The following is an edited transcript of the remarks delivered by BCBSF President and Chairman William E. Flaherty at the 1995 Annual Sales and Marketing Conference October 11, 1995, in Jacksonville, Florida

I'm glad to have this opportunity to address one of the finest sales and marketing organizations in our industry.

Last year's gains were truly remarkable, and they reflect the competencies and capabilities of this fine group of people. Last year was our sixth consecutive year of strong customer growth and solid retention accompanied by excellent financial performance.

The company grew in 1994 by 150,000 new customers. Just stop and think about that for a minute. That's a number we wouldn't have dreamed of during the last 20 or 25 years. It was only in our industry's infancy, when there was no product in the market, that we had growth of that size.

To do that in an active, competitive market is truly a fine accomplishment and speaks so well of each of you. And I want to thank you for the commitment and dedication that went into that accomplishment.

So far this year, we're up about 100,000 customers — another excellent start.

Health Options grew by 35% last year and the customer retention rate was 92% — both excellent indicators. Health Options was ranked the 7th fastest growing HMO in the country by *Managed Healthcare* magazine (May '95).

Dynamic Industry

The growth in our managed care programs underscores the shift occurring in the marketplace. We're not doing this in a market free of other competitors, but rather in the face of multiple competitors. Ours is truly a dynamic industry.

I find it particularly ironic that there is so much energy in the marketplace for improvement at a time when inflation has moderated so much. In my way of thinking, the customer (employers in particular) is not reacting to an *annual rate of change* but rather to *10-15 years of accumulative price increases.*

As we all know, the marketplace *is* shifting from indemnity to managed care. Today more than 60% of all working Americans with private health insurance receive some form of managed care. In Florida alone, we have nearly three million enrollees in HMOs.

The winners within the market are those who can capture economies of scale and still be local-market oriented. That is, they don't do everything differently in every city in the country but they leverage the commonalities while focusing on the local communities. I think this is important, and I'll come back to that a little later in our conversation.

Challenges

As the industry continues to evolve, traditional roles and relationships between consumers, providers, insurers and government are being redefined. For example, new competitors are entering the marketplace.

I started in this business almost 35 years ago in sales and marketing. The top ten competitors remained relatively constant from 1960 to 1990, but as a result of accumulated consolidation in the last five years, we've seen the elimination

of Equitable, Hancock, Travelers, Metropolitan, and others.

We have to be careful not to try to retain our *insurance* culture as the industry moves to *managed care*. In five more years, it could be that there will only be one or two, if any, companies that transition from insurance to managed care. And while those people have the advantages of a customer base and finances, they also have the disadvantage of a split or diffusion in their focus. They may not be able to outperform a pure managed care company.

Going forward, we have to match off to the new competitors, match off to our markets, and determine what it takes to win in the face of those changes.

Our challenge is to protect the assets of our existing books of business, continue to move to managed care, and continue to move to market leadership in the managed care environment where we're seen as the best. Out of that will come both economic and personal success in our long term futures.

At the same time, we have to recognize that the health care delivery system is consolidating all around us. Who would have guessed a year or two ago that Jacksonville would effectively be down to two networks. We've looked at Miami and while it seems to be so competitive and so fragmented that it could never consolidate, we are realizing that it will, even though we can't predict how it will.

Another challenge for us as a managed care company is to successfully deal with a consolidated delivery system — in terms of customer expectations, product design, provider relationships and many other features.

We're also operating in a regulatory environment that continues to place increased scrutiny on the industry.

Usually you see this level of regulation only in monopolistic circumstances — like a public utility. But in our case, we have regulation *and* competition and plenty of both. That makes our challenge all the greater.

We also see some other challenges. There is right now, and has been for several months, a series of very negative, one-sided managed care stories on national television. This is not accidental.

Partisan give and take has resulted in the political use of anti-managed care messages, as evidenced by the negative newspaper articles and television programs. We have to operate in this kind of environment.

In Florida, we continue to see anti-managed care legislation proposed in the legislature. And there is a group of workers' compensation attorneys hard at work on an anti-managed care ballot initiative to amend the Florida Constitution.

There is also a group working on another ballot initiative to convert the entire Florida health care system to a Canadian-type system. This seems a little passé today given the enlightened knowledge and data about the Canadian system — how it does and does not operate. Nonetheless, we have a dedicated group of individuals trying to sign up some 450,000 people to get this proposition on the ballot.

Stepping away from the political/legislative arena and looking at the marketplace, we're experiencing downward pressure on profits — most recently on sales and retention in almost every product line and segment. This is particularly true in Medicare supplement products, and we're also seeing some deterioration in the underwritten group business.

It should be noted that we've had five or six years of extraordinarily fine profits.

Profits that are a reward to this company for more than a decade of hard work in developing managed care.

Having a range of products, being in the market early, staying with it, and learning from our mistakes — combined with daily dedication — produced sales and strong earnings.

But the market continues to force competition, and profits are going down dramatically — in Florida and nationally. We're seeing such things as the seemingly indiscriminate use of rate guarantees.

I know there's the fear that if you're working an account where there are only one or two other meaningful competitors, and you offer a rate guarantee, it's predictable that your competitor will offer one in response. The next day you're no better off competitively but you do have a new financial responsibility. And not all of those turn out positive.

It's the old price war scenario between two gas stations across the street from each other. You end up paying the customer to come take your gasoline. You don't sell any more than what you sold before when you sold it for $1.25 a gallon.

When you get into the process of "price matching" — which I'd be the first to agree sometimes has to be done — you really have to guard against the fact that you're entering into more than just a price war. For what you give, the customer doesn't recognize you've done anything special because everyone else matches it. You end up back to where you started.

That's just one example of the intensified competition we're seeing. We also see a tremendous difference in the health care delivery system itself.

BCBSF's Response

To match off against this dynamic environment and win in the marketplace, we must significantly change — and achieve dramatic improvements in — the way we do business.

We have selected Marketing and Managed Care as our key business strategies. They will help us move in the direction we need to go.

We're also continuing our grassroots initiative. This initiative is designed to help neutralize the threats to managed care, deal with some of the political pressures we talked about earlier, and enhance the understanding and acceptance of managed care products in the marketplace.

Marketing Strategy

From a marketing standpoint, we're trying to build on our current position with market leadership in selected segments and position ourselves with providers and customers as *the* clear market leader.

For us to survive in the marketplace, it's critical that we achieve our strategic marketing targets by the year 2000. These targets are to achieve 25% customer penetration and about a $10 billion share of the revenues flowing through our providers and network products in Florida.

We can't achieve 25% market penetration by doing the same things we do now — even if we do them more effectively. We have to pursue new opportunities.

Successfully implementing our Marketing strategy depends on a number of key elements including:

- developing an ever-deeper knowledge of our customers' needs, values and expectations;
- understanding how the competition is perceived by its customers, and beyond that, understanding our major competitors' strategies, cost structures and human organizations in detail;
- strengthening our market data collection and analytical capabilities

so we can evaluate new markets and sub-segments of markets and identify business opportunities ahead of our competitors; and

- maintaining a product portfolio that will provide a diverse customer base with the array of products and services they need and want while achieving economies of scale.

A recent McKinsey article, one of the world's leading management consulting firms, focused on the managed care industry. *["Winning in the Health Care Storm: Recent Sailing Strategies and Navigational Equipment for the Future" by Michael S. Pritula, Director in McKinsey's New York Office.]*

One of their key conclusions was that if you separate the winners from the losers and the marginal operators, the winners matched off by market — south Florida separate from north Florida, etc. But they did enough things alike to gain economies of scale. What does that mean? It means you only have differences that are economically justified.

To the degree that we have different standard operating procedures between Tampa and Miami that are not economically justified, we're carrying extra cost that hurts our competitive position. We could be a company of a million customers, broken down into 20,000-member segments, each very tailor-made to its own market, and fail utterly because we haven't captured the economies of being a million-member organization. And that would apply to corporate overhead and a whole host of other areas.

We need the ability to develop products and to support them. We also have to anticipate them and be sure we can gain the economies of scale that are central to winning in the marketplace.

For example, one of United Health Care's key strategies is to be low cost on a PMPM basis so they can enter any market. For those of you familiar with their numbers, they are pretty low. So we've got to gain economies and yet have products that match off to segments of markets. The genius is in the execution of the broad thought.

Managed Care Strategy

I'd like to talk a bit about our Managed Care strategy. We need to develop capabilities that add significant value to our customers in the way they receive, and providers deliver, health care and related service.

Implementing this customer-focused strategy means that Blue Cross will take increasing accountability for the *total health care experience* of our customers.

This is fascinating. Fifteen years ago we used to say: "Can't control the docs, don't know what's going on, the claims sure went up."

More recently we've said: "Got to negotiate a good price, got to influence inpatient admissions, got to moderate utilization, and we are somewhat responsible for the resulting circumstances."

Tomorrow we're saying: "All of the foregoing is needed, all that accountability for cost is there, but we're actually going to have to take accountability for the health and wellness of our customers."

The winners are going to be those companies that figure out how to do that. This means work in prevention, illness management, health outcomes and generally adding value to our communities.

Continuous quality improvement for the entire corporation will be key to our success. While there has been excellent work done to gain NCQA accreditation, we've just started the journey and have a long way to go. This framework of continuous quality improvement, or total quality management, needs to extend across all functions of the company.

Successfully implementing our Managed Care strategy also means developing win-win, collaborative relationships with selected providers. We need to move to the point where the provider believes that we have a genuine interest and concern for their success and their well being. This has to be based on our behavior, not just our words.

Business Transformation

You've heard before that the magnitude of change we face is significant. We recognized that incremental improvements would not be enough, though they'll be needed.

The reengineering effort underway is designed to make significant, fundamental changes. Reengineering is one component of our Business Transformation initiative. It works in conjunction with transformation of the human organization, and the effective use of information technology. All three need to be integrated to get the key results we need.

What are those key results? We have a document labeled "A Case for Change" that defines the key results.

The Case for Change says we must get to four million customers by the turn of the century.

We have to cut administrative expenses from the current 15%-17% of revenue range to 5% to 10%. That is a major change!

We have to keep medical cost increases on our managed care products to zero or less.

And, we have to reduce the time it takes for product development and rollout from 18+ months to six months or less. This clearly entails planning ahead and forecasting the kind of products you need. You can't decide in a six-month period to conceive a new product, get the required information technology, and take care of the rest of the implementation. As we learned with Care Manager, it doesn't happen that fast.

So we need to change the way we develop and rollout products. We need to do more things in parallel, we need to do more prototyping, and we need to accurately forecast future market requirements.

It is surprising how much of that is possible. As I'm sure many of you know, Care Manager has been an emerging product in the marketplace for more than 10 years. While we've had difficulty resolving different views on what it should and should not be and in implementing it, there was ample lead time in the market. So, focusing on the market is part of improving that performance.

As we look at the Case for Change, and see the decrease in administrative expense and the increase in customers, I'd like to emphasize that our focus is not just on cost reduction. It's really on completely transforming the business. To understand that more fully, we need to relate back to our two key business strategies — Marketing and Managed Care.

Going Forward

We cannot allow ourselves to be lulled by past success and we cannot rely on current business practices for future success. Today's environment demands that we do a great deal more.

Financial and sales results through the third quarter this year are below plan, making fourth quarter performance critical. It also underscores the absolute necessity of implementing the Marketing and Managed Care strategies as well as our Business Transformation initiatives.

When senior management looked at 1995 and did the initial forecast, earnings were not adequate. So we initiated a series of medical expense reduction (MERT) activities. One of those was to install the

RBRVS payment system. This was a wonderful effort on our company's part because we said: "We did forecast the future. It was not what we had hoped; therefore, we will do more things, even more difficult things, to bring about a better result."

Taking a sense of responsibility for a future condition of the company is so valuable, and I think we're going to have to do that in a number of ways. We've had poor, not inadequate but poor, financial results for August and September. As I mentioned earlier, they were led by poor results in the Medicare supplement business.

We can anticipate continued financial pressure. We think Medicare supplement expenses have gone up for all our competitors as well as ourselves. Even then, the regulators may say, "Don't talk to us about a rate increase of any consequence right now."

So the pressure on finances comes not only from medical cost structures and competitive activity, but also on the revenue side because of regulation. It brings together some of our earlier discussion about being both a regulated and a competitive industry.

As we move into 1996, the centerpiece of our efforts are the Marketing and Managed Care strategies as well as the change initiatives that flow from those strategies.

Competition in this time period is going to be intense. First, it's going to be based on price. I'm sure some of you have seen the ad that recently caught my attention. PCA has entered the Jacksonville market with an individual HMO product priced in the $75 range. Obviously, we're just going to have lots of opportunities to compete!

Dealing with Conflict

In my view, the one thing that's characterized our success during the last 10-15 years is the teamwork and support that we've shown for one another. As we tackle the various issues before us, it's inevitable that conflict will surface.

One of the most powerful researchers/writers in the field of business and change management talks about conflict this way. When you have competent people within multiple disciplines (like sales, finance, systems, health care services), they will think about a business problem with different frameworks of reference and will arrive at different conclusions. Because they do, conflict will be a given. The only way to eliminate that conflict is to have mediocrity. If you homogenize your people so they all see the world the same way, then you can eliminate conflict. But you also eliminate the chances of having a winning strategy.

Because we do have strong, capable people with diverse experience and backgrounds, conflict is inevitable. What we do with that conflict is up to us. If we can constructively confront it by saying: "Let me tell you what I see...these are the factors I'm considering...this is why I'm concerned..." If each of us can do that with greater skill — questioning and listening — then between us, we can arrive at informed decision that represent our excellence as a team as well as our excellence as individuals.

Central to our ability to work together is the ability for middle management and professionals to solve problems that in years gone by, may have gone to senior management. There is simply too much change to deal with. Senior management needs to support strategy, but we need multi-disciplinary teams across the organization identifying and resolving issues and innovating as we move forward.

Conclusion

Six years of consecutive growth and financial success is a tremendous accomplishment. However, our industry is complex and the rate of change is accelerating. This will require increased effort from all of us if we're to remain competitive.

One of the bonuses I get from attending national meetings is the widespread acknowledgment that we are one of the high performing companies in the industry. We are not the highest, but we are one of the handful of the highest. We all need to take a moment and reflect on that high accomplishment — and then we need to take a deep breath and start moving forward.

We look forward to this being our seventh good year. While it's not always clear exactly how the next year is going to be quite so great, I'm sure it will be as well. I appreciate the role that each of you plays in developing and helping our company achieve its success.

Despite the challenges and threats, we are producing excellent contract gains. I personally rejoice in the retention numbers, too. The improvement we've made in retention is absolutely remarkable. I know it reflects a team effort on the part of everybody — from the people helping with service all the way to those who are out in the field calling on customers.

I know our challenges are significant, but so are our opportunities — opportunities to develop innovative new products, expand access to affordable health care, and to increase the value we provide our customers.

Our strategies are sound: we've had expert counsel, our people have read widely, and they have talked to others in the industry. We think we have the relevant information to make our decisions, and we're moving ahead. I'd like to thank you for your hard work and ask for your continued help and support.

On a personal note, right now is probably the most exciting it's been in the 35 years that I've been in the industry. We will see by the changes that take place in Medicare and the continued shift of the market to managed care, a total change of our industry in a very short period of time. And, I really do look forward to working with you for the continued success of the company.

Thank you very much.

ATTACHED: McKinsey article

Winning in the Health Care Storm: Recent Sailing Strategies and Navigational Equipment for the Future

Michael S. Pritula

For all the turmoil in the financial services sector over the past 15 years, nothing has quite matched the storm in the health care payor and provider market. As always, change produces winners and losers and never more so than in this case. Over the past 5 to 10 years, the winners hewed to a common set of management principles and strategic themes better than the also-rans. As a result, the market rewarded the winners by assigning them an economic value that is quite staggering by previous industry standards.

Imagine a hospital company with a market value over $15 billion. Imagine HMOs valued above $10 billion.

Fortunately, the storm of the past decade provides some help in forecasting the weather ahead and the sailing strategies required to win. Almost certainly, some recent winners will fade, while some current also-rans will emerge from the pack to join the winner's circle. The new winners, however, will have to introduce several significant enhancements to management practices in the industry and adopt different tactics from those winners of the recent past.

Significant Shifts in Value Creation

After several decades of stability, the U.S. health care industry witnessed a remarkable transformation in the 1980s and early 1990s. Between 1950 and 1980, the market shares of indemnity insurers and the Blues changed little.

Metropolitan, AEtna, and The Travelers were the top three health insurers in 1963, with roughly 30 percent of the private health insurance market premium, and—surprise—Metropolitan, AEtna, and The Travelers remained the three largest health insurers in 1980, still with roughly 30 percent of the market. Provider share and capacity were similarly stable. True, Kaiser Permanente had begun its long and steady push toward leadership status, but still lacked market clout in

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1980. Physician capacity grew at a very steady 2 to 3 percent per year, every year, between 1960 and 1980. Across all health care segments, it was a monotonous market to watch.

But in the early 1980s, employers began to ask a lot of tough questions about the value delivered by insurers and, more important, providers. Groups of hospitals and groups of physicians in several local markets began to assert that they could deliver greater value to patients than aggregations of their peers could. By the early 1980s, the gaping inefficiencies of the U.S. health care market were clear and under attack by various organizations. For the next decade, these institutions chipped away at the inefficiencies. A handful—the winners—did it so successfully that in 1995 these institutions have built enormous economic value—the highest in the history of the U.S. health care system. Never before have we had health care entities as successful as these.

Because the health care world is different from other markets, a strong caveat is warranted. Economic value (i.e., the value of estimated future cash flows of an organization) is just one of several objectives for most health care institutions and not the primary objective for many. For example, few academic health centers would put financial performance ahead of research and medical innovation. Still, economic value is increasingly the yardstick that will be used to allocate very scarce capital in the industry, including capital deployed by not-for-profit institutions. For that reason alone, industry participants will need to pay more attention to measures of economic value.

Exhibit 1 presents two simple but compelling lists. List A shows the 16 largest health care organizations, measured by economic value, in 1993. Remarkably, 9 of the 16 would not have appeared on a similar list in 1983; they have emerged largely in the past 10 years. List B shows the 11 winners in the industry—those institutions that have created the most economic value between 1983 and 1993.

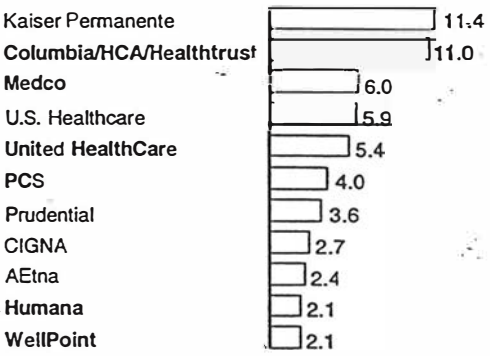
The winners list ranges widely—with pharmacy benefit managers (Medco, PCS), HMOs (Kaiser, United HealthCare, U.S. Healthcare, Humana, WellPoint), hospitals (Columbia/HCA/Healthtrust), and a few of the traditional indemnity insurers that have managed to change with the times (Prudential, CIGNA, AEtna). Interestingly, between 1989 and 1993, more value ($66 billion) was created by publicly held HMOs, insurers, and providers than the rest of the health care industry (Exhibit 2).

EXHIBIT 1
Largest Value Creators

List A
Health care payor/providers with largest value 1993
$ Billions

1. Kaiser Permanente	15.0
2. **Columbia/HCA/Healthtrust**	14.5
3. **Medco**	6.6
4. **U.S. Healthcare**	6.3
5. **United HealthCare**	5.9
6. **CIGNA**	5.7
7. **Prudential**	5.0
8. **AEtna**	4.0
9. **PCS**	4.0
10. National Medical/American Medical	3.6
11. **WellPoint**	3.1
12. **Humana**	2.9
13. **New York Life**	1.6
14. **Caremark**	1.4
15. **Manor Care**	1.4
16. **Value Health**	1.2

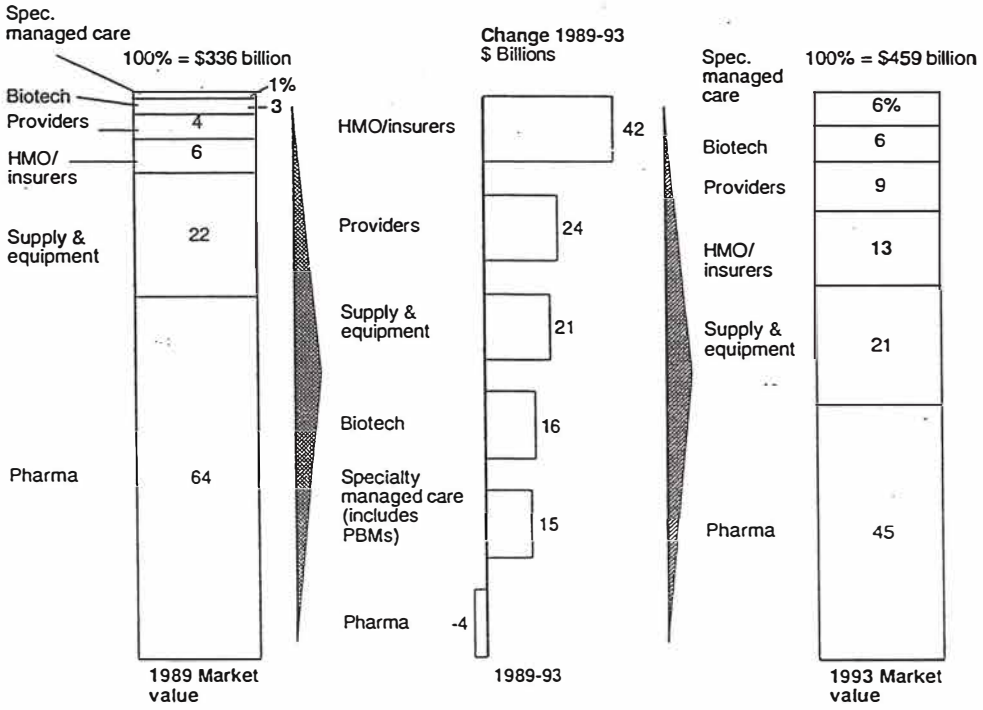
List B
Largest creators of value among health care payor/providers 1983-93
$ Billions



Note: Companies in bold are newcomers, i.e., not on the list in 1983
Source: Compustat; annual reports

EXHIBIT 2
*Changes in Health Care Market Value 1989–93**

Constant 1994 dollars



* Companies assessed include publicly traded hospital, long-term care, outpatient, and psychiatric/substance-abuse companies; publicly traded HMOs, Kaiser Permanente, and the top 5 group health insurers; publicly traded speciality managed care companies, DPS, and PCS; and all publicly traded biotech, medical supply/device, and pharmaceutical companies; Blue Cross/Blue Shield plans and individual physician income were excluded from this analysis
Source: Compustat

For all the attention paid to leading-edge, integrated delivery systems, the primary shifts in economic value within the health care payor and provider segment over the last 15 years were more familiar. There were four:

- **Shift 1—from indemnity insurers to HMOs.** The wave of lives cascading across the managed care spectrum finally began to drain the indemnity and managed indemnity segments in 1993 and 1994; the indemnity books of most insurers declined. The market value of publicly traded HMOs increased from $ 0.6 billion in 1983 to $28.0 billion in 1993.

- **Shift 2—from pharmaceutical manufacturers, insurers, and HMOs to pharmacy benefit managers (PBMs).** The market value of PBMs in 1983 was essentially zero; by 1993, PBMs were worth $16.5 billion.

- **Shift 3—from not-for-profit and more complex medical centers to for-profit and less complex hospitals and outpatient facilities.** Large, integrated hospital care gave way to more efficient outpatient plus core hospital care. The number of beds in not-for-profit hospitals declined as a percent of total beds in the United States.

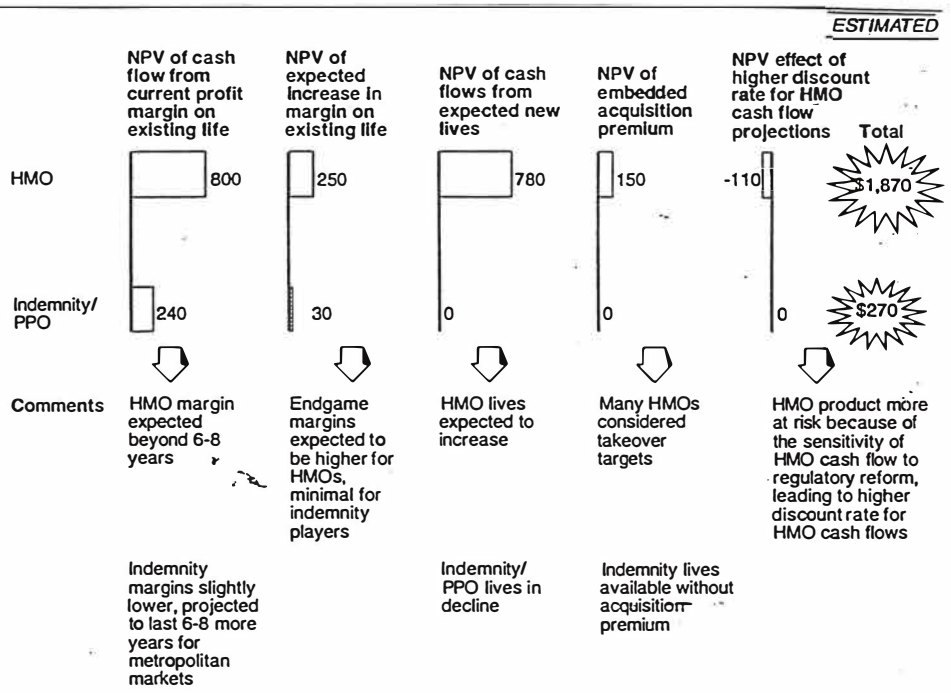
- **Shift 4—from bundled, monolithic health care payors and providers to specialty care providers.** Previously bundled packages of services were increasingly unbundled, as niche providers of services developed leading-edge capabilities in a number of areas.

Among these shifts, the trend from indemnity to HMO and point-of-service (POS) products stands out. Exhibit 3 highlights sober facts about the market's confidence in HMOs: an HMO life today is valued in the vicinity of $1,500 to $2,000, an indemnity life around $250 to $300. This sevenfold difference reflects several factors about the value of HMO lives today. While the value of HMO lives seems unjustifiably high, it indicates expectations about the cash flow derived from current margins, expected increases in these profit margins, the anticipated growth in HMO lives under management, and an imbedded acquisition premium.

EXHIBIT 3

HMO Life Valued More Highly for Several Reasons

Dollars per life



Source: Compustat; A.M. Best; annual reports; McKinsey analysis

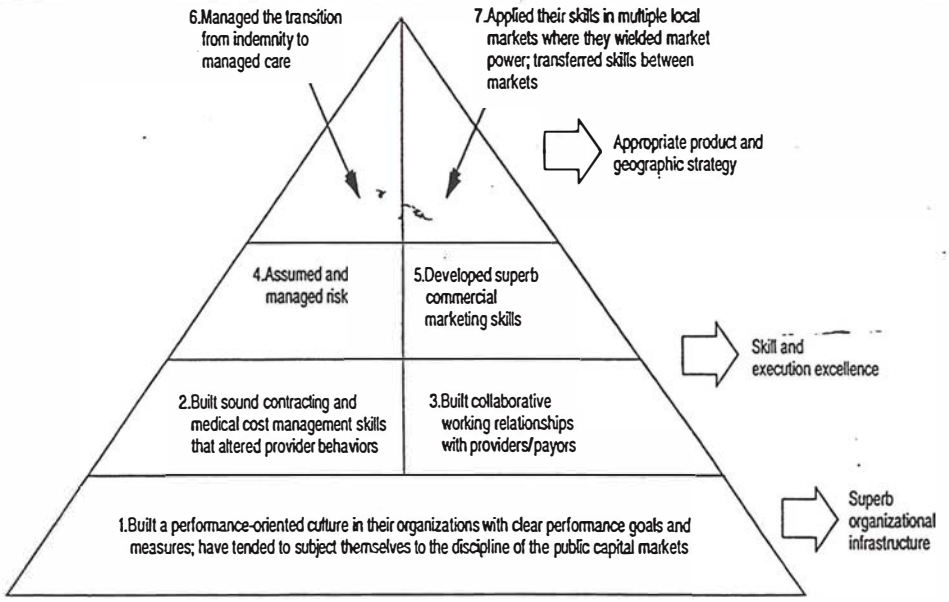
Indemnity lives offer none of this sizzle. The modest $250 to $300 value reflects simply the 3 to 4 percent margins on annual premium of roughly $1,200 per life, projected out 5 to 10 years with little or no terminal value. Beyond rural markets, the indemnity business may be in runoff mode, even if the runoff stretches over the next 10 years. Even the high-end, high-choice markets in metropolitan areas—long considered a preserve for pure indemnity/PPO players—will increasingly fall prey to high-end HMOs that put together flexible POS products. In the New York market, Oxford is searching for and increasingly finding the correct tacking strategy for the shifting winds in the high-end segment. Indemnity players may remain, but primarily for their distribution strength; the management of medical costs for high-end customers will be left to the managed care players. This dire forecast hems the indemnity players, including the Blues, into a more modest set of strategic options.

The Winners' Approach 1983–94

Despite the turmoil in the market, the distractions of reform discussions, and formidable competitive challenges, the 11 organizations on List B in Exhibit 1 rose and created significant economic value where others did not. They generally understood better than most that frustrated employers and employer groups represent an enormous opportunity and that provider inefficiencies can create room for new products to meet the needs of employers. Employer frustration and provider inefficiency remains a frighteningly simple, yet golden, equation.

Still the concept needed to be converted to operating reality, and all 11 winners set management agendas unparalleled in their conversion success. While their strategic and operating agendas differed slightly, the winners usually pursued programs that followed seven principles, which constituted the Triangle of Success for health care payors and providers over the past decade (Exhibit 4).

EXHIBIT 4
The Triangle of Success for Health Care Payors and Providers 1983–94



1. **Performance-oriented organization.** The winners are characterized by far-reaching aspirations that explicitly call for the organization to build a substantial role in the health care world. Financial performance aspirations are high, but do not dominate the overall mission. Objectives are crystal clear and balance the trade-offs inherent in simultaneously pursuing financial performance, quality of care, and customer satisfaction. These goals are also specific, both by market and by product.

   The backbone of these performance-oriented organizations is a set of tough, stringent measurement systems, linked closely to evaluation and reward mechanisms that produce meaningful consequences for both high performance and nonperformance. Operating agendas and priorities are unambiguous, with an appropriate balance between short- and long-term objectives.

   The use of public capital has been a necessary and energizing tool for most of the winners. Nine of the eleven are publicly held organizations and several—notably Columbia/HCA and WellPoint—have used public capital markets extensively. The two winners that

have not employed public capital to date—Prudential and Kaiser—may be forced in that direction if their network investment requirements outstrip current cash flow and conventional debt sources. Still, public capital should be recognized for what it is—nothing more than a financing vehicle—and not be viewed as a strategy in and of itself.

2. **Aggressive medical management skills.** Make no mistake: the primary value added by leading health care payors and providers over the past 15 years has been their ability to aggressively manage medical costs while delivering quality care. And their work is far from complete. Most studies benchmarking top-flight staff and group HMOs against the U.S. health care system indicate that significant excess cost remains in the system. Despite laudable cost-containment progress over the past 15 years, medical cost management still represents the first, second, and third objectives for most employers. Competitors that ignore this fact do so at great peril.

   Customer service and quality of care will gain importance, but leading payors and providers will continue pursuing comprehensive approaches to medical cost management. In managing medical costs to date, the winners have:

   - Believed their "raison d'être" is to manage medical costs aggressively for their customers, not just process transactions.
   - Set priorities for medical cost management by assessing the magnitude of the opportunity and likelihood of capture.
   - Built appropriate networks and negotiated contracts aggressively. Once basic networks and contracts are in place, most medical cost management savings are typically achieved one transaction at a time; the winners, therefore, devoted management resources to case-level reviews.
   - Understood that the forging of very close working relationships with physicians and other medical suppliers is the fundamental building block of medical cost management.
   - Recognized the importance of achieving scale in a local market and then using that scale to secure favorable prices and behaviors from suppliers and customers.
   - Adopted a "continuous improvement" mind-set to medical cost management and sought to replicate strong success from one period to the next.

Many health care organizations understand these principles. Few apply them with rigor and recognition of the need for frontline focus on details. Exhibit 5 highlights two examples from successful HMOs and PBMs—modest examples because they are replicated again and again in each major therapeutic and diagnostic area by the leading organizations.

3. **Close linkages to providers.** Value creation over the past 10 years has required extraordinarily strong relationships with providers and in some cases integration with them. Collaborative strategies, not the contentious relationships with providers pursued by wary insurers, hospitals, and HMOs, have delivered results. This collaboration has taken many forms: direct equity participation via joint ventures by physicians and other parties; profit-sharing arrangements between physicians and other parties; joint training/education programs with incentives for participation; joint outcomes research; and binding and nonbinding peer review.

4. **Risk assumption and management.** The traditional underwriting and risk management skills of insurers need not be relegated to the scrap heap; markets still reward companies that assume and manage risk. Lost in the rhetoric of the health care revolution of the past 15 years has been the dramatic movement of risk from payors to employers, back to payors, and now to providers. The fully insured health contracts of the 1970s gave way to ASO arrangements, which have, in turn, yielded to capitated contracts involving payors and, increasingly, providers. Payors and providers now assume risk—not because employers do not want to bear the risk—but because employers want payors and providers motivated to behave as if every medical procedure involved their own money. Most winners have assumed considerable risk.

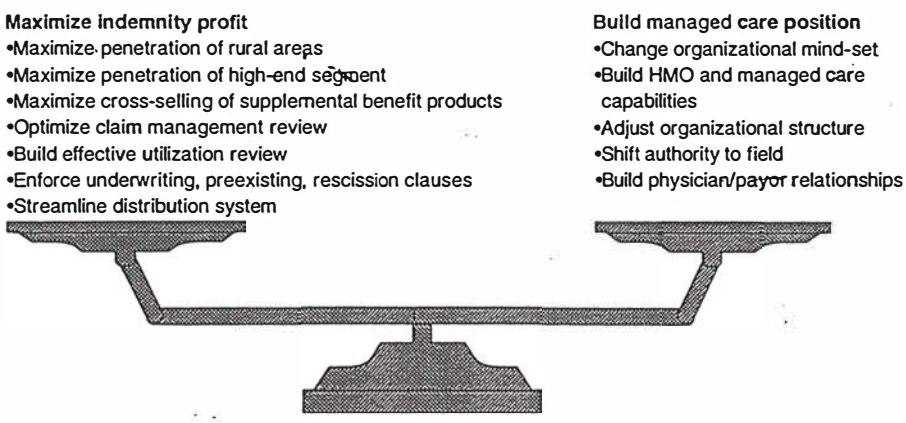
5. **Superb commercial marketing skills.** Notwithstanding the Clinton Administration's attempt to weaken the role of the employer in the U.S. health care system, employer-driven health care looks like the system of choice for the foreseeable future. While much has been made of the need for retail marketing capabilities in HMOs, value creation by the winners over the past 10 years has been driven by their commercial marketing skills—including the ability to define target employer segments and their needs, design products to meet target segment needs, develop a first-rate sales force and identify appropriate internal resources, establish a broker-intermediary strategy, and create a consultative selling approach. While retail marketing skills are gaining importance, they still take a backseat to these commercial marketing capabilities.

EXHIBIT 5
Medical Cost Management Execution

	HMO example (Pregnancy)	PBM example
1. Understand medical costs for entire book of business; identify opportunity areas	Pin down major areas of cost; normal pregnancy costs are significant percentage of total	Monitor total drug spending, overall, and for each account
2. Analyze provider behaviors that drive these costs	Conduct focus groups with physicians to understand regional treatment protocols and rationale	Profile physician-prescribing patterns to identify outliers
3. Establish best practices for each area, drawing from internal and external benchmarks	Document optimal normal pregnancy length of stay based on national and regional best practice studies	Develop formularies for generic and therapeutic substitution where appropriate
4. Evaluate current incentives and training causing gap between current behaviors and best practices	Expose physicians to best practice behavior and performance; identify barriers to achieving optimal performance (physician self-discovery)	Undertake pilots to test physician willingness to change prescriptions or allow them to be changed by pharmacists
5. Change peer review, incentives, training, and education for individuals driving medical costs; and/or change network configuration	Develop actions to reduce length of stay; improve prenatal care (e.g., random peer reviews, incentives for training, monthly obstetrics newsletter)	Share profiling/outlier data with heads of physician networks to encourage peer pressure for change
6. Measure and monitor impact of changes on medical costs; adjust program as necessary	Set goal for reduction in length-of-stay, complication rates; install targeted measurement program	Track prescription switching to on-formulary drugs resulting from specific switching efforts (e.g., physician education campaign)
7. Outsource specific medical management tasks where changes do not deliver as much impact as specialized suppliers	Expectant mother education programs outsourced to specialized firm	Contract case management service to monitor/communicate with high-usage patients (e.g., those with asthma)
8. Adopt continuous improvement approach to medical cost management	Task force reviews normal pregnancy cost and outcome management once a year	Integrate drug claims data with customers' medical data to better understand relationship between drug usage, medical outcomes, and overall medical costs

6. **Management of the transition from indemnity to managed care.** Most winners have faced the formidable challenge of managing an organization through the transition from indemnity to managed care. The winners have struck the right balance—maximizing the profit potential of the indemnity book while shifting the company toward managed care and building HMO scale. Exhibit 6 highlights the balance organizations need to strike.

EXHIBIT 6
Striking the Indemnity-Managed Care Balance



7. **Applied skills in multiple local markets.** It is worth repeating: health care is a local market game. Yet the leading creators of economic value over the last 10 years have proven that significant value creation occurs predominantly with a multilocal strategy. All of the winners compete in a dozen geographic markets or more; all have worked hard to share their best skills and capabilities across all their local markets. Value creation across local markets is difficult, and even the winners have struggled with the fundamentals of cross-market integration. Yet they have stayed the course and created value.

Traps to Avoid

Just as instructive as what the winners have done is what they have not done. In general, they have avoided five traps:

1. **Indemnity-will-last-forever syndrome.** Winners have not clung to profit maximization programs in their indemnity books of business at the expense of investing in underlying medical cost management and care improvement programs.

2. **Attila-the-Hun administrative cost management.** The winners have been driven by value and growth and have not focused their organizations unduly on administrative efficiencies and head count reduction programs.

3. **Technology infatuation.** Winners have not been driven by technology, but have relied on pragmatic, user-driven information technology programs.

4. **Program-of-the-month syndrome.** Winners have not pursued generalized "quality" or "reengineering" programs to the exclusion of operating fundamentals.

5. **Acquisitions and mergers to soothe the soul.** Although recent activity suggests otherwise, generally, the winners have not relied on acquisitions or mergers to create their value over the past 10 years. The recent wave of mergers and acquisitions has caused many to re-evaluate whether this is a trap or a solution. Without sufficient clarity of purpose, preparation, and execution, mergers and acquisitions remain very treacherous waters.

Value Creation in the Future

While the window into the recent winners' tactics and strategies is clear, the future brings a different set of challenges. Because so much inefficiency and ineffectiveness remain embedded in the U.S. health care system, significant value will be created over the next 10 years, as new payor and provider winners improve health care delivery by further reducing medical costs and improving outcomes and service. But the winners will have to meet a new generation of requirements in the seven areas that drove value creation in the past, while increasingly addressing the challenge of managing large institutions and avoiding the distractions of "new wave" management programs as well as the siren song of acquisitions and mergers.

The new generation of requirements veers sharply from the past; organizations will have to work hard not to rely on the behaviors and skills that led to past success. While past winners have built performance-oriented cultures and strong measurement systems, in the future they will need the ability to instill performance-oriented cultures in organizations that are large (over 10,000 employees) and geographically dispersed. They will need more sophisticated and integrated measurement systems that track behaviors and performance from the front line through to senior management.

The medical cost management skills of the past will likewise need to evolve into best of the breed. The market will require more sophisticated partnering and risk-sharing arrangements between payors and

providers that influence physician behavior more strongly than today. These risk-sharing arrangements should put physicians in the driver's seat so that they lead medical cost management. But the driver's seat is not without responsibilities; physicians must be financially accountable for their performance. First-rate medical cost management will also require superior collection, management, and use of information to review the efficacy of alternative treatments, compare the costs of alternatives, and develop practical protocols for optimal treatment approaches. These information systems must be able to handle employers' demands for measurement of their costs and service requirements, explicit incorporation of these costs and service requirements into treatment protocols, and also much greater emphasis on customer service. Finally, medical cost management will require outsourcing portions of medical care delivery when other participants can provide care more effectively and/or efficiently.

Collaborative working relationships with providers will need further development. Winning in the future will require health plan-hospital-physician group relationships based on shared objectives, mutual trust, and common philosophies of medical care delivery. Winners must become more agile at purchasing provider or administrative/marketing capacity on the margin in markets where overcapacity exists and at sharing equity ownership with other stakeholders where overcapacity does not exist. In some local markets, the winning organizations will be a PHO with an administrative/marketing partner. In other markets, tight HMOs with strong provider contracts will emerge as the winners. The distinction, however, is minor. Both markets will operate similarly.

Risk assumption skills will need significant enhancement, including much deeper actuarial understanding of underlying causes of risk for specific managed care populations. An ability to price to reflect underlying risk and to change price as needed will be critical. In addition, winners will recognize that providers ultimately bear more risk and adjust operations accordingly. Finally, laying off risk for treatment areas and specialty benefits where others can better manage the risk will be essential.

New-generation commercial marketing skills will involve more professional, consultative selling capabilities for midsized and large accounts, and deeper relationships with brokers in the small account market. Retail marketing skills will need to take a step forward as well.

The final transition from indemnity to managed care will find the winners creating full-fledged programs to capture the conversion value remaining in their indemnity books, developing clear rural market game plans, fully converting their indemnity skills and mind-set to

managed care, and pursuing market-driven product development that leads to innovative choice-based products (e.g., point of service).

Over time, the practice of health care and the management of its delivery will become more uniform across local markets. The information revolution will ensure this homogenization. As it proceeds, cross-local management will become even more critical. Choosing appropriate multiple local markets to compete in will require much greater clarity about the right strategy for each local market—low cost, niche, or integration. Programs to share best management practices and medical management knowledge across local markets will be necessary. The goal of this geographic assessment will be to build a position among the top three competitors in each local market or decide to exit. As in the past, the winners will be more resolute and courageous in their exit decisions.

New-Generation Requirements

The new-generation requirements will place an enormous burden on senior management to capture the benefits of scale—the winners will increasingly grow to employ 10,000 to 20,000 employees or more as they achieve the benefits of cross-market scale. These organizations will need:

1. **Access to capital.** Investments required to build local positions of scale will be significant, in many cases exceeding current cash flow. More aggressive use of public and private capital markets will be needed, provided an appropriate strategy in which to deploy the capital has been outlined.

2. **Access to leadership/management talent.** Winners in the payor-provider segment will grow to scale positions calling for separate business units in many local markets. General management and leadership skills will require significant upgrading.

3. **Maintenance of values and culture.** Larger, geographically dispersed institutions will have greater difficulty maintaining and reinforcing their values and culture. To prevent defections, spin-offs, and highly variable geographic performance, senior management will need to ensure consistent adherence to the underlying values of the organization by all its members.

4. **Connection of middle management initiatives and actions to senior management agenda.** Larger organizations undergoing significant growth and change must devote more time and attention to ensuring consistency of purpose and strategy across all levels of the organization. They will need significantly enhanced management processes and information systems.

These new-generation requirements would be daunting in the best of times. With competitive intensity in this market at an all-time high, with wild-card reform initiatives springing up all over the map, and with larger and larger organizations to manage, senior management should focus on answering a number of critical questions in order to win in this market over the next 10 years (Exhibit 7). The best of the industry's competitors today are well on their way to addressing these questions. The stakes and the competition require both the answers and the execution to be right on the mark.

EXHIBIT 7
Questions for Senior Management

Future requirement	Key questions
1. Performance-oriented culture; strong measurement systems	1. What are the underlying performance aspirations of the senior management team? Are they sufficiently high? 2. Are measurement systems in place that allow the performance of personnel to be rigorously tracked? 3. Do these performance systems lead to meaningful differences in rewards for top performers?
2. First-rate medical cost management skills	1. Is there sufficient confidence in the organization's medical cost management skills to offer capitated rates? 2. Are suppliers sufficiently motivated to control their costs and improve service levels? 3. Is information available to assess medical costs, outcome, and service performance for each major area of medical cost? Are ongoing measurement systems producing this information? 4. Does the organization understand where it is not the best manager of medical costs and where it should turn to outsiders and outsourcing options?
3. Collaborative working relationships with providers	1. Is there a high degree of mutual trust among the physicians-hospitals-payors in each of the local delivery systems in which the organization participates? 2. If high levels of trust are not evident, is that fact understood and are there plans in place to establish trust? 3. Is provider-payor capacity utilization understood in each local market, and is it appropriately reflected in the contracting and alliance strategy? 4. Are shared-equity alliances actively being pursued?

Future requirement	Key questions
4. Risk assumption	1. Are actuarial capabilities first-rate in relevant markets? 2. Are pricing models flexible and up to date? 3. Is an active risk management program in place?
5. Superb commercial marketing skills	1. Is it clear which employer segments are being targeted, what their service and product needs are, and what distribution channel can best reach them? 2. Are there skills in place in the organization to develop trust-based relationships with employers?
6. Fully manage transition from indemnity to managed care	1. Are there plans in place to convert current indemnity lives to new products? 2. Are there plans in place to maximize penetration of rural markets? 3. Is the organization's orientation and mind-set shifting quickly enough from a fee-for-service indemnity mind-set to a capitated, managed care market? 4. Are choice-based "bridge" products available to help in the transition phase?
7. Participation in appropriate multiple local markets	1. Is the source of competitive advantage of the organization clear and compelling in each local market? 2. Are adjacent geographic markets adequately penetrated? 3. Are skills, capabilities, and best practices transferred easily among different local markets within the organization?
8. Access to capital	1. Are current levels of capital adequate to meet the growth and expansion needs of the organization? 2. Have alternative sources of capital been adequately evaluated in terms of their cost and constraints? 3. Have the cost and benefits of public ownership been rigorously assessed?
9. Access to leadership/ management talent	1. Are business units within the organization sufficiently distinct, and is there adequate general management talent to run each business unit? 2. Is the organization constantly recruiting and seeking out successful managerial talent within the industry?

Future requirement	Key questions
10. Maintenance of values and culture	1. Are the values held by members of the organization consistent? Are these values linked to the performance aspirations of senior management?
11. Connection of senior agenda to operating priorities and economic impact	1. Is the strategic and operating agenda of senior management clearly stated and agreed to by members of senior management? 2. Is the overall strategic and operating agenda understood by middle management? 3. Are the specific action plans, projects, and frontline initiatives linked to the senior management agenda? 4. Are frontline personnel pursuing actions and initiatives that are linked to improved financial performance?

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