RECORD OF SOCIETY OF ACTUARIES
1984 VOL. 10 NO. 1

INVOLVEMENT OF INSURERS IN HMO's, PPO's, EMPLOYER COALITIONS AND WELLNESS PROGRAMS

Moderator: VINCENT W. DONNELLY. Panelists: PAUL S. BOULIS, JOSEPH H. WALTON**, RICHARD S. WOLF*

We are at the beginning of a revolution in the financing and delivery of medical care. Employers are trying to take control of their health benefits plans. Physicians are forming Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's). Legislation is being introduced which either protects a particular health care delivery system or seeks to create a new one. Insurers are heavily involved in these efforts. During this session, panelists will discuss:
- A successful HMO
- A dynamic employer coalition
- An emerging PPO
- An industry-sponsored "wellness at the worksite" program

MR. VINCENT W. DONNELLY: Our topic today is health care cost containment. Any of us can "talk" about it - and do. But only a few are really involved in "doing something" about it. Today we have a rare opportunity to hear from three persons who are significantly involved, on a daily basis, in containing health care costs - one with Health Maintenance Organizations (HMO), one with Preferred Provider Organizations (PPO), and finally one with a newly formed employer coalition. At the conclusion of their remarks, I will show a film which promotes the concept of "wellness at the worksite", which is just another important concept for controlling health care costs.

MR. PAUL S. BOULIS: Most of you, by now, have heard of the Blue Cross network through the publicity associated with United Airlines (UAL) purchase of the product in 1982. Since this time we have refined the product somewhat and have formally named the network "HMO-USA". There are a lot of attractive features and benefits this product can offer an employer, and its employees as well. Before I talk specifically about these, however, let me first tell you a little about our involvement with HMO's nationally and some background on how and why we developed the network product.
Currently, the Blue Cross Blue Shield system includes 40 plans, 59 HMO programs and over 1.5 million HMO members (a 26% increase in 1983). This represents approximately 11% of the total national enrollment of 12 million. The reasons we have gotten involved to this extent have been market demand and proven cost savings. One example is hospital costs. They have been cut-in-half. This savings is now beginning to show up in premiums. I can recall when HMO premiums were almost always higher than traditional insurance premiums. This is not the case anymore. In fact, for the period 1980-1982 traditional premiums for individual subscribers increased 46.6%

* Mr. Boulis, not a member of the Society, is Executive Director, Blue Cross/Blue Shield Assn., Chicago
** Mr. Walton, not a member of the Society, is Director of Marketing, Connecticut General Life Insurance Company, Hartford.

compared to 29.2% for HMO's. For family contracts, this same comparison showed traditional with increases of 42.6% verses 34.4%. If this trend continues, in 1-3 years the HMO premiums will almost always be less than traditional. Ford is a good example in translating these premium charges into actual cost savings - in 1982 $5 million, in 1983 the savings were $7 million. Because of this kind of savings, when corporations address their health care cost containment needs they almost always include HMOs in their scheme of things along with benefit modifications, PPOs, coalitions, etc. HMOs provide a nice back up option when implementing a cost sharing program. Today, there are over 50,000 employers offering the HMO option -- most of your larger employer policyholders are among these.

More interesting than this statistic is the number of different HMOs being offered by these employers. In a 1983 study NAEHCA discovered that their member companies offered an average of 20.5 HMOs. Non-members offered an average of 9 HMOs. If you translate this to a geographic picture you can imagine how the HMO administrative complexities can grow. Think of what you do for one HMO and multiply by 20, e.g., enrollments, gathering rate information, resolving claims inquiries. Your policyholders may not be offering this many HMOs, but the potential is there. Hence, we developed the HMO network product. This is really not something that is brand new. Blue Cross Blue Shield has been doing this for one of its largest accounts for several years. In fact, many of those features are incorporated into the HMO-USA product.

We have not been as aggressive with a private network. Primarily due to questions of market acceptance and adequate coverage. However, the environment has changed. Employers offering HMOs have become commonplace and our capacity to provide national HMO coverage has grown dramatically. As you know, the Blue Cross Blue Shield national capacity far surpasses the competition. Of our 25 state HMO capability, the HMO-USA product serves 21 states with 38 HMO programs. Translating this into a geographical picture you can see this is an extensive amount of coverage. I do not mean to imply that the entire state is served by an HMO. However, most large cities in these states are covered. Comparing this to where your policyholders are located you will most likely find a large percentage of their employees served by Blue Cross Blue Shield HMOs. The bottom line is the network will make the job easier for a multi-state employer.

Let's look at some of the specific features and benefits. Probably the most obvious is central accountability. Obviously if you can channel your activities through one source vs. ten, efficiency has got to result. As a result of the agreements we have with all network HMOs a policyholder can expect a greater degree of program continuity. Instead of having to approve or provide direction for multiple HMO offerings, this can all be coordinated by the control HMO. You can go through a central source or you can have the option of contacting your local HMO.

Your legal counsel doesn't have to review and approve multiple contracts. By virtue of standard contract language, pre-agreed to by all HMOs, the policyholder can be sheltered from the normal diversity of HMOs. By virtue of the fact we have signed contracts by our network, HMOs performance is ensured. What this all boils down to is added program credibility.

A single billing statement can cover all HMOs. There's no need to prepare individual checks. Because of the control plan--participating plan configuration, a form of central eligibility can be maintained. From a practical standpoint, however, this has to be done locally anyway. Additions and terminations which can be time consuming to administer can be handled centrally. Flexibility is important. If central billing is not compatible with an employer's system, local billing can be arranged.

One of the more attractive benefits is the financial protection arrangement. Each participating network HMO is backed by the local Blue Cross Blue Shield plan. Should an HMO go insolvent, employees would not be responsible for unpaid medical bills. This obviously means added security for employees. Often times, one reason a corporation requires all HMOs to be federally qualified is to satisfy the employer'sneed for financial protection. This is inherent in our network without federal qualification.

HMO-USA will provide accounts with management reports. The information will be aggregate. Obviously account specific information would not be valid because of the relatively small enrollment base. At some point in the future this will most likely be possible.

What all of these features boil down to for an employer is reduced cost because of reduced communications and correspondence, reduced staff time, simplified administration, and greatly reduced duplication.

One of the more unique benefit features for employees is urgent care. Employees have access to other network HMOs for urgent care. The advantage is that they don't have to use a hospital emergency room, although this option remains open. It is important to point out this is not for routine care. Employees use a wallet size card to get access. The card has information such as telephone numbers, hours, addresses, etc. If an employer has a policy of frequent employee transfers, this can be simplified with the HMO network. The control HMO can provide advanced details and enrollment information. Employees will, of course, retain the right to convert to direct pay in the event they terminate employment. What all of these benefits boil down to is greater employee satisfaction.

As you can see, this is a rather unique approach to offering HMOs. It provides some very cost effective features for the employer and at the same time improves the overall HMO benefits.

We began test marketing in the fall of 1982, looking for a few potential customers who we knew were pro-HMO and who were/are acknowledged leaders in their industry. United Airlines met these, and other, important criteria. Their indemnity carrier is CIGNA and has been for over 15 years. In other words, United was not a current Blue Cross and Blue Shield customer. We also demonstrated that HMO-USA provided a Blue Cross and Blue Shield entree into an industry in which we are under-represented. In the past, because of United's policy of centralized decision-making, no Blue Cross and Blue Shield plan-affiliated HMO outside of United's Chicago corporate headquarters area had any UAL enrollment. The expense and time-consuming nature of having HMOs in Los Angeles, New York, and other distant sites needing approval from UAL corporate headquarters in Chicago before marketing their HMOs locally made UAL a bad prospect for these HMOs. Currently, however, approximately 25 HMOs participate in the United network. Prior

to offering HMO-USA, United had a written corporate policy of offering federally qualified HMOs only. Because of the Blue Cross and Blue Shield seal of approval, financial guarantee and improved out-of-area benefits for employees, UAL waived this policy for the network. In sum, in selecting United Airlines as one of our test market targets, we sought a company in which Blue Cross and Blue Shield and their affiliated HMOs had no inherited advantages; and we successfully demonstrated the appeal of the concept and network product.

A second test market case was Home Savings. This HMO client was enrolled by Healthnet -- the Blue Cross of California HMO. Last summer, Home Savings threatened not to renew the HMO contract because Maxicare presented their network to the account and Home Savings decreed they would not offer two similar HMOs to their employees. Because our network had HMOs in more places where Home Savings has employees than does Maxicare, not only did Healthnet retain its enrollment but HMOs in Chicago and St. Louis gained their first-ever Home Savings enrollment.

Test marketing is now complete and we are marketing the program nationwide as of last December when a press conference "officially" launched the network. The nationwide implementation came too late for the numerous January 1 health insurance contract renewal dates. However, we are currently talking with over two dozen major national companies which have July 1 and October 1 contract renewal dates and we're very optimistic of substantial success in the near future.

MR. RICHARD S. WOLF: Over the past few years, the rapid rises in health care costs have caused health benefit plan costs to rise to a point that they are now a very significant budget item for most employers. In many companies, this has resulted in the financial people being very much interested in the plan costs and possible alternatives to the spiraling increases. In an effort to capitalize on collective strengths, it is only natural that employers have formed coalitions to work towards putting a lid on these costs.

During the next few minutes, we will be discussing a specific coalition rather than the concept itself. In focusing on the Atlanta Coalition, we'll be discussing such things as (a) how the Coalition was created, (b) specific parameters describing the Coalition, (c) its goals, (d) how it is organized to reach these goals, (e) its efforts thus far, (f) its successes, and (g) its shortcomings.

We'll then wrap things up by discussing several unique aspects of the Coalition and how insurers have been involved.

As an Atlantan and an employee of a company heavily involved in this Coalition's activities, I'm very happy to be sharing this information with you. The Coalition's efforts thus far represent a tremendous amount of work by a number of very dedicated people.

Background on Creation of the Coalition

Like other areas of the country, the Atlanta area has experienced rapidly rising health care costs for several years. The rising costs created enough concern in the business community that in late 1979 a meeting of community leaders was held to see what might be done. The outcome of the

meeting was the creation in March, 1980 of the Task Force on Health Care Cost. This task force was formed under the auspices of the Atlanta Chamber of Commerce to: (1) identify controllable causes of rising health care costs in the Atlanta area; (2) focus community attention on them; and (3) gather broad support for community action.

By late 1980, a full review of the community medical care cost problems had been made and tentative solutions identified. The culminating meeting of the task force was held as a public forum education conference in early 1981 with some 1,000 persons in attendance.

The resulting success of the forum led to the recommendation to create a more permanent organization. It was felt that a permanent, community-based organization, properly funded and staffed would be the most effective vehicle for meeting the objectives identified by the task force. This organization would bring together a broad range of viewpoints and concerns and would guarantee a total approach to the health care cost problems of the area.

In August, 1982, the Coalition became incorporated and in January, 1983, the first Board of Directors' meeting was held. Thus activities, prior to 1983, were focused on generating the support and organization necessary to create the Coalition.

The Coalition

In order to get some idea of the scope of the Coalition, it is helpful to review some of its key features:

1. Geographically, the Coalition serves an area consisting of seven counties in metropolitan Atlanta. The population is roughly 1.8 million people with Coalition members representing a substantial number of lives.

2. Membership is open to any employer, association, or individual. Despite broad membership, much of the support and impetus of the Coalition has come from the larger employers. At the same time, the involvement of the provider community and individual members has proved to be very beneficial. Several of the larger employers in the Atlanta area include Southern Bell, Coca Cola, Georgia Power, Georgia Pacific and Lockheed Georgia.

3. The Coalition, while having strong Chamber of Commerce support, operates separately with its own policy-making Board of Directors. The Board has roughly 50% representation from sustaining members and 50% from other members such as physician groups, hospital groups. Blue Cross/Blue Shield and HMO's.

4. Initial funding has come from membership dues, seed money from the Chamber and an 18 month planning grant from the Robert Wood Johnson Foundation. The Coalition is now working towards securing from the Foundation an implementation grant which may be as much as $1.5 million.

5. The Coalition staff consists of an executive director, an associate director, and a full-time clerical person. Until earlier this year, the executive director job was occupied by a person with duties split between the Coalition and the Chamber of Commerce. Now the job is a

full-time position devoted to Coalition activities and answerable to the Coalition president.

Goals

In general, the primary goal of the Coalition is to control rising health care cost in the greater Atlanta area and, to the extent possible, throughout the state of Georgia. This is to be done without impairing the quality of health care being delivered.

In order to meet this goal, there need to be cooperative community support, and effective organization, adequate staff, and specifically defined objectives. All of this, of course, requires funding.

As you might suspect, the more immediate goals of the Coalition have been to get people involved, create an effective committee structure, define tasks, secure additional membership support, and secure outside funding support, such as from the Robert Wood Johnson Foundation.

While the Coalition's list of future projects is significant, the initial project involves designing and implementing a program for managing the utilization of hospital services. This project, known as the Utilization Management Project, has the goal of reducing hospital inpatient days by 7-10% in the first year and 5% each of the next two years.

Organization

In order to pursue its goals, the Coalition has a permanent full-time staff which works in concert with the committees and the Board of Directors. Committees established thus far include ones for the Data Project, Community Education, Legislative, Public Relations, and Utilization Management. There is also the Executive Committee and the Project Steering Committee.

As noted earlier, the Coalition is governed by a Board of Directors. The Board consists of senior people from the business and provider communities. The active involvement of these people, as well as the resulting participation of others from their organizations have given the Coalition efforts credibility, visibility, and direction.

1983 Efforts

In general, 1983 was a very busy year for the Coalition. Some of the efforts and accomplishments during 1983 were as follows:

1. A program of employer education workshops was set up on a bi-monthly basis to expose employer representatives to outside speakers on a variety of health-related issues.

2. By mid-1983, the Benefit Manager's Council was established in response to concerns as to how employers might work together to institute cost control features, share ideas, etc.

3. Committees were organized and staffed to begin planning for longer range projects.

4. In August, there was a leadership retreat to allow the Board an

opportunity to focus on Coalition activities thus far and better define its future course.

5. In the latter part of the year, successful efforts culminated in the securing of a $100,000 18-month grant from the Robert Wood Johnson Foundation. This grant is being used for planning the Utilization Management Project. By qualifying for this grant, the Coalition became eligible to apply for the much larger implementation grant.

6. Efforts were directed towards defining an action-oriented Utilization Management Project for implementation of Atlanta area employers, hospitals, and physicians. The idea is to focus on reducing hospital admissions and length of stay, using pre-admission hospital authorization, concurrent inpatient review, and discharge planning.

7. Finally, efforts continued to enroll new Coalition members and renew the membership of existing ones.

Plans for 1984 (And Beyond)

The major project effort for 1984 and beyond involves planning and implementing the Utilization Management Project, hopefully with implementation funding from the Robert Wood Johnson Foundation.

In 1984, efforts will be directed towards planning the project and positioning the Coalition to secure the Robert Wood Johnson Foundation implementation grant. In general, this will involve data gathering, marshalling systems resources, and designing the program itself.

The Utilization Review Program is expected to be started on a pilot basis in late 1984 and go full steam in 1985. Other efforts of the Coalition will involve such things as: (a) promotion of cost-effective alternative financing and delivery arrangements; (b) promotion of competitive pricing of health services; and (c) health and wellness promotion.

In addition to the above, the Coalition is also preparing legislative projects, including the monitoring of appropriate issues, as well as tort reform and the simplification of the regulatory process at all levels of government.

Successes

In general, the major success of the Coalition thus far has been to generate broad community support and commitment.

While outward results have been few and many problems are yet to be solved, getting people together from different segments of the delivery system to discuss the problems has been a major accomplishment. Out of this discussion has come a focus on the priority project of controlling hospital utilization. This focus, staff efforts, and Board direction helped in securing the initial Robert Wood Johnson Foundation grant.

Shortcomings

Probably the biggest shortcoming of the Coalition has been the slowness with which things have developed. This can probably be attributed to

(a) delays resulting from key changes in the Chamber professional staff and (b) the diversity of the Coalition support and the need to resolve differences.

Another shortcoming has been that of defining data needs and developing an efficient way to gather data from members. Here the main problems have involved determining the Coalition's needs and an approach to overcome a number of logistic problems. Most of these problems exist because of carrier differences in definitions and systems.

Unique Aspects of the Atlanta Coalition

How does the Atlanta Coalition differ from others?

1. Certainly the broad community participation of employers, physician groups, hospital groups, organized labor, HMO's and insurers is a major distinguishing characteristic. Other coalitions tend to be business-based or provider-based.

2. The Atlanta area has historically been noted for having a strong business community, physician groups, and hospital groups. Each have their own interests but are working together under the Coalition. In order to have an upfront understanding between employers and providers, a formalized "Articles of Agreement" document was prepared.

3. In Atlanta, everyone shares a major concern of the oversupply of hospital beds, with overall occupancy under 60%. The Coalition recognizes that as its programs reduce inpatient days, the problem will get worse unless something is done to reduce the number of beds. This problem must, and will, be addressed.

Conclusion

Each organization involved in the Coalition obviously has something at stake. In general, the degree of involvement varies accordingly. For example, insurer involvement has varied depending on the extent of community ties, volume of group business in Atlanta, and general interest in cost containment. My company, being headquartered in Atlanta, has supported the Coalition by being a sustaining member with Board membership and substantial committee involvement.

Most participants in the Coalition do so with the feeling that (a) something must be done, (b) getting involved can only help, and (c) failure to self-regulate is likely to lead to more government regulation.

The Atlanta Coalition is still very much in its early stages but even so has already generated a tremendous amount of productive activity, enthusiasm, and cause of optimism.

MR. JOSEPH H. WALTON: During the 1970's we witnessed a very rapid growth of dental insurance. At the end of the decade, approximately 87 million people were covered under some form of voluntary dental benefit plans, approximately a third of the population. And with the growth of dental insurance, national expenditures for dental care also grew. In 1970 the nation spent $4.6 billion for dental services. By 1980, dental expenditures rose $10.7 billion to bring the total outlay to $15.4 billion. On a per capita basis, expenditures for dental care increased from $22 in 1970 to $67 in 1980.

What accounts for the $10.7 billion increase in national dental expenditures? Most of it is attributable to inflation. In terms of constant 1967 dollars the increase was $2.2 billion, costs attributable to population growth, increased use of services and changes in the nature and intensity of services. The proliferation of dental insurance exerted an important influence. As insurance reduced the cost barrier the nation's population purchased more dental care and more expensive dental services. Currently about a third of all expenditures for dental services represent crown and bridge work.

Looking ahead, national dental expenditures are expected to increase from the current level, approximately $22 billion, to $27 billion in 1985 and $42 billion in 1990. Expenditures per person will rise from $98 to $111 in 1984 and $167 in 1990. Rising personal income, an aging population and an oversupply of dentists marketing their services will help to shape this trend.

Increasingly, corporate benefit buyers are becoming concerned about the cost of dental benefits and are seeking means to contain this expense with other health care benefit costs. Insurance payments for dental care in 1983 came to about $6 billion. A major part of that $6 billion was paid by employers as dental benefit plans tend to be non-contributory or employers pay a large share of the premium costs. As with medical benefits, corporate benefit buyers have adopted a pro-competition strategy to contain dental benefit costs. This works in several ways, but the end result is to place economic pressure on doctors to charge reasonable fees and to not overtreat. Competitive health care delivery systems accomplish this goal.

Connecticut General's response has been to experiment with the Preferred Provider Organization (PPO) concept as an alternate means to deliver dental benefits. Very simply, this is an arrangement with a group of dentists to provide care at a reduced maximum fee, and submit to utilization review. In exchange for these concessions the carrier agrees to promote the dentists group among its insureds so participating doctors may realize a gain in patient flow.

The PPO has certain advantages. It is compatible with fee-for-service delivery of health services, the foundation for health care products offered by commercial insurance companies. The PPO concept does not lock the patient in. One member of the family can choose a PPO provider, another member of the family can choose his or her regular dentist. In some respects the PPO entails less administrative burden for the employer. A PPO program can be implemented without a change in benefit plan design. There is no necessity for an enrollment to track what employees are in what program.

The PPO also has some disadvantages. Particularly with dental coverage, there is a limit on plan design incentives that can be created to encourage the user of services to choose a PPO provider. A plan that reimburses beneficiaries at 80%, 90% or 100% for major restoration services obtained from a PPO dentist, vs. the typical 50% or 60%, will increase utilization and costs. Effective copayment features must remain a part of plan design for benefits as elective as dental care. Perhaps another disadvantage is that the PPO does not exert as much efficient control on utilization and costs as may exist in other alternate delivery systems that place the provider at risk, i.e., capitation plans. A reduced maximum fee schedule is usually the main incentive for choosing a PPO dentist.

When Connecticut General set about creating a PPO we began by establishing objectives. First, we wanted a quality group of doctors. This is largely subjective when evaluating a doctor's people skills and the technical quality of his services. In part those that select the PPO doctors depend upon resources in the community to guide their choice. Leaders in the profession have a good idea with whom they want to be associated in a PPO group. Dental labs can help to identify dentists who rank high as skilled technicians. The state licensing board can answer questions concerning pending malpractice suits. Quality of the providers is a very important PPO consideration.

The second objective concerned our desire to minimize, as much as possible, cost shifting. If a doctor offsets savings generated by a PPO agreement by increasing fees and providing necessary services for non-PPO patients there is no benefit for society as a whole. Thus, we wanted evidence of a real commitment on the part of the doctor to build his practice revenue in accordance with sound business principles. We wanted doctors who intend to increase revenue by offering better services and by marketing to attract more patients, not just CG-insured patients, but patients insured by our competitors and non-insured persons.

Another objective was to contain administrative cost for the PPO by structuring the program so that this expense is largely borne by one of the potential beneficiaries of the endeavor, the doctor who stands to benefit from increased patient flow. Finally, we wanted a PPO structured so as to provide consistent, uniform quality, a network to serve our insured population base that was spread across the country.

After exploring several approaches to organizing a dental PPO and working with various groups we decided to make an agreement with United Dental Network(UDN) headquartered in Denver, Colorado. United Dental Network is a franchise organization providing market and management support services for independent private dentists with a common identity. Conceptually, you can compare UDN with Century 21, which has linked hundreds of independent real estate firms into a national network.

Thus, we created a dental PPO in a franchised setting. That helped us to achieve our objectives. Dentists that affiliate with UDN must subscribe to a quality assurance program. Through an investment of time and money in a franchise, UDN doctors have demonstrated a commitment to a greater patient flow by applying sound practice management and marketing concepts. UDN's dentists selection and orientation process provides the uniform quality important to our customers. Through a PPO association with

Connecticut General, UDN is able to enhance their marketing programs to build patient flow for member doctors. In return, we are able to hold down PPO administrative costs as dentist recruitment and utilization reviews are integrated with UDN's overall franchise operation. Participation in the PPO is voluntary on the part of individual UDN member doctors. In the franchise environment offered by UDN we believe the practitioner is less likely to become overly dependent on CG for patient flow. This is an important consideration for attracting quality doctors and preserving the strengths inherent in the independent, private practice system.

Doctors participating in the PPO must agree to a maximum fee schedule. Our schedule is designed to produce a maximum fee that is approximately 85% of the average charge in the community. We are obligated to adjust the schedule periodically, usually once a year, based on total charges in the community, taking into account inflation and any other factors that need to be weighted. Participating UDN doctors must charge our certificate holders for deductibles where they are present, and patient copayments, billing us on the basis of the actual charge to the insured.

One of the features of the PPO is that Connecticut General insureds in the community receive immediate benefit from the reduced fee schedule. There is no action required on the part of the employer, although we are obligated to urge the employer to actively support the PPO by promoting utilization of participating UDN dentists.

Utilization reviews are periodically conducted by UDN personnel and this work is subject to audit by our claims examiners. Records of participating dentists are examined for consistency in treatment recommendations and compared with treatment patterns for uninsured patients. Audits are also conducted to ascertain that patient copayment features built into dental benefit plans are not circumvented. All of CG's regular claim processing procedures, including Predetermination of Benefits, are applicable on claims received from participating UDN dentists.

What are the lessons learned? We have implemented two PPO programs with UDN. The first was established in Colorado this past July. There, we have a relatively small insured population base spread throughout the state many in small cases written through a large number of producers. Sustained promotion of the PPO with this widely dispersed audience has proven to be difficult. UDN's franchise operation by itself, beset with capital development problems, has not developed in Colorado as expected. Dentist membership is low, less than 20. Measured in terms of patient flow, initial results in Colorado are negligible. At best, our Colorado effort has been a testing ground as we felt our way along in a prevously untried venture.

Our most serious effort with a dental PPO is in Ohio. This program is scheduled to be effective on April 30. Initially, it will function only in Franklin County where Columbus is located. We have more certificate holders in Franklin County than in all of Colorado, approximately 130,000, and access to these insureds is relatively easy. About two-thirds are employed by six or seven large organizations in the area. Columbus, I understand, is a national test market for new products and services. It's a cross section of America. If the PPO flies in Columbus, Ohio, perhaps it will fly elsewhere.

The professional community in Franklin County, Ohio, is conservative and is characterized by a club-like atmosphere as most of the doctors are graduates of Ohio State, School of Dentistry. They stand together. It took UDN more time to recruit doctors than we thought would be the case. Yet, 29 doctors have joined the PPO effort. This number appears sufficient to meet our initial need. And we have confirmation from independent sources that these doctors are highly regarded in the professional community.

In Columbus, 55% of our PPO doctors have been in practice for more than 10 years 37% have been in practice from five to ten years. They also have substantial practices. Forty percent of the doctors gross in excess of a quarter of a million dollars, and 40% gross revenues between $175,000 and $250,000.

What has been the reaction of the provider community? On the whole, I think positive. Among the profession's leaders there is an attitude of acceptance that change is coming and new ways must be established to better serve the public. Of course, not everyone believes PPOs are an answer. I have received phone calls from doctors taking my company to task for having anything to do with PPOs. The conversation usually ends up with the doctor saying, "In no way, Mr. Walton, am I going to lose any of my patients to your program, I'll cut my fees to meet your price." That's the sound of pro-competition strategy working effectively.

Some doctors dislike the franchise concept. They want to join the PPO, but don't want to invest money for practice management and marketing services. I can understand that, but on the other hand, go back to our basic objectives. We want quality doctors. This requires screening on the front end. Moreover, we want to attract doctors that subscribe to sound business practices and hold down administrative cost to encourage a truly effective delivery system. A PPO in a franchise setting helps accomplish these goals.

The response to the PPO on the part of corporate buyers has been universally positive. It is a relatively visible cost containment program that is easy to implement as it does not require a new benefit structure or special enrollment. Conservative benefit buyers still closely wedded to traditional delivery of health services are more comfortable with a PPO program than with capitation plans that have the potential for undertreatment and impose a greater restriction on the selection of a provider.

Key questions remain unanswered. While our policyholders and their employees are benefiting from a maximum fee schedule designed to reduce the cost of care, we do not yet have a good measure of the overall savings. This is dependent on the number of certificate holders motivated to choose a participating UDN dentist. (We are hopeful UDN's franchise program, providing marketing independent of the PPO promotion, will help in this regard.) And doctors are likely to remain in the PPO only if this program results in new patient flow. How much patient flow can be changed without significant benefit advantages, e.g., elimination of deductibles and many copayments as is typical in capitation plans is an issue that will receive much attention.

In an environment where there is an oversupply of dentists a quality group of providers can be attracted to a PPO. Structuring a PPO in a franchise setting can help to assure uniform quality, minimize cost shifting and reduce administrative expense. On the other hand, there is risk in

associating with the franchise movement as these organizations typically are short on capital and offer a concept that has yet to demonstrate widespread success. Finally, setting up a PPO requires an intensive effort to create a fee schedule geared to local charges, implement utilization reviews and communicate with all parties. A lot of organization must go into a PPO if they are to be cost-effective.

What is the long term outlook? We will see more alternate delivery systems, PPOs and capitation plans. Traditional fee-for-service dental benefit plans will lose market share. How much and what product will be the winner remains to be seen. Ultimately the consumer will decide.

In the Broadway hit, "Ain't Misbehaving," there is a line that says, "Find out what he wants, how he wants it and give it to him just that way." Providers, both dentists and carriers, who heed this advice as they seek to serve their customers in a pro-competition environment are almost certain to be winners.

MR. DONNELLY: Each of the panelists has described a practical method for controlling the rising cost of health care. Essentially, each of their methods addresses the problem by concentrating on the costs of treating people who become sick. I'd like to describe to you today a different approach to health care cost containment, one which can logically supplement any or all of the methods you have just heard. My message is simple - the best way to control the cost of health care is to do a better job of keeping people healthy.

The life and health insurance business, through the Health Insurance Association of America (HIAA) and the American Council of Life Insurance (ACLI), has begun a major "wellness" promotion within the last few years. The theme of the whole program is "Wellness At The Worksite". Basically, the message is being directed to employers, encouraging them to establish smoking cessation, fitness, weight control, etc., programs right at the worksite. I think the best way to tell you about the industry-sponsored program is to show you a film recently produced by the HIAA and which is now being shown to the chief executive officers of our group insurance policyholders in an effort to get them to establish "wellness" programs for their employees. (Title of film: Wellness At The Worksite.)