INSIDE CALIFORNIA'S HMO MARKET: A CONVERSATION WITH LEONARD D. SCHAEFFER

by John K. Iglehart

Prologue: *Over the past decade, us health insurers have reshaped their products around managed cure, a growing number of Blue Cross and Blue Shield plans have pursued an entrepreneurial course that stands in contrast to their historical roots and important history. No figure has been more important in charting this course than Leonard Schaeffer, a direct, self-confident man who has held a variety of leadership positions in federal and state governments and in private-sector organizations . In this interview Schueffer sets forth many of the ideas that have shaped Blue Cross of California in the years he has presided over it. Long before many other Blue Cross and Blue Shield plans (in California they are separate organizations that compete against one another), Schaefer mowed away from traditional indemnity insurance and toward managed cure. He came to the attention of Wall Street in 1993 when Blue Cross of California sold 20 percent of its vast managed cure business through a public stock offering. In March 1995 Blue CrOSS and Health Systems International (HSI) , another large managed cure plan, signed a definitive agreement for WellPoint Health Networks, Blue Cross's for-profit subsidiary, to acquire HSI. However, because the companies were unable to resolve significant differences, they are now engaged in discussions to mutually terminute the deal. Schaeffer has a candid personal style and possesses a quick, self-deprecating wit. Before joining Blue Cross he was chief executive officer of Group Health, Inc., of Minneapolis. He also has served us administrator of the Health Cure Financing Administration. Earlier, at various times, Schaeffer was chief operating officer of the Student Loan Marketing Association and a vice-president of Citibank. Schaeffer, a graduate of Princeton University, currently is chairman of the board of the National Institute for Health Cure Management.*

Reorganizing Blue Cross of California

Q: *You became chief executive officer of Blue Cross of California in 1986. Not long after you arrived, you discovered that the plan was in serious financial trouble, bordering on insolvency. How did you turn the plan around?*

A: The company was very close to being insolvent, but, ironically, we did not know that. Accounting in health insurance companies is extremely arcane. In addition, the books were probably not that accurate. The good news was that we had to face serious financial issues before the rest of the industry did. The bad news was that the issues were very serious. The classic way to turn a company around is to begin by reducing internal operating costs. That was a very unpleasant experience because we were forced to pare a workforce of 6,500 employees down to 3,000 in eighteen months. But that was only the first step along our road to recovery.

Q: *How did you proceed?*

A: I did not come to California as a specialist in turning around companies, although it was a subject I knew something about. I came to California to implement my theory that health care finance could be organized in a way that would incentivize providers to be more cost-effective in delivering care and patients to be more cost-conscious about its use. So while we were compelled to start with "We have got to cut our overhead," the real goal was to transform Blue Cross of California into a managed health care company.

Q: *How did you actually pursue that goal?*

A: First, and most important, we decided not to organize by function, the way the company was organized when I arrived, and not by product, which is the way most health care plans are organized. Rather, we decided to organize by market segment. The idea behind this approach was based on the following observations. If you organize by function, everybody can do their function correctly and still end up with nothing. That was certainly the case at Blue Cross of California. We had excellent sales, excellent actuarial capacity, excellent everything, but when we added it up at the end of the day, it did not spell profit. Indeed, it spelled a loss of $157 million.

If a company organizes by product, the company tends to fall in love with its product. Although this may offend everybody in the business, that has been HMOs' conventional approach. Most big HMOs are "in love" with their product, and it is simply the wrong focus. General Motors provides a classic example of this strong attachment to "product." Its Buick division set a strategic course to reduce its U.S. market share by 9 percent. Buick, convinced that it was building a terrific car, believed that the public was too unsophisticated to recognize the value of its "terrific car."

Q: *When Blue Cross of California reorganized to be market focused, what did that mean, more precisely?*

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A: To organize by market segment means simply that. A company organizes around an identifiable segment of the market. It creates products and delivers services that will meet the needs of the people in that segment. The challenge at Blue Cross was first to identify the segment and then charge managers with the responsibility for meeting the needs of customers within that segment. We identified two market segments as our prime business targets. For one segment we lumped together the individual- who purchases insurance directly-and small groups-from two to fifty people. The second segment was large groups over fifty. Each of these segments has an identifiable set of needs and expectations. If you organize around providing them, it is possible to create successful products. In this process, we really rediscovered the individual who needs insurance. Prior to our business decision, these people had very limited options for coverage.

Q: *Have these market segments proved to be profitable?*

A: Yes. We challenged the conventional wisdom that a company cannot make money insuring individuals and the employees of small businesses. But our insurance products have been extremely successful because demand for them is high. We insure more than one million people in these segments, and the business is extremely profitable. There is enough latitude in California so that we could design products and price them to be economically viable. Over time I became very concerned that we would be accused of creaming-that is, insuring only the healthiest people-or that a health care reform law would force us to make certain that our membership reflected the risk profile of the broad population. So we pledged to enroll a higher-risk group for every three groups that were deemed to be average or below-average insurance risks. The criticism that has been leveled at our approach is that a higher-risk person pays a larger premium, and that is true. But there are only three levels of premium for individuals or small groups that are considered good risks, average risks, and high risks.

Q: *I assume that the imperative of Blue Cross of California, like any private business, to sell only economically viable products limits its availability to millions of people in California.*

A: Unfortunately, you are right. From a social policy point of view, the biggest problem is that for these products to be viable, premiums must cover costs. In California there are millions of poor immigrants, some of them undocumented, and other people (many of whom are employed) who do not earn very much money. I don't think the private sector can cover people who have little or no capacity to pay. A state-sponsored insurance purchasing pool for small employers, the Health Insurance Plan of California, which began operation in July 1993 (see *Health Affairs*, Spring I 1994, page 350), enables some workers to buy coverage at more affordable rates, but millions remain uninsured.

Public, Nonprofit, And For-Profit Organizations

Q: *You have presided over both large public agencies and private corporations. In managing such enterprises, what differences strike you as being most important?*

A: I would enlarge your definition by saying there are really three classes of organizations. One is organized on a not-for-profit basis, a second is a for-profit enterprise that is privately owned, and a third is a for-profit that is publicly held, meaning there are stockholders and that stocks are listed on exchanges. In terms of the first two types of organizations, I have seen both excellent ones and very bureaucratic, very ineffective ones. The key differentiating features are leadership and oversight. If an organization's leadership is strong and it has a corporate culture that is performance-oriented, it does not matter whether it is organized to turn a profit; that organization will make headway. But if the leadership of a not-for-profit is lacking, no external pressure exists that forces it to perform in an economic sense.

Q: *When you served in government, what level of accountability were you held to, in your opinion? Was it greater or less than what you have experienced in the private sector?*

A: Congress holds public agencies accountable, not economically, at least during my time, but in very soft policy terms. And, most of the time, unfortunately, accountability quickly degenerated from a focus on helping the poor to a focus on a particular scandal on a particular day. For example, an eighty-six-year-old Medicare beneficiary who is thought to have been released "quicker and sicker" would receive disproportionate attention compared with the much more vexing policy questions that face the entire program. That approach to accountability will not lead to better, more thoughtful policy. Rather, that is government by anecdote, or what we used to call "government by horror story." When I headed the Health Care Financing Administration (1978-1980) they distributed daily what was called the "Green Sheet"-a compilation of press clippings from the leading newspapers and periodicals. We all lived in fear of being singled out and criticized in some simplistic fashion in these clippings. The Green Sheet, however, is not a measure of the quality of an organization. So it is lack of accountability that allows large bureaucracies without strong executive leadership to drift.

The Profit Motive And The Social Ethic

Q: *How effective is the profit motive as a measure of accountability? I am thinking of the incentives that drive a for-profit company , particularly the imperative to perform quarter- by-quarter.*

A: There is no question that the pressure for economic performance and thus accountability to investors is very real. Competition is a very good way to engender financial accountability and to add cost pressure. But in health care, I think it is rare that large, well-known companies can fail to meet the legitimate health care needs of their enrolled members just to bolster profits. There are bad actors in every sector, but a company can't survive over time if high profits are its sole operating goal.

Q: *How does the mentality of Wall Street influence the way in which your company operates?*

A: The difficulty, as you indicated in your previous question, is that market pressures are extremely short term. Stock analysts who follow companies want them to perform to their calculated profit estimates every quarter. Having said that, though, I do not think there was any real big impact when Blue Cross of California converted its managed care business from not-for-profit to for-profit. We had learned our lesson in the early 1980s about losing money. We were very focused on economic success, on financial strength, and the market we served was also very focused because there had been bankruptcies in California. So there was almost no change in how we behaved. We were one of the most profitable plans in the United States. However, when we became publicly held, and listed on the stock exchange, for the first time ever there were incredible pressures for achieving our goals for quarterly earnings.

Q: *You are in the forefront of those Blue Cross and Blue Shield plans that are pursuing a highly entrepreneurial course. Some critics of that approach say that the Blues are abandoning their traditional social ethic that grew from their beginnings and long history. What is your opinion on that issue?*

A: My observation would be that both ends of the spectrum are a bit extreme. I don't think that not-for-profit health plans, when they reach any size, are as socially motivated as people would like to believe. My observation is that some Blues plans-some hospitals, too-hide behind the claim that they are driven by a social ethic. Therefore, they have an excuse to be inefficient and should be held accountable in different ways. So I think that has been overpainted. Any type of organization should have incentives to eliminate waste and to operate cost-effectively. There are a few organizations that are accountable because of their structure and membership-like Group Health Cooperative of Puget Sound and Group Health Cooperative in Minnesota-but if you are accountable to your membership, that is different than taking on accountability for all of society.

Market Transformation For Blues And HMOs

Q: *Given the rapid transformation of the system, what is the future of the Blue*

Cross and Blue Shield association of plans? The plans are bound by a well-known trademark, but they are increasingly competing against one another in different markets through companies they own that bear other names.

A: I think one should recognize clearly that in a rapidly changing market environment, size works against an enterprise. Typically, the bigger you are, the less agile and less innovative you are. That is not a judgment about people, it is a judgment about how systems work. Most Blues plans are very big; thus, most Blues plans have not reacted quickly to marketplace changes. The managed care revolution, if you will, has gone by many of them. The second important observation has to do with age. How long has an enterprise been doing the same thing, and what is its record of success? The Blues were very successful for a long time, and their traditional operations got embedded. So many plans said, in essence: Why should we change? A third issue is the unwieldy politics of a national association with sixty-nine independent plans, each with a vote on the board, each representing different medical markets, each with a different approach to salvaging a profit.

Having made these observations, I conclude that it is going to be difficult for the Blues system to function as a system. In the future, instead of sixty-nine plans, I envision that there will be thirty, perhaps even just twenty, organized on a regional basis. There is no economic reason for the association to continue as it has in the past.

Q: *How does Kaiser Permanente fit into the changing market picture in California?*

A: Kaiser Permanente has done a marvelous job for its membership, the bulk of which resides in California. But, as a nonprofit HMO, I don't think it has done much for other Californians. Kaiser does not enroll those who cannot pay its premiums. In fact, I argue that Kaiser has taken all of the medical revenues of its California membership-almost, five million people-out of the state's pool of available health care monies, put it in its own private health insurance system, and therefore made the rest of the system bear the burden of caring for all of the people who are uninsured. I would say much the same thing about Group Health in Minnesota, which is a company I formerly headed. It is an excellent company. I remember that in our board discussions, we were very concerned about our social role. But it was not our unique social role to provide care to people if they could not pay their premiums. Rather, it was a broader societal responsibility.

Q: *Do you see the not-for-profit HMO as a dying breed?*

A: Health care organizations need capital, and it is very hard to generate enough capital from operating revenues. So, I think that for-profit plans will increasingly dominate the industry in terms of the number of organizations, the amount of revenues that flow through them, and the number of people that they enroll.

Q: *Many of the traditional HMOs, like Kaiser Permanente and Harvard Community Health Plan, own their own facilities and thus must maintain and revitalize them. Given the excess capacity that exists almost everywhere, is ownership a competitive liability at this stage of the system's evolution?*

A: Yes, I think ownership is a major liability. This comes from my experience in the Twin Cities with Group Health, and it is not a criticism of the way Kaiser operates. In an era of grotesque overcapacity, ownership causes two problems. First, when an organization maintains its own capacity, particularly hospitals, it becomes very expensive, far more so than contracting for these services with hospitals that a company does not own. Second, when an organization owns a hospital, it is physically in one place, but populations move, highways are built, and so forth. Kaiser is addressing that problem now, prompting some of its regions to sell hospitals and contract for services through other institutions they do not own. A number of Kaiser's regions also are developing their own provider networks outside of the Permanente Medical Groups, a historic step that underscores the importance that consumers attach to broad access within the framework of managed care.

Q: *At some point, presumably the overcapacity of the system will be squeezed out, and managed care plans will no longer be able to buy care at marginal costs. What will occur then?*

A: There will be a magic moment when that occurs. One of the business issues we face is estimating when that moment will occur and positioning our organization accordingly. We own a medical clinic, and we are learning about that business. We are a substantial shareholder in a company that manages physician practices, and we are learning about that as well. It is not beyond the realm of possibility that we will become more involved in the delivery of care, but until the oversupply is really squeezed out, ownership of capacity will not be the most efficient way to deliver services.

Q: *In a health care system that is transformed on the basis of price competition, how should things like biomedical research, medical education, and patient care that is at the clinical frontier be financed?*

A: In my mind, these are very much public goods that federal and state governments must focus on. The essential question is, How much money should society earmark for these purposes? Health policymakers have never addressed that question very explicitly, so until now these functions have been financed through cost shifting between payers and cross-subsidies between functions. I do worry about these functions because I think that managed care, when executed well, can control costs, but it does not really address the issue of how research or the education of the next generation of physicians will be financed. I worry that our whole research capacity could wither as a consequence of the emergence of a market-based system unless Congress addresses this as a major public policy issue.

Q: *The American health care system is in great turmoil, in large part because of the market-driven transformation and the failure of society to settle with any precision on what role government should play, other than perhaps trimming its sails. Is it possible to go through a transformation like this with less tumult?*
A: One irony is that we Americans have the best medical care in human history. Period. The downside is, we can't afford it. How then do we bring economic discipline into an endeavor that is completely undisciplined economically? We would like to think that there is some way we can do this in a balanced and controlled fashion, but there isn't. It's not going to be pretty. People and institutions are going to get hurt. And it will swing from one extreme to the other.

The Role Of Government

Q: *Do you envision that over the next five to ten years the pain of which you speak will be driven by the private sector, with government largely a bystander?*
A: I think the short answer is yes, there will be painful downsizing forced by the private market. When I arrived in Washington in 1977, the notion of economic value did not apply. Health care was a human right; society had an obligation to provide it. I would still like to believe that, but the point is, economic resources are finite, and the payers don't believe they are getting value for their money.
Q: *Americans rejected comprehensive health care reform through their collective voice-Congress-because of a mistrust of the federal government. Do Americans have it right on that score, that government simply lacks the capacity to manage and finance large health cure programs!*
A: In health care, as opposed to other endeavors where government's role has been defined more clearly, I think they are right. There are two key concepts to remember about health care. One is that health care is a locally delivered, locally consumed service. So size and economies of scale are not meaningful concepts, although some people would disagree. I doubt whether the lowest-cost, highest-quality hospitals are going to be operated by national chains because it is simply too difficult to run hundreds of institutions from a central office. So I see it as a local challenge that is very difficult to organize, very difficult to finance, and most difficult to finance equitably.

But even at the local level-take the recent upheaval of the county-run system in Los Angeles-government is sometimes inept. I think that the county ought to be a purchaser of care, not a provider of it. There are a number of health plans that would be very happy to provide that care, if the business was constructed properly. The county should find a way to purchase care from people who are in that business rather than attempting to run an operation whose role is to serve the poor, but whose real operating

purpose may be to employ a large cadre of people for an awful lot of money.

Physicians In A Changing Market

Q: *As purchasers aggregate their market power through coalitions and various alliances and as health plans grow through acquisitions and mergers, will physicians be able to level the playing field through the creation of physician-controlled entities, which will become effective competitors?*

A: Physicians are a match for buyers today. Their problem is the gross oversupply of doctors and thus the market opportunity that this presents health plans to purchase medical care at lower costs. That is a matter of supply and demand, not that physicians are being abused.

Q: *Recently, the Mulliken Medical Group, a physician-controlled organization headquartered in southern California, merged with another medical organization. Do you view these larger aggregations of physicians as one of the waves of the future?*

A: They may well be, but I think that managing large groups of doctors is very difficult. I am a firm believer, as a lay person, in multispecialty group medical practices. But when the group exceeds 100 or 200 physicians, it becomes a very difficult management challenge.

Q: *Is that because of the nature of the individual who gravitates toward medicine?*

A: That certainly has a lot to do with it. There is a self-selection process at work that favors those who are independent-minded and smart. Equally important is the nature of medical practice itself. Physicians practice alone. It is the doctor and the patient alone, and the physician is trained to make tough decisions. Most doctors are not amenable to being told by someone who was not in that treatment room that the course of treatment should have been different.

Q: *We seem to be groping toward a system that places physicians in charge clinically, but within a new economic framework-that is, through contract or employment, placing physicians at some financial risk and exacting agreements that they will provide a set of benefits to an enrolled population on a fixed budget. My impression of managed care is that, through private organizations rather than government, society appears comfortable with letting health plans ration resources through their fixed budgets.*

A: You are making my speech. I agree. Where I think we might part company is that it takes different skills and a different set of organizational management principles to deliver care, as opposed to running a hospital. Hospitals don't manage their doctors; they provide a workbench for physicians who do whatever they want to do. That is why I think that integrated delivery systems are a great idea intellectually, but operationally they are just too

difficult. I favor the phrase "virtually integrated system." By that I mean different organizations with different sets of skills that are bound by contract to offer health care to third-party payers. It's not this simple, but to make the point, primary care doctors provide basic medical services, inpatient care is delivered in hospitals, and health plans provide financing and the benefit product design. Each has its own management challenges and sets of skills. Being a well-trained physician does not mean you can run a health plan, and vice versa.

Q: *Increasingly, though, one hears medical groups say, if we could only eliminate the middleman-the managed care plan-and contract directly with the payer, that would be a more cost-effective system. The profits extracted by the health plan could be eliminated. Is that a pipe dream?*

A: If the middleman can be eliminated, that's terrific. If the middleman adds no value, get rid of him absolutely. But there are very few examples of that working. The best-organized physician practice I have ever seen is the Mayo Clinic, period. You have to ask yourself why is there only one place in the United States where every doctor has the same size office and the same amenities and agrees to deliver care based on strict protocols. That culture is a function of the thinking that the Mayo brothers brought to medicine. It has not been replicated, as far as I know. Even the Mayo practices that are far from its Rochester, Minnesota, headquarters are not the same as what you can observe at the "mother house." (The two other Mayo operations are in Jacksonville, Florida, and Scottsdale, Arizona.) So managing doctors and managing the practice of medicine is inherently difficult, especially among professional colleagues.

Q: *What is your vision of the role physicians will assume in a decade or two?*

A: I think that we will see the emergence of more physician-managers. The difficulty-and this is a fairly esoteric point, but an important one-is this: Successful physicians possess a certain kind of skill set, world view, and ego strength. They place tremendous value on being independent and making decisions based on personal, hands-on observation of patients. To be successful, a physician must look at the patient, look at the test results, and make a decision. Bang! You don't work through other people-you do it yourself.

Human organizations are very different. What tends to be important is hierarchies. Decisionmakers in a large, labor-intensive organization rarely see the actual situation; they are insulated because they deal through other people. Teamwork and cooperation are the key words as opposed to individual decision making. The physician-managers who become successful will be those who figure out how to bridge the physician culture and the organizational culture.

Q: *We talked earlier about organizational accountability. I'd be interested in*

your views on how to make physicians more accountable, especially because of the value they place on independence and the sanctity of the physician/patient relationship.

A: I think that it is generally recognized that physicians differ in their clinical skills, experience, and knowledge. Because of these differences, there is tremendous variation in the medical care that patients receive. Patients should have the peace of mind that they are getting high-quality care based on scientific evidence and not on factors such as where they live. Many plans, including ours, are making investments in data systems that support utilization review, quality management, outcomes assessment, and provider profiling, which will allow us to identify cost-effective treatments and providers who are not using them. I believe that this is not a punitive approach to accountability, but one that allows the system to educate its providers to give the best quality of care.

Medicare Reform

Q: *Medicare reform may allow providers to form networks that contract directly with HCFA to provide services on a capitated basis. This has been an issue for your industry. In general, do you agree with the direction Congress is taking on Medicare reform?*

A: I am very supportive of Medicare reform, because we cannot continue to sustain a program that is built on a 1965 fee-for-service model that hasn't kept pace with the managed care developments in the private sector. Restructuring the program to expand choice of managed care plans is a very positive step. At the same time, I have some concerns with the details of the proposals that have emerged. Establishing a level playing field is critical, but creating a separate federal regulatory framework with separate standards for provider-sponsored networks (PSNs), giving them a competitive advantage, violates this principle. A competitive Medicare market also means that plans should be able to charge a market rate as opposed to federally set premium caps. Additionally, policymakers should take steps to control the selection bias that is likely to occur, in order to achieve a more equitable distribution of risk among all Medicare options. Congress is right to uncouple the average annual per capita cost from fee-for-service expenditures, but policymakers should implement incentives to encourage the less healthy to choose private-sector options and develop a prospective risk adjustment system.

Note-For-Profit To For-Profit Conversions

Q: *The last subject I would like to explore with you deals; with the conversion of not-for-profit companies into for-profit enterprises. Many Blue Cross and*

Blue Shield plans are examining their options in this regard. You were at the center of the recent conversion to for-profit status of the managed care business of Blue Cross of California (WellPoint Health Networks) that provoked controversy in California. Was the public well served by the result?

A: In California the laws are very clear. If an organization converts to for-profit status, the value that has been created in the process must be earmarked for charitable purposes. Before the conversion of WellPoint, the value of every single company that converted to for-profit status was significantly underestimated. What was granted to charity turned out to be much less than was realized a week, a month, or a year later, when Wall Street placed a true market value on the for-profit HMO that resulted from the conversion. Almost all of the value created went to the management and the boards of those companies. In WellPoint's case, charity will receive the maximum public benefit value.

Q: *Are there several outstanding examples that you could cite where the market value of the for-profit HMO was greatly underestimated?*

A: FHP International, Foundation Health, PacifiCare, TakeCare, you name it. These are companies that today are led by multimillionaires who achieved that status by virtue of receiving stock that was dramatically undervalued at the time of conversion. After the company went public, the market set the value, and suddenly California had a new set of millionaires. Blue Cross of California is the only company in the history of the state that has said we will endow a charitable foundation with all of the assets of our company-$3 billion-rather than see the conversion redound to the financial benefit of management. Neither I nor any senior officer has any stock options or any stock advantage from this conversion.

Q: *Who will be the stewards of this largesse, and what will be their relationship to Blue Cross of California?*

A: Two foundations were formed to avoid taxation of the gift. Without this structure, the gift itself would be taxable at a rate of $6-$8 million a year, which obviously would reduce its value. There is no overlap between the boards of the two foundations and Blue Cross of California. Initially, all of the funds will be granted for charitable social purposes in California, but ultimately the boards will make the funding decisions.

Q: *Thank you.*