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Session 110IF
Industry Consolidation—Impact on Health Products

Track: Health

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Summary: This session updates the changes in the health insurance industry due to recent mergers, acquisitions, and demutualizations. What has the impact of this consolidation been on health products? What have been the effects on supplemental products, including life and disability insurance? What is the outlook for continued future consolidations in the health insurance industry?

Mr. Craig M. Baldwin: The topic of discussion is how industry consolidation has impacted health products, their pricing, and their availability. Presenting will be Mark Litow, Harry Sutton, and Rick Hodgdon. Presenting first will be Mark Litow. Mark is a principal with the Milwaukee office of Milliman & Robertson, and has been with them since 1975. His area of expertise is individual health-care programs and evaluation of health-care reform proposals.

Harry Sutton is currently senior actuary for health care in the mass-marketing division of Allianz Life of North America, a major reinsurer of catastrophic health-care services for the HMO industry. Presenting third will be Rick Hodgdon. Rick is president of Transamerica Re's Group Life and Health division, and is responsible for all strategic development and implementation for Group Life and Health products.

Mr. Mark E. Litow: As you all are undoubtedly aware, there has been a tremendous amount of consolidation on the managed care side of the business. I want to specifically talk about how that has impacted product design and pricing.

To understand its impact you first have to look at why consolidation has been occurring in the industry and then look at how it has created an affordability dilemma. Simply put, it means that health care has diverged greatly from what wage growth has been on average in this country for many, many years. The

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Note: The tables referred to in the text can be found at the end of the manuscript.

result has been a mushrooming in the uninsured population in this country. I'll talk about that in a minute.

This cost shift has been occurring from the government to all private plans because of changes to the payment schedules promulgated by Medicare and Medicaid. Interestingly enough, back in 1992, in the presidential debate between Bill Clinton and George Bush, Clinton claimed that the problem with Medicare costs was that the private commercial industry was shifting costs to Medicare. To make it worse, George Bush agreed with him.

Given a frame of reference for the definition of what constitutes a tragedy, let me address the affordability dilemma. I did a study a while back that looked at what had occurred in medical cost inflation versus the wage growth experienced in the U.S. These numbers in Table 1 can be obtained from the statistical abstract of the U.S. Based on non-farm payroll it showed that wage growth for a 21-year period had been 4.7% per annum. The CPI went up 5.1%, while medical costs increased by 9%.

This increase in medical costs included Medicare, Medicaid, and the entire commercial market all combined into one. Using simple compound interest, if your budget or your expenditures go up by 9% a year and your income goes up 4.7% a year, what do you think is going to happen? Well, a lot of people are going to be in financial trouble with bankruptcies, etc. Of course, with our government and its normal reaction to such a problem, we can just create a larger budget deficit.

Medicare, for your information, is currently producing about $75 billion in deficits a year. That simply represents the payroll taxes paid in plus the premiums paid by the participants, minus what is paid out. Of course, if you continue that for a long period of time, you're going to have a great deal of difficulty.

Why do we have so many uninsured in this country? There may be other reasons, but the primary one is people simply cannot afford health care. The average citizen can only likely afford about 40% of what they could some 20 years ago. And that, of course, is continuing.

Now let us address the cost-shift dilemma in Table 2. The key element to understanding the cost shift is how the 9% annual increase is divided between the segments of the market. If you look at which segment is predominantly influencing the shift, you will see that Medicare and Medicaid, on average, keep cutting the cost that they pay to providers on average every year. Some years, it's very little; other years, it's several percent. Whether you agree or not, those are in effect price controls, and they don't directly refer to them as that in Washington because everybody readily admits that price controls don't work in a free market. But the point is, Medicare and Medicaid now pay providers on average close to 50% of what's paid in the private market as a market rate.

HMOs get bigger discounts and fee-for-service plans get less, but if this is all blended together, it is going to impact utilization and ultimately, the price paid as the market attempts to adjust to the controls.

When you put in a price control, the price initially goes down. It saves the program money for a while, but you can watch the utilization go up. Why? Any prudent businessperson will tell you that if you try to artificially reduce his or her gross revenue in an efficient market, there is going to be tremendous pressure to reduce his or her product's net cost to restore his or her expected profit margin. As a result, in a system such as Medicare and Medicaid providers turn on their computers and find out which areas in Medicaid or Medicare they can optimize their returns and which ones they can't. Or they attempt to find ways to reduce the number of services provided where they don't make money or they eliminate them completely.

In effect you are not doing things for efficiency, but doing things to survive. You can't blame a business for that. Unless the market solves this particular problem, since the government pays half of all medical costs in the country, the system cannot survive long-term. There can be little doubt that the total issue has to be addressed through a cooperative effort on the part of the private sector and government. How that gets done in reality is anybody's guess.

Why do we have a managed care backlash? Well, a lot of people have different views on that. I think, first of all, if you look at our whole health-care system, our public policy is greatly flawed. It's pretty simple.

For example, look at the post office. What does the post office do? The post office competes with UPS, Federal Express, etc. It advertises in competition with them on the radio. Then the government fines it millions of dollars for not following the promulgated regulations. Doesn't anybody find something wrong with that? And is our health-care system really any different?

The government is an insurer. They're a price-setter. They regulate us. They provide subsidies. How can you do all those things and have a system that works? It's really against the whole foundation of our system. The government is supposed to have a well-defined role in our free-market economy. They follow the model in most things, with the obvious exception of health care, farming, and a few other areas, and we find ourselves in big trouble.

What's happened? Why do we have a managed care backlash? Well, employers pulled the managed care companies from their plans because they couldn't afford them any longer. They didn't want rate increases any more; they were sick and tired of it. Who could blame them? It was becoming a bigger and bigger proportion of their overhead expenses. They had to go from pulling the managed care game to a discount game or combinations thereof. Ultimately, that's going to cause a lot of problems.

I do work in Canada, Japan, and South Africa. When you see a socialized system, these types of things always happen. You get the gap-filler policies that come in because people are unhappy. And that's what's happening in this country.

When you incorporate capitated arrangements, they naturally create a dilemma for the doctor. The HMOs now are moving to more consumer financial involvement and trying to blend the clinical and financial aspects together, which I think is a very good and positive development. The public has a very negative image of HMOs that is certainly reinforced by portrayals in the movies and the media.

Let's talk about low-profit margins as shown in Table 3. Many of the HMO markets in certain parts of the country are in distress, particularly where you have some difficult health-care reform legislation. I'm estimating that the targeted profits to individual- and small-group carrier markets are, on average, maybe 1% of premium, including investment income on the reserves.

Of course, there are some that are doing quite well while others are getting killed. There's quite a spread. I have yet to find a profitable HMO in New York State. Of course, they're required by law in the individual market to take all applicants. Otherwise, they will be forced out of the large-group market. They're all running 150-200% loss ratios. There's quite a variance.

The point is, there are few, if any, investors to put money into an investment with a prospective rate of return equivalent to a profit of 1% of premium per year, including investment income. Even the large-group market with 3.5% of premium return, including self-funded plans and everything else, is having trouble attracting new entrants. The numbers quoted are from 1998 to 1999, so they may be aggressive in light of the current situation.

What are the possible new visions resulting from consolidation? What will be the impact of this activity on product design and pricing? The result, I believe, will be a single-payer system. Whether it is the government or the free market, only time will tell.

Given my bias toward free markets, let us now talk about what the free-market solution has to offer and how it will impact delivery. Today, the new e-commerce companies are trying to turn the market in the direction of a defined contribution (DC) approach, much like what has happened in the pension arena. This thinking is consistent with that of the employers. They want better controls and more predictable benefit-cost increases in the range of 3-5% a year. They believe this can only occur if the users are incentivized to help control utilization through the use of greater co-pays and larger deductibles.

Will this approach solve all of the system's problems? Certainly not, but it will encourage the system to move in the right direction.

Another area of the system that will be impacted is the Medigap policies offered by the private insurers. Coverages are reverting back to the bygone era when

products looked very much like those offered in Britain's system where they have dread disease, hospital income, and surgical policies. It will move further in this direction if a government system dominates the landscape. This result would be very similar to what has happened in every country that has allowed the government to set the rules.

The DC approach, as shown in Table 4, will attempt to combine managed care and financial incentives to encourage a better informed public to make better use of the system. The goal will be to get the consumer involved in every aspect of health care. If managed properly, this approach, I believe, has great possibilities. It has worked in other markets, but it will not be without its problems.

Selection and adverse selection are going to become even more critical aspects in a company's pricing assumptions than ever before. A better-informed public will naturally be further prone to try to beat the system. The industry will have to be more involved in public-policy decisions to make sure that market adjustments do not go in the wrong direction. Everyone recognizes that you need to have sufficient controls in place to avoid adverse selection. Without those controls you may be lowering costs artificially with everyone ultimately paying a higher cost later on.

Generally, in a free market somebody wins and somebody loses. Everyone wins in the aggregate if the market becomes more efficient as a result of enacting prudent controls. Unfortunately, up to this point we have not followed that route.

Financial incentives to decrease utilization are going to become far more important in the future. These, combined with the net-cost increases realized by the employer and the employee, will determine the direction of future changes.

Given the current trends, I would anticipate that we will see further consolidation. But you have to question whether this will hinder innovation. Almost everything tried so far in the Medigap arena has been targeted at controlling costs. Whether that will work in the long run is anybody's guess. It does, however, accomplish one thing. It puts end users in the middle of the equation, where they definitely should be. Whether this will encourage an expanded threat of litigation remains to be seen.

In conclusion, I would like to predict what I believe to be the likely path for this country over the next few years, and also comment on how the future will impact design and pricing. For the next five years, I believe you are going to see a battle between the private sector and the government as the government tries to enact incremental reform. It appears that the pendulum is swinging back toward free-market alternatives.

Many states are starting to look at viable options for mandated coverage. I believe you will also see some repeal of guaranteed-issue and community-rating provisions. It will be slow in coming, but it will pick up momentum. There will also be an increased demand for Medigap policies from the market.

But at some point, sometime in the near future, the market will collapse under its own weight. Only then will true reform occur. In the interim, and during the reform period, I believe actuaries will play a huge role. I only hope we're up to the challenge.

Mr. Rick Hodgdon: What I'll be addressing is the impact of mergers and acquisitions (M&As) on the self-funding side of the A&H market. In the self-funded arena I will concentrate my remarks on the specific and aggregate forms of reinsurance.

As you know, with specific coverage you limit your exposure on a per-person basis with the aggregate coverage limiting your exposure on a group of specific risks. The role of the reinsurer in this equation is to limit exposure to catastrophic risks.

Generally the reinsurer would be looking to assist the client in reducing their minimum capital requirements, risk-based capital (RBC), provide expertise in analyzing the risk, plus provide pricing insight, underwriting support, and medical- and claims-management assistance.

Self-funded, unlike the fully-insured market, is covered under ERISA, which is a good news/bad news situation. It does, however, preempt specific state regulation and provide for uniform benefits, but does not promulgate solvency requirements, which is a big issue in and of itself.

The family structure and the general demographics in the U.S. are changing dramatically. Unlike in the life insurance direct and reinsurance markets, all of these trends work against health care.

Small business, which is heavily weighted toward the self-employed, is growing dramatically. With this growth and change in demographics comes the need to control the growth of medical expenses, especially since they are becoming a greater portion of the employer's overhead expenses. With increased longevity we have created a fear of living too long. With that, we have developed a quality-of-life risk.

Treatments in the future will tend to key on preventive measures versus treatment of acute conditions. This will increase the demand for wellness programs that the industry is not ready to deal with. Managed care will have to concentrate on cost containment in partnerships rather than continuing the adversarial relationships we now have.

The self-funded premium market is suffering from a paucity of pertinent pricing data. Most of our current data dates back to 1996. With the market evolving as fast as it is, it is going to be very difficult to quantify the risks and appropriately price for them. Also, most of the experience data that has been accumulated is in the under-100 life market. That leaves reinsurers largely without relevant data for

the evolving market, since most of their market potential is at the larger end of this scale.
The self-funded market grew from $69 billion in 1991 to $88 billion in 1996. This growth is continuing. In the traditional indemnity plans, 9% of employees are enrolled in employment-based health plans, and 91% are now in managed care programs.

On the self-funded side, 38% are in the increasingly popular personal provider organizations (PPOs), and 25% are in the point-of-service programs.

As far as the number of participants, in the primary market you have 152 million in the employment-based plans. On the self-funded side, you have 55 million. The self-funded is starting to grow, especially with what is happening to the HMOs and the fully-insured marketplace right now. We, as an industry, must find a way to partner with the providers if the market is going to retain any semblance of sanity. This, in conjunction with a drive to develop and use relevant data, could restore the user's and the provider's confidence in the market.

The reinsurance market from 1990 to 1999 grew to about $2 billion of annual premium. With what has happened over the last four years, major reinsurers have abandoned the market. Loss ratios during that period eclipsed the profits that were made from 1983 to 1995 and effectively wiped out capacity. This eliminated a tremendous amount of naive risk capacity. What had happened is that you had underwriters setting reserves. It created an incredible underwriting loss bloodbath. Don't get me wrong—naive risk capacity is still out there. You are always going to have that in a free marketplace.

The underwriting results are key to everyone's survival. Quite a few people did not understand that, especially the property and casualty players who came in and thought they would make a quick dollar in the health marketplace. What also contributed to this is inconsistency in the industry's historical underwriting experience.

An additional factor contributing to the problems the industry faced was the flawed nature of reserve methodology. The numbers simply did not add up. The reinsurers would grant ceding allowances that, when combined with the anticipated loss ratio, almost guaranteed them a loss. It does not take a genius to figure out that that recipe will not get you to the targeted ROE.

If you look at the merger activity in the market, I believe M&As actually hurt this industry. The reasons you typically merge are to access existing business and clients, and, hopefully, reduce competition and increase profits. Further, it should spur new product development and increase your knowledge capital. This, unfortunately, has not been the case. Loss ratios are out of control, and the filing for rate increases is behind the curve.

All too often companies were writing and underwriting for top-line revenue growth. This approach ultimately hurts the people bearing the risk. And it has really begun to hurt.

Distribution used to be driven by the managing general underwriters (MGUs). It was not company-controlled or well-focused. Without a direct link to the market, I believe you are courting disaster. The MGU almost functioned like a puppeteer. You had the reinsurer on one side and the direct writer on the other, and if either one started to question the relationship, the MGU would pull the plug on them. There was plenty of capacity elsewhere.

What the industry is reshaping to be is more of a vertical alignment between the parties. This gives the risk taker much better control of his or her destiny. The carriers now get to see the source of the business and ask the direct writer the tough questions without the MGU as an interpreter.

We tend to think that chaos drives opportunity. Although for the most part it does, we need to concentrate on and create embedded value for our organizations. If you are just writing business for revenue minus expenses, you are obviously not creating shareholder value. We need to balance the top line with the bottom-line results.

Obviously, we need to write new business. Without it you do not cover your fixed expenses, you don't deploy your capital, and you ultimately disappear. But there has to be a balance between that and the bottom-line results. Underwriting profit has to be the key business driver.

We need to understand and be able to control distribution as it impacts underwriting, and we have to find a way to directly market to the TPA and the employer.

We, as an industry, need to reduce the food chain in expenses. There are too many people nibbling at the piece of cheese, and there is not enough left over for the risk takers. Each partner in the relationship has to bring value-added expertise, and there has to be a measurable cost/benefit.

In order to address this at Transamerica, we formed a strategic alliance with CCN, a nationally known provider discount network. It was the very first time that a reinsurer had actually aligned themselves with a network. They were very surprised to see us at the table. But you have to take extraordinary measures in this day and age to protect your interests.

The industry needs to do a better job of anticipating underwriting cycles. That is considered to be part of proper data management, meaning that if we see trends going a certain way and we reserve properly we should be prepared for the cycles.

All of this is part of finite risk management. Without it, you are only guessing at your ultimate liabilities. Your goal should always be to protect the bottom line. This has to be done on many occasions to the detriment of market share.

Mr. Harry L. Sutton, Jr.: In the last 2 years, there have been roughly 66 mergers a year in the HMO industry, mostly little ones being bought out by big ones, but there are still a few big ones out there.

Preliminary reports from the NAIC on risk-based capital (RBC) show that there are roughly 20 or 25 HMOs with RBC of less than 70%, which is the mandatory state takeover level. In fact, if you want to compare this to the HMO health industry in general, nearly 28% of the HMOs that have reported to the NAIC are subject to regulatory oversight because of low capital ratios.

However, many have a grandmother or a grandfather, a hospital with $100 million backing them up, or a big insurance company, so that is not quite as bad as it looks. For comparison purposes, the percentage of individual life companies subject to NAIC regulatory oversight is 2-3% while for the Blue Cross/Blue Shield industry is at 3-4%. The HMO industry, at 28%, is in a difficult position.

What I would like to address is the scenario where there is an HMO insolvency and what happens to premium rates when there are higher insolvencies or changes in the number of HMOs.

Under the dominate state regulation, which has not been adopted in its entirety by all the states, if an HMO closes shop, all the other HMOs in that area, assuming there are some, have to reopen enrollment for a month to 60-day period and take all of the abandoned members into their HMO under the same premium rates that they were quoted at the beginning of that fiscal year.

If the new HMO is too small, or they cannot take members from so many employers, or they don't have enough doctors in their plan, there is a mechanism to force all of the existing HMOs still in existence to enroll all the individuals by lottery to help them get a random selection.

Unique to this market is something called insolvency coverage. Insolvency coverage offers two things. The state wants to be sure that people who have paid premiums get full coverage up to the date for which the premiums have been paid. Insurance carriers who reinsure in the HMO business typically guarantee that, if at the time the HMO is defunct and ceases operations, there's a member in the hospital and they will cover the claims until the patient is discharged from the hospital.

In addition, if there are advance premiums that have been paid, or if the operation shuts down in the middle of the month, they will cover the claims up until the end of the period for which the premiums have been paid. These interact with the hold-harmless provisions that the states may have required; many states require the physicians to work for nothing until the premiums have been earned. And when

you see how the states are unwinding these transactions, you understand how it fits in.

Let's talk about Rhode Island, which is a very small state, but with a very high HMO enrollment penetration. The national average HMO enrollment penetration is about 38%. Rhode Island is about 64%. New Hampshire, the other case, is a little bit below average, 35.2%.The Pacific region is 55.5%, Mountain region is 43.1%, West North Central region 35.4%, East North Central region 33.7%, Mid-Atlantic region 40.3%, New England region 46.2%, South Central region 26.1%, and South Atlantic region 37.4%. These are the two states where insolvencies actually occurred, but the penetration by HMOs is important in looking at what is going to happen to the results.

Key to understanding the results to be expected is the way the states viewed the participant's liability in the particular cases.

One case was a branch of Harvard Pilgrims located in Rhode Island, which was originally Rhode Island Group Health. This was the third time it had gone insolvent over its life history. Now it has dissolved and disappeared. Essentially, in the state of Rhode Island, there were 3 HMO carriers that had about 65% of the market.

The state mandated access and said that any doctor who refused to see a patient because he or she was afraid he or she was not going to get paid because of the hold-harmless provisions of the state, will be sued. As an aside, one of the insolvencies in Florida, because of their financial crisis, neglected to pay their reinsurance premiums. Therefore, the reinsurers' liability in the event of insolvency did not exist.

The state tried to reinstate coverage by paying the back premiums, but the reinsurer denied reinstatement. The state learned a valuable lesson about reading the coverage language that should be learned by others.

Several of these insolvent plans hired investment bankers from Wall Street to find a buyer for them. First, they try to find a buyer that will cover the deficit. This becomes an exercise in futility.

All of the competing HMOs have to wait in line and they will have a chance to enroll everybody who was enrolled in the bankrupt HMO anyway. Why would any of them want to spend money to take them over?

When they couldn't find a buyer, they tried to get somebody to buy clinics to house the doctors so they could recontract with another HMO. In Rhode Island the attorney general was the one who had to decide that the plan was essentially insolvent. When that occurred the state called in the other HMOs to assist. They had 175,000 members enrolled.

The state really did an excellent job. It started enrollment on November 1. It only knew in September or August that the HMO was insolvent, and it couldn't find a

way to rescue it. As a result it set up an enrollment period. It got the list of every single subscriber—that is, the family or the employee in whose name the contract was issued—and wrote to all of them. It set up this lengthy process, and while the law only requires 30 days, it took them almost 2 months to get it structured for the open enrollment.

Within two months, everybody had some kind of coverage. The state did not want a person to be without coverage. The 2 remaining HMOs agreed and approximately 95-98% of the enrollees were enrolled in the 2 HMOs. They still had 63% penetration in the state, and the remaining HMOs are now bigger with a brighter future.

But now there are only two HMOs in the state of Rhode Island, so we have a really small oligopoly. And at one time, they were all on the verge of insolvency.

The other insolvency mentioned earlier was United Health Care of New England, which had been losing money. There were 151 HMO failures from 1985 to 1993. During that same period there were maybe 500-600 HMOs in the U.S. Routinely, 25 would go under and 25 new ones would start up.

The number today is maybe 600-700, but that number is dropping because most of them used to get licenses to get Medicare, and there are normally only 4 waiting instead of the usual 25. Most mergers that occur in the surviving group of HMOs generally impact less than 50,000 subscribers.

Failed HMOs in the year before they went out of business had premiums set way below market rates. Generally, they were trying to grow rapidly and needed to garner market share to cover their administrative costs. The result was easy to foresee.

Interestingly, the successful mergers that occurred were with small HMOs that had high premiums, which meant they were not too competitive from a premium-rate standpoint, but probably weren't losing much money either. Also during this period, if a national HMO like Aetna or Wellpoint bought an HMO it actually had a negative effect on market rates. Premiums tended to increase in the marketplace. HMOs in competitive markets had lower premiums.

In the last 3 years, over 50% of the HMOs have lost money. Mark mentioned that the finances are not very good. This year is a projected recovery year. The industry projects it will produce $3 billion in profit, on somewhat less than $200 billion in revenue. That amounts to a gross profit margin for the industry of 1+%, which is not very good for the stock market.

In the HMO business the underwriting cycle seems to be more like ten years compared to the old Blue Cross cycle of about six years, because they have more staying power. There is no underwriting cycle; it's a marketing cycle. HMOs wanting to command a bigger portion of the market leave their rates artificially low,

not reflecting their actual cost of doing business. Eventually they have to recapitalize by greatly increasing their prices.

Back in the late 1980s, we had 3 years of 20% rate increases in the HMOs. This is the 1990s cycle and we are seeing the same relative cycle we had ten years ago.

Mr. Thomas J. Stoiber: When members are forced to join another HMO because of an insolvency or merger, what happens to the provider contracts? The acquiring company obviously has existing arrangements with their providers under one fee schedule. If the company taking over is forcing the providers to stay under the insolvent company arrangement with a different financial arrangement, who wins?

Mr. Sutton: In the Rhode Island case, all the physicians who were in the HMO that went under had contracts with the two existing HMOs (Blue Cross and United Health Care of New England) so the members that used those doctors could keep the same doctor and simply shift HMOs. It was very friendly and very well done.

In the New Hampshire case, that didn't happen. There were only two large HMOs in New Hampshire (CIGNA Health Source and Blue Cross), and there was a large overlap of physicians. The state did not have to intercede. The brokers switched the business. Once a high rate was filed for the plan that was going insolvent, the brokers got new commissions and put all the business with the other two HMOs. They did not raise their rates until after the merger was affected. They would have raised their rates as a matter of course, but they held the increase back because they wanted to get the enrollment. They competed through the broker market.

Mr. Stoiber: But in those circumstances does the provider win or lose? The provider has a contract with the insolvent company and they have a contract with the company that's taking over. Under which contract do they get paid? In other words, which contract do they honor?

Mr. Sutton: During the transition period, the hold-harmless agreement applies and they are paid under the original contract with the bankrupt or insolvent HMO. If they also have a contract with CIGNA or Blue Cross, they revert to that reimbursement rate as soon as the enrollment shifts to their current contract. They are obligated under the hold-harmless agreement until the period for which premiums were paid runs out.

Mr. Timothy Michael DiLellio: With regard to the increasing trend in large claims that is impacting the reinsurance market, to what do you attribute this trend? Is it the incidence of premature infants, transplants, such as bone marrow and liver, or other new procedures? I presume the increase in the use of new technology and advanced procedures is what is contributing to the cost inflation.

Mr. Hodgdon: I wish the answer was that simple. The experience that the reinsurance market is seeing and getting hurt by is a combination of poor pricing and a desire to protect market share. Most players are being damaged by their experience in the specific portion of the market and not the aggregate. There is, or

was, a lack of pricing discipline and an inability to respond to an obvious need to increase specific deductibles in concert with increased rates. With that lack of discipline being very prevalent you have the results we have today.

Mr. James P. Galasso: With the scenario you mentioned of repackaged managed care, you thought that increased financial incentives for providers could be coupled with decreased incentives for the clinics. How do you see that working in reality?

Mr. Litow: The increased incentives I was talking about would be for consumers to encourage them to decrease utilization. The goal would be to have them more involved in controlling the demand side of the equation. The other side of the incentives would be aimed at judiciously discouraging the providers and HMOs to decrease the financial ties between them. The Patient's Bill of Rights will probably have a great deal to say about this if it gets enacted.

Mr. Scott E. Guillemette: In light of the HMO industry's capital adequacy problems, what do you see the HMO industry doing to respond? Do you think they will attempt to go public to raise capital or just continue to ride the marketing cycle?

Mr. Sutton: I think the mergers will continue as a short-term solution. Their stocks on Wall Street have recovered about 25% from their bottom, but some of them are still down close to 50% from where they were last year at the same time.

This is what I predict. Although many of the HMOs look like they are losing money on the surface, some of them are not in as bad a shape as it looks because they're owned by hospitals who have $100-plus million of back-up capital to invest to keep patients flowing into their hospital system. Even with this type of back-up staying power, the industry still has to ultimately become profitable in a real sense. That will only come when they realize that they need a different formula and approach to achieve true profitability. Mergers are only a short-term solution.

Mr. Ira Slotnick: Concerning your comments about current distribution systems for the stop-loss market, I assume that you are implying that having the market go direct will effectively eliminate the MGUs as a distribution arm. Do you see that as a real possibility given that the MGUs founded a major portion of the market? What is the real likelihood of that happening?

Mr. Hodgdon: Given the current backlash to the London Market Excess and Unicover situations, I think it is going to be quite a while before the MGUs can reestablish their credibility, if at all. In the grand scheme of things they add very little to the equation. After all, it is the risk takers who should control the ultimate risk and distribution of it.

Mr. Robert M. Sackel: I would like your opinion on what would happen to the health-care system if the right to sue is enacted. Would this greatly increase the potential for insolvencies in the reinsurance market?

Mr. Litow: I do not believe it will have the impact of increasing insolvencies. The reinsurers will undoubtedly increase rates, however. The final plan enacted will likely be a negotiated compromise that will be tested in the courts.

TABLE 1
AFFORDABILITY DILEMMA TRENDS
1975–1996

Category	Annual Trend	Cumulative Trend	Ratio to Wage Growth
Wage Growth	4.7%	2.62	1.00
CPI	5.1%	2.84	1.08
Wage Growth Plus 2%	6.7%	3.90%	1.49
CPI Medical	7.8%	4.84	1.85
Medical Cost	9.0%	6.11	2.33

TABLE 2
COST SHIFT DILEMMA ILLUSTRATION OF
21-YEAR CALCULATIONS

	Base Trend	Cost Shift	Base Trend Util.	Util. Trend	Benefit Adj.	Util. Chg. Ben. Adj.	Man. Care Util.	Adv/ Pos Selection	Grand Total
Medicare	5.1	-0.8	1.2	3.5	0.50	0.25	0.00	0.500	10.5
Medicaid	5.1	-0.8	1.2	2.5	0.50	0.25	-0.30	0.800	9.5
Uninsured	5.1	-0.5	1.2	0.2	0.00	0.00	0.00	2.700	8.9
Individual	5.1	2.5	1.2	0.2	-1.00	-0.50	-0.10	3.500	11.3
Small Group	5.1	2.0	1.2	0.2	-0.40	-0.20	-0.20	2.50	10.5
Large Group	5.1	1.3	1.2	0.2	0.60	0.30	-0.60	1.50	9.9
Other	5.1	0.0	1.2	0.2	0.30	0.15	0.00	0.20	7.2
Composite	5.1	0.2	1.2	1.2	0.30	0.20	-0.20	0.90	9.0

TABLE 3
DEMONSTRATION OF LOW PROFITS

Private Industry Expense by Market and Function	**Individual**	**Small Group**	**Large Group**
Admin. Costs	1.75%	1.50%	1.25%
Overhead, Misc.	3.00	2.00	0.50
Issue/Underwriting	3.00	2.00	0.50
Actuarial	1.00	1.00	0.50
Recordkeeping/ Policy Service, Compliance	1.25	1.00	0.75
Claims	3.00	3.00	2.00
Subtotal	10.00	8.50	5.00
Commission	11.50	9.00	2.00
Marketing	1.50	1.50	1.00
Profit	1.10	1.00	3.50
Subtotal	14.10	11.50	6.50
Total	24.10	20.00	11.50
Premium and Other Tax	2.5	2.5	1.5
Total	26.60	22.50	13.00

TABLE 4
DEFINED CONTRIBUTION
DESIGN AND PRICING

			New Offerings	
Pricing Variable	**Current Offering**	**MSA**	**HMO**	**Comprehensive**
1986 Per Adult Cost	$2,700	$2,700	$2,700	$2,700
Risk Selection	1.00	0.95	0.95	1.28
Discounts	0.95	0.95	0.75	0.95
Managed Care Util.	1.00	1.00	0.85	1.00
Cost Sharing	0.84	0.62	0.96	0.84
Cost Sharing Util.	0.99	0.80	1.06	0.99
Leverage	0.99	0.93	1.00	1.02
Loss Ratio	0.85	0.85	0.85	0.85
Ins. Plan Prem.	$2,484	$1,322	$1,958	$3,276
MSA Contribution*		$1,162		
Total Employer Cost	$2,484	$2,484	$1,958	$3,276
MSA End of Year Balance		($523)		
Net Offering Cost	$2,484	$1,961	$1,958	$3,276
Percentage Distribution	100%	35%	50%	15%
Composite Employer Cost	$2,484		$2,340	
Composite Net Offering Cost	$2,484		$2,157	

*Assumes the employer pays 100% of the MSA contribution. Includes 2% administrative load.