for membership in the near future. We are experimenting with the Florida CHPA program. So we've dedicated staff and resources to trying to understand how small-group business works within an alliance context, for example: What is guaranteed issue all about? What does it give you in terms of case mix and structure? What are the premium structures like? Can we live with a community rating?

Even though this does take time and staff resources that we can hardly spare for other ongoing projects, we believe it is important enough to dedicate those resources and to try to figure out whether one can live within an alliance structure. And this is boring to us. We're not a small-case carrier, and this essentially moves us back into the small case business in a big way, dealing with terms and concepts that we have not really dealt with at all before. So, again, it's a big challenge, but it's something that we have to do. It's something that we think is extremely important for a mid-sized carrier to look at.

Finally, we're assuming that if Congress does not act in 1994, I think the states are going to move ahead with a flood of legislation. It's going to be more far-reaching than we've seen in the past. No longer small-group reform, but total systemic reform along the lines of Minnesota's system is probably what we're going to be looking at.

I have a feeling that if we don't get federal legislation in a comprehensive form, you're going to see Employee Retirement Income Security Act of 1974 (ERISA) waivers popping up here and there. They will be granted rather readily by Congress, either through the tax code gyrations that we saw with the New York situation in 1993 or through indirect explicit exemptions from ERISA for certain states or for certain state programs. They will be limited, but they will allow states to reach the self-funded market. They will allow states to reach large group programs. They will allow states to impose their requirements on those kinds of programs on a state-by-state basis, which for Mass Mutual will be a very serious matter.

If you do get federal legislation, we are hoping against hope that there are massive preemptions of state laws in the federal legislation that will essentially limit the states from doing anything more extensive. I don't think we're going to get that. We have lobbied that point, too. But the fact is, you're going to see states probably have the right to do single-payer programs, and you're going to have rights for states to enact

legislation that is more restrictive than the federal legislation. And that's going to be a nightmare. Unfortunately, it's going to compound the problems that we see today.

So much for the regulatory legislative trend. Our strategy sessions have pointed out that, if anything, we will be put under the marketplace trends that are evolving independently of reform. I think that's the important thing to understand. Market trends are accelerating so quickly, and have been doing so over the last three to five years, that they are outpacing reform in many instances. Many of you have probably confronted the magic of the HMO acronym.

Mass Mutual is not an HMO carrier; we do not have any HMOs. We are a preferred provider organization (PPO) carrier and an exclusive provider organization (EPO) carrier. However, in areas where managed care is farther advanced and more mature and where you have more than 30% of the market in an HMO product, the marketplace is becoming unbearably competitive.

There is something magical about the HMO acronym that leads brokers and consultants to move business in that direction. We really haven't figured that out yet except that it becomes a natural response, an unthought response. We can produce an EPO or PPO that has equal results for the participant and probably has equal financial results for the employer, but it doesn't matter. They're not going to listen if you're in a market where the maturity is such that HMO is a necessity.

We're seeing extreme contraction of the marketplace in those areas, and the contraction over the last two years is accelerating at a rate that is very, very frightening. This extreme contraction is not happening in the markets where the HMOs are not as mature, or where the managed care market is not quite as mature. We're seeing dramatic differences, in fact, in the marketing environments, and that is driving our strategy to those areas where the kind of managed care that we know and have is going to work, and where we can develop from the ground up a viable option to the HMOs, or develop HMOs themselves.

States like Georgia, markets like New York and New Jersey, where for all intents and purposes HMO penetration and HMO recognition is not quite as far advanced as in California, are going to be much more attractive for a company like Mass Mutual than California or Massachusetts, or Minnesota where HMO penetration is at a much higher rate.

What is part of our strategy, and how does it reflect the marketplace trend and the regulatory trends? Well, you come up against the old rental versus ownership debate. Quite frankly, our strategy has been to rent. We have a few equity interests in some PPOs around the country who are minority owners, and the only place where we actually did a PPO directly is in our backyard, in Springfield, Massachusetts.

Renting has hurt us in many respects in the marketplace because there's been a certain suspicion of renters as being fly-by-night operators and not truly being managed care players. Other small or mid-sized companies have experienced this reaction. Today, few carriers have the resources to build or to buy HMOs at the current price, which we're estimating to be $2,000 or more per member. At these outrageous levels, an HMO cannot be purchased in a mature market. It will hurt the

group line's return on investment, which is what we're judged on by the corporation as a whole.

On the other hand, shifting provider alliances and priorities may make short term relationships more desirable in this marketplace. We are seeing, market by market, an extreme variation of how the providers are reacting, how the hospitals are reacting, and their willingness to get together and do ventures with a carrier such as Mass Mutual.

We basically adopted a middle ground right now of getting into joint ventures with providers and building where we can from the group up. Managed care entities, whether they're HMOs or HMO look-alikes doesn't really matter. The market is going to tell you whether you need a HMO, the magic three letters, or whether you can use an HMO look-alike, an EPO, a highly managed EPO, or something like that. But we have found that we have been getting good reception in those markets where HMOs aren't well advanced. Providers see us bringing capital, risk variability, and a little organization to their venture.

Hospitals are not very sophisticated yet as to how to build these kinds of structures. They're very concerned about assuming risk and we are walking in and saying that we are a risk bearer. We can do this for you through arrangements of stop loss or whatever else. We'll develop something that can provide a risk cap for your venture, but you, your organization, your hospital, and your physicians are going to be the ones who will assume an element of risk. If you can cap that, I think it becomes much more achievable.

Local providers are necessary for this. We have to completely abandon any pretense of having a national strategy and having national consistency because of the nature of the health care market. I mean this is an old saw, but health care is essentially local, and you're seeing that again and again.

We're also seeing an opportunity for several carriers to get together to do something. There were several ventures in which we have worked with other mid-sized carriers to put together networks, and we're going to work with other carriers to put together HMOs in markets where the HMO makes a lot of sense. If you can pull resources like this, it makes a lot of sense because of support from the providers. We get capital from the other carrier partners, and you also have the built-in base for patients from the business of the combined carriers.

We've looked at this from an antitrust point of view. Our antitrust counsel has said that as long as you're acting as purchasers and you don't have more than a certain share of the market, this is a perfectly legitimate thing to do in today's environment. That may not be true in tomorrow's environment if we had different kinds of rules regarding the antitrust issues, but I don't think that. It's going to get that kind of market penetration, which is going to raise the eyebrows. And you're probably not going to attract the percentage of providers in the network that would cause problems.

What we've done internally is try to keep control of these joint ventures by having the various super majority and other provisions built into the bylaws so that we have

some continuing control. We, meaning the carriers, have some continuing control over the structure of the strategy of that entity. You're going to have to give equity to your providers—they're going to want equity. They're going to want an opportunity to grow with that equity. But you don't want to give control to them. If you do give nominal control to people other than the carriers, then you have to build provisions in your bylaws providing for a certain kind of super majority votes of the directors if the program is changing its direction, its strategy. And you have to work very hard to develop your strategy document so that it is a meaningful document that you can point to and say, "Hey, this is something that's far, far removed from the strategy that we agreed to, and we're not going to allow that." Otherwise, you might be in deep trouble.

What have we learned from all the gyrations and thinking that we've done? Obviously, mid-sized carriers must focus on key markets. You must look to your managed care strength and ability on a market-by-market basis, and ask yourself where your type of managed care is going to be successful. We're not going to be successful in California, unfortunately. We'd like to be. We have a big presence there, but I don't think we're going to be. I don't think we would be that successful unless we buy an HMO. We don't want to spend $20 or $40 million for such a purchase.

The fact is that we have realized that we cannot be a national carrier to the same degree as in the past. It is important to communicate this kind of thing in an early time if you're a sales organization. You've got to be prepared to move the sales organization around, to pare it down, close offices, and bolster other offices with a regional presence that's going to be most profitable.

Yet, on the other hand, Mass Mutual continues to want to offer to the 100- to 3,000-life market. We must be prepared to deal with multi-site employers and have managed care options available everywhere that employee may exist. So, although we don't have a sales presence in that area, we will develop what we call "quick-response managed care link-ups" that will allow PPO, EPO, and maybe even HMO access to these multi-site employers on an ad-hoc basis. And that's part of our strategy in the future. The key there is to sell centralized administration of a multi-site managed care operation.

Finally, what's a carrier to do for growth in these times? Mass Mutual has embarked upon two acquisitions in the last few years: Mutual of New York, a New York business, and more recently we acquired, so-called acquired, Hartford's business. Now these were not really acquisitions. These were arrangements we had with the carrier where we had what we call the *right of first quote*. We had an arrangement with them where we went in and had our salespeople have early access prior to the renewal; make the pitch for the Mass Mutual product, and see what happens.

Quite frankly, we are not concerned about keeping and renewing all that business. In fact, these kinds of deals probably only result in 30–40% of the business being retained, as a general rule. So it's not exactly a panacea.

There may be lots of opportunities for these kinds of acquisitions; you're still in the same kind of position in the marketplace. You're going to be sold. Other carriers are going to come in and sell. Other brokers and consultants are going to have the

opportunity to pull that employer away. Yet, at the same time, if you keep racking up 30–40% of a number of carriers and business, then you're going to be successful. You're going to actually grow your block of business, whereas the marketplace is probably not going to let you do that.

The other option, of course, is assumption reinsurance where you actually assume the risk of the contract that you're dealing with. But there are many state regulatory hurdles here. You need the consent of policyholders, and you may, in fact, lose them at that point, too. So I'm not sure that this really is a viable option.

Finally, like other carriers, we have to look at other types of business. Association business, for example. We do not do association business right now, but we're looking at it. We have to look at it because that's one of the facets of the market that the Ways and Means Committee bill provides. It's a separate market, and it's a separate pool. And that may be very attractive. And, of course, if there are small-group business alliances that are popping up from state to state, then that's where we want to be. We want to see if we can operate within that, and that's why we're doing the experiments that I talked about.

We want to market nonmedical products more aggressively. Dental has been a growth product for us; it's complimentary to health products; and it probably won't be affected by reform. And we want to get more involved in the other type of nonmedical business like vision coverage that we already write.

Next, there are the supplemental products. If there is federal reform and if there is a standard benefit package, there may be a market for supplemental products. That may be a regulated market or it may not be a regulated market, but we're looking into that with some caution. We think that will be a commodity market. Many carriers that have no other options will go into that market, but that will not be an economically desirable market for a company like Mass Mutual to pursue. We tend not to be a commodity company; rather we're a company that tries to differentiate itself on the basis of service.

Finally, we have the question of the reaction to the market requirement. What if we *are required to operate in all markets? How are we going to do that? Do we want* to build the infrastructure internally to do that? Not at all. But we would like to work with carriers that do have that expertise. We could work with small carriers with individual lines and small group lines, and find some way that we can private label that product as our own through an arrangement with that carrier.

We also would like to pool our marketing resources. If you're a great small-group carrier in a market, and we're a great large-group carrier, we would like to get together and work on that in a symbiotic fashion. We would also like to use that as a leverage or key to getting into all markets and saying that Mass Mutual is an all-markets carrier. We are lobbying this point. If all-markets mandates do develop, we're going to make sure that a carrier can meet the all-market requirement by working with these carriers and developing private labels.

In conclusion, what have we learned from all this? I think one of the key things is that you have to have information. You have to have an internal structure that will

be able to read what's happening, and it must be able to allow your senior staff to react quickly. Second, I think you have to try to influence the outcome. Work with your member of Congress closely and hard and suggest what reform means to you, to your company, and to the employees at your company.

Third, experiment with new types of options and delivery systems, such as HIPCs. It's all new to us. It takes a lot of staff time. But I think it's extremely important.

Four, we must understand our markets, and then build in them. Commit to those markets and commit resources to those markets, and work with other carriers to try to find a way that you can be a survivor in those marketplaces. I don't think many small or mid-sized carriers can do it alone. I really think it will require joint action on the part of carriers to succeed in many marketplaces facing the regional and national giants. That's going to be very difficult. We can combine under the current antitrust laws with little problem provided the market share is small enough.

Finally, cross your fingers. Let's hope that federal reform, if it does come this year, is not as onerous as it may be shaping up in some of the committees. If it doesn't happen this year, let's hope that the states don't go crazy and get ERISA waivers all over the place, and really put a crimp on the business, at least from Mass Mutual's point of view. Stay tuned; that's really all you can do.

MR. NORMAN E. HILL: Let me begin by giving you a few statistics about my company. We have about $24 million of statutory capital and surplus. In terms of the volume of claims that we pay, on the individual health side we pay about $18 million a year. For group health, in terms of risk assumption, we pay about $8 million. On a self-insurance basis, that is a third party administrator (TPA) basis, we'll pay about $30 million a year. And on an outsourcing basis for other insurers, we'll pay about $60 million a year.

My preference when we talk about health care reform is to cross out the word *reform* and call it *change*. To me, the word *reform* implies that the system is fundamentally flawed, and I don't agree with that.

The most recent private sector annual claim cost expenditures have been increasing at a rate of less than 10% per year. They've been in double digits most of the time, in our recent memory, and now they seem considerably less.

The private system is still tax-driven. It's employer-driven. But today, more and more employer plans have a significant amount of employee contributions. Post-retiree plans have a significant amount of retiree contributions. We have cost-conscious employers that have already been through the pain of downsizing, reengineering, and restructuring, which means layoffs. And they're conscious of international competition. And so we have all these incentives and pressures today from the private sector to control health costs.

But no matter how you slice it, the U.S. health care system can be described as going through the largest reorganization of any industry since upheavals in the nineteenth century.

Some of the things a small company might do to cope with events going on today: First, get out of the business, and switch your emphasis to life insurance, individual life. But there's no panacea because, to cope with the life side, you need products. You need to train a distribution force to sell life insurance if they're used to selling health insurance. It needs systems. If you stay in the health insurance market, you may switch your emphasis to the so-called exempt plans, those plans listed specifically in the Clinton draft bill as exempt from the regulation of that bill.

One reason to switch to the exempt plans rather than just regulation is because the general type of major medical fee for service plans may now become more vulnerable to lapse at a large scale. Or it may become more vulnerable to people switching over to small-group coverage away from individual if small-group coverage becomes more readily available than it has in the past. So these so-called exempt plans would include indemnity coverage like hospital indemnity, cancer, long-term care, disability income, and also Medicare Supplement.

But a carrier that wishes to emphasize any type of individual health plans has to keep in mind some of the developments on a regulatory side. It's very likely that in the near future 65% minimum loss ratios will become commonplace. They're already in effect for a few states. Sixty-five percent for a new issue. There will also very likely be caps—maximum amounts of annual rate increases, which will probably be 25% in any one year.

Commissions, undoubtedly, will have to be cut. The first-year rate of commission will probably be the one that will be reduced most significantly. Commissions may be leveled completely. So individual health products will become more price competitive. We already see a lot of that in the Medicare Supplement where the 65% loss ratio exists already. And in the other products, too, we're going to see a lot more price competition and price consciousness than there has been in the past.

Of course, other carriers have the same idea of purchasing life and health business. We have noticed recently that companies have jacked up the prevailing prices on their blocks of business. You also must have the systems to handle the blocks of business and absorb them and integrate them into your own structure.

Another option is outsourcing for other insurers. If other insurers wish to get out of the business, the small carrier, if positioned properly, may be able to take over the administration for those blocks of business.

Now, coping on the group side: you may know that it seems most group coverage today is some sort of PPO. PPO means there is a contractual arrangement with hospitals, insurers, and employers where the employer, that is, the insurance company, receives a discount on the hospital claims. And this preferred arrangement or discount may apply also to doctors as well as hospitals. In some cases, the employee has the option to go to nonpreferred provider members and give up the discount. In other cases, the employee does not have that option, and these are known often as EPOs.

Until recently, these PPOs have been nonrisk-bearing; that was the insurance company's function. There is some trend for them to become, or we think they're going

to become, risk assumers in the sense of being contractually bound to be paid only a fixed amount per employee or per member regardless of what their own out-of-pocket expenses are or what they have to pay their employees. So that would mean that PPOs are definitely assuming the risk. The term capitation, meaning so many dollars per member, may come into play more often under PPO arrangements. So hospitals and even doctors are becoming more subject to price competition than they have in the past.

Report cards on various PPO plans are also going to be given more and more frequently. Consumer organizations are rating plans that are national or multi-state, describing the service they give, and rating them. And this is going to become more common. So the gap between insurers and hospitals is becoming narrower. We see hospitals often setting themselves up to pay claims directly. We see hospitals buying doctor practices in many cases.

A small-group carrier probably has to be regional in its focus. It may be able to expand from one region to another, but it probably would have to start at least in some confined area of the country where it has a presence already, where it has a fair number of clients. The giants are going to be seen nationwide, but small companies will have to stick to certain areas.

I think the small company has to be very conscious of trying to foster a spirit of cooperation with providers that wasn't there before. In the past, I think it has been us against them, just one confrontation after another. The insurance company is the one that's trying to keep hospital charges behind them if the company thinks they're above reasonable and customary. The insurance company tries to get patients out of hospitals as soon as possible to cut down costs. And instead, when you have PPO networks, you want to approach hospitals and also doctors with the possibility of mutual cost savings. Everybody benefits, not just the insurance company.

Often a small company will have the flexibility to react quickly and to make quick moves to legislation or market developments. Small companies are less likely to have bureaucracies, so that decisions can be made quickly. And, of course, they have to be the right decisions, at least some of the time. The small carrier may also choose to switch emphasis from traditional major medical and fee-for-service over to other group lines such as long-term disability and dental. Of course, other carriers are thinking along the same lines, and we think the competition in these group sublines is going to become more intense as a result.

The small company may look to acquire blocks of group business, although since group would normally cover a one-year term, there's no guarantee that they're going to keep the business. The small company has to establish the relationship with the customer, with the employer. But even here, the move to acquire blocks of business seems to be jacking up the price just as it is in the individual side. The small carrier may also try to outsource business—trying to acquire the outsourcing rights to other companies getting out of the group business. And finally, the small carrier may be in a position to become a reinsurer for certain HMOs or certain PPOs that I mentioned before, which may be evolving towards risk assumption.

The small carrier may have options to acquire different organizations or enter into joint ventures with them. These would include TPAs so that they can be bigger players in self-insurance. Utilization review capabilities, I think, are becoming more important for a group carrier.

HMOs were already discussed in terms of the way their prices have skyrocketed recently. Some rules of thumb I've heard, in addition to the price at $1,000-2,000 per member of the HMO, would include the fact that you need at least 20,000 members to become cost competitive or to enjoy any economies of scale. That translates into a purchase price of $20–40 million for a HMO, and that's beyond the capabilities of many small carriers; it certainly is for us.

We already have a PPO network. We're trying to expand it to other hospitals and also include doctors in it. It's more difficult to get doctors in a PPO network than it is to get hospitals, but we think we're making some progress there.

There's another type of entity that I call a "national discount network" that may have some potential for a small carrier. These organizations make the pitch that any claims submitted to them will be renegotiated by them directly with a hospital, perhaps with a doctor. They renegotiate downward, and they'll share with the insurance company in the savings. We think there are limitations as to how far this could be successful, but it is going on right now.

A small carrier might also wish to convert the existing fee-for-service business that it has over to a form of managed care before the employer and competitive pressure forces it to do it anyway, or it loses the business. Overall, you could summarize these developments as vertical integration. The insurer has to be capable of providing service on a broader scale than in the past. So it's vertical integration if and to the extent the insurer can afford it.

To cope with everything going on today, the small company has to have specific plans. They may be limited plans, but they have to be specific in terms of a goal and action steps that will be taken. Capital expenditures are likely to be required in several areas, and you have to be specific about what dollars you think are going to be needed, how much you're willing to spend, and what the incidence of the expenditures is going to be. The large carrier, perhaps, can afford to round its numbers to the nearest $10 million or even more, and the small carrier ought to do its rounding to, let's say, the nearest $10,000.

Another issue is all the legislation today proposed on both the federal and the state level. In the case of our own company, we lobby. We belong to some trade associations. We do not have paid lobbyists in Washington due to considerations of cost. I suppose one of our lobbying hot buttons would be preservation of rights for self-insurers, the employers that utilize TPA services today. We definitely want to keep those intact.

Recently, there seemed to be a flurry of proposed NAIC model bills and various aspects of health insurance. These included voluntary purchasing alliances, regional voluntary purchasing alliances, a utilization review model bill, and a provider credential model bill also. And, of course, on the federal side, there was the Clinton Bill.

Various versions of it ranging all the way from single payer to medical individual retirement accounts (IRAs), which you have to keep on top of.

There's always the threat that a viable PPO network may be legally forced to provide coverage to people whom you didn't intend. These people may include AIDS patients. This may include the equivalent of state and assigned risk pools. Recently there has been a proposal to further modify the small-group bill along these lines.

Small-group proposals are pending to change to a form of adjusted community rating. This method would still allow three age bands, and it would still allow rating differentials to some extent by geographic areas, but it would prohibit rating by gender and occupation. The small-group carriers, just like larger carriers, will probably want to prepare qualified plans that appear marketable under purchasing alliances as they become more common from state to state. Of course, the purchasing alliances objectives are to be able to use or purchase the power of numbers, and be able to have group insurance available at affordable rates for various employers.

There's another area, too, that I just recently noticed you want to keep up on. If you're an insurer, of course, you're conscious of RBC. RBC has already been passed by the NAIC, and the model act has been adopted in some states now. There are certain factors for minimum capital required for different sorts of health insurance, individual and group.

There's another proposal in the works now that was originally intended only to apply to a limited area: Blue Cross and HMOs. But it appears that the proposals may be extended to all kinds of health insurance it's individual or group, insurance companies, or whatever. I've only looked at the preliminary proposals, but the risk capital factors they seem to be proposing range anywhere from two times to five times what's currently in the law as it has been adopted so far. So insurers will have to keep on top of those requirements and all the implications of them.

Let me be a little more specific in the area of capital expenditures. One area likely to require dollars and expenses is your claim system. In the past, the claim system was adequate if it kept up with claim histories and could check to see if claims didn't exceed the maximum, the aggregate maximum, deductibles, and so on. But that's not going to be enough anymore.

You have to be able to pay claims in accordance with the terms of PPO contracts. There may be various doctors involved under the PPO contract, and you have to know which doctor is the referring doctor and which is not. You have to be able to verify bills that are submitted to see how they comply with the PPO master contract. If you're going to be a reinsurer for HMOs or PPOs of a stop-loss coverage, you have to have the systems to administer this.

A small company is going to be receiving many different types of proposals—proposals from other insurers for joint ventures and partnerships, from brokers, from consultants, from a wide variety of people. Maybe implied in all the proposals is, "Trust me. This is going to work and be successful." But, of course, you can't trust them automatically. You have to do as detailed an analysis as you can do, given your resources. And given these resources, the small carrier will not be able to

choose very many of these options. The insurer will only be able to choose a few and will need to be able to react and to pull out, if necessary, if things don't appear to be going properly.

Prior to concluding, I should add one more thing. In terms of the federal legislation, any partnerships you enter into, any joint ventures and any PPOs, for that matter, you always have to be cognizant of antitrust problems. These can often crop up very rapidly in areas where you didn't intend to see them.

So in conclusion, a small-group company will probably have to be regional because options are limited, but I do think a small-group company can survive. Many small carriers are going to pull out of the business. There's no doubt about that. But I hope that a small-group carrier is not automatically a dinosaur. So while we can't predict the future, I hope that in a few years, at least in terms of my own company, we'll be able to use the words of Mark Twain: "Rumors of our death are greatly exaggerated."

MR. ELY: We have plenty of time for questions. I'd like to start with a question for both Steve and Norm. I noticed in both of your speeches a fairly heavy emphasis on PPO products, as opposed to HMOs. Do you see HMOs evolving into every market, or do you think there will always be a place for PPO-type structures regardless of what happens?

MR. BOSWORTH: I think that the movement toward managed care is sort of a generic trend that is at different chronological points in various parts of the country. I think it's all moving towards a much more acute situation where the providers accept risk. I think that's the key to it.

It's in those immature markets where the providers are reluctant to assume risks that you don't have the HMO penetration. Whether it will be an HMO or some kind of new acronym that eventually takes over everywhere, I don't know. But I think it's going to resemble an HMO. I think it's going to involve significant risk-sharing between the providers and some involvement by insurance companies with a stop-loss type program. And I think that's going to be everywhere in a number of years.

MR. HILL: I think that HMOs are still not universally perceived as providing quality service because the American public is still accustomed, in general, to demanding quality service. And so I think right now, at least, there is still a significant place for PPO coverage as well as for HMOs. I mean we're fortunate, perhaps, that we're in an area, the Southeast, where HMOs are not that widespread yet.

MR. JOSHUA JACOBS: I'd like to ask the panel for comments on what the impact is going to be of these integrated service systems. In St. Louis we have seen some very big hospitals joining together and getting doctor groups affiliated with them. It looks like they are planning to deal directly with employers.

In fact, some of them are talking about eliminating the third party, that is, the insurance company. And I think they are a threat to all the HMOs and even to the big insurance companies, as well as the small ones, but how can the small ones cope with this? Or do you think this movement won't go very far?

MR. BOSWORTH: That's a good question. We're seeing that increasingly in some markets. Again, although there's a general trend towards hospital consolidation, we're going to see a lot more of that, and certainly any of the reform efforts are going to accelerate that.

I think whether a hospital network, or a combination of hospitals in a certain region, can do that depends upon whether they really have the capital and the expertise to do that.

In some markets, they will have the capital. If they have the capital, then we're in trouble because we want to bring the capital to the table. We want to bring the insurance to the table. If they're able to capitalize and to assume the risk themselves, then, in fact, they can eliminate us. But I think it's not likely that that's going to happen in every market.

We've seen in many markets that the hospital industry, even after consolidation, is relatively capital poor. The hospital market is very uncertain of how to proceed, and it is genuinely looking for some kind of assistance from carriers or other consultants to help it get into the risk-sharing business. They're not used to that. Yes, it's true that they may, at some point, not need us, but we hope to get in on the ground floor and become an important part of that process wherever it seems to make sense regionally.

MR. HILL: I think that kind of a development is a potential threat to us. We've experienced it in a way, which I can describe to you. When we were forming a hospital network for a PPO, we had in mind hospitals in a certain area, which were needed to accommodate employers. We went to one particular hospital, a fairly large hospital, and the administrator of the hospital made it clear that he was going to try and cut us out of the picture and go to various employers himself. But right now this individual has certain limitations because although he has a big hospital, it's a hospital in one area.

We already had a plan. Actually, we were geared up to accommodate employers that were not national, but multi-state. So we knew what we intended to do and what we had to do for those employers because we knew the needs of the employers. So we were successful in thwarting his efforts at this point. But he is a capable individual, and he has already gone through some of the steps I outlined in the presentation, about buying doctors' practices and such. And in a given area, certainly, he'll be a formidable presence.

So I suppose one thing that comes out of this is that when you're dealing with hospitals try to get in on the ground floor with a nonconfrontational approach and add to it in some way to instill working together for all of us. In this way, even when hospitals merge or acquire other hospitals, an insurer should be in a position to be a significant player.

MS. RHONDA HAGEN: I had a question for Mr. Bosworth. As far as a full-time employee account, or some sort of cost estimate, do you have any cost estimates on how much you've spent on the federal regulation? And for next year, do you project that number to keep growing as far as the number of employees?

MR. BOSWORTH: I'm not sure I have the exact figure. We have a general budget for legislative purposes, and, that's in the multimillion dollar range. Of that, I believe about 40% right now is being dedicated to health resources. And we were thinking this year would be the peak, assuming that something passes this year. We dedicated almost half of the resources this year to health, and it has been a big change because previously our individual lines and pension lines had almost exclusive rights to those lobbyists and the people.

We don't have a full-time person for any other discipline in Washington. There Doyle, our Washington office person, is health only—she's the only full-time staffer we have in the professional staff that we have down there. So we made a commitment this year, which is big. And we're saying that next year, if anything passes this year, it will be less. If it doesn't pass this year, it probably will be more of the same—just sort of a conglomeration next year, or 1996 will be the big year. It's very hard to predict. We're committed to staffing whatever we need to there; it's a high priority for us. Federal legislation is the highest priority right now.

FROM THE FLOOR: Seeing that the regulatory and the marketing areas work fairly closely together, I just wanted to compliment the company on getting that. It seems oftentimes you talk about regulation and you forget about the marketing part.

MR. BOSWORTH: That's true. I think looking at both regulation and marketing is important to strategy. That's why our management has brought together all the players and tried to get everybody to sit down in one room and work it out. That is important, and I'm glad that we're able to do this.

MR. ROBERT M. DUNCAN, JR.: Let's look at the polls, the quagmire in Congress, and the recent example up in the Rochester area where the representative up there was for the Clinton plan and then backed off when she found out that the Xerox and Kodak companies didn't want it and could do the thing alone. Mr. Bosworth, how are you working with your employer groups and consumers to build an assessment of what is needed in the marketplace? Most of the reform efforts seem to neglect the fact that people either don't understand or don't like the reform that's going on, and that's what caused the slowdown and the whole lobbying effort.

It seems that everything you have discussed is from the company standpoint out through the government, but what are you doing from the grass-roots level to build brand loyalty and things like that?

MR. BOSWORTH: It's a really good question because we thought that through several times and have not been as active with our policyholders as we might be on this issue. We would start with our policyholder base. What do our policyholders want to see out there? We do a poll on that, and it's sort of a mixed bag. We have some that are vehemently opposed to any mandate even though they are providing insurance coverage right now.

Of course, our position is that we need a mandate if we're going to have a system that works. So we have had to tread rather lightly in that area. And I think some of the bigger carriers have had a special problem when you have some big groups that have taken a position against mandates and they've been unable to really utilize that.

We've also called upon our general agency field force to try to get some sense from their contacts, where we want to go on this. And, of course, the word we get from there is that there is no mandate. And again, we're kind of stymied. So we have a little conflict within in terms of the interest that some of our policyholders want to see ensconced in federal legislation and that which we think we need as a health carrier.

I think the HIAA has faced the same thing. We have companies that want one thing and some want the other, and we really have had a hard time forging a consensus. The consensus has only been at the most general level on many aspects of this. It's a dilemma, and I don't know how we can get around it.

MR. HILL: I don't think we've done as much as we should or we want to. We have been making efforts internally to improve service, trying to make all employees at every level conscious of the need for service. The company is not going to survive if we don't have a good image as a service organization.