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Panelists: JOHN M. BERTKO
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Recorder: BURTON D. JAY

Summary: Experts in specific areas reported on recent and current happenings in their field.

Mr. Burton D. Jay: From disability to the newest kind of managed care organizations, anything that is happening out there in the real world and is current is fair game for this session. Our first speaker will be John Bertko. John is a principal and senior health actuary in the health care consulting practice in the San Francisco office of Coopers and Lybrand. He has extensive experience with innovative approaches to Medicaid and prepaid managed care health programs, as well as the development and implementation of new health care reform programs.

John is the engagement partner on current projects with the State of Oregon, related to the calculation of capitation rates for prepaid plans and the new initiative to develop a prioritized payment system for Medicaid. He was also the engagement partner and senior actuary on the project for the State of Hawaii to develop and implement a state health insurance program for the uninsured in that state. In California he is the engagement partner for innovative work for the State of California major medical insurance boards, three programs for the uninsured and low income mothers and children in the Health Practice Council Purchasing Alliance. For the 1995–96 term John is Vice President of the health insurance purchasing cooperative of the American Academy of Actuaries (AAA). Prior to joining

Coopers, John was employed by the Metropolitan Life Insurance Company, in the group division in San Francisco, and also in the New York office.

Mr. John M. Bertko: Each of us has a few hot topics to talk about, and I think you're going to get a decent mix of interest. I think the first one that I'd like to discuss is the Kassebaum/Kennedy bill, and I describe it as hot in two ways. Certainly it's an appropriate topic of discussion right now, and also hot from the point of view that there's a great deal of controversy about parts of it. I have a few components here to talk about.

Apparently things are still in discussion. Senator Trent Lott (R-Mississippi), as well as Senator Thomas A. Daschle (D-South Dakota) were at the White House meeting with the Clinton administration recently to talk about how to solve the problem. As I understood it, conferees have still not yet been named, so things may be moving. I think the mood swings from optimism to pessimism at least once a day, if not once an hour.

What are the parts of this that might be of interest to us? Well, the first, of course, is just what are the cost issues. I'm just going to report to you on what some of the numbers were, and certainly, if this invites questions I'd be glad to take them.

The biggest controversy is probably about the cost of portability from group to individual coverage. I didn't do the work, and can't claim any credit for it, but the AAA had a work group ably chaired by Tom Stoiber that had a great deal of participation that released a study. I said, in the best estimate, with some actions by states, the cost increase could potentially be 2–5%. In theory, if the Kassebaum/ Kennedy bill passes and the states don't do anything, the answer might be zero. But, there certainly would seem to be some effect along the way.

The Health Insurance Association of America (HIAA) in putting together its own estimates said that in the short term the midpoint estimate was 15%, while the longer-term estimate was 22%. HIAA does make a few different assumptions along the way.

I would also point out that two other groups, the Congressional Research Service through work done by the Hay Group using Ed Hustead, and RAND put together other sets of numbers. Those numbers, basically, range from about 1% to 6%. The estimate that I found most interesting was that the RAND people said they took new versions of numbers from the Current Population Survey and from another survey that was done for health insurance status, and reworked those numbers using the highest methodology and came up with a number that's below the 6% end. I'm only providing those estimates as a set of numbers for you to see ponder.

It's certain the bill will have some effect, but the size of the effect is still subject to considerable discussion. As part of the political process, though, this cost discussion seems to have gone past Congress; that is, the current discussions are not focused on cost. Congress seems to have made a public policy choice to say, let's proceed with the portability.

The next part of the bill on mental health parity sponsored by Senator Pete Domenici (R-New Mexico) has certainly continued to be controversial. Everybody, I think, agrees that there's a cost there. Some of the work that the AAA did said that there would be a cost shift from government to private employers, possibly resulting in a savings of $1–2 billion in the system as a whole. My most recent information says that because of the cost shift, even the backers of parity are saying, we know we can't get it all done now. There have been several attempts at compromise; the first attempt is to create another commission to study it. Most recently discussion centers on parity only with a first stage, requiting the upper limits to be equal so that the annual and lifetime caps would not be subject to tough inside limits, but would be the same as any other kind of benefit.

The provision that's certainly in the middle of the controversy these days is the medical savings account (MSA) provision. Those of you who followed the debate know that the House passed a fairly interesting version incorporating MSAs. The Senate, and particularly Senator Kennedy, are finding MSAs to be anathema. Now we're having some negotiation. This, as I understand, was the subject of the meeting between Senators Lott and Daschle and the White House.

The most recent proposal that I'm aware of said: let's only apply MSAs to a part of the universe, not to everybody in the country. The initial limit was for small groups of 100 or fewer and individuals across the country. There were other thoughts about segmenting it geographically, but that doesn't seem workable.

The current discussions say that some agreement may come if the number eligible is pushed down to 75 employees per group, or again, as low as 50. The general accounting office is being asked to come up with a number of individuals involved.

At this point, Kennedy, from all reports, is still against MSAs and has threatened filibuster. The other parties, again, from time to time seem to have some optimism that they'll actually reach a compromise and then deal with Senator Kennedy after the compromise.

One additional provision that I think bears some interest here is the talk of small employer joint purchasing. The bill had provisions on joint purchasing actually put into it, and to the best of my knowledge, dropped as sponsors got down to the final

language. There was definite interest in helping small employers band together in purchasing alliances. The opposition, frequently from the National Association of Insurance Commissioners and other state regulators, was, as I understand it, that the provisions would remove purchasing alliances from state supervision. There's quite a bit of controversy about that.

Personally, I've been doing some work on many of the purchasing groups, and I thought I would just give a quick update of what's happening around the country. In my view, being a West Coast person, I see purchasing groups as one of the next forces coming into play. All of us, in some way or another, as consultants or as company actuaries, or otherwise, are going to need to understand and deal with these entities. As noted just a moment ago, the federal Kassebaum/Kennedy bill almost had a provision to encourage the development of them.

I think large groups have been active with purchasing groups in one sense or another for a number of years. Many of the large groups, I think, have had trouble staying "glued together" to accomplish anything, and I thought I would just report on a variety of these.

Certainly, in my backyard, the Pacific Business Group on Health, which is the new name for the group which for years went by the name of Bay Area Business Group on Health, has had a large degree of success expanding from about 20 companies and a million and a half members in the Bay Area to perhaps 30 or 35 companies now, spanning California. It has had active rate negotiations for the last few years with a fair amount of success.

In a different area, the Minnesota Buyers Healthcare Action Group is trying to do things to spur competition in the Minnesota market. I view Minnesota and California as being two very distinct versions of highly evolved managed care markets. In California, we have many people in managed care and lots and a great deal health plan competition. John Fritz could certainly comment about that from his experience with Family Health Plan (FHP). In Minnesota you have many people in managed care, and again, from an outsider's view, very little competition because of the way the market is structured. There, the Buyer's Healthcare Action Group, I think, is trying things with direct purchasing by employers in order to spur competition beyond what's present now.

In couple of other places in the country things are getting started. In Colorado, the Colorado Business Group on Health is trying to start up. Also in Colorado, we happen to be working with the state on a public employers' purchasing coalition.

I see many seeds planted and sprouts coming up. Perhaps we'll have many more of these over the next couple of years.

There are three ways to classify purchasing alliances: old, modified, and new style. I would view one way of looking at purchasing groups as old style. That's not meant pejoratively; it just means they've been around for a long time. That's generally where a group of employers has gotten together, like Council of Smaller Employers in Cleveland, and bought health care en masse from one carrier. They had a choice of benefit plans, but only a single carrier choice.

Modified style is one in between where now we have multiple carriers that may have emerged from the single carrier history. And, from what I understand, the Connecticut Business Insurance Association has gone from having a single carrier to having multiple ones just recently. And then there's the New style which starts with many carriers. The Health Insurance Plan for California is my favorite model and client. While some still worry about the effects of the Health Insurance Plan for California, we still have carriers clamoring to get in. In our case, we have expanded the Health Insurance Plan for California by a couple of carriers each year for the last three years, and carriers are still banging on our doors to be able to offer themselves for this kind of business.

In Colorado, the Colorado Health Insurance Program, is another group purchasing alliance, mainly with small employers. It also offers coverage to the larger end of the market and works like a much smaller version of the Health Insurance Plan for California.

A first common characteristic of purchasing groups (the new style model) is employee choice. The purchasing alliance offers, like in California Public Employees' Retirement System, or the Health Insurance Plan for California, as many as 10, 15, even 20 plans in a major market, and each individual gets to choose for their family the plan they want. We find that as you get older, buyers of insurance, particularly for small businesses, have different needs than their much younger employees. Before, all employers may have been "stuck" in a preferred provider organization (PPO) because the owner and her husband wanted a particular set of doctors. By purchasing through a cooperative, the owner can get her PPO and everybody else can get his or her favorite health maintenance organization (HMO) in a state like ours.

In some cases, a second characteristic is limits on carriers offered by the purchasing alliance. One of the reasons, I think, that health plans (HMOs and other carriers) will participate in the purchasing cooperative is because they see the chance of more business. And, in some cases the strategy of the purchasing group is to say:

"We're going to invite as many carriers as possible who want to come to the party," and then cut down the invitation list to four, five, seven, or ten plans. That is not the strategy, generally, of the Health Insurance Plan for California, but it is the strategy elsewhere.

The third major element is that these folks try to do their job as tough negotiators. In general we've seen some success over the last couple of years. I won't deny the point of just being lucky, but at the point in time where we brought up the Health Insurance Plan for California to becoming operational, competition in the health care environment changed so everybody was saving money in California. We do think that actual decreases in premium costs are the result of tough negotiations. There were some real reductions in rates.

Last in my potpourri of topics is just a quick mention of some of the effects on managed care that we've observed in California. There is a recent article in the spring issue of *Health Affairs* that talks about this in much more detail, done by a colleague of mine. In a highly evolved health care market, the effects on selected groups, physician groups, have been pretty spectacular. That is, for a period from 1990–94, we found that health care capitation rates for about five or six major health care plans were either absolutely flat in nominal dollars, or falling in some cases as the HMOs gained membership and gained more clout. The second comment is that the negotiated capitation rate band, again, measured empirically, was fairly wide in 1990 and remarkably narrow at the end of the study period in 1994.

A word of warning here. Many of the physician groups in California, at least the ones that we studied, operated on their base capitation at a deficit. That is, they can't get enough money per member per month to pay themselves and have anything left over. They are either dipping into surplus, or as they succeed, are solvent only when the hospital incentive pools are paid back to them.

That has a number of implications. Eventually, the hospital incentive pools will run dry and certainly, Herb or John can speak to that. That says if physicians don't "clean up their act" financially, they may have insolvent medical groups a number of years out. Of course, that means that some of you in the room might be left "holding the bag" if you're actuaries or other managers of health plans. At this point, the physicians are still healthy. We have, I think, at least by anecdote, physician out-migration in California. As you heard from Governor Lamb, I'm glad some of our specialists are going elsewhere because it makes our market work a little more efficiently.

Mr. Jay: Our next speaker is John Fritz. He is a Fellow of the Society of Actuaries (SOA) and a Member of the AAA. He has been involved in the life and health insurance industry, and even more recently the HMO industry, since 1967. John is currently president and chief executive officer of FHP Life Insurance Company, and senior vice president and chief actuary of FHP Financial Corporation. His responsibilities at FHP have also included the function of chief actuary for the company's HMO operations. Prior to joining FHP in 1991, Mr. Fritz was a consulting actuary with Tillinghast. Effective July 1, 1996, John will be joining Ernst & Young's health actuarial consulting practice on the West Coast.

Mr. John F. Fritz: I structured my "Hot Topics" talk around the managed care or HMO side. I wanted to start by making some comments generally about health care reform, and then lead into some issues that are affecting HMOs, especially with regard to Medicare and Medicaid. Three or four years ago, right after President Clinton took office, health care reform was probably center stage. right after President Clinton took office. Comparing that time to now, the federal government is kind of at a standstill; not a whole lot has occurred recently. We heard about the Kassebaum/Kennedy bill from John Bertko, and that's a good example of how things get stalled in the political process. For example, he mentioned the issue over the MSAs. A year-and-a-half ago. Senator Kennedy was one of the strongest proponents of MSA. And now, as the politics surrounding the presidential elections heat up, Democrats are afraid that MSAs could be for Republicans what Medicare was to Democrats, back in the 1960s. They don't want to have this big "plus" happen for Republicans right before the election. Consequently, I doubt that anything major will happen with that bill before the elections. Even Ted Kennedy is standing in the way of a bill he seemed to favor strongly before.

However, there is an area that I think Congress will start addressing even before the elections, and that is on issues affecting the budget. And you can't talk about the budget or about balancing the budget without addressing Medicare and Medicaid. These are such big ticket items in the federal budget that you just have to deal with them. So, there may be some activity going on in those areas even though things seem to be stalled for health care reform right now.

At the state level, we continue to see health care reform. John talked about the purchasing cooperatives and similar initiatives. In addition, there are other things happening in small group reform at the state level, such as the inclusion of individual health, as well. These state initiatives have taken away some advantages that insurance companies have had over HMOs in the small group marketplace. For example, the rating flexibilities and preexisting condition exclusion features used by insurance companies in the small group marketplace could not be used by HMOs.

So from the HMOs' perspective, the reforms have leveled the playing field so that HMOs can compete very well in the small group market.

Another area that we generally don't think about in terms of health care reform, or don't put on top of the list, is merger and acquisition activity. I consider this also to be an important part of health care reform. We're going to talk a little bit more about that later on in the program.

Let me get into some hot issues on Medicaid. As we know, Medicaid costs have been increasing significantly. I was sitting next to Guy King at lunch. As we talked about various federal programs, he made the comment that in the 1990s Medicaid costs have been escalating at double digit rates, similar to what we saw on the commercial health side in the 20% range. Also, Medicaid increases have been in the 30% increase range. That has been a really big problem from a federal government standpoint. Total costs in that system are in excess of $100 billion per year just for the federal government's portion. For example, in the last three years, since 1993, there has been a great deal of managed care activity in Medicaid. States have applied for waivers so that they could start incorporating more managed care programs into their Medicaid programs. Since 1993, the percentage of membership in the managed care side of Medicaid has more than doubled over what it was back in 1993. In 1995 alone it increased by 51%, so that today, about one in three Medicaid beneficiaries are actually covered under a managed care program.

I mentioned balancing the budget. The issue there on Medicaid, between the Democrats and Republicans, has been to try to figure out how to bring those costs down in some way. Last year I think they were something like $125 billion apart on how much the target reductions in cost should be over a five- to seven-year period, in an attempt to balance the budget. Now the two sides are probably a little closer. They are more like $30 billion apart. So they're getting closer to an agreement. But unfortunately, it wasn't that the Democrats moved their targeted cost reductions higher; it was that the Republicans have come down in what they're willing to accept for cost reduction targets.

Let's discuss the Medicare side. The annual costs are approaching $200 billion. I'm talking about the federal government's share; or out-of-pocket costs or other insured costs being incurred by Medicare beneficiaries. I'm referring to the federal government's share of cost. The annual increases, Guy tells me, have been running in the 9–10% range in recent years. Of course, that includes not only health care inflation, but also the aging of the population. As we know, this aging issue will become a bigger problem over time. As a matter of fact, for 1996 it is already projected that the federal Medicare budget will be approaching 3% of the gross

domestic product (GDP). It's already 2.7% of the GDP. By the year 2020, if those projections are right, it's going to be approaching 6% of GDP.

The Board of Trustees for Social Security and Medicare issued its report a month or two ago. In that report they projected that, under the most likely scenario, the Hospital Insurance Trust Fund will be in a deficit position by the year 2001. It had decreased in the 1995 fiscal year by about $2.5 billion. In the first six months of this 1996 fiscal year, the fund decreased by $4.2 billion. The fund is decreasing in an accelerating fashion. Currently, the trust fund is at something like $130 billion, but dropping rapidly.

During the "balanced budget" debate last year, the Democrats and Republicans were about $150 billion apart in terms of their five- to seven-year targets for Medicare cost reductions. They are now a little closer together, about $40–45 billion apart in terms of targeted reductions in future spending. Again, it was the Republicans coming down in their target reductions.

These reductions do not mean costs will not go up, and that's part of what the American public misunderstands about the debate. In fact, even the $150 billion of reductions the Republicans were talking about last year resulted in Medicare cost increases each year. The targeted cost decreases were not going to decrease the cost of Medicare in the country; they were just going to slow the growth in cost. The primary vehicle to reducing costs, again, has been looking at ways to incorporate more managed care.

The rate of growth for managed care in Medicare has not been quite as dramatic as it has been for Medicaid over the last couple of years, but it has still been pretty dramatic— there has been a 67% increase since 1993. This includes only, what I'll call, traditional Medicare products—the Medicare risk and cost contracts. The risk contracts represent about 82% of the about four million Medicare beneficiaries covered under managed care in the Medicare system. And, in order to encourage more managed care growth, the Health Care Financing Administration (HCFA) has started allowing HMOs to use a point-of-service (POS) approach as an alternative to the traditional HMO approach, allowing beneficiaries to opt out of the HMO network at the time service is rendered. Some HMO plans have introduced POS and other plans will follow suit, so we'll have POS products as a new way for HMOs to deal with risk contracting and increase their Medicare membership. In addition, HCFA had asked for proposals for demonstration projects to test other ways of applying managed care to Medicare, to increase that growth even more.

Out of that request for proposal (RFP) process came 25 successful bids a month or two ago. These 25 candidates are spread across eight cities in the country and five

rural areas. The numbers and types of organizations participating in these demonstrations are nine provider-sponsored networks, eight provider-owned HMOs or provider groups that have a partnership with HMOs, and eight HMOs or managed care organizations.

We're starting to see what may become a trend in Medicare managed care, i.e., where the contracting may be directly with the provider groups. And that's going to be an interesting development. However, I don't expect a whole lot, other than what's going to happen with these demonstration projects, until after the elections, because there's a lot of controversy surrounding these demonstrations. For example, some of these organizations, since they're not HMOs, may not have state licenses and thus are not subject to any state regulation or solvency tests. HCFA is looking at working around this problem by developing its own solvency tests. This creates a whole new area of HCFA jurisdiction in conflict with current state regulation, which can create a very "unlevel" playing field for the various competitors.

In addition, there are discussions about waiving the 50/50 requirement. Currently, HMOs are not allowed to have more membership in their Medicare risk contracts, for example, and Medicaid, than they have in their commercial business. So they can only go up to the 50% level in terms of their Medicare membership. HCFA plans to waive that requirement for some of these demonstration projects, at least on a case-by-case basis. That's creating a great deal of controversy and unhappiness on the part of the HMOs that have to abide by the 50/50 rules.

There's another area of major controversy that we, as actuaries, can really appreciate. This is the potential adverse selection possible when providers directly contract with Medicare. For example, there is the temptation for the medical providers in these demonstrations to seek out the more healthy Medicare beneficiaries, leaving the less healthy to the HMOs or to "fee-for-service" Medicare. Since these providers are directly involved in the delivery of the health care, they are in a very good position to know a Medicare beneficiary's state of health, take advantage of that information and use it to their benefit. The net result of such adverse selection could easily be higher overall Medicare costs, rather than lower costs.

One other demonstration that is also creating a great deal of controversy is the one in Baltimore. There has been a great deal of discussion within the HMO industry and with HCFA about using competitive bidding in the managed care Medicare programs. Nothing has really happened as a result of these discussions. In fact, the industry was sort of stalled on this whole issue. HCFA has decided to go ahead with a demonstration using this concept in Baltimore. I'm not sure how far along it is. I know that the American Association of Health Plans (formerly Group Health Association of America) has sent a letter objecting to certain aspects of this

demonstration. Basically, HCFA wants to mandate that all current HMOs that offer a Medicare risk or cost contract must competitively bid, or they cannot participate in the Medicare program in Baltimore. HCFA will specify the set package of benefits that it will be asking HMOs to quote on. Also, HCFA will decide what the level of government contribution will be for its benefit package, based on the responses to the proposals HCFA receives.

In the first year, HCFA has said that it will make sure that the government's contribution will be greater than the rate levels for most of the plans quoting. But nothing is said about future years. Part of the problem with this approach is that some plans may need to bill the Medicare beneficiary for very small amounts of premium that are in excess of whatever the government has agreed to pay in contributions. Alternatively, the plans may have to forego the extra revenue that they anticipated in their original quote. Stay tuned to this demonstration; it should be interesting to see how this ultimately comes out. It could have a dramatic impact on the future of managed care in the Medicare system.

Mr. Jay: Our next speaker is Herb Fritch. Herb is president and cofounder of North American Medical Management Inc., which is a wholly-owned subsidiary of PhyCor, and has over 20 years experience in the HMO and managed care industry. Prior to North American, he served as regional vice president for Aetna Health Plans. Previously he served as executive vice president of Partners Health Plan of Southern California and before that was a principal at Milliman & Robertson. Herb was also a cofounder of SANUS Corporation Health Systems. He is a Fellow of the SOA and a Member of the AAA. He practices particularly in the area of physician provider organizations, and the focus of his discussion will be what's going on in that area.

Mr. Herbert A. Fritch: I'm going to focus, from a provider perspective, on the tremendous change that's taking place in the health care delivery system world these days. This change is being fueled by the movement to managed care and especially risk-based HMO products into the mainstream of the health insurance business. Provider organizations have to respond to that change by adapting to risk-based contracts. In part, that process has been marked by a tremendous degree of consolidation. You've seen it on the hospital side driven by Columbia/HCA. On the physician side, the consolidation has taken two forms. One is by hospital systems trying to integrate, and the other is by this new phenomenon, of which I am now directly involved, called professional practice management companies. That growth and consolidation is now fueled by Wall Street.

Both Med Partners and PhyCor are publicly trading at huge earnings per share multiples, and there are several new companies on the drawing board and venture

capitalists lining up, who are willing to fund anything that sounds like a reasonable provider consolidation scheme. That almost certainly is going to make the growth and consolidation move even more quickly in the future.

Part of what has resulted from all of this is you have provider organizations that are much more sophisticated in many ways. This is true both in the management of their own practices—certainly in the access capital—but also, they are more focused on how you manage risk as a provider organization, and more on how you provide high quality care and outcomes measurements. There seems to be, in all the markets in which we are involved, a real interesting dance going on between hospitals, physician organizations, and payers. It really seems to evolve around who is going to control the contracts, who is going to control the patients, and who has the negotiating leverage in each market.

In some cases the hospitals are buying up doctor practices to gain leverage over the doctors and go to the payers as a single provider entity. In other areas the payers and physicians are forming alliances. It's real interesting to be in Nashville these days because we will have payers come in to talk with PhyCor about national kinds of alliances when you know they've been meeting with Columbia HCA about the same kind of alliances. In some markets we work with Columbia/HCA and in some markets we work with its not-for-profit competitor hospital systems. All that makes for interesting days in the provider community. One of the keys to all this is who can manage risk best.

We are seeing more sophisticated provider-based risk organizations emerging. From the perspective of a student of health care delivery and financing, I have noted some of the characteristics. First, clearly the primary care doctors have emerged into a position of power in the health care world. Frankly, that simply revolves around the fact that these physicians now control the most critical point of leverage right now; that is the ability to control referrals to the rest of the system, including their fee-for-service patients. Quite often, they are able to leverage the high-cost specialists and potentially the hospitals into participating in primary care controlled risk organizations simply because of the potential of moving their fee-for-service referrals elsewhere.

The second thing we see more frequently is specialists being paid under direct capitation in these networks. Rather than trying to create incentives for primary care gatekeepers to control fee-for-service specialists, we find that directly capitating the specialists simply works better. We have seen a much more dramatic change in practice patterns and utilization with much less outside intervention in those kinds of systems.

The third phenomenon we see, especially as we move to global risk or risk where the physician groups have a significant amount of incentive to manage institutional services, is a structure where there is typically a physician or a small group of physicians who are hospital-based. These are typically internists or critical care intensives, who are either the coattending or the admitting physician on all admissions from the medical group or individual practice association (IPA). That doctor has incentive and is put in a clear position of responsibility to manage hospital admissions to dictate the number of referrals that those patients get in the hospital, and in general, to move the patient through the institution care system.

Since these providers are hospital based, they can order tests and get results back in a matter of half an hour or hour and move on to the next step of treatment. They are also put in the position to be the gatekeepers for emergency room admissions. That structure, if done well, creates the potential to manage hospital days 20–25% better than the more common concurrent nurse reviewer structure.

Most of these systems are finding that physicians, rather than fighting managed care, have now accepted it, and are really taking the attitude that it's a different game that must be learned. With proactive, positive physician participation in day-to-day management of these delivery systems, we are seeing more effective managed care delivery systems, both in terms of the quality and the resource management. Most of these organizations now have their own on-site management, to pay claims, to do contracting, and to do utilization review. In effect, all medical management functions have transaudient to provider entities as risk has also shifted to the providers. The other key is provider entities getting timely access to meaningful management information. On the actuarial side, providers are learning the importance of the incurred but not reported (IBNR) calculations as well as sophisticated physician profiling systems. The latter is a very detailed analyses of both primary care practices and specialty practices.

As a result of provider entities taking on financial risks, we believe that what we are seeing is a shift from what we would term a payer-driven system to a provider-driven system. Providers are grouping together in either IPAs or multispecialty groups to take risks, where, for the most part, the providers select the specialty networks, the labs, and the ancillary providers with whom they want to participate in the risk-bearing network. They drive the medical management functions through contracting incentives, claims adjudication, management information systems, utilization review credentialing, and they usually have their own medical director setting up protocols and working through a layer of approvals if needed. All this has been facilitated through the transfers of financial risks of the provider groups. If the risk is not transferred, then none of this occurs, and the systems remain payer driven.

Currently, part of what we are seeing is all kinds of providers, physicians groups, hospital groups, and physician hospital organization (PHO) groups, actively seeking because they now understand that if they take the risk and control the contract, they can control all the aspects of health care delivery mentioned above and potentially get some upside financial benefits if they are able to effectively manage the system. About half the payers, most of them based in California, have evolved using these kinds of provider contracts and are very comfortable delegating those functions to provider groups.

As we move eastward across the country, there are several hospital systems and PHOs wanting to contract on a global risk basis, but not many payers, if any, are willing to give it to them. At issue is the payer/provider struggle over who really adds the value to the system. Who is really going to control all these different elements of health care delivery? As John mentioned, I think there is certainly some payer paranoia focused on whether or not these sophisticated provider groups are ultimately going to evolve into their competition and start to contract directly with payers.

Speaking from the perspective of one of the more sophisticated provider organizations in the country now, we're clearly trying to avoid that position. We saw what happened to Humana a while back when it tried to be both a hospital company and an HMO company. That did not work. We very consciously try to avoid equity participation in any kind of a payer organization. That said, if Medicare starts to allow direct contracting with provider organizations, it's clear all the tools are there to do it, and much more so than in past years. I would not want to imply that every IPA or multispecialty group has that kind of sophistication or tools, but I would say the level of medical management expertise possessed by most provider organizations is rising quickly.

I do not believe you can say there is going to be a clear winner among the hospitals, the doctors, the payers, all of whom are consolidating to gain leverage. Market by market the winners and losers are going to vary. The power shifts are going to occur differently, which continues to make health care interesting. About the only thing I think I am sure of is that the pace of change and consolidation is going to increase. We're going to be seeing much more of it, especially as you move in the east, the Midwest, or the south—areas that traditionally have not been as affected by managed care and provider consolidation.

Mr. Jay: Our final speaker is Ron Wolf who is a principal of Tillinghast-Towers Perrin in the St. Louis office, and is health practice senior consultant for North America. Ron's actuarial career began with General American Life Insurance Company in 1967. In this position he worked in the individual life insurance area.

In 1973 he joined the actuarial consulting firm of Nelson & Warren, which later became Tillinghast-Towers Perrin. While with Nelson & Warren and Tillinghast-Towers Perrin, Ron has practiced and specialized in accident and health insurance matters, including individual and group medical business, disability business, and supplementary health products. He has participated frequently in appraisals, actuarial projections, financial analysis, and corporate planning assignments for life and health insurance companies.

Ron has served as a member of the AAA Committee on Health Insurance, as chairperson of the Health Committee of the Actuarial Standards Board, and as a member of the Health Section Council of the SOA. He has also served as consultant regarding health insurance subjects to the SOA Education and Examination Committees, and as chairperson of the Health Practice Research Committee of the SOA. He is currently a member of the Health Financial Issues Joint Committee of the SOA. Ron is going to change the direction of the discussion from the medical coverage areas to the longer-tail coverages, such as disability income and long-term care.

Mr. Ronald M. Wolf: This session was advertised as Hot Topics in Health Insurance, and I'm going to push that a little bit and talk about individual disability income insurance, which is an area where I have done a fair amount of work over the last few years, and which has been undergoing some very fundamental change. In this area of individual disability I'm going to talk a little about what has been hot, what has been going on the last few years, what's going on now, what's hot now, and what might be happening in the future to this product type.

In terms of what has been hot I submit that there are two things: one is unfavorable financial results and another is consolidation. Regarding unfavorable financial results, there probably hasn't been a carrier in this business in the early 1990s that has not reported poor financial results in one form or another. Whether you talk about statutory accounting, generally accepted accounting principles (GAAP), or whatever, financial results have been disappointing. In some cases, even large loss recognition reserves, perhaps in the magnitude of hundreds of millions of dollars, have been set up on a GAAP basis for this type of coverage. This has brought pressure from some of the rating agencies like Best's and Standard and Poor's (S&P), which seem to be focusing on the individual disability income business as a potential problem area and risky area, much in the same way they have done, and continue to do so, on annuity business.

We think the problems have been concentrated in certain risk categories. We've heard from both Herb and John a little bit about these pressures on physicians, and certainly physicians have been an occupation or part of individual disability risk

where there have been problems. Regarding consolidation, we are going to talk a little bit about merger and acquisition implications for the lines we've talked about. Let's address a couple of things here. We have seen a number of carriers exiting the risk to form marketing ventures with some of the major carriers, and also some outside acquisitions. In addition, these pressures for consolidation have occurred with both direct writers and also reinsurers.

What's going on now? What are we doing about some of these problems? I think the buzzword is risk assessment and risk management. In a nutshell, we're trying to figure out what has been going on that has caused these problems, and we must decide what to do about them. Companies have been trying to understand, or at least better understand if they had an idea before, what are the key financial drivers of this line of business? Obviously, morbidity is important, but so are other things, such as investment earnings.

Early in our meeting, we had a good session on investment strategies for disability business. Disability business builds large reserves, large assets that back them, and therefore, investment strategy presents an opportunity. Federal income taxes have been a problem for this line of business. The deferred acquisition cost (DAC) tax hits it hard. The differences between statutory and tax reserves result in taxes being paid before earnings are made and can result in an effective tax rate for a product of over 40%. Not only are companies understanding generically what the key drivers of this business might be, but they are also trying to understand what is actually happening in their own business practices, in relation to these key drivers. They are then taking appropriate action to balance risk and reward.

Much of the coverage that has been written for quite some time now has been noncancellable coverage with long-term own-occupation definitions of disability. The concept that the noncancellable own-occupation contract is plenty risky goes without saying. Companies have been more aware of how risky it is to have long-term rate guarantees combined with long coverage guarantees. Just think to yourself, how many insurance type coverages, or even financial instruments we have out there that are very long term in nature, where the price cannot be changed? There are not too many of them.

We've seen that the typical definition of a claim is open to social change. Some of the changes that have hit doctors may, at some point in time, hit lawyers, or even in our own industry. There may well be some issues relating to employment and carrying over to disability.

The disability line of coverage can give volatile results in a statistical sense. Low frequency, high severity gives high volatility. We can also have nonrandom

fluctuation due to the social changes that I've eluded to before. Think, for example, what might happen to the medical industry if we get to a single payer system. I don't think that will happen in the near future, but I can count on just about every month reading something in the inside editorial in our St. Louis newspaper about the merits of a single payer system.

With all this risk, the question that carriers are asking now and should be asking is, what rate of return is commensurate with such a risk? In my opinion, it's at least 15%. Then the question becomes, is the related premium marketable? If we can price a product that would earn such a rate of return with some fairly heavy risks in it, is the premium so high that perhaps nobody can afford it?

I think that the issues for both direct writers and reinsurers are, first of all, managing what some people have called the closed block. If we're talking about a company that hasn't been a player in the past and has a business that has some imbedded risks or some imbedded, perhaps, underpricing in it, that can't be changed, how do we manage that going forward?

Along with that, deciding how to play in the future is important. Does a company want to continue to be a risk taker or perhaps, just be a marketer and take a commission on the business? If the company wants to be a risk taker, what will be the form and the nature of that risk taken? What type of contract will we write? I would say that both of these questions depend heavily on understanding and managing the morbidity risk. Let's just talk about that for a while.

One of the ways that we have tried to help companies understand and manage the morbidity risk is something that we call the risk profile. You're probably aware that individual disability has a large number of risk segments. You open up somebody's rate book, and the rates are all over the place because there's so many different risk variables, such as benefit period, elimination, occupation, benefit amount, income amount, and the existence or absence of riders, like cost-of-living benefits or residual benefits.

What we mean by a risk profile is not all that profound. It's really two elements. One is what kind of exposure do we have on each one of these highly segmented variables? There should be some sort of financial measure, for which we have used an interest- adjusted loss ratio on a developed or accident-year basis. What we mean by that is not just looking back historically on a book or financial statement basis measuring claims as paid, plus or minus the change in claim reserve, but using a technique that I think our property and casualty brethren use more than we do, and that is to focus on losses by accident year and look at their stream of payments

as they have emerged to date, and look at an estimate of their remaining reserves. Discount that entire stream back to the loss date.

Table 1 is an example of what might be the result of a so-called risk profile study where benefit period is the risk variable that we're measuring. You can see, down the left-hand side, different benefit periods that one might have for a disability product. In this illustration, over on the right hand side, our measure of exposure is monthly indemnity in force. I'm just showing a percentage distribution for a sample book of business. The key numbers are in the middle. In this particular case, it's pretty clear that a problem area exists, perhaps in underpricing or underwriting, somewhere in the longer benefit periods. Something like this might be further segmented by occupation or even by area, to help the company figure out where the problems in its booklet business is. So, we're focusing on understanding and managing the morbidity risk. And this risk profiling technique is one method that we have used.

TABLE 1
RISK PROFILE SUMMARY
RISK VARIABLE: BENEFIT PERIOD

Benefit Period	IALR*	Indemnity
Life	96.8%	42%
To Age 65	72.1	47
5 Year	55.8	6
1–2 Year	52.9	5
	81.2%	100%

*Developed GAAP interest adjusted loss ratio by accident year over the period 19XX–19YY

Continuing on with understanding and managing the morbidity risk, some other factors that can be incorporated include understanding and realizing what your contract provisions are in terms of definition of disability, and in particular, restrictions on mental and nervous claims, which have been a problem area for claims in recent years. Both claims administration practices and underwriting practices are being reviewed closely and changed. Under claim administration, varying degrees of settlements are taking place. Typically, companies will try to settle claims for less than the reserves that they are holding. In doing so, however, they have to balance that with undue coercion from a legal sense, when claims are settled.

Regarding underwriting, one of the problem areas has been income placement ratios, having benefits as high as $15,000 or $20,000 a month with income replacement ratios being well over 60%, which has caused problems.

And finally, in understanding and managing the morbidity risk, a good basic actuarial technique is performing an experience study, or a morbidity study. We believe that a morbidity study in disability insurance should be frequency and severity based. And what we mean by that is pricing, financial projections, reserving for disability coverage on a loss ratio basis without a pure projection of claim cash flows is inadequate. We believe that a morbidity study should be done on first principles. That's hard to do because a large body of data is needed to do it, in a statistically reliable sense, so it can also be done on an actual-to-expected basis. It should be done calendar year or loss year by year and done cumulatively to see emerging trends.

Once that is done, though, since the line of business is long tail in nature, the estimates that we make are still going to be somewhat dependent on our long-term termination rates, or our assumptions in the future about how existing claims will complete themselves. One of the hypotheses that we made a few years ago was that with an increasing proportion of long-term own-occupation contracts in force, we may be looking at a significant increase in our claim population of so-called healthy, disabled lives. In other words, we're talking about lives whose mortality and morbidity will not exhibit that of a disabled or impaired person, but someone who is disabled purely on a technicality, and otherwise, has a normal life expectancy, which would not be anticipated in the longer portions of the tables that we now have.

Some of the investigations that we have done indicate that this type of phenomenon of a much expanded proportion of so-called healthy, disabled lives in our claim population has not taken place up to this point. I think that it still may be a possibility in the future. Herb, you were talking a little earlier about continuing pressure on physicians' incomes. Perhaps there is yet another wave of that to come, and something that we might look out for. The words I wrote down here when you spoke were, *potentially insolvent medical groups*. Maybe there might be more of that, and we will see more of this so-called healthy, disabled life phenomenon.

How about the future? What might be happening for this line of business in the future? This involves a little crystal ball gazing on my part. I can't support this with a lot of hard statistics, and you might have a different opinion. But, I believe that there really is a long-term need for private coverage for this risk. I'd like to stop here by asking for a show of hands. How many of you in the audience, or even on the panel, have long-term disability coverage through your employer? Wow! Almost everyone. How many of you provide it for yourself? How many of you buy it individually for yourself? Well, we have just a few hands. How many don't have any coverage? Essentially, you are self-insured.

With the way our economy is going, with outsourcing of work and an emphasis on smaller firms and more entrepreneurism, there will be a long-term need for private, individual disability insurance. I think that need coincides with more responsibility by us, as individuals, and less by social plans for the types of benefits that we have had in the past. I think, too, as productivity increases, all of us are working harder, trying to work more efficiently. I think our work ethic is picking up and I would like to think (maybe this is wishful thinking), that there will be less tendency for carriers to offer disability benefits that may be abused, and less tendency for people who are insured to abuse them.

I see reduced product guarantees in the future. We probably won't have too many financial instruments where more of the risk is coming back to us. Witness your 401(k) plan, which is a self-directed plan that kind of puts the risk on you to make the right investment. I think the disability products that will be offered in the future will have less guarantees in them which, for no other reason, will result in less allocated capital and less capital costs for these products, which will be important.

Finally, for this line of business, I see further consolidation in the new term, but I'm also beginning to see new players that may emerge who kind of take a contrarian view. These players see some opportunities in the future. Maybe it is companies that have not participated in this line of business in the past that don't have a big closed block of business that is in less than desirable financial condition at the moment, and are therefore better positioned to take a contrarian view. I see the possibility that there may also be new players of a global nature. We are aware of some companies that are looking very hard at disability income as coverage for the future worldwide.

To summarize, the news in the early 1990s has not been good. There have been some disappointments. Companies are working hard to understand and manage their risks. I think there will be a need for this coverage in the future, and I think it's going to provide us with plenty of opportunities and challenges as actuaries.

Mr. Jay: As I reviewed the early drafts of the outlines of the presentations that were to be made, one of the things that became clear was that everyone mentioned, at least to some extent, a great increase in consolidations, mergers and acquisitions. This would be big companies buying little companies, and sometimes the reverse. I particularly noted that John Fritz put together a study that compared the cost of HMOs versus indemnity acquisitions. I will now call on John to present his findings.

Mr. Fritz: I thought it would be interesting to look at some of the multiples of recent acquisitions, where HMOs were acquired, as well as some of the multiples of

when either HMOs or other entities bought health insurance operations. The most recent acquisition here in Table 2, of course, is Aetna buying U.S. Healthcare. Notice the ratio of purchase price to net income. It is 23.6 times the net income. Other multiples of the purchase price were 2.49 times sales revenue and $2,915 per member. The overall average per member purchase price for all six of these major recent HMO acquisitions cost is $1,726 per member. The U.S. Healthcare purchase is the highest per member but more in line (even on the low end) as a multiple of net incomes with the other HMO acquisitions. U.S. Healthcare's profit margins have been among the highest in the industry, explaining the apparent anomaly.

TABLE 2
PURCHASE PRICE MULTIPLES—HMOS*

Target/Acquirer	To Net Income	To Sales Revenue	Per Member
U.S. Healthcare/Aetna	23.6x	2.49X	$2,915
GenCare/United	28.4	2.13	1,445
Intergroup/Foundation	31.8	1.70	1,591
Ramsay/United	28.6	1.21	1,556
TakeCare/FHP	25.5	1.20	1,411
HMO America/United	36.5	1.10	1,440
Average	29.1x	1.55x	$1,726

*Greater than 250,000 members

Contrast these HMO acquisitions with what has happened with some of the recent health insurance company acquisitions (Table 3). You see here that the multiples are much lower. The average for these four acquisitions is 11.1 times net income, 0.38 times sales revenue and $443 per member. It is easier to compare the two if we look at a summary table, just comparing the averages (Table 4). If you look at the comparison of purchase price per member and multiple of sales revenue, they are basically four times as large for acquisitions of HMOs as they are for insurance companies. Obviously, part of the reason for this is the higher profit margins HMOs have experienced, as well as the lower risks that HMOs take on. But, if I had to really come up with an actuarial justification for a $2,915 per member purchase price, I'm not sure I could.

So, with that background on purchase price multiples, I'll turn it back to you, Jay, for any further thoughts on merger and acquisition activity.

Mr. Jay: John, did you have some observations that you'd like to make?

TABLE 3
PURCHASE PRICE MULTIPLES
GROUP HEALTH INSURANCE OPERATIONS

Target/Acquirer	To Net Income	To Sales Revenue	Per Member
Mass. Mutual/Wellpoint	8.0x	0.19x	$317
Emphesys/Humana	10.9	0.39	665
MetraHealth/United	10.3	0.33	502
Provident/Healthsource	15.0	0.62	289
Average	11.1x	0.38x	$443

TABLE 4
AVERAGE PURCHASE PRICE MULTIPLES
HMO VERSUS INDEMNITY

	HMO	Indemnity	HMO/Indemnity
Net Income	29.1x	11.1x	2.6
Sales Revenue	1.55x	0.38x	4.1
Per Member	$1,726	$443	3.9

Mr. Bertko: Just one other that Herb may not be able to make now as part of PhyCor. But, one of his competitors has been incredibly active in the markets in California, and let's see if I can do the acronym right. Med Partners, policy processing sheet (PPS), Caremark Mulligan. The interesting thing is there are roughly 700,000 physicians in the U.S., and if I can believe newspaper reports, I would say that acronym owns about 7,000 of those physicians, which again, is a very small part of market share. But, I submit to you that out of southern California, that's probably enough force to begin making a difference in the California market. I'd also say, and this is where Herb may choose to disagree, while there is a great deal of PHO activity going on in other places, where it's an individual institution with a bunch of doctors glued to it in some sense, money or otherwise, I haven't seen much impact. It's only when they get really gigantic, as in the case of PhyCor or the Med Partners or Malcolm that you begin to make a difference. All of a sudden we may be at the next turning point where the doctors conceivably can start pulling back a little bit.

Mr. Fritch: Let me share our view of the health care world from PhyCor's perspective. PhyCor has grown by acquiring 33 different multispecialty groups spread throughout the country. We are concerned about having too much concentration of business in California. We are concerned about the economics where the provider loses money until it gets its hospital bonus. We have decided to stick with a pure play practice management business. In regard to the Caremark acquisition by Med Partners, the majority of Caremark's revenues are derived from pharmacy benefit

management operations. We were concerned about entering a number of businesses in which we had no operating experience. In addition, there are also some other lines of business apart from physician practice management.

One thing we are seeing more frequently are hospital systems coming to us that have acquired physician practices over the years as a way to gain control, but have paid too much, put in the wrong kind of incentives, and are consistently losing big dollars in the physician practice business. These systems are looking for some relief and help with a business they really do not understand. That is a pretty common experience in terms of related health care entities that have been buying up practices. I think we will see more hesitation by hospitals to acquire physicians. I have read two things recently from different financial analysts that estimated this market of consolidating physicians into groups, and the business of physician practice management companies will grow dramatically. One of them expected growth of 6.5 times by the year 2000, the other, estimated growth of ten times. That is why Wall Street likes the industry. Wall Street likes PhyCor so much because it has been the one company that has proven it can grow and consistently make money at the practice management business. There are many companies getting into the business.

The other comment I would make is, it is not a very easy business at which to succeed. Physicians, for the most part, do not make good employees, and I think there are going to be several companies stumbling along the way as we see the new players scrambling to get a part of the 6.5–10 times the expected growth in the business.

Mr. Jay: Ron, do you have a word to add?

Mr. Wolf: I'll just add one thing with regard to consolidation. One of the remarks I made was the idea, in the disability area, of trying to understand your risks and determine what kind of rate of return you want to earn on your product that's commensurate with that risk and then the ideas, if you can calculate a premium that can do that, can you sell any? Is the premium so high? I think as this line of business consolidates, perhaps that provides more opportunity for higher prices or firmer prices, but we'll have to see how that goes. I know if I was a buyer of the product myself, my response to that would to push out my elimination period. Rather than buying a 60-day product, I might buy a 90-day or 180-day product, which, again, is more of a leverage product. It has less frequency, so how can you manage that risk. I see consolidation, perhaps, as being somewhat beneficial in firming prices, which is probably necessary. I think that's the case for both direct writers and for reinsurers.