RECORD, Volume 24, No. 3*
New York Annual Meeting
October 18-21, 1998

Session 34I
HMOs—The Role of the Actuary

Track: Health/Actuary of the Future
Key Words: Futurism, Health

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Summary: Over the years, many HMOs have gone about their business without the benefit of actuarial input. Has this hurt HMOs that did not have such expertise? Is it reasonable for HMOs to continue to operate without actuarial guidance? This interview explores these and related questions

Ms. Karin M. Swenson-Moore: For the first half of this session, I'll be posing some questions to the rest of the panel, and then during the second half, we'd like to take questions from the audience.

I'm from Milliman & Robertson in Seattle, and I'd like to introduce the rest of the panel. Dave Nelson is vice president for risk management at Humana, which is what Humana calls the actuarial and underwriting department. Dave, in addition to his Humana duties, is also on the Academy Committee to review risk adjusters, so I'm going to stay in touch with him and find out more about that.

Harry Sutton is currently the senior actuary for Health Care at Allianz Life Insurance Company of America out of Minneapolis. Among Harry's many activities is his involvement on the State Health Committee and the Academy Committee on Federal Health.

Bob Wilcox is currently the national director of insurance regulatory consulting at Deloitte and Touche. He's based out of Salt Lake City. He was formerly insurance commissioner of Utah, so he has a great deal of interesting regulatory experience that he'll be sharing with us. He is also the chair of the Life Practice Council for the Academy and a member of the Health Practice Council.

How is a managed care organization similar to, and different from, a traditional health insurer or from a Blue Cross/Blue Shield Plan, both in general and specifically?

Mr. Harry L. Sutton, Jr.: I'll go first because it's going to cover a second subject I'm going to talk about. Originally, the Blues represented providers and were a means for the providers to prepay their health care. Commercial insurers came in and worked primarily for employers, but really were private business ventures, designed to produce a product to sell and make money. All the Blues were originally not-for-profit by statute, and HMOs, during their early phases, were either cooperatives or not-for-profits. Until probably 1980, the majority of the HMOs were not-for-profit. Many of the early HMOs were set up to provide health care to large populations that had no access to health insurance, such as government employees, City of New York employees, Kaiser Foundation Health plan employees or actually the Kaiser Industry employees who worked in areas where there was no health care. HMOs come from a different background and with a different perspective of the way to do business.

Mr. Wilcox: There were some of those early HMOs that were coming from the medical provider community as well, like Dr. Gumbiner's operation with FHP that was trying to find a better way to deliver health care, even where there was not necessarily an under-served population. If you ask Karin about managed care organizations, she'll tell you that's really an additional discipline that can be laid over any of these. I am specifically referring to the level to which managed care can be applied to traditional fee-for-service kind of care, or an HMO, or a Blue Cross organization. Each one, in a different way, can impose a managed care discipline over how they pay claims.

Mr. David R. Nelson: I think they're all kind of getting similar because they started out with the Blues and the HMOs having really good deals and maybe being able to avoid some of the more scientific rating principles. You have everyone using experience rating, and everybody has to have a good deal and sales expertise to compete in the marketplace. They're all tending to look more like each other now.

Mr. Wilcox: I think that's right, Dave.

Ms. Swenson-Moore: That brings up a really good point. Historically, how were actuaries involved in the early health care management organizations or managed care organizations?

Mr. Sutton: Originally, Blue Cross plans were captives of the Hospital Associations; Blue Shield was a captive of the local medical society. HMOs were not-for-profit

and sometimes captured by or started by a population and cooperatives; therefore, they didn't worry that much. The early Blue Cross and Blue Shield plans had more risk than the Blues do now. They had to guess at data. They didn't have actuaries and there weren't any actuaries that knew much about health care back in 1927 and 1928. Most people went into the hospital to die, and companies didn't want to insure them anyway. So Kaiser and a lot of the other insurance companies, merely hired doctors on salary so they could budget. They'd say, we need roughly one doctor for every 2,000 people, and they'd hire doctors from different specialties who built their own clinics. Everything was relatively simple. There were no copayments, no deductibles, and no co-insurance. They just had to estimate how much they were going to spend in salaries and figure out how many people they were going to insure on the average and charge them enough of a premium.

In the beginning, community rating was being used and when rates were raised, everybody's rate went up at the same time. So if they started losing money, they'd raise everybody's rate.

The regulations weren't that bad. In fact, a lot of them weren't even regulated. As Dave says, until we got into this more modern environment and we had the same problems when we were talking about marketing and pricing today, they operated on this very simple basis. They had financial people, and budgeting people, but they didn't know anything about actuaries. Even now, I think a majority of the independent HMOs do not have any actuaries. Now, the big ones that are merged with insurance companies are much more conscious of that. Twenty years ago the Blues hardly had any actuaries, back when the Academy gave a special exam for Blues financial people. In the1970s, insurance companies had actuaries, but the Blues didn't.

Mr. Wilcox: Insurance companies had actuaries because they were there when they started the health business. The actuaries had enough influence over the business to make sure that they played a role in health insurance.

Mr. Sutton: They priced it the same way as life insurance, didn't they?

Mr. Wilcox: That's right.

Mr. Nelson: The HMOs just had actuaries to do their filing, to do an ACR for the Medicare program or to do a rate filing for the state. The reasons early on were to satisfy this regulatory requirement; that's why we have some actuaries. We'll hire as few as we need to get our regulatory work done, and we don't need any additional analysis.

Mr. Wilcox: Dave, I did the first actuarial work on HMOs back in 1973 or 1974 and it was in that sort of an environment that I was trying to meet whatever regulatory requirements there were. As Harry pointed out, they were not that onerous.

Ms. Swenson-Moore: Can you talk more specifically about the problems that resulted due to the HMOs failing to see the value of actuaries in their organizations?

Mr. Wilcox: I can talk a little bit from some of my experience as a former regulator, and perhaps a specific case in point might be useful. This happened while I was insurance commissioner as we were at annual statement filing time for our domestic companies. There was one particular domestic HMO that indicated that they would need an extension of time for filing their annual statement because they didn't have the information together. Of course, for regulators that always sends up red flags because if they don't have their information together at the time that it's due, when it is together, it probably won't be very good. It turned out that when they actually filed their annual statement about a month late, it showed negative surplus that was not below what they required. It actually showed a negative surplus. It was only $1 million negative. After my chief examiner worked it over and classified some items as non-admissable, and came up with a better picture of what was going on, it turned out to be somewhat more than that.

This was brought about in today's environment where you have large organizations with subsidiary HMOs. We immediately pointed out that they had a major problem, and it needed to be fixed immediately. We were trying to avoid negative impact in the marketplace because this was an HMO with a parent company with presumably deep pockets. The parent's response was, "We have lots of money, what's your problem?" It took two or three meetings to convince them that it wasn't our problem and it was their problem. They needed to act quickly and we had to put some steps in place. They were clearly underpricing. They were overpaying. There were a number of things that were wrong with the enterprise that should have been detected if there were appropriate experts involved in the process, but they were not detected. In fact, it took a fair amount of time for the right people to get involved. Even though they did have some actuaries at the parent level, their view of actuarial involvement just wasn't deep enough. It was dealing with rate setting—what are the appropriate rates that we should be charging, and how are we reserving? It was just not a careful enough analysis to really point out the problems that they had. Eventually, the HMO was essentially out of business, as a result of that.

Mr. Sutton: In the 1970s when federal projects were financed a bunch of smart Beltway Bandits, if I could use that term, came in with the federal government, and

they would submit an application and the federal government would approve it, if they knew who did it because they could recognize the style of the bandit. Occasionally they hired us, and they believed an actuary can only bless the numbers that they had put on paper, and they came up with the numbers. When we started correcting them and talking to their clients, they refused to use us anymore as a consultant, because we would take the business away from them.

Bob is right. Even today, actuaries are hired by plans, and they give companies some financial data or maybe their budget, and they construct a set of rates. Sometimes it doesn't necessarily fit. I'd rather see the whole budget for the HMO, as well, and know how they're doing.

Mr. Wilcox: But you really have to get beyond the budget. You have to see what's actually going on. In this case, the amounts that they were budgeting seemed to make sense. It just turned out that their computer system was overpaying all of the providers. In fact, after it was finally dug out, that was a major part of the problem. The view was that if we just then put down that receivable for the recoverable that we're going to get from the providers, then that'll put our balance sheet back in good condition again.

Mr. Sutton: One of the things that we'll talk about later is that people have delusions of grandeur, and they keep paying and they think it's less than what they think it is. The systems by which they estimate their financial position are so weak that I think there are a lot of HMOs that are insolvent out there right now. Of course, you can read in the newspaper about ones that may be insolvent. They really don't spend the time to analyze their internal business, so that they know right where they are at a given moment.

Mr. Wilcox: When you talk about being insolvent, it brings to mind that the regulations on risk-based capital will be interesting at the end of 1998.

Mr. Nelson: I think many HMOs were real sloppy in the beginning, in terms of their financial management, but they could get away with it because they had great provider deals. There were a number of cases where they couldn't make it because they were not financially disciplined, but the typical HMO had really good hospital deals, and relatively good physician deals. They could go in and shadow price the competitors and basically get in with a lower price than the traditional insurer. That advantage has slipped. So when you're going against another insurer, they might have deals that are very good compared to what you have. The traditional rating approaches that need to be used to accurately reflect the costs need to be done by the HMOs, just as well as the insurers. Things are starting to look more similar.

Mr. Wilcox: Dave, don't you find that the employers, particularly the significant employers, are getting much more sophisticated, and are bringing actuaries in from their side and repricing the bid from the HMO? If it's not at the appropriate level of margins, they're, in fact, bargaining for a better pricing because they have experts who know?

Mr. Nelson: I've yet to find a consultant who asked us to raise our rates, but I think there have been a few that have pointed out the desirability of lowering rates.

Mr. Wilcox: But I've seen some instances where they've brought in consultants who had the data to back it up. These consultants were able to say, "Your rates should be lower and here's why and how much lower they should be."

Mr. Sutton: I'd like to second one of Dave's comments. When I moved back to Minneapolis in 1974, the Blue Cross Hospital utilization rate was about 850 days per 1,000. Minnesota had a very high rate, and among the Blue's plans was one of the highest utilizing states in the country. Therefore, in California it was running at 400 days per 1,000 Blue Cross plans. Once you start looking around the country, you realize that it doesn't have to be this way. The doctors say they have the best health care because everybody's in the hospital sick and they've gotten cured, I guess.

Mr. Wilcox: Everybody's in the hospital. But now, as Dave points out, our average utilization is somewhere around 270 days per 1,000. The Blue Cross utilization is somewhere in the 300s, and the only part they can't control is mental health or chemical dependency. All the HMOs are down in the 260–270 level. In California, they're down at the 180 level and you were competing on the cost of basic primary care and not so much on the hospital costs. As Dave points out, there were huge profits and an easy going in the beginning because all they had to do was knock the hospital use way down. Now some of this is outpatient; nevertheless, those were the big savings. The question is, how do you manage primary and outpatient care, prescription drugs and those things that are running away with the cost?

When we started and we got data from national samples and we borrowed data from Kaiser, you have to convert everything because they don't count everything the same way. We used to run less than three physician visits per 1,000; it does depend on how you define it. Now they're up to between five-and-a-half and six. As people have become educated to this coverage, they go to see the doctor more and more often. How do we control that cost, even though we have stripped down the inpatient cost? We can't control some of the changes in medical practice, and we just have to bite the bullet and absorb those or raise the prices to cover them.

Mr. Richard C. Tash: Mr. Sutton, your last point is a good point, but there seems to be a bubbling effect. As you squeeze down the inpatient, you're pushing people to outpatient and possibly some of that is happening with physicians as well. As they're squeezing down some of the costlier services, you're funneling them into less costly services.

Mr. Sutton: On the surgical side, that's certainly true. Half the surgery is done on an outpatient basis now. Some of the stuff that might have been done in the hospital is now chemotherapy and heavy therapy treatments. So some of it is there, but the routine visits seem to be a lot higher than they used to be.

Mr. Wilcox: I'm sure that's true, and it takes some pretty careful analysis to see the effect of that bubble. Are you pushing people to lower cost care and hence, reduce the overall cost? That's what you would like to see happen. If you push them into an area where that cost is not managed or not manageable, then you're going to get adverse results.

Ms. Swenson-Moore: The managed care world has gotten much more complex. We might call that a maturation process, or we might call it something else. How has the actuary's role changed as that has occurred, and what does a managed care organization need from an actuary that maybe it thought it didn't before?

Mr. Nelson: At our company, we have an actuarial role that is pretty traditional. It looks like a lot of other big insurers. We do a lot of financial projections. It has been my experience that when you go to an HMO, a lot of the financial projections are done by the accounting area. The accountants will be very involved with the reserves. We have a monthly process where we project the profitability of the company for the next two years and we do that on a monthly basis. We also do a renewal adequacy process, where we look at how the renewals that we're delivering compare to what we think is needed. So those two responsibilities of financial projection and renewal adequacy have probably been absent from a lot of the HMOs that we've talked about. It's just a measure of financial discipline that I think you need to have at a well-run HMO, and if you don't have it, you're probably in for big trouble. We've gone from this situation where shadow pricing was profitable, because of the cost advantages, to where it's going to threaten the viability of your organization. You've got to replace shadow pricing with some financial discipline; with a prediction of your future costs, and a process to make sure that you get the rates that you need. I It's not just an actuarial exercise; there is company-wide recognition of a skill set that you need to add. Everybody has to look at this a little bit differently. We're not going to go out and match our competitor's rate and be a viable organization. We've got to know where our cost

level is and get our rates up. It's instilling some financial discipline in the organization.

Mr. Wilcox: I think that financial discipline is important. When you talk about the accountants being heavily involved in the reserving process, one of the things that I've seen when it has been primarily driven from the accounting side, is it becomes too much of a rote process that doesn't look at the changing dynamics. It would simply extrapolate from recently paid claims, without recognizing that your payment lag has changed since the last time you looked at it. So the discipline that an actuary brings by looking at all of the risks that are involved in the process, both in reserving and pricing, is critical. If the reserving gets off, the pricing gets off.

Mr. Nelson: Reserving can be more accurate in an HMO than in a traditional insurer because if you have encounter information available to you, you can make better estimates on your most recent experience periods. A traditional insurer may still be two or three months out on the most current trends, where an organization that's getting encounter information might be having better estimates at the most current periods.

The other thing that is tricky about reserving is when you're in an HMO, there's all kinds of additional reserving that needs to be done because you frequently have agreements with providers where they're at risk for certain portions and certain funds, and there's a risk-sharing portion. You might say that you're 100% capitated, but you're paying the claims. If the actual claim payments exceeds what you've agreed to as a reimbursement rate for that provider, you could be in a deficit. You have to keep reserves on these different funds to know if you're in a deficit situation with your providers and if you have to go to your providers to get letters of credit or collect deficits. There's an additional level of detail with providers that you need with your reserves. It's relatively complicated.

Mr. Sutton: There is another area that relates somewhat to that issue. The actuary may not know, but he should know, if they're changing which hospitals they're going to use or changing to different medical groups. You can't forget the problem of predicting what your future negotiation with him will be if they don't renew until the middle of the year. I've seen a lot of plans nearly go under. They changed hospitals and they don't change the way they analyze their claim reserves. Let's say you take a factor times paid claims and you've already changed hospitals. The new one is 20% more expensive than the old one. If you haven't thrown it into your reserves yet, you're in deep trouble. There are two plans that have done that. One of them paid the hospital bills through a Blue Cross pass-through ASO contract. Blue Cross wouldn't give those discounts anymore, so they terminated. They thought they'd go out and renegotiate the same contracts. It took three to six

months to do it. In the meantime, they hadn't changed anything in their budget or claim liabilities, and the costs went way up. Instead of producing a big profit, they produced a big deficit, which happened to be three months before they were going public.

Mr. Wilcox: Good timing.

Mr. Sutton: The gentleman who did that was let go from the organization, which was almost beyond his control. He knew what was happening, but apparently he didn't get that to corporate headquarters.

Part of the problem in consulting with HMOs is that you have to spend a lot of time with them to know whether they are changing hospitals or doctors or there is a new kind of contract being renegotiated. Many consultants don't stay on top of that. I review a lot of consultant reports, because we do joint ventures with HMOs. We write the out-of-network part of point-of-service. It's very hard to guess how much leakage there's going to be. We get statements from actuaries saying this is a mildly controlled HMO, so they are going to have 375 days per 1,000. I asked why they picked that number? The management said they didn't think they were going to be very good in the beginning, and it was a medium-sized number. We asked what contracts they had with the hospitals? They said they hadn't signed them yet. So what do we use in the budget?

Mr. Sanford B. Herman: It would seem to me that one of the key roles of the actuary today should be heavy involvement in the negotiating process. This can be done either directly or by specifically telling the negotiators that, given the price that the marketing people want in order to sell, you've got to be able to deliver these kinds of days per 1,000, visits per 1,000, prescription drug savings. I don't think the actuary is that deeply involved in it.

Mr. Nelson: I think you hit on the key relationship issue. You need the salespeople to tell you what it's going to take to sell in the market. You need the actuary to turn that into targets for the contractors. You need the contractors to tell you what is possible and what we can get done. There's probably give and take in all three areas. Salespeople want the widest network and the lowest cost. The network people can tell you what you can do so making sure that dialogue takes place and the actuaries have a role in that dialogue is the key part of the product development job.

Mr. Sutton: I think Dave's point is very good. I have a problem with how these things get approached. I think the actuary needs to learn enough about delivery of medical care and needs to get enough data from the providers that are going to be

part of this plan (assuming they're all going to be synthesized) to tell them that they're not practicing good medical care. Now that isn't quality. What I'm saying is, it's expensive medical care, and it's not marketable medical care. The doctors have to be educated that they can't go out and order twice as many labs and x-rays and come in and be paid 80% of their equivalent fee. You can analyze what they do. The doctors aren't making enough money. They say, "Order twice as many x-rays and twice as many labs." That's practice management.

Mr. Wilcox: Whether you do them or not.

Mr. Sutton: It is done whether you need them or not because that's how you get more money.

Mr. Jon Harris-Shapiro: Associates in the field and I have worked with many HMOs and provider organizations that are bearing risk. To many of them, the term 'actuary' is a dirty word. Whether they have the tool kit, not whether they bear the title of 'actuary' is probably the more important discussion in terms of their viability. Do they understand the big pictures that the actuaries bring to the table, or are they going through things by rote? The most amusing story that I could bring is the underwriting department in the HMO that neglected to put any retention on the premiums charged to the medical people. Amusement aside, when you try to get past the resistance, folks that we're talking to need the actuarial tool kit. Colleagues of mine are focused on product development and marketing and trying to do the right thing by their clients and they get this resistance. When you try to get past it and find out what's going on, there's a perception that the actuaries don't understand the delivery of health care. These colleagues say, "They may know numbers, but I know how to deliver care. I don't need them."

Mr. Sutton: I experienced that with one of my clients that happened to be in Colorado. It's an HMO that went bankrupt. The head of this HMO was one of the first people into Medicaid. He went around the country giving talks about how he knew how health care was delivered and I didn't. I sent a filing in, and they changed the filing that I submitted. They said, "Our actuary is pretty good, but he doesn't understand health care in Colorado." Actually, one of the people on the staff showed it to the Commissioner and said, "We'll just let it go." They were selling rates at 20% lower than what I recommended as the rate filing. They thought they didn't need any claim reserves and they thought that what I was doing was not representative of the care they were delivering, even though it was their numbers. The data came from them.

The crowning blow came when a friend of mine went there to apply for a job running the HMO to try to rescue it. He met with the chairman of the board who

was an architect and she said, "We can't be insolvent because we have a CD in the bank for $50,000." This was a 100,000 member HMO.

Mr. Wilcox: One CD?

Mr. Sutton: One CD for $50,000.

Mr. Harris-Shapiro: The biggest understanding gap appears to be risk exposure; one member is not equal to another member; the fact that a member is different than a patient; adverse selection. One health plan, run by a group of doctors, actually went on the air trying to get into the commercial market. Its advertisement said, "We will cover you; we have no pre-existing conditions excluded." The fact that pre-existing conditions had been set aside in the state through small group reform was irrelevant. They were the only ones that were advertising their ignorance of the facts.

Mr. Nelson: The answer is twofold. Part of it is that people are just going to have to lose money and go out of business. If you're going to ignore financial realities, and you're not going to be disciplined, some people are going to go out of business. If you're going to work in an HMO, or if you're going to be a consultant, there's a responsibility to explain what kind of benefit we can bring to the organization. If people limit themselves to just doing the reserves or just preparing the rate filings and kind of passively do what's asked of them, then we should blame the profession some. I think we need to be out there creating the understanding about what kind of financial reality is going to be present if things don't happen. Much of that is dependent on the people who are doing this work now.

Mr. Wilcox: One of the things that you pointed out was that Colorado approved those lower rates because they were lower. One of the problems from the regulatory side that has existed is that there has been enough abuse in the health field overall that regulators oftentimes overemphasize controlling the rates, as opposed to making sure that the rates are appropriate and adequate. That creates some real problems from the regulatory side. So there's more than one dimension to this lack of communication. When we were doing the initial work on risk-based capital for health organizations, we had a fair amount of participation from the American Hospital Association and people of that type. Initially, there was this kind of attitude that Jon was talking about. These people thought, "We know health care. Why do we need actuaries to tell us how much money we need in the bank to stay in business? We shouldn't be subject to that because we are health care providers, not insurers." Over time they came to understand what we were talking about in terms of providing for that risk and being able to stay in business under all sorts of adverse circumstances. It takes some time. You have very bright people

running the health insurance industry, as well as bright people in the insurance industry or in the actuarial profession, but they don't use the same terms to mean the same things. There are some real language barriers that you have to overcome. Keep at it and keep working with it. Eventually, you do overcome those language barriers. What makes sense logically and reasonably ultimately prevails before they go out of business.

Ms. Stephanie G. Hurlbut: We've been talking some about providers bearing risk, and different ways that we can manage costs. There has been a lot of movement in the industry towards these global caps, and these full risk-provider arrangements. What is your opinion about five or ten years into the future? Will provider groups gain the savvy that they need to maintain the financial integrity of these deals, or do you think these will ultimately fail as a way to control costs?

Mr. Nelson: I think physicians are the true owners of the health care process, and to the extent that we really lower costs, physicians have an incentive in keeping the cost low, which makes a lot of sense. From that perspective, I think there are many reasons why physicians have some skin in the game and being responsible for at least a share of the health care dollar makes a lot of sense and that ought to be a low-cost alternative. From an HMO standpoint, when they're taking full risk, they're almost the insurance company and you need to make sure that they're in good shape. That's why you might want to consider always paying the claims yourself and keeping track of these funds. That way, you know if they're in a deficit or not. The providers probably need to have actuaries on their staff so that they can keep track of where they are with all the issues that we just went through. Well, it's obvious that there's going to be a lot that are going to go under. They're going under as we speak.

Mr. Sutton: I come from an area where there are almost no solo practitioners. Every city has a 25-man medical group, no matter how small the city. We have Mayo Clinic and we have Park Nicollet Clinic with 350 physicians. Those are big doctor groups, just like those in California that have 300–400 physicians. These physician groups might own their own hospital or they're hooked up with a hospital. Most of them, unless they're a medical school type and have a different kind of a problem, manage the utilization and are able to control it. They just used to take 80% of the premium and manage the whole thing.

Now the state has told them that they are taking too much risk for the hospital, so the hospital can take a capitation, the doctors take capitation, and then they have a risk-sharing arrangement, which gives the savings back to the doctors, for the most part. I think working with a large medical group, assuming it is willing to change the way it practices medicine to be efficient, is the easiest way to go. Many good

plans were started that way. First, it's easy to get data out of a group. I have seen groups that practice profligate medical care. In other words, they overdo everything and they have twice as many coronary bypasses because they have a big heart department, and so on. You can't tell if patients are attracted to join because they have a heart problem, or if the doctors take borderline cases and do coronary bypasses. You can, however, bring that to the doctor's attention. Sometimes they will not pay any attention to you. When we started we tried to divide the risk evenly. What has happened is a lot of the carriers and HMOs, eventually tried to force the doctors into the price when the doctors didn't understand what would happen. The doctors are rebelling against it because they find out they're only getting 70 cents on the dollar, and they didn't understand what would happen. They may not understand how to operate under that set of rules, either.

Mr. Wilcox: Let me put the regulatory oar in the water on some of this. When I was insurance commissioner, my first responsibility was to protect the policyholders, or the members in the case of an HMO. As an insurance commissioner, I take the view that there is a population of people that I'm responsible to look after. If the HMO is responsible for making sure that those obligations are met, we can examine its resources and its obligations and make sure that they are adequately providing for the various contingencies that can arise. If the HMO says, "We don't have that liability; we passed it off to the hospital or we passed it off to the medical practice group," as a regulator, I might be inclined to say it's fine. I would ask the HMO to show me its books and records and let me see how financially secure it is. Believe me, the hospitals don't want to supply those kinds of records to the regulatory authorities who could then see that there are resources there.

There are various answers given. In the case of the HMOs, you look at hold-harmless agreements that are supposed to protect the policyholders if something goes bad. Those agreements might protect those individual members of that HMO, but where's the burden carried? By everybody else. There are some inappropriate kinds of transfer of risk that go on in those kinds of situations.

We talked earlier about the fact that even though there are different organizations coming together from different directions, they become more like each other than less like each other. An unfair marketplace exists when there is guarantee of statutory mechanisms for guaranty associations and some organizations have no protection at all. So there are a lot of regulatory issues around this transfer of risk that need to be addressed. Actuaries need to take a proactive role in resolving those kinds of questions. Every risk-bearing entity, whatever it is, whatever it looks like, needs to recognize the risk that's there. If you take those outside the regulatory

environment, you're tying the hands of the regulator to create the fairness and the protections that need to exist in order for the system to function effectively.

Mr. Sutton: I consider the biggest immediate danger to the solvency of this industry to be the existence of the medical management company or the physician practice management company. There are three of them that are either insolvent or on the verge of insolvency. FPA Medical Management has caused the write-off of expenses in three large HMOs of about $150 million in a quarter. FPA and CIGNA sold their hospitals and clinics in California, and then recontracted with them at less money than they thought they could run it for. Maybe it's the greater fool theory. They're selling their system and then leasing it back for less money. Why do they think the people they're selling it to can run it for less?

Mr. Nelson: One of the reasons is, if you have staff facilities, all the patients have to be members of your plan, and if you spin that facility off, then it can take fee-for-service patients. There are other methods by which they can get additional cash flow.

Mr. Wilcox: It does that.

Mr. Sutton: They are doing that, in a way, but I think they operate on a cash basis. They don't set up any reserves for claims and they can't necessarily match fee-for-service claims against the capitation contracts that they have. That's what I am concerned about. I've looked at some of their statements and they don't show any claim liabilities anywhere.

Mr. Wilcox: If they improved the hospital occupancy rates significantly with non-HMO members, then I can accept what you're saying, Dave. But if that doesn't happen, then I think Harry's right on track.

Mr. Nelson: I think the ownership flip is hard to run. It is difficult to run the staff model facilities because then you're very price competitive. You have to compete with price. People want a wide network, so if you have a staff model facility, you have a tight network. You have to compete on price. You have to be very low and it's hard to make the economics of that work. Because there aren't too many staff models that are really operating effectively and spinning them off, I think, this does make some sense.

Mr. Sutton: I believe Harvard Community Health Plan had the physicians organize into a group practice and accept capitation in order to reduce the costs of their staff model clinics. At the same time, as a method of increasing income and reducing plan costs, they encouraged physicians to accept patients from outside the plan.

Health Insurance Plan of New York originally had its own medical groups, but allowed them to see fee-for-service patients as well. The City of New York unions forced them to stop seeing the fee-for-service patients. In order to finance them better, it's opening it up again, but in the meantime it has no patients. It has been closed for so many years. It only has emergency room walk-ins. It will be a very hard thing for them to create a lot of money and interest there.

Mr. Robert J. Myers: I'm a longtime student of Social Security. I'd like to ask the panel to elaborate on the responsibility of the actuary to the members of the HMO. Rather than looking at whether the HMO is merely financially sound, should we evaluate matters such as, are the premium rates paid by different groups of members consistent and equitable, and are the medical services provided adequate?

Mr. Nelson: Premium rates are really a matter of regulation, to the extent we have regulations that dictate what's fair. Fair is a hard-to-explain concept. If we have rates that are fair and the actuary certifies them as rates and makes sure that the rating system of the company conforms to the regulations of the markets where you're doing business, I think that's how that's done. I think the actuary probably has a strong role in knowing what rates are being charged and there are probably a lot of cases where people don't know what rates are being charged in every case. We found that to be true when we've done acquisitions; people haven't had a real good handle on just how much variation there is. If you can keep a discipline process in place in your company and can certify that your rates conform with regulation, I think you've satisfied that requirement.

Mr. Wilcox: The regulations don't always create the environment that Bob is talking about. Sometimes they do. There are some requirements of fairness and equity in the rating structure. Oftentimes there is the ability to charge a rate that would be inadequate in one instance and make it up with redundant rates in another category (or at least have widely varying rates of profitability based on your ability to market to those particular communities).

Mr. Nelson: Isn't that a measure of the account's leverage with the insurer? Some accounts have more leverage.

Mr. Wilcox: I think it depends a lot where you're coming from. The fair market for traditional insurance coverage really depends on the marketplace to ultimately set rates. You have regulatory control over those rates that varies from jurisdiction to jurisdiction, but ultimately it's the price that can be charged to sell the product in the marketplace that will determine the rate. I think the question that Bob's heading toward is: Should there be a requirement for the actuary to impose some fairness on what goes on in rates and services? I think that's an appropriate thing to debate.

Mr. Nelson: That seems like a quagmire to me because a case that gets a really good rate with a very low or negative profit margin might be a very big case that has allowed the HMO to get a provider deal in that market that benefits everybody in the market.

Mr. Sutton: One of the risks we look at is whether your coverage base is based on federal employees or some other state employer or something like that. They cover such a large part of your overhead that if they left, your average retention would go up from 10% to 15% and you wouldn't be competitive on anything.

Bob's point is that the Blues were community rated for many years, up until the 1960s. I think the thing that killed the Blues was they had all the Rust Belt industries and the big unions and usually state employees. They covered retirees under the same premium as the actives. So they had community rates and that made their rates noncompetitive for a new company with no retirees. Eventually Medicare rescued that. The HMOs had community rates and somewhat the same problem, but they were newer, so they didn't have as many retirees. They had community rates, which meant the same rate was used for everybody, even the co-ops. But they have had to change to variations in community rates by age and sex, and then experience rate modifications, all of which, theoretically, are subject to regulatory requirements, which might be different from the federal side and the state side. The federal employees demand to be community rated, and they have their own definition of what that means. They sue everybody if they think your rate came in too high. So the HMOs have had a real difficult time changing their philosophy of having no copayments and having 100% coverage and everybody paying the same premium rates.

Mr. Wilcox: I think one of the areas where there has been disparity in rating has been between large groups and small groups. In some places it has produced purchasing cooperatives that allow individuals and small employers to try to band together and have the same sort of clout to get similar rates to those that a larger employer would be able to bargain for.

Mr. Nelson: My experience has shown that the state laws that create bands (the customers with the lowest morbidity get a favorable rate and the customers with high morbidity get a higher rate), end up being the real protections for the small employers. Associations fall victim to the same market dynamics that exist elsewhere, while the cases with the best future experience are going to go out and get the cheapest rates.

Mr. Wilcox: That provides some of the protection within the small group market, but it doesn't provide the protection between the small group market and the large group market.

Mr. Nelson: I'm not sure how much.

Mr. Wilcox: That's where this purchasing cooperative idea comes into play.

Mr. Sutton: The HMOs and even the Blues originally never used brokers or agents; they have their own salaried marketing staff. They finished the large group. When they got into the small group market they had to change and they had to pay commissions to somebody or they couldn't sell. So that forced a difference in their rates. Many of the Blues originally had the same administrative loading on all their business.

Mr. Nelson: You can't run an association in a small group marketplace if you don't pay the same commission that you pay to the regular business. I'm not sure how much protection the association really is going to give a small employer versus a large employer because the costs for the small employer market are going to have to be recognized and indicated.

Mr. Sutton: If you mandated coverage, like the Clinton Bill proposed, maybe you can get around it. I don't know.

From the Floor: I'm with the State Teachers Retirement System of Ohio. We have about 110,000 retirees and dependents, and I have one large block that's currently in fully insured HMOs. We're looking at self-insuring our HMO members. Can you tell me what you think some of the pros and cons are for the purchaser to go self-insured on the HMO? Can you speak to risk sharing with budgets?

Mr. Wilcox: For quite a number of years, the Utah Public Employees have been self-insuring. If I think back far enough, I can probably remember when it started. It was in the 1970s and it has worked quite successfully there. If you have questions about how to structure it, call Lynn Baker at the Association in Utah and he can give you some input on that.

Mr. Sutton: I think you're talking primarily about retirees and Medicare—either Medicare supplement or Medicare replacement through an HMO.

Mr. Wilcox: Utah does both.

Mr. Sutton: Because of the Balanced Budget Act, the question is whether the HMOs are going to stay the course on the HMO risk contracts or whether any of the new organizations will ever get started. The government has had a program called Medicare Insured Groups, where any large employer can take on the risk of a Medicare Risk Contract. If you don't have any experience trying to control hospital utilization for Medicare members, you'd be in deep trouble. You must separate the selection aspect of the HMO out. In California they're running 1,000 days per 1,000; Medicare runs 2,900 days per 1,000. In Minnesota, our HMOs are running 1,200 or 1,300 days per 1,000. They've reduced the hospital utilization by 50% or more. Medicare fee-for-service is the last bastion of fee-for-service where the doctor and the patient can do almost anything they want. You might have a difficult time competing with an HMO because you don't have a health system and you're not managing the health care; you're only going to pay claims.

From the Floor: We're already talking with one of the largest carriers that would basically become a TPA. They already have all the contracts, so we would be enjoying all their discounts. I'm concerned about the risk aspects from the risk-sharing arrangement, and some kind of a budget is one big issue for us.

Mr. Wilcox: I want to mention the situation in Utah again. They've put together a number of innovative kinds of things to manage that risk and to control the risk as well as a lot of managed care elements of how they do that to keep the risk from running away from them. It enjoys a very strong reputation because of the success that it has had.

Mr. Sutton: There must be a tremendous risk, like a half a billion dollars for the people that you talked about. I think you can protect yourself around the edges with some reinsurance or something. It would depend on the health care system that's in there. That's a very big risk for a governmental agency to take. In theory, they can always raise taxes to pay for it. We're allowing counties or groups of counties to get together and take the Medicaid risk themselves in Minnesota. However, they don't have any concept that they're taking any risk. They call us about writing reinsurance for catastrophic claims or something and they want us to tell them what we should be doing? I said what rates do they get with hospitals? Do they get the Medicaid rates? They didn't know anything about that. They're supposed to have this thing set up by January 1. No one in the counties understands the kind of risk that they're taking.

Mr. Wilcox: Years ago, I worked with some folks in Idaho who had a county-based system. They were concerned because when you got down to a county with 700 residents, it sort of seemed to fall apart.

Mr. Sutton: Theoretically, you have the right of taxation. The state reserves the right to investigate whether the counties are solvent or not before they contract with them. It's in the brochure, so you know that somebody has a concern that they won't be able to raise taxes enough to pay the money back to the state.

Mr. Wilcox: Obviously it isn't just a size issue. Orange County might have a hard time with that.

Mr. Sutton: That's right.

Ms. Swenson-Moore: Let's talk a little bit about risk-based capital and some of the other regulatory issues that actuaries are often thinking about and companies feel that they should be thinking about. What will be the effect of some of those new rules and what should actuaries be doing to prepare themselves and their organizations?

Mr. Wilcox: There's another session at this meeting on risk-based capital (72PD) for managed care organizations. I would suggest that anyone who has some concerns about this ought to take a look at what's going on. We have found in our contacts recently that there are a lot of HMOs that have not modeled the new risk-based capital formula and determined how much effect that will have as they file their financial reports at the end of 1998. You are going to have to file those financial reports for this coming year. It is part of the financial statements that are required. Even if a state hasn't yet adopted it as a requirement, which would give them a basis to put you into receivership, it would make public the shortfall of the financial organization relative to the required capital structure. It certainly will challenge some organizations that have not kept the records and the information that will be required to accurately prepare that report.

There are always fall-back positions on each of those items. If you lack the detailed records necessary to calculate it, you can always move to the higher number. That may not solve the problem that you're looking at, if in fact you're operating with inadequate surplus. The most immediate problem that I see, from a regulatory aspect, is risk-based capital. So many organizations are unaware of the requirement and have not been through the calculations or have not estimated what's required. Even some of the rather large organizations have not done the job adequately. I'm referring to those where there is a holding company and a number of subsidiary HMOs that are going to find that they may have sufficient capital and surplus, but it has to be redistributed. You have to get it into each of the legal entities that is required to show that they have adequate capital and surplus in the various jurisdictions. It will be very important for the companies to do a really thorough job of modeling to show where that risk-based capital is going to go and what's going to

happen in the future. Because even if you calculate it this year and find yourself short, if you don't have a procedure and a process in place that's going to get you on track to correct that problem, you might not be able to convince the regulators that this is a solvable problem and you are solving it. You better have a way to solve it, because you can't just go to the regulators and say "This was a surprise to me too." That's not a very good answer, if in fact, you're only holding half the capital and surplus that the new requirements say that you ought to have.

I might indicate that the original work that we did in determining a risk-based capital formula for health organizations was probably the most statistically detailed analysis that was done of any of the risk-based capital formulas that are in place for insurance companies. It has been modified somewhat as it was finally adopted by the NAIC and put in place in 1998. It's a pretty solid formula that looks at what you really ought to have. It examines how long it takes you from the time that you identify the fact that your premium rates are inadequate, until you can adjust those premium rates, get them into effect and get back into a solid position. That was predominantly what was used in determining what risk-based capital is required.

You are going to have to have some experience on a rating system structure before you know that your rating estimates were correct and that your reserving is working and that your contracts with the providers are doing what they are supposed to do. You have to look at the time lapse between when you identify the problem and when you're able to fix that with cash in the door. That was the primary factor in determining the inadequate C-2 risk on the formula that's in place.

Mr. Harris-Shapiro: I think that this points to probably a larger challenge for the actuarial profession: Dealing with provider-oriented managed care organizations., Thanks to the fee-for-service economy we have in place, many of the organizations don't even understand the need for surplus requirements. They are so used to taking all the capital out of their practices at the end of the year that they want to do the same thing to the insurance company that they may own or whatever entity is bearing risk. As a result, they're not going to understand risk-based capital, which means they're not going to like it. This would be a major challenge for us. They can barely keep their hands off the statutory surplus, let alone anything that you would need for prudent business practices for down underwriting cycles and that sort of thing.

Mr. Wilcox: We had the American Hospital Association representatives talking about why they need capital. It's not an easy sale because it takes a lot of time to get them to understand the language and the nomenclature so that they can grasp why there is a need for the capital requirements.

Mr. Harris-Shapiro: I live in Philadelphia, one of the communities where Allegheny Health Education and Research Foundation made its mark. Those that are based in Pittsburgh at Coventry also have recognized the need for capital. Those are probably the worst deals that any of us could imagine as actuaries. It raises an interesting question. I'm not sure how much of these are my own words and how much of these are words I've heard other people say. I'll just pretend I'm a provider right now: when it's my own services and I'm taking a per member, per month fee instead of a fee-for-service payment is that insurance or is that risk?

Mr. Sutton: Based on our formulas, the answer is no. In other words, an individual can take a risk on his own time because he's not at risk for somebody else's expenses. So, we can give good credit to a large medical group that takes a capitation as long as they don't refer out much. The limit for referrals outside the group is 5%.

Mr. Wilcox: There's another element to that, and it's a short step from promising your own services to promising that services will be provided. Is there a provision in that agreement that pertains to not being able to practice tomorrow? You can't deliver the services personally, but have you made the promise in such a form that, at least until the end of the current contract period or something, there is an obligation to provide services, even if you can't personally perform them? As soon as you cross that line, you are a risk-bearing entity and you become an insurer. You are probably not an insurer that wants to act like one, but you become an insurer.

Mr. Sutton: I have a problem with medical groups. As you say, they operate on a cash basis and at the end of the year they distribute their bonus to physicians because they are a for-profit, professional corporation and don't want to pay any income taxes. There isn't any way of getting around that without them becoming an insurance company or something. They really need to convert to an accrual basis of accounting, but then they don't have anything to sell because if they sell their medical practice, they sell it for their receivables. They don't count how many liabilities they have; they just count how many receivables they have.

Mr. Herman: I have a two-part question. First, we talked about the role of actuaries in HMOs, but the other side is the regulatory end. Question number one probably begs the best-known answer. From your involvement with the NAIC, do you think there's enough actuarial expertise on the state side to look at all of the HMO situations, whether it's solvency, reserves, or whatever? The second question pertains to risk-based capital. Obviously it sets formulas and may require HMOs to raise rates. That becomes a big political issue in terms of affordability. Do you anticipate, irrespective of all these formulas, that there are going to be political pressures to keep those rates down? I recall that the nonprofits, especially those in

the Northeast where there were specific arbitrary surplus limits, (e.g. the Blues had to have 10% of premium as their surplus), were allowed by the state to float surplus a lot lower so that they didn't have to raise rates.

Mr. Sutton: I wouldn't let them raise rates in spending.

Mr. Wilcox: In answer to the first part of your question, about adequate actuarial resources, the answer is absolutely not. The current environment in which the state regulatory system works does not provide adequate resources for the insurance regulators to hire the quantity and the quality of people that they need to have to adequately regulate the industry. There are a few states that are much better equipped than others. On a state-by-state basis, you have a majority of the states that have no actuarial expertise at all. If they do have some, it's spread so thinly that they're unable to respond adequately. There is political pressure that is brought to bear, and I will guarantee you that when it comes to a legislative environment, podiatrists have more clout than the insurance commissioner. It's difficult in that kind of situation to be able to bring the resources to bear that you need to adequately regulate. The insurance commissioner generally has the ability to retain outside consultants to do some of that kind of work, but in so many states that I see, the primary pressure is to hold the rates down. They worry about solvency when there are some bankruptcies occurring. That'll be something to talk about. But until then, just hold the rates down.

Mr. Sutton: I think the result of the risk-based capital formula, is if the plans can complete the forms properly, which is a big if, they probably will have an increase of capital requirements of two or three times what they have now under the old NAIC formula, which is 1% of the first $150 million of premium and 2% of the excess. It's probably going to go between 2% and 3%.

Many of our largest HMOs are not-for-profit. Not that there aren't plenty of large ones that are for profit that probably already converted. A not-for-profit plan can't raise capital very easily; it can't sell stock, and of course, the stock market isn't very good in HMOs right now anyway. The problem is, how do HMOs get the capital to double their surplus, if that were required?

Mr. Wilcox: The most logical source is for the providers who have an interest in their survival to dig down and provide that.

Mr. Sutton: That seems like a logical source.

Mr. Wilcox: Unless you're a provider.

Mr. Sutton: They may all want to go back to fee-for-service.

Mr. Nelson: Yeah, I can't see the providers lining up to bail out the HMOs.

Mr. Harris-Shapiro: I actually can speak from personal experience. I know of a plan that took a misstep, dipped into technical insolvency, and the providers that owned the plan worked for free. They recapitalized the company to the tune of nearly $1.2 million or something like that. However, they agreed to that because it was the lower cost alternative to unwinding the company right then and there. Keep it afloat and unwind it more slowly. Unfortunately, it was too much for them to swallow. You could only go to the trough so many times and then they decide fee-for-service is better, not necessarily recognizing that some 800-pound gorilla is going to come down the highway from the urban area and basically take over the way that they practice medicine. Why do they go into it in the first place? That was done to maintain some semblance of control over their own practices.

Mr. Wilcox: In some cases, that's absolutely right.

Mr. Sutton: One of the worst organizers is organized medicine or hospitals. Many of the proprietary systems, of which Humana is now a remnant, are separated from the hospital system. It's very hard to separate the ethic of the hospital manager filling the beds and making more money from an HMO that is being paid on the other side for not letting patients in the hospital. It's very hard for those people to figure out what they're supposed to be doing. So most of the proprietary systems owned HMOs and dropped out of them, even though they sometimes threaten to go back in and become a supermed or whatever. They still have this notion of making money by filling their hospitals up. That's another big problem.

Mr. Wilcox: One issue that I think actuaries need to take some responsibility for is quality. There have been a number of studies that have made it very clear that quality and cost are inversely correlated. The higher the quality, the lower the cost. Very often HMOs, in their efforts to manage the costs, do things that adversely affect quality. As a result, they get exactly the opposite of the result that they're trying to achieve.

There are some examples, such as the phone call that I got one day from an individual who has been an HMO patient and had gone in for a routine bronchitis examination. He was introduced to Dr. Jones. Dr. Jones wasn't a medical doctor; he was a physician's assistant (PA). This PA gave the patient a prescription for an antibiotic and, without asking any more detailed questions than that, the patient went to the in-house pharmacy and picked up the prescription. He didn't see a pharmacist, but instead saw a clerk. The clerk did have the presence of mind to ask

the patient if he was allergic to penicillin. The individual said, "Yes, I am." The clerk then looked back at the prescription and said, "Oh, well, this is amoxicillin, so that's not penicillin, that'll be okay." The patient took the medication, had the adverse reaction, and it ended up costing the HMO money. This was all done in an effort to save money by using PAs, clerks, and other lower level medical staff. I've seen so many instances of managed care organizations trying to reduce costs by moving RNs out of the picture, and bringing in LPNs and others who are less skilled and less trained in patient care. It is all done in an effort to save costs. If done in the right way, there are some cost savings that can be achieved, but, in many instances, the quality of care goes down. As I said, quality and cost are inversely correlated. You get just the opposite effect of what you're trying to achieve. So this is an area where actuaries need to take a good hard look at what's going on and how the HMO or the managed care organization is dictating the practice of medicine in order to save costs. Is it really going to save costs or will it produce adverse results instead?

Mr. Sutton: I think there's another aspect on the quality but we didn't talk too much about that. Actuaries don't necessarily get involved but they have to. There's a big movement to allow more and more doctors into every plan, whether it's a point-of-service (POS) plan or something else. You can have a very well-run medical group that delivers high-quality care, keeps good data, and experiments with trying to improve health outcomes. If you add another 5,000 doctors because you want to go outside with a POS, the doctors lose control of the patients.

The employers want to satisfy their employees by giving them a wide choice of doctors, but that defeats the purpose. Under the new Medicare rules, the HMO has to certify to all the activities of the out-of-network doctors, in the same way as if they were part of their medical group. The HMOs are saying, "How can we do that? We don't know who he is. We can't control the patient going to him or control what he does. How can I control the health of this patient?" Those are the kind of rules the government is coming up with.

This push for greatly expanding access in limiting the size of the medical group is really going to add to those problems because nobody can control the rest of the doctors that are out there. You haven't credentialed them. They haven't learned how to practice medicine the way your group practices or the way your medical director wants to. It's unfortunate because in the past you had a plan and everybody went to the same clinic. They were much smaller then. Park Nicollet out of Minneapolis has 20 locations and350 doctors. They have almost every specialty and they refer to a good hospital that they own, but that's not enough in today's environment. You have to allow everybody the freedom to go wherever they want.

Mr. Wilcox: They can very effectively lobby legislation to allow that to take place. I've taken those kinds of complaint calls. I received a call from a doctor who thought this was unfair. He said, "This particular HMO admitted my partner to practice with the HMO, but it won't allow me to practice with the HMO." He called the HMO, and the HMO said, "We decided we needed two doctors in that particular specialty." The doctor who called was number three and his partner was number two. The HMO couldn't justify having three doctors in the same specialty. It sounds like a very valid complaint and one that would get the attention of legislators who can make rules that say you can't keep them out.

Mr. Sutton: We probably have 100% more physicians in big cities than we need. If hospitals were operated efficiently, we would probably have more hospitals than we need. The problem is, once we try to squeeze them, the rest of the doctors want to get into the game. As much as they attack HMOs, they also call to complain that they're not being allowed to join them because it's a financial question. We're the only country in the world that has so much excess medical capacity. We could divide it and let them fight against each other on a price basis. Most other countries don't have enough. Many countries in the world don't have any basic access at all, and we are so surfeited with healthcare, we organize half of it to compete with the other half.

Mr. Tash: You are touching on some of the issues that I wanted to ask about, such as disease management. It's sort of the HMO getting more involved in actually managing the care for diabetes and cardiology or specialties of that sort. What should the actuary's role be and what should the actuary consider if he is lowering the cost of care. There's also an expense side that has to be considered, which we don't always think about. The retention has to be considered in that.

Mr. Sutton: There's another problem with both employers and health plans. We spend a lot of money on prevention and outpatient care now in order to save costs ten years from now. But what if the patients move to Florida? We have the expense of reducing the cost, but we don't benefit from it because they move. If the employer could put the cost onto Medicare and then shift the cost to Medicare, there would be an incentive. Sometimes what you do increases the cost in the short term, but it's helped to save cost in the long term. It's very hard to convince people to spend more money when they aren't even sure they're going to be around in the long term or if they're going to be paying for it in the long term. Most of our plans in Minnesota try to exchange information. Somebody might be doing a study of diabetes and the best way to avoid hospitalization, which is by controlling a patient's problem. All the HMOs are studying some of the same things. They can get together and try to determine what's best practice and make it available to all of them. They have to get past the thinking that they have a secret about how to treat

diabetes and don't want to tell anyone how they do it. There must be improved basic medical practice and expansion of the information pertaining to that medical practice.

Mr. Wilcox: They don't know how many people they insure.

Mr. Sutton: The employer just says whether he's employed or a dependent. They don't keep any data or at least they didn't in the past. They might do more now as HMOs, but they didn't have the capacity for doing this. The HMOs have a locked-in population. It turns over or changes 15-20% a year, so it's not perfect. At least they have a captive population to measure public health outcomes. The governments are interested in the public health outcomes—not only the cost of medical care, but the outcomes of public health.

Mr. Wilcox: There's one other aspect of actuarial involvement that can come out of this discussion. Whenever you get into an area of managing the care (meaning determining the actual way in which care is going to be rendered), there's risk involved with that. You have to make sure that the individual that is interacting with the patient and the provider is competent to do so. You shouldn't have a claims clerk telling a physician that you're no longer going to pay for a very sick patient to be in the hospital or to prescribe a particular course of treatment that may be contrary to the doctor's own experience. There is a risk that legal action will be brought back against the HMO as a result. As the actuary, you need to be responsible for identifying and controlling or mitigating those risks because it does have an ultimate effect on the solvency of the organization. This is an area that many actuaries overlook. I believe you do have a responsibility to identify and manage those risks.

The solution with regard to quality of care can lead you to other sources of risk, if you don't do it right, one of those being privacy. There are a lot of rules coming into play right now with regard to privacy, and if you don't carefully manage that risk, you'll have another potentially huge liability for the entity.

Mr. Nelson: So you're suggesting that the actuary needs to review the credentialing process of the HMO and to make sure that it's not letting in providers who are incompetent?

Mr. Wilcox: If you are not reviewing the credentialing, make sure that it's being reviewed because that's an element of risk that the HMO needs to look at.