PERSPECTIVE continued

Identity Crisis Looms as HMOs Jockey For Growth in a Crowded Field

Headquartered on opposite coasts, California-based Foundation Health Corp. and New Hampshire-based Healthsource have more in common than the cross-country distance would suggest. Waving the banner of cost control, they, like many other aggressive HMOs, are set on finding new, profitable markets. But whether consumers will be able to tell one HMO from another could be their biggest challenge.

Their tactic is to pinpoint specific markets that present distinct advantages. This means geographically hopscotching across country to serve markets "where we can get a significant economic relationship with a quality provider," said Thomas Congoran, chief financial officer of Healthsource, at a recent meeting of the Association of Insurance and Financial Analysts.

Healthsource has set its sights on underserved midsize cities and aims at continuing its current level of enrollment growth, which for the 1994 second quarter was 34%, Congoran said.

This article was prepared by Diane Ferraiolo, senior editor.

The company's main advantage is price, which is driven by the basic cost equation: Occurrence times average cost drives price. Instead of reacting to cost increases as indemnity insurers do, HMOs start with the cost of treatment to determine price. This close scrutiny is what has helped HMOs take the high ground in the health arena, and will be increasingly important in the future, Congoran said.

Utilization reviews and payment methods like capitation or per diem plans, which cap payments to health care providers, stabilize costs for HMOs. They also equip HMOs with an arsenal of tools to negotiate economic contracts.

With costs under control, Healthsource's marketing strategy is to adapt its products to different markets. Congoran said Healthsource can funnel self-funded employer plans into point-of-service programs and use the company's network to contain costs.

The company also thinks that it can wring out huge savings from government programs. Last year, the company formed a joint venture with Liberty Mutual Insurance Co., Boston, to control workers' compensation costs in New Hampshire's residual market. The program already has yielded savings of 12% in medical costs and 10% in wage replacement costs. Because of this success, Healthsource is planning to apply these techniques to the voluntary market in New Hampshire, Congoran said.

The other government market Healthsource is eyeing is Medicare and Medicaid risk. But Healthsource isn't alone.

Foundation Health also likes this market. Big government contracts like the company's contract to provide managed care services to retired military personnel in California and Hawaii caused revenue from this business sector to surge 70% over the past five years.

These contracts give HMOs tremendous bargaining power with health care providers because of their exclusivity. An award of a large government contract can double an HMO's membership, said Bradley Rubin, an analyst for A.M. Best's life/health division. It also holds the promise of huge patient increases for health care providers that the HMO wants to add to its net-

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PERSPECTIVE — continued

work. The potential patient increase offsets the reduced compensation that the health care provider accepts in joining the network. The loss of one of these contracts, however, is an equally big hit, Rubin adds.

Foundation Health recently lost its government contract in California but won a similar contract in Louisiana and Texas. It also won a Medicaid contract in Massachusetts to administer programs that place Medicaid recipients in managed care networks.

Here again, the potential rewards are enormous. Government Medicaid and Medicare programs are a largely untapped market for HMOs, said Best's Rubin. The application of managed care techniques to reduce average hospital stays and the high reimbursement rate for traditional indemnity Medicare patients offer HMOs enormous opportunities to reduce costs, Rubin noted.

Taking supplemental managed care products like dental and vision care to the Medicare market is an easy sale, said Jeffrey Elder, chief financial officer at Foundation Health. These products reduce consumers' out-of-pocket expenses and allow Foundation to get more mileage out of the same product. The idea is to "drive different programs through the same system," Elder said.

This is what the company is doing in Britain by providing an elective care coverage, which supplements the country's national health care system. Elder estimates that his company can sell this supplement for 15% below the competition's price through the use of managed care networks.

While Foundation still likes the California market, which some have found crowded, the company nevertheless is going east. With acquisitions pending, the company is heading into Arizona, New Mexico, Texas, Louisiana, Alabama and Florida, among other states.

This track is being traveled by other California-based HMOs, finding their home state saturated. The California-Texas-Florida link offers huge potential, but it remains to been seen how well HMOs will do in markets like Texas with independent-minded consumers who don't like to be told what to do, Rubin said.

The strategy is to spread costs over a larger market share. The more aggressive HMOs will scramble for market share, Mark H. Tabak, president of AIG Managed Care, said. Ultimately, margins will narrow; it's hard to say over what time frame, because regulations can alter the market's course, he added.

Of even greater concern is how well HMOs will be able to differentiate themselves as markets become saturated. When an employer offers five HMO plans, how will the consumer tell one from another, Rubin asked. An HMO's biggest challenge will be its ability to stand out from the crowd. Over the next five years, there will be probably half as many HMOs as exist today, Rubin predicted. ■