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**THE IMPACT OF MANAGED CARE
ON HEALTH INSURANCE PROFITABILITY**

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Panelists will discuss the financial (pricing) implications of managed care for health insurance profitability. Three company actuaries will discuss actual experience in this area.

MR. ERIC L. SMITHBACK: We have three excellent speakers with us. David Wille, vice president and chief actuary of Humana, is here to share his views on where managed care is going from the perspective of one of the premier managed care companies in the U.S. Paul Austin, vice president of actuarial and underwriting services for Blue Cross/Blue Shield of Michigan, will talk about his experience in a company with a diverse portfolio of managed care and more traditional products. Our third speaker, Howard Bolnick, recently president of Celtic Life Insurance Company, will talk about the role of managed care in the traditional insurance company.

Before we start, I wanted to mention a very relevant, recent news item. It was announced that United Healthcare agreed to purchase MetraHealth. MetraHealth, as most of you are aware, is a joint venture between Traveler's and Metropolitan that contains all the group health and managed care of the two companies. This transaction is interesting for a couple of reasons. First, the 1994 combined group health writings of these two companies would have made them the second-largest group health insurer in the country, yet they sold out to a managed care company.

The second thing that's interesting about that transaction is that MetraHealth had more covered lives than United Health Care. But the purchase price for all of MetraHealth was far less than the valuation of United Health Care. That seems to imply that the market is saying the future is United Health Care, and the past is MetraHealth. And that leads to some interesting speculation, which I hope our speakers will help us with.

With that as an introduction, let me first go to Dave Wille who will talk about what he's doing at Humana and what developments he's seeing in managed care.

MR. DAVID W. WILLE: The subject of this session is the impact of managed care on health insurance company profitability. That's a very broad topic, especially for those of us who work at Humana. There's too much to cover in this session, so I'm just going to speak about profitability issues for a managed care company. The other speakers will get to other parts, but I'm going to start out with this narrower topic.

First let me give you a little background on Humana. We're strictly a managed care company, and our primary businesses are group HMO, group PPO, Medicare risk, and Medicare Supplement. We have 2.1 million members in 14 states and the District of Columbia.

The question is, What does it take for a managed care company to be profitable? You can analyze this in different ways and put a lot of thought into it, but it always comes back to the same issue and you get the same answer. The answer is that the company that does the best job in terms of cost control will have the most competitive products, the best growth rate, and the greatest profitability. Cost control is the whole game in terms of maintaining a profitable company. So I'm going to go over some of the cost control issues.

Of course, having a good premium rate formula is important, too. After all, that's what actuaries do and why you have actuaries. But I believe the primary role of the actuary in a managed care plan is to keep the system honest. The actuary should look at his company's claim costs separately in each market, and design a rate formula that passes on to customers in that local area his company's cost of doing business. That's what the rate formula does.

You can have the greatest actuarial department and the most thorough actuarial analysis with everything done right, and still the company won't be successful if the company has a high cost base. Even though actuaries do many good things, the actuary alone cannot get you to a profitable position.

Expect competition. Your competitors will still be there. Sometimes we wonder how they come up with their rates. Competition will be there. The only way to effectively deal with this is to keep your cost base down.

There are nine things we are doing at Humana to control costs. I'll cover each of the nine:

1. Get medical care on a fixed-fee basis rather than any kind of charge-based reimbursement or usual and customary scheme. Try to negotiate fixed fees such as per diems for inpatient hospital care, fixed charges by procedure for specific outpatient procedures, and a fee schedule for physician services.

We made a major effort over the last couple of years to convert hospital outpatient services from a percentage discount off of charges to a system where we have a fixed fee amount for each specific service, and it makes a big difference. There's much better control in fixed amounts. Several years ago we moved most of our inpatient business to a per diem basis. And, of course, once you have the fixed fees, keep after it. Make an effort to keep the fees down, so you can have a competitive price.

2. Perform utilization review. We have a detailed, elaborate hospital precertification program run by the medical affairs department. We also have utilization review and precertification of selected surgical procedures that the medical people feel are worthy of a look before the surgery is done. It takes a major effort by medical affairs to do it, but we feel that there's room to go even further. We've kept down the number of hospital days, but there's still room to bring it down further as we understand more of what's needed and what's not, and keep working on utilization review.
3. Capitate primary care. This is available only for an HMO plan. In our typical way of doing business in the HMO plan, we have a fixed table of capitation rates for

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primary care services that varies by plan, local market, and age and sex group. For each member we pay that capitation rate to the primary care physician, and that's all the physician gets for delivering primary-care-type services.

Once you're capitating, the physician has no room to increase income by raising the intensity of the services, increasing the number of services, changing the type of services, using new technology, unbundling of services, or anything else. There's no opportunity for that type of increase in cost. The only opportunity is to renegotiate capitation rates, and you get two parties at the table on that. You have the HMO and the physicians talking about capitation rates next year, and both parties can discuss capitation levels and maintain some control over inflation. The physicians cannot raise their income unilaterally.

4. Capitate specialty care. This has to be done market by market. For example, we would approach one or two of the cardiology groups in a city and tell them we'll offer them a contract that will pay a minimum fixed amount per member, and tell them all cardiology type services will go to their group. They're our network. All the referrals will go to them. They will take care of anything in that specialty. Once we've done that, we gain a great degree of control over inflation, at least in that specialty. Because, again, there's no room for the physician to introduce new technology, or increase the intensity of the services, or change the way of coding, or anything else, to raise the income of the cardiologist. It's all on a fixed fee and a fixed basis. But it takes a lot of work to get there. You have to negotiate separately with each specialty in each market.

To help our markets negotiate, we prepare detailed reports every quarter with claim information separately by market. Within each market we show separate claim costs for each of 35 different specialties. By saying to them, "Here's what your specialty claim cost is," we give them direction as to where to look next. For example, a recent report showed in Las Vegas that anesthesiologists there were costing our HMO \$5.15 per member per month. This compares with \$2.87 per member per month in our HMOs nationwide. And you ask, "Is that because the people in Las Vegas are sicker? Is it because they need more intensive services? Is it because they're getting better treatment, or they're being taken care of better?" I don't think any of that is the case. It's just a more expensive way of delivering anesthesiology services. So our local medical affairs people and local network development people are talking to some anesthesiologists in Las Vegas to either get a reduced fee schedule, or to capitate one of the groups, or to explore other alternatives to help control that particular specialty, because compared to the rest of the country that one was out of line.

5. Capitate mental health and substance abuse. In general we do not provide our own mental services for HMO members. We contract with specialty medical groups whose only business is the provision of medical care for mental illnesses. We pay them a fixed capitation, and they assume the full risk of providing mental care. They've been very successful in providing good treatment and taking care of mental diseases at very little out-of-pocket cost to the employee. But they do it in a way that emphasizes out-of-hospital treatment, which keeps the number of hospital days down. Because of that, the cost is dramatically lower than if we just paid on a fee-for-service basis for the same benefits.

6. Put gatekeeper procedures in place. We have gatekeepers in our various HMOs, which means that an approval is required from the primary care physician before any specialty visit or institutionalization takes place. The primary care physician has to go through a referral process. Our claim system is set up to administer this. When a claim comes in for a specialty, the claim system stops it until it can find the referral record in the electronic claim system and match it with the claim. If the referral is there, we pay. If the referral is not there, we contact the primary care physician and try to find out what's going on. But if there's no referral, we don't pay for the procedure. The whole system is set up to work that way.

Just having that provision though is not enough. You also have to have a gatekeeper who functions effectively, who, of course, is the primary care physician. To help the primary care physician understand the issues and what's going on, we have a computer system that tracks what we call the service fund. In this system we keep track of every specialty service and institutional service charged against that primary care physician's account. We then compare these with norms for the standard charges in that market for specialty and institutional services, and tell the physician where he stands. We give feedback to the medical affairs people, to the physicians and to everyone else on how he functions as a gatekeeper.

And then, of course, our medical affairs people can use this to counsel the physician. This is tied to financial incentives. Every market has a different way of doing it and negotiated it in a different way, but they all get back to the same intent, which is to measure the use of specialty services compared with the norm, and part of the primary care physician's compensation will be tied to the value of gatekeeper services. There are many different ways to get there, but there is always a financial incentive for gatekeeper services.

7. Enhance the claim system. Our claim system has a detailed software system that looks for evidences of miscoding, up-coding, unbundling, coding the wrong service, and so on. The system looks for it, and the system will pick it out and say, "We're not going to pay for that." This has reduced the covered charges on many claims.
In general, the member does not suffer when these things take place. We send it back to the physician with an explanation. We explain how we reprocessed the claim and normally the member does not have to pay anything extra. But that's part of the system to make sure the costs are controlled.
8. Negotiate lab services. We're trying wherever we can to move lab services out of the doctor's office and into a specialty lab provider. This is a cost control device, but it's also quality control. The quality ought to go up by using a lab that specializes in lab services, gets trained people, checks them, and makes sure they're all validated. They have quality control in the lab. I think we have a higher quality there than in the doctor's office. And in those places where we have enough volume, we've put these things out for competitive bidding. If the various labs put in bids for this type of service, we'll reduce the cost through competition.
9. Enhance drug controls and drug networks. We negotiate with networks of pharmacies and dispense drugs only through network pharmacies, which means we

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can work out the best arrangements in terms of low ingredient cost, low dispensing fees, dispensing of generics, and all the right things we want the pharmacy to do. But the pharmacist alone is not the party that needs to control drug cost. It's our own physicians. Our network doctors are writing the prescriptions and our medical affairs people are working with them to put a formulary together. The formulary is used to provide the best treatment possible as well as to control cost.

That's a very long list. What I'd like to do now is tie it all together and give you the common themes that underlie cost control for managed care companies. There are just four requirements to have what it takes to be effective in cost control.

The first requirement is geographic concentration. If you have a number of members in one local area, you can be much more effective on cost control. If you have everyone together, then you can work with the local physicians. You can work out capitations together. The concentration of members is necessary to be able to start up.

The second requirement is the commitment to managed care. A company needs to be committed to hire the network development people, to hire the medical affairs people, and to set up products and support these products. You have to be committed.

The third requirement is information systems. You'll need an information system to support all these things. There's a lot that can be done in cost control, and a lot of actions that can be taken, but you need information to get there. For example, a very detailed look at specialty services by local market for a current time period with sufficient volume of claims can identify some specialties that need work. You need a sophisticated information system to get you there.

The fourth requirement is that the HMO product has certain advantages over any other kind of product. There are many of these things that you can do through an HMO-type plan that you can't do through a PPO. Examples are capitated primary care services, capitated specialists, and capitated mental health services. You may be able to set up a PPO with a gatekeeper, but you can't do capitations except through an HMO. And because of that it looks like the HMO will have a crucial advantage over other types of managed care products like PPOs.

To give you some idea of the difference between the two, we can look at our business at Humana. Our HMOs currently have a claim cost of \$100 per member per month. The PPOs have an average claim cost of \$109 per member per month. We expect the difference to be widening in the next few years, because there are so many more opportunities to hold costs down with the HMO than any other product.

MR. J. PAUL AUSTIN: I'm the chief actuary from Michigan Blue Cross and Blue Shield Plan. I'm going to give you a little background about the Blue Cross system because although I noticed a few of you here are from the Blue Cross system, others of you may not know what the Blues are all about. There are 69 plans countrywide. Some are Blue Cross, some are Blue Shield. We are Blue Cross and Blue Shield of Michigan. We cover the state of Michigan. We are a nonprofit company. We are the market of last resort, so when our competitors refuse to write someone because they're older or not healthy, we wind up with them in our plan.

Much of our system is very interesting. As David was going through a managed care environment and talking about the things that the managed care companies do, I realized that we do about half of them in our traditional plan. We have a diagnostic-related-group (DRG)-based reimbursement. We have an outpatient price-based system. We have a physician fee schedule. We do a lot of these things in our traditional plan. That's part of the problem we have when we try to integrate a managed care product into an existing Blues plan.

There are all kinds of things that you're doing in different ways. You have different alliances with your providers. They may be thrilled with one and not so thrilled with another.

We also have systems that are typically very old. As Dave was telling you, you ought to have a state-of-the-art computer system. We have a 30-year-old system that was developed for a fee-for-service system many years ago and we have cut and pasted for the last 25 or 30 years. That's very difficult to change quickly.

One thing I want to talk about is the fact that, when you dominate the marketplace, which Blues plans tend to do since they are generally very regional, and there's a big shift into managed care, guess who loses? We do. Our biggest problem is integrating HMOs and PPOs into traditional plans. When consultants come in and say, go with more managed plans, all kinds of issues arise, such as how to deal with retirees.

To help you understand what the Michigan plan is like, here are some of the relevant numbers. We have about 4.4 million members, all in the state of Michigan. The state of Michigan is over nine million people. Take away the uninsured, and take away the Medicaid population, and you have about seven million. So we have something close to 60% of the covered lives in the state of Michigan covered one way or another. We have a variety of different features in what we call the managed care continuum. We have two staff model HMOs, two network-based HMOs, two PPOs, and a traditional plan. We have GM, Ford, and Chrysler as customers. We have groups of two, nongroup, and a tremendous variety of activity.

Something that's noteworthy in our plan is the strong regulation we have in Michigan. The other thing that has made this complicated is the self-funding of our traditional business. It has changed things because you're administrating for large companies. They're doing their own calculations. The actuary can't set the rate for GM. It doesn't matter what you think. GM is going to set its own illustrative rate, and it is going to look at HMOs and PPOs. We have had a lot of contention because this has disaggregated the community rate, but we're not going to talk much about that here.

I think probably the most significant strategic issue for any company that has traditional business and managed care business, arises when you're looking at both sides of the spectrum. You have to make sure that your pricing, sales, and contracting strategies are aligned properly. If you don't do that, you have all kinds of problems.

I will go through a couple of examples for you. When you contract with a hospital under a traditional plan, you are not the hospital's enemy. You provide volume to the hospital and to the doctors. The Blue Cross plan has open access, so you try to give as many providers

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as you can the same deal. Now you put on your HMO hat, and if the hospitals or doctors already own an HMO, all of a sudden, you are the enemy! This leads to very interesting situations when the traditional plan can secure a DRG-based reimbursement that may produce 30% to 35% off billed charges. And the HMO, which it owns, is paying the billed charges. You have to decide whether you're a competitor or not in the marketplace.

This is very important because customers, without exception, expect a more managed plan to cost less. Period. They don't like to get into demographic adjustments, benefit differences, regional variations, and so on. They say if it's more expensive, they won't offer it.

The second critical issue is the sales incentives. You might ask, "Well, I'm an actuary. What do I have to do with sales incentives?" You have to get involved in these kind of issues because they drive the ultimate result.

If the sales incentives are improperly set so that your sales force is encouraged to take existing business and convert it to the HMO, the sales people will spend all their time arguing among themselves instead of arguing with the competitors. They're not consulting for or doing what's best for the customer. They're trying to get the maximum incentive. We unified our sales force to make sure that the sales force wasn't just rolling business over, but rather improving the situation.

As actuaries we generally set prices. It is amazing how many times we've had a situation where failing to properly set up rate relationships has caused absolutely ridiculous price problems out in the marketplace. And the actuaries will say, "Well, you know. I just updated that factor last decade or so, and yes, it's a little outdated, but it can't be off by more than a few percent." You start looking at the compounding of deductible relationships with territorial boundaries and perhaps some of your trend assumptions, and you can get a rate to a group who may also have an HMO that's rated 20% less or 30% more.

One of David's points was that getting accurate data is a key point because you have to reflect cost. If you don't reflect cost, all of a sudden all kinds of decisions are made that are inappropriate. Some of the angriest customers I've heard got that way because we didn't tell them that a factor we set up wasn't correct—perhaps your family rate relationships may not be quite right. You're a little overaggressive one year on trend and all of a sudden there's a rate shortfall, and you have to raise rates a lot the next year. You have to make sure these things fit well together.

The other problem with HMOs, including our four, is that although they typically are owned by us, they have an independent board, an independent president, and basically an independent everything. We can influence them, but they make their own decisions. Oftentimes, the decisions appear to say to a customer that Blue Cross doesn't know what it's talking about. In reality what happens is that decisions are independently reached, and they don't make a lot of sense when viewed together.

Here's an example of what actually occurred in one of our HMOs. A local HMO couldn't contract with a major tertiary care hospital because the hospital owned a competing HMO in the marketplace. So a very large percentage of the HMO's expenses were paid at charges. Meanwhile, Blue Cross is getting over 20% off the billed charges in that

particular location. The HMO also couldn't get the specialists to feel warm and fuzzy, so the HMO gave them a lot of money. The HMO ended up paying substantially more than the Blue Cross plan did for the same service. Also, the rating territories that the Blue Cross plan set up weren't quite right, and although overall it averaged out, in some places we had some artificial rate biases.

The sales incentive, of course, was set up to promote HMO business. When the president of the HMO lowered rates artificially (below cost), many of our customers rolled over to the HMO in one year. The financial statements reflected significant losses. This HMO immediately turned around and significantly raised the rates. Of course, on the Blue Cross side, we fixed our rating problems and all of a sudden we became 20% lower.

The HMO lost 20% of its business the following year. In the process, it had hired people, administrative problems occurred, and the president lost his job along the way. I believe that much of this could have been eliminated if there was a strategy for fitting these things together. That's what we've embarked on recently.

Self-funded customers have much to do with this whole process. In the Blues system, you often have the very big players. Besides the three auto manufacturers, we have the state account, we have teachers, retirees, active people, and so on. Usually on a self-funded plan, you have to tell the customer what the reimbursement arrangements are because customers ask you what they are buying. You provide information on an area-specific basis if they ask, so they know what arrangements you have.

You have the self-funded customers looking at cost. You have HMO rates that are under tremendous scrutiny. If the HMO raises rates in order to raise profit, there may be an additional employee contribution. If they try to get too fancy with the benefit plan, they may have a strike if there's a union involved. So much of the customer involvement is very important.

I think actuaries sometimes lose sight of this sitting in the back room and not paying attention to what's going on in the marketplace. If the customer is driving a lot of these changes, then you have to keep an eye on that because if you don't, you're going to lose those customers.

The contracting I mentioned earlier is very important, also. But besides pure contracting, which is reimbursement, David mentioned the issue of trying to make sure that the incentives with the providers are set up properly. One of our HMOs actually paid an incentive to providers the year they lost money. It was because they weren't looking at the financial side. They were looking at credentialing issues and many other things that were legitimate objectives; however, when all was said and done, the financial impact wasn't being taken into account.

The HMO calculated a financial loss at the same time it paid out additional incentive. You can't do that. There is some room for not being lined up exactly the same, but you have to be very careful that your incentive to your providers is tied to your performance. You win together or you lose together. I think it's very important in this managed care process.

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Back to the customers for the last time. We have to be consultants to the customers. Our customer is getting more sophisticated. We once took a block of business and found that if we eliminated all retirees, the active cost would be reduced about 19%. That gives you just a hint of the problem if an HMO only writes active employees, and ours is a traditional plan that doesn't differentiate between active employees and retirees. There's a tremendous demographic bias that customers are waking up to. Certainly the auto manufacturers are aware of this. They have some very sophisticated procedures in place to see whether or not the reason your costs are lower is because you have less expensive people, and we have to be aware of that.

Let's discuss the underwriting gain for the best of our HMOs. This HMO is one that has the same reimbursement arrangements that the traditional plan has. It has the unified sales force, selling consultatively. It has provider arrangements that have multispecialty capitation plans that share incentives all the way down the line. It has adequate surplus. It has long-term rate stability. It has a 15% per member growth for the last five years and has done well. It has a cycle, but it bottoms out at an 8% gain.

Now consider a combination of our other three HMOs. These HMOs include a staff model that has cost problems. Sometimes the staff model costs are a function of productivity. This group also includes the one that has contracting problems in several locations where the local hospitals own HMOs. Collectively they've done fine, but they're not nearly as profitable because they don't have all the features working for them.

Now consider traditional insured business. Blue Cross of Michigan has a rating formula that requires that, if we make too much, we give it back. If we make too little, we have to raise rates. We have a very predictable 1% to 2% corridor that we operate under. Some of the accounting rules come into play as to whether or not you can claim receivables, and so on, but putting that aside, we're always going to be somewhere between 1% and 2% on about 40% of our business.

You can see that both of the managed care companies outperform the traditional indemnity plan. What is amazing when you look at the well-managed plan is that five provider groups have half the members and on average they're 20% better than the rest of the providers in that well-managed plan. Even the poor performers are good, but the good performers are outstanding. If you consider some of these features and what David was saying, and you follow through on a multiinsurance option plan, you get these kinds of situations.

Michigan is a less advanced state as far as managed care growth goes. In 1994 about two-thirds of our business is still traditional or indemnity kind of business. That excludes Medicare. If you include Medicare, it's 72%.

We are a very strong union state. Many unions, the UAW in particular, do not necessarily support managed care except as an "alternative plan." If you have a better plan that members can choose, fine. But you can't take away access because that's a negotiated benefit. That filters through the whole Michigan marketplace. It could very well be, if that were to ever change, there would be tremendous movement into managed care.

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Our PPO plan is at about 19%. We have two kinds of PPOs. I call one an unmanaged PPO. It has some of the basic PPO features, or managed care features, but we don't put the providers at risk. If the provider runs the meter up, the only thing you can do is throw him out of the network. Point of service is 1.2%. That's where we actually have a primary care gatekeeper. But once again, you have access outside of the network, but at a lower level.

The HMOs are 12.7% with all four of them combined. We have 4.4 million members in total, and the HMOs represent a half a million.

I think we're a rather typical Blues plan, but there are a large number of variations. Now I will turn it over to Howard who will talk about the traditional indemnity plan.

MR. HOWARD J. BOLNICK: I will discuss the problems that are faced by traditional insurance companies that are moving through the managed care spectrum from fee-for-service plans, managed fee-for-service plans, and widely disbursed PPOs into managed care. It has been a particular focus of mine over the last couple of years, and I've given it a great deal of thought. I've had a great deal of frustration over it, and I want to share some of that frustration with the rest of you.

I have a question though that I'd like to start out with. How many people in the room are working for companies that you call traditional insurers that have either managed fee-for-service plans or widely disbursed PPO networks that are emphasizing discounts? It looks like more than half. I would also like to ask, how many people are working for HMOs that are struggling with and trying to do the things that the heavily managed or effectively managed HMOs are doing? Just let me call them "lightly managed" HMOs at this point in time. A handful. How many people are working for what we'll call *effectively managed* HMOs? David, you can raise your hand.

What I'm going to be talking about is the predicament that I think the majority of you find yourself in. I'd like to cover a number of things quickly and then we'll get into the meat of what I want to say, which you'll see is a different way to put together what David and Paul talked about. First, I'll take the opportunity to feed in some background information on what I have to say.

I'd like to touch briefly on the legal and regulatory environment, and the competitive environment that companies that are in traditional business are faced with. And last, I want to talk about the strategic and operational challenges that companies such as yours and mine had in terms of trying to move from traditional business into managed care.

First, I have a comment about health care reform. I think we have to keep in mind what's happening in the legislative environment. Clinton's program, as you know, was a lot of noise and little action. But everything that has happened in the last few years has had real consequences on the environment within which traditional companies are operating. I think there are three consequences:

1. Much of what's happened in the legal regulatory environment has undermined the traditional risk management tools that companies used. We're seeing movements towards guaranteed issue, rating bands, and portability. All those movements are

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aimed at undercutting tools that have been effectively used over the years to price risk and screen risk.

2. Many of the legal/regulatory things that are happening are encouraging managed care. The most visible one today is the debate over how strongly Medicare ought to move into managed care.
3. Last, and I think this is important for many companies, many of these legal and regulatory moves favor large competitors. Guaranteed issue, risk pools, and standardized benefits tend to undermine companies that have a very small market share, and favor companies that have a significant market share in the state.

What's going on in the competitive environment? I call it "The Triumph of Effective Managed Care." I think four things are happening:

1. Effective managed care is gaining market share over indemnity plans, the fee-for-service plans, and what I'll call lightly managed care. I don't think I need to go into much of a definition of lightly managed care. Everybody in the audience seems to understand the difference between lightly managed and effectively managed care.
2. I think we're seeing in the marketplace a great deal of experimentation with organizational structures, and these structures have two characteristics. First, who's in control of the care? Is it the payer? The hospital? The physician? Or are they integrated systems? Second is the question of the breadth of these structures: whether they cover a single state, multiple states, or a region. We see a multitude of things going on, a multitude of initials thrown out, and everyone saying, "Well, I've got the best way to do things, and I'll just put them all in a category called experimentation."
3. I think there's a great deal happening with respect to new data and electronic systems, a great deal of capability that's allowing interplay between the physicians, the providers, the patients, and the payers that make managed care more effective, and make effective managed care easier to carry out if you can master the new environment that these electronic tools give us.
4. We're now seeing an expansion of managed care into the new market segments. Managed care, like traditional insurance, grew up with a large group segment. And, as we all know, we're seeing Medicaid HMOs, Medicare HMOs, and much interest in small group HMOs. All this is happening very rapidly.

Now the question is, "What does this mean? What does this mean for traditional insurers? What strategic and operational challenges do we have?" I think there are four things that we need to look at: (1) traditional insurers need to come to grips with the idea that managed care is a different business than the one that they're currently in; (2) effective managed care requires new resources; (3) effective managed care requires a revised business strategy; and (4) perhaps what's most important is we must wrap these together. It's a very difficult transition from being an indemnity insurance company or a lightly managed care company to effectively managing care.

Let's look at each one of these points separately. First, consider the idea of effective managed care being a different business. Once again, this is very important because companies compete on their concept of their business. As you'll see, if you don't understand what's different about effective managed care from the traditional business, you'll probably never get there. There are differences here that are obvious, and there are

differences that are very subtle, and it's the subtle ones that make it so difficult to do effective managed care.

Some of the points that you need to think about are that in the effectively managed care business you have, for the first time, the provider being seen as a new partner or customer. Providers were never thought of, in the equation, as people you had to think about from day to day as you ran your business. All of a sudden, the provider is there as a partner, or as a customer, depending on how you in the managed care business think about them.

This causes obvious differences. You have the issue of provider selection. You have to hire people to do that. You have to hire people to contract. You have to hire people to manage care. That's all very obvious. There are certain less subtle issues that are caused by this. There is the issue of electronic links: if you have your provider as a partner, you want to be in touch with that person in the most effective way possible so that you get into the idea of electronic links to these people.

There are issues of governance to consider. How are you organizing your health care plan? What is the role of the provider in formulating how care is going to be managed and then managing the company? This is something you never had to deal with before. You have very subtle effects, too, from the provider as a new customer or a partner. I can give you some examples in claims.

For instance, first, there are differences in eligibility verification. If you're working with providers as customers or partners in the claims area, you can't go around denying claims after the fact. You have a provider partner who's provided care, which makes it very difficult for you after the fact to say, "Oops, there was something wrong with the enrollment. There's something wrong with this claim. I'm not going to pay you" because now you're not paying your partner. It's not just a person who's a third party at arms-length and you don't care what happens to him.

Another eligibility example is that, when one of your customers shows up at a provider's office, you want to be able to let that provider know that the person is, in fact, eligible. You don't worry about that too much in traditional insurance. You have to worry much about little things like that if you're in an effective managed care environment.

Second, consider the idea of geographical focus. Concentration, as David said, is fundamental to the difference between the traditional business and the new business. It affects everything you do. You have to sell differently. You're in a different competitive environment. You have to act differently from top to bottom.

Third, you have new customer services requirements, and we can spend a great deal of time on this. Just think of it this way. You now have a customer or insured. You have providers whom you are presenting as being part of your system, and therefore you have an obligation to help the customer through the provider system.

Obviously, as we have providers as partners and we're passing off risk to them, we have to do this in a way that effectively incents the providers to do what we'd like them to do. But on the other hand, if it gets too Draconian, we are taking the customer, a partner of ours, and foisting losses on the customer. That doesn't play well in the long run. We have to

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think about risk sharing and how we price our products and how we work with the providers in a very different way to be effective.

Last, it's a very tough competitive environment. When you're in a traditional insurance environment or a lightly managed care environment, you have widespread contracts and selling in many areas. Let's say you're selling the same products in a hundred different cities. What happens with competition in one of the cities? Take Denver, for example. Suppose the competitive environment gets real tough. What do you do? Nothing. You just don't sell much business in Denver until things turn around.

If you're in three or four geographically focused areas and one of them is Denver and Humana comes in and cuts the rates by 20%, you have a big problem, and you can't just wait until Humana gets wise. You have to react to that competitive environment.

To make matters worse, managed care plans are very aggressive. I don't think that many of us who work in traditional insurance understand what it means to have aggressive competitors until you get into a situation where you're fighting with some of these big aggressive entrepreneurial HMOs that have lots of bucks and want market share.

To summarize, I'd say that effective managed care is a very different business than the business that we're traditionally used to dealing with, if we come from a traditional insurance business. Operating in this business requires new resources. One thing that I'm learning, and having come from traditional insurance every day is a learning experience, is that effective managed care is an information business. The more information you have and the more effectively you organize, gather, analyze, and utilize it, the better off you are.

That means two things. First, you have new data needs. What you gather in HMOs to be effective is different from what you gather in a traditional insurance company. That means that you probably need new operating systems. Trying to be an effective organizer and manager of medical care using the systems and the databases that we're traditionally used to using just won't work. You're going to be left well behind. Even if you have this information, you need resources with the knowledge and the skills that a select few have today, to truly analyze the data and truly use that to organize and deliver care. So you need both new knowledge and new skills.

Having new provider partners, different customer needs, and different data needs means that you have to have new methods of doing business. Some are subtly different and some are radically different from your old needs. Internally, you need to organize differently than you did before, and think about your business differently than you did before.

Second, there's a stronger integration between the financing and operation of a managed care plan than there ever was in a traditional insurance plan. I think both David and Paul gave some good examples here. David was recounting all the specific services that he was watching the capitated rates on. He was then going out and reorganizing the provider community around different types of contracts in order to get a lower cost and more effective care. This is the nature of the business.

You have to have the data and you have to integrate that financial data into the operation of the company into more effectively managed care. And once again, this is not something that is done by traditional insurance companies.

To do this requires a revised business strategy. There are several things you need to include in that business strategy:

1. **Geographical focus, or concentration.** As I mentioned before, and you've heard from both Paul and David, concentrating into narrow geographical areas is very important to the success of a true managed care plan. So you have to figure out where and how you're going to compete.
2. **You need to think about, in great detail, your relationships with providers.** We all know we need relationships with providers in the managed care environment. But how you go about doing that becomes the character of your company. You could have anything from a very intimidating authoritarian environment where you deny coverage, where you ratchet down costs, and where you treat the providers pretty poorly, to a very supportive educational type of environment where you're giving them information, talking with them, encouraging them to manage care better and better. There's a wide range of different approaches that you might take, and this is something that each company needs to think through with respect to its own strategic and operational plan.
3. **You have to look at the market segments that you want to serve.** There are the large group markets, the mid-group markets, the small group markets, individual markets, Medicaid markets, and the Medicare marketplace. Obviously, you can hide in various places and shape your own business to one or more of these different markets.
4. **You need to define and establish a competitive advantage, and that competitive advantage may be based on cost.** It may be based on the quality of providers. It may be based on choice. There are different possible ways to establish an advantage. Just as a kind of experiment, let me give you some different examples, because I think we all think there's only one way to do managed care. I'll argue that there's more than one way to do it, more than one way to organize your strategy.

One example is perhaps David's situation. The strategy of what I call an effective managed care megaplan is to gather a major, if not dominant, market share in a given geographical area. By gathering the major market share, it develops clout in contracting and in managing care, which, in turn, drives the low cost that David was talking about. The low cost, in turn, drives the ability through a virtual circle to have a large market share. This is the dominant strategy for some of the bigger well-known managed care plans.

There are other strategies though, such as what I call a "boutique strategy." In this example, you might be trying to hit a certain socioeconomic market segment in an area by adopting a high-quality strategy. As part of your strategy you want to have

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a limited enrollment. You're not interested in having 40% of the Chicago area; instead, you might be happy with 4% of the Chicago area.

To get this limited enrollment, you would probably choose preferred providers—ones that people would recognize as being of high quality. You might even pay these people more than they would be offered by a megaplan in order to get the right quality providers in the plan. Through benefit design, you would allow the members a certain amount of freedom in choosing their own providers. This is a more expensive plan, but it may appeal in certain areas to a certain market segment. I'm just using that as an extreme example, which is contrary to the megaplan, so that you can see that there is room to conceptualize different types of strategies for effectively managed care plans within a given geographical area.

A further issue that needs to be dealt with is perhaps the toughest one, and that is that a transition from traditional business to effective managed care is very difficult to plan and execute. There are a number of reasons, I think, that this happens. First, there's the reluctance of old dogs to learn new tricks. Large companies that are successful have people who have a vested interest in things as they are. As much as they might intellectually understand that things need to change, they don't want to. Plus, you're successful. You're making money. How do you change what you're doing and develop something else? How do you do that without lowering your profit margin on existing business, or cannibalizing your existing business and your profitable business in order to get to this new world? So this idea of transition and the people's reluctance to do the transition can be a pretty powerful barrier to changing into an effective managed care company.

The new company also has to focus on managing care rather than managing risk. I guess all of us have had to understand through the health care reform debates over the last year that traditional insurance companies have spent a great deal of time managing risk and this, of course, is particularly true for small group carriers, or individual carriers. All those things that we learned need to be rethought, and we need to get to an environment where we can manage care rather than manage risk. We've heard this. We've heard this from our critics. We've heard this from our friends. We've heard this from our senior executives. But what does it mean, and how do we do it? It's not easy to make that change.

We must also consider the issue of systems migration. Effective managed care takes different data. It takes different systems. Somehow you have to plan to migrate from where you are in your existing system into these new systems. And all of us who have been through systems migration and system change know that, just by itself, is an enormous barrier, and an enormously difficult thing to get done.

You have the issue of capturing and handling different data. I can't emphasize enough that effective managed care requires different data, different ways of looking at it, different ways of using it. But somehow you have to come to grips in a traditional insurance company with that data; find ways to gather the data, learn new ways to analyze it, and find effective ways to utilize it in order to manage care.

Last, and perhaps what's most dangerous, is that there is generally a mismatch between old and new customers. I guess the biggest example of that is MetraHealth. I know that when Metropolitan was thinking through what it was going to be doing, its people were off

visiting a lot of companies and they came and visited me. We were talking about their managed care strategy, and they said that, even with the huge block of business that they had, there were only about 40 markets in the whole country where they currently had enough business where they felt they could have an effective managed care plan.

I can give you an example of Celtic Life Insurance Company. When we thought about doing effective managed care in various areas, we asked ourselves, in how many areas did we have enough business to even get started with managed care plans. The answer was pretty close to zero. There wasn't any place that we had enough business and we had a base to build on. There was a total mismatch between our existing in-force block of business and what we needed to execute a strategy of becoming an effective managed care company. This means you're throwing out your old customers and starting from scratch. And this forms another significant barrier that needs to be overcome in managed care.

Where does this leave us in terms of some conclusions and some ideas about what it means for profitability? First of all, I'd say that the lesson from all this is that the environment is changing rapidly. It has been for the last year or two, and I suspect it will continue for the next three to five years. There will be perhaps less change motivated and driven by the legal regulatory threat, because I don't see a new Clinton care plan on the horizon again. But more change than expected is going to be coming from the accelerated competitive threat that, in large part, might have been accelerated or set off by the legal issues and the federal scrutiny of health care over the last few years.

I believe that every one up here has said, and I'd be surprised if anybody in the audience would disagree, that effective managed care is going to increasingly dominate the health care scene. As I said, the transition from traditional lightly managed products to effectively managed products is going to be a major strategic and tactical challenge for health care organizations. It's going to require planning skills, provision, leadership, and also a great deal of change in the trenches in order to organize and move from being a traditional insurance company into an effective managed care plan.

If you're sitting in a traditional insurance company or a lightly managed care plan, what does this mean for profitability considering the choices that you have? I think, as you go through all the things that need to be done, there are three choices. First, if you decide that you're going to stay a traditional insurance company and stay with these lightly managed care products, this is a strategy. You don't want to play with the big boys. You don't want to get into effective managed care for many different reasons. What you're going to be facing is a situation where there's a diminishing segment of the market that's going to be looking for your products.

There may be a diminishing number of carriers that are taking that strategy, but my guess is there will be more carriers trying to execute a strategy of staying with the market until it's no longer there than there are customers out there. So this strategy, I believe, is going to see a diminishing number of companies fighting for a greater share of a diminishing market, and I think that will result in diminished profits.

A second strategy is to go into true managed care. But, once again, I want to emphasize that you must understand what you're getting into in doing that. In order to get into true managed care, you must make a major investment in everything—systems, people,

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knowledge, and sales. It is a major investment, not a small one. At the same time, you have a major risk because it's not so clear that the strategy is one that you're going to be able to execute. Some can be and some can't be.

But with this strategy comes the opportunity for an increased profit, and both Paul and David were showing you the profit margins on HMOs, and they looked pretty fat right now. And I think that's true at the moment, but I would caution you that from my perspective those profit margins will not continue for more than a few more years. We're in a phase right now where those companies that have figured out in the last few years how to effectively manage care have been able to cut the increase, or actually cut the cost of care much more than they've been forced to reduce premiums. We're seeing large profit margins result from this, which I frankly don't believe will continue to exist too long into the future. So if you choose to adopt the strategy of going into true managed care, you have a major investment with a major risk and an uncertain profit margin when you pop out at the other side.

And the last strategy that I think you could look at is to exit the market. Obviously, this strategy is just cashing in for what you can get your existing block of business, calling it quits, and playing in another ballgame.

MR. SMITHBACK: I think we have time for a couple of questions.

FROM THE FLOOR: Do you think there is any possibility or correlation that managed care will lead to inadequate care?

MR. WILLE: We see just the opposite, that there is often a correlation between more managed care and an increase in the quality of care. It depends on how good your network is and how good your physicians are, and whether you have the right physicians and the right system. But often, you can get an increase in quality by restricting care to a limited number of physicians. For example, we try to get everyone in our system board certified for the specialty they serve in. In fee-for-service medicine, the physicians are not all board certified. So, in some ways, you get an increase in quality.

FROM THE FLOOR: A couple of months ago, the front page of *Business Insurance* had an article about employers asking HMOs for more options in self funding. What do you think of the combination of self funding and HMOs in the future?

MR. AUSTIN: It's being done today. It's not very popular. There are a lot of regulatory problems that you get into. We have to go through a third party administrator that has to be set up just the right way to do that. There's a tremendous number of groups like Med-Stat that come in and look at the data and say to the large customers, "Do you know how much they made on your program?"

The problem with community rating, which is exactly what brought it down for large customers 20 years ago, is that the ones who can figure out they're better than average will opt out. I absolutely think that this will happen.

Providers don't care as long as they have a risk incentive built into it. One of the problems you have is that it exposes the administrative expenses very clearly, and managed care is

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very expensive to deliver because it's much harder to manage care than it is to just pay a claim. But I think that is absolutely going to happen. You'll see a lot of that in the next ten years.

MR. WILLE: I have a different opinion on that point. We don't offer our HMO plan on a self-funded basis. We just don't want to make it available that way. And so far we've been successful without self funding.

The problem with self funding is that it's hard to have the employer assume the risk at the same time that the provider assumes the risk. They can't both assume the risk simultaneously. All the things we do—like specialist capitation, physician incentive, primary care capitation, capitating mental, and all the things down the line—don't fit with self-funding.

The capitations paid to the physician are fixed, and most employers don't have in mind fixed capitations when they ask for self funding. So to answer the question, we're not in that kind of business, and I don't see it as a real growth industry.

MR. SMITHBACK: There is a new competitive force out there in provider organizations that are starting to take risk. Although the regulatory environment, at this point, is very uncertain and many states have not taken a position on providers accepting risk, I have worked with a number of provider organizations that are offering the employers the ability to self-fund through the provider groups.

This belief tends to support Howard's comment that the large investment that you need to make to get into managed care may be hard to recoup because of the increased competitive environment.

Added competition will come very quickly when you see many provider organizations coming into this market.

MR. PETER K. REILLY: The unprecedented levels of risk transfer to providers over the last five or six years has occurred while underlying cost trends have been relatively benign.

Has Humana given any thought to, or made any contingency plans for, the possibility of an upturn in underlying trend pressures? Specifically, with regard to the provider's ability to accept the risk financially from a risk capital standpoint, has Humana made any contingency plans as to what would happen if the providers ran into financial difficulties when costs are going up, or there are cost pressures?

MR. WILLE: This is an important issue, but in the HMO business, if the provider fails, then we as the HMO will assume responsibility for the care. For example, if we contract with an individual practice association (IPA) that takes the risk of providing care and, for whatever reason, they go out of business and can't provide care, then we have to take on the risk.

It is something to be concerned about. We worry about it, and we look at the financial situation of the organizations that we contract with all the time. So far, we have not had many failures. There have not been many insolvencies.

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However, as the environment gets tighter, and as costs start to go up, there may be some. I think the best you can do is to look at the financial picture of each provider group you contract with and make sure the risk you take on is it's reasonable.

