RECORD OF SOCIETY OF ACTUARIES
1987 VOL. 13 NO. 1

PREFERRED PROVIDER ORGANIZATIONS (PPOs) -- A CURRENT ASSESSMENT

Moderator: PAUL R. FLEISCHACKER
Panelists: KENNETH S. AVNER
GEORGE C. ORROS
LYNN SEERMON*
Recorder: JOHN M. STENSON

- o Types of sponsors (hospitals, insurers, Blue Cross/Blue Shield, etc.)
- o PPO structures
- o Are PPOs effective?
- o Regulation

MR. PAUL R. FLEISCHACKER: Approximately a year ago I had the opportunity to give a presentation at the meeting of the American Health Systems. The audience consisted primarily of hospital administrators and suppliers to the medical delivery system. The moderator of that panel asked me to give a definition of what an actuary does and, given the audience, you can imagine I had a difficult time trying to find a definition that they would understand. I finally came up with one that I felt was appropriate for that audience and I'd like to share it with you. The actuary is a person who passes as an exacting expert on the basis of being able to turn out with prolific fortitude the infinite strains of incomprehensible formula, calculated with micromatic precision from value assumptions which are based on debatable figures taken from persons of doubtful reliability and questionable mentality for the avowed purpose of annoying and confounding a hopeless group of esoteric fanatics referred to all together too frequently as practical people. You can imagine that they enjoyed that kind of definition. They haven't had the best of experiences with actuaries in the past, at least from their perspective.

* Ms. Seermon, not a member of the Society, is a Senior Manager with Ernst & Whinney in Chicago, Illinois.

As you all know, PPOs have experienced phenomenal growth over the last several years, particularly from 1983 to 1986. According to a recent article published in the *Business Insurance and Medical Digest*, there are approximately 500 operational or near operational PPOs. Most of these became operational during 1984-1985. In 1986, approximately 20% of the total came into existence and started their operations. There is smaller growth, however, in the number of dental PPOs. Depending on who one talks to, it is estimated that up to 30 million employees and dependents have a PPO option available to them, with enrollment being approximately 8 million members.

PPO plan sponsorship has changed during the last few years. Initially, medical providers were the primary force in the growth of PPOs. Recently, there has been a tremendous increase in PPO sponsorship by insurance companies and Blue Cross/Blue Shield plans. In percentages the providers currently sponsor about 50% of the PPOs, with insurance companies and Blue Cross/Blue Shield plans comprising another 32%. The balance is made up of various private investors, third party administrators, HMOs, and self-insured employers. Insurer and Blue Cross/Blue Shield plan sponsorship increased almost 100% between 1985 and 1986.

Geographically, PPOs are located in all but approximately ten states. The most by far are in California with over 100 operational PPOs. California is followed by Ohio, Illinois, and Florida, with less than 50 each. Internationally, there are other countries that are watching closely what is happening in the U.S. in the way of financing the delivery of medical care. As you will shortly hear from George, some of these countries are adopting some of the features of the PPO programs in the United States.

Our first speaker will be Ken Avner. Ken is an actuary for Blue Cross/Blue Shield of Illinois in Chicago. He is responsible for the actuarial portions of their alternative delivery system products which include HMOs, PPOs, and other managed care products. He has been with the plan for approximately a half year. Prior to that he was a consultant for seven years with Tillinghast/TPF&C.

MR. KENNETH S. AVNER: I'd like to give you a Blue Cross/Blue Shield perspective on the PPO phenomenon. I suppose a good place to start is why Blue Cross and Blue Shield plans view PPOs differently than a commercial carrier, especially a national carrier. The first difference is that we are not new to contracting

with providers. A part of this is that it is important for us to make sure that hospitals who are Blue Cross hospitals, but are not going to be part of our PPO network, are not alienated.

A second point of differentiation I see is that, at least at my plan, we felt it was essential to cover our whole service area, the State of Illinois. In fact, we wanted to cover even more than our state -- the border areas of adjoining states. If a group is near the border and has employees living in both states, we felt it was important that the network and our PPO products be available to all group employees.

Finally, I think that there is probably a difference in the targeted market. We see a major opportunity for small groups in Illinois to benefit from our PPO. Many jumbo sized groups feel that the right way to approach the PPO phenomenon is to build their own networks and get TPAs or other organizations to administer their claims. While we do not agree that this is as easy as it sounds, it is certainly their prerogative to try.

On the other hand, for smaller groups, we feel that our position as a local Blue Cross plan with a dominant position in our market gives them the benefit of the clout they do not have alone to negotiate preferred arrangements.

Considering that so many of you are already involved in PPOs, I would like to make another comment based on my company's experience. The way we look at it, if we are not careful, we are going to end up with two preferred networks, or really a network and a subnetwork. First, there are all the providers in the state. Second, there are our Blue Cross or Blue Shield providers. Finally, there are our PPO providers. We have gone out of our way in Illinois to try to assure that we do not reach that level of complexity. In the case of hospitals, where every hospital in the state is a contracting provider with us, the first two classes collapse into the Blue Cross hospital network and the other class is our PPO network. In the case of some types of providers where we do not have every provider under contract, skilled nursing facilities for example, we made a decision that the nursing homes that were not under contract were non-PPO nursing homes and the ones that were under contract were PPO nursing homes. As part of our standard arrangement, a facility not under contract has a benefit

differential anyway. It tied in very nicely with the PPO benefit design we wanted.

Before I get into the more formal part of the presentation, let me give you some numbers about Blue Cross plans in general and what they are doing in terms of PPOs. The latest census I have seen, which is from the end of 1986, showed that 49 of the 78 Blue Cross or Blue Shield plans have operational PPOs and that these 49 plans cover 35 states. Also, there is movement by the association to link the various PPOs together. At the end of 1986, we had 450,000 members in our PPO program.

Probably more important, especially for the short term, is that we have participated in some situation specific links in order to answer the needs of certain groups. Typically the group might come to us and say, for example, "We have people in Chicago and Southern California and Texas; is there something that you can work out in those three areas?" There is a lot of informal network building that is not being done under the general umbrella of the association.

Now let me turn to an overview of our PPO, and when I say *our* I mean the Illinois plan. I should first point out that it is a point-of-service PPO; I assume most of you know that members do not actually enroll in the PPO, as opposed to a traditional plan. The patient makes a decision at the time of getting the service to go to a PPO provider or a non-PPO provider.

As an aside, we have co-opted the acronym PPO. For us it stands for Participating Provider Option. The reason the word *participating* is used, and I probably should not have used *preferred* network before, is because of our sensitivity to our providers. This program was presented to them as an optional program that they were capable of joining, if they could pass the selection process to become a participating provider.

When we put our program together, we had the benefit of learning from what had happened with other plans in other environments. We were not the first to go into PPOs. California and other areas were far ahead of us. It was our intention to capitalize on what the other plans had learned, and what they had developed, and then produce the best product with the most attractive features that would fit our market.

Like many carriers, we had a product portfolio that included a wide range of traditional products and a statewide HMO. We saw an opportunity for a new product that would fall mid-range on these two spectra: price and freedom of provider choice. The HMO is low priced for the benefit design but has restricted freedom of choice. The traditional products have a comprehensive network but also have higher costs for their benefit designs. The PPO, as I said, was designed to be mid-range on both of these spectra.

Paul mentioned our managed care product. That product falls somewhere between the PPO and traditional products in this comparison. Some of us feel that the traditional products are going to evaporate, their place being taken by similar managed care products.

Back in January of 1985 we went to the Peoria, Illinois region and tested our ideas about how a PPO should be developed. We tested a new claims system. We tested a new utilization review program. We tested a number of benefit designs and we tested our negotiation process with the hospitals. In the Peoria region there were 11 hospitals, 5 of which were chosen as participating hospitals. The results from the test were positive beyond our expectations.

From what happened in Peoria, we developed a set of criteria to expand the products statewide. We felt we wanted broad geographic accessibility, a full range of services, and a full range of types of institutions. We think these goals are essential, at least for our product. Of course we felt we could deliver a premium reduction for our groups.

The statewide network was completed in three stages after groups were clammering for a PPO in the Chicago area. We then expanded to the other state urban areas, such as Rockford and Springfield. Finally, we worked with the rural hospitals.

There is an essential point here. These are really three different environments. In the Chicago area there are fewer patients, and we have less doctor/hospital loyalty. Doctors have multiple admitting privileges. The hospitals are more sophisticated. Groups require much more. In the Chicago area, what you are used to hearing about PPOs is pretty much what we expected to see and what did result.

When we get to an outstate metro area, as they call it in Illinois, the typical situation is that there no longer are hospitals every couple of miles, but maybe three hospitals in an area. There is a religious hospital, a municipal hospital, and a voluntary hospital. There is more patient loyalty and a lot more doctor loyalty. We were still able to be reasonably effective in our negotiations with hospitals.

On the other hand, with the rural hospitals, the situation is much different. The typical rural hospital may be the only facility in the county or maybe even in a multicounty area. As you might guess, the patient loyalty and the doctor loyalty is absolutely fierce. The hospitals look at you and say, "Is there anything that could possibly be in it for me? The basic primary care admissions are going to come to me anyway. You are not going to make somebody who is a normal OB admission drive 100 miles to go to a different hospital. The tertiary care I do not give now. So why should I participate with you at all?" The answer was that there are not many reasons to join a PPO. But there are some utilization review reasons and also some other minor reasons.

From the carrier perspective, we feel we needed three different strategies, depending on which situation we are in. In addition to the Illinois participating providers, we negotiated contracts with providers in the border areas of adjacent states: Missouri, Indiana, and Iowa. We offer a broad range of services and a broad scope of institutions. We felt that each type of hospital had something to bring to our network in terms of the range of hospital services which would be required by our members.

What's the product? The first thing the Blue Cross PPO has is full freedom of choice of physicians. Although we have built a physician PPO network within our Blue Shield network to answer the needs of large groups who insist on it, our basic PPO product offers a full choice of physicians. The patient chooses from our network of efficient and quality hospitals and the employee must participate in our Medical Services Advisory (MSA) program which is our managed care program. The MSA, in addition to serving as a patient counseling and advocacy program, includes the following: preadmission review, a second opinion program, concurrent review, an individual benefits management program, and discharge planning. The individual benefits management program is used when we feel there are cost effective alternatives to the treatment a patient might

otherwise be forced to choose because of benefit design. It is really a case management program, both in and out of the hospital.

The whole MSA program, which is an essential part of our PPO, is driven by a phone call. It can come from anyone: the patient, the physician, and the hospital. The only requirement is that we are contacted prior to an elective admission or within two business days of a maternity or emergency admission. To answer the question that I guess I feel should follow from that statement, we hold the employee responsible for making that phone call. If someone else makes the phone call, he is still given credit for it. But ultimately, the responsibility is the employee's.

Assuming a hospital admission is approved at the time of the call, a member is counseled on going to a PPO hospital. This reinforces the education they have already received and accounts for increased channeling. They are reminded that by going to a PPO hospital, they will maximize benefits and minimize the out-of-pocket cost.

I feel the benefit designs should also be broken into three categories: small groups, medium groups, and jumbo groups. The jumbo groups call their own shots. They design the program, they tell us everything they want to do and, if we can do it, we deliver it for them. We are simply delivering the network and the managed care program. For small groups, under 100 lives, we designed a set of five comprehensive major medical programs with several deductible options, a range of coinsurance options, and several out-of-pocket limits. They all include drug cards and well-child care. For medium groups we say, "Tell us what you need and we will see whether we can deliver it."

The drug portion of our product is a paperless system. We have 3,500 member pharmacists and it works very well.

The real key to the product is the education and the MSA program which reinforces the education. We try to make sure that our PPO product is not a discount program but really is a way of changing the employee's attitude toward health care utilization.

For sources of savings, there are the hospital contracts and utilization gains. As I mentioned before, with each PPO hospital we have at least two contracts. One is for our traditional Blue Cross coverages and one is for our PPO coverage. There are different reimbursement arrangements for each of these contracts. I say *at least* because in some cases our HMOs have separate contracts with the hospital too. The hospital contract results in reduced or less expensive hospital care and is reinforced by the MSA which is controlling the utilization in the first place, getting people into the right hospitals, and keeping them there the proper amount of time. The channeling to the PPO hospitals assures that these savings will continue to accrue.

The MSA program is our way of managing the utilization of the program. As part of our hospital contracts, there are also utilization review guarantees. The bottom line is that we guarantee 10% to 20% savings on a premium basis from what a group would pay if it did not have PPO coverage. This of course depends on the benefit design, what cost containment programs were in place before it switched to the PPO coverage, and where the group is located.

We feel that these savings will continue over time. Typically, our provider contracts range from two to three years. We feel the channeling is effective in keeping people in the PPO network, and we also feel that we will have a better way of controlling the cost increases with PPO hospitals.

MR. GARY D. MCDONALD: You have mentioned as a source of savings the utilization review program and the contracts with the hospitals. Do you have any kind of negotiated savings in your contracts with the participating physicians at all or is it a strictly usual and customary type of reimbursement?

MR. AVNER: Blue Shield physicians are always reimbursed for usual and customary fees without any balance billing. That is part of the Blue Shield agreement. I'm a little reluctant to start talking about our physician PPO because, as I said before, we don't market the physician network. Our PPO product, at least for now, includes all physicians. If you are a very large group and you insist on the physician PPO network, we deliver it.

MR. RICHARD BILISOLY: You wanted to avoid a conflict between preferred providers and your regular Blue Cross providers; if the preferred providers are

truly preferred, how can you do that? The second question I have regards the savings of 10% to 20%; does that count the existence of an incentive type plan with slightly higher benefits to induce people to use the PPO?

MR. AVNER: Our PPO program does have that incentive. There's a benefit differential between PPO and non-PPO. It is point-of-service PPO.

MR. BILISOLY: Even then do you get that 10% to 20% savings?

MR. AVNER: Yes.

MR. BILISOLY: That is really good.

MR. AVNER: You get the savings especially in the Chicago area where it is more sophisticated. You get downstate and it's much harder to get those kinds of savings.

MR. FLEISCHACKER: Our next speaker is Lynn Seermon. Lynn is a senior manager for Ernst & Whinney in the Chicago office. She is a member of the managed care practice area specializing in strategy development, provider network development, and business planning for managed care programs. Her clients are providers and insurers. Lynn has an MBA from the University of Chicago.

MS. LYNN SEERMON: What I'm going to talk about are the trends that you see in the industry regarding organization arrangements between the payors or insurers with providers, hospitals, and physicians. Insurers are right now facing a variety of options in terms of exactly how they are going to be relating to providers in this new managed care arena. Those relationships range anywhere from joint venture, acquisition arrangements, to different kinds of contractual arrangements. What insurers need to be doing now is figuring out exactly what their needs are and what types of organizational arrangements best fit the strategies they are trying to implement. I'm going to cover what has been tried, what has been learned thus far from those organizational arrangements, and what we might anticipate in the near future.

Essentially, insurers trying to develop relationships with providers are looking for ways to broaden their product line. I have heard much discussion on different methods that companies are using to develop the triple and dual-option arrangements. Another reason for getting involved with providers is to reduce medical costs, by having access to the more efficient providers and to providers that are providing discounts. In addition, relationships with providers can provide a vehicle for insurers to realize greater market penetration and growth than they have historically in their traditional insurance products.

First of all, let's go back to about 1985 and review what the key strategies were in terms of insurer/provider relationships. The key thing in reviewing that period is to see that essentially the relationship was provider dominated. Some of the major health care providers as well as some major employers were dominating the scene; for example, General Motors was introducing the triple option. Back in 1985, insurer PPO activity was primarily limited to responding to requirements from some major accounts to set up a PPO network in their particular market. In 1985, the banners seemed to be calling for the set up of a national strategy for managed care products. What was dominating the activity at that point in time was really the provider side of the insurer provider relationship. The strategy of the four largest hospital management companies was to buy an insurance company and become an insurer. One of the major motivations for doing that was Wall Street analysts' assessment that it was very important for hospitals or hospital companies to be truly vertically integrated health care delivery systems. Translated, this meant they needed to go beyond the narrow scope of being a hospital company and integrate into insurance. The managed care strategies of alliances (formed as a result of the formation of hospital management companies) were in response to what the major for-profit hospital management companies were doing. One company, Voluntary Hospitals of America (VHA), entered into a joint venture relationship with Aetna. VHA essentially is made up of 83 shareholder hospitals. These are freestanding major hospitals in predominant communities throughout the country. Around those 83 hospitals there have been organized regional networks by these shareholders and, in total, VHA now represents about 685 hospitals. American Healthcare Systems (AHS) is also a voluntary alliance but its makeup consists of voluntary hospital systems as opposed to the freestanding systems that are represented by VHA. Within American Healthcare Systems, you have about 32 systems representing 495 hospitals. While this strategy to joint venture with insurers was similar to VHA,

AHS's selection of an insurer partner was two companies, Provident and TransAmerica.

I would like to illustrate the kind of organizational arrangements that were being tried back in 1985. Voluntary Hospitals of America had a subsidiary called VHA Enterprises, a for-profit company formed by all of these hospitals to essentially undertake different investment opportunities on behalf of the voluntary hospitals. Essentially it was supposed to become a vehicle to allow the voluntary hospitals to compete with the hospital management companies which had access to the public markets for capital. Here the VHA enterprise would be a vehicle by which the private hospitals could invest and pool their money and undertake various programs. What was formed between VHA and Aetna is still a company called Partners National Health Plan.

Essentially the purpose of that company has been to help the local hospitals and their regional shareholders to develop different kinds of programs that they call patient acquisition programs. Forming the hospital-physician networks and bringing different insurance products and services together allowed the local providers to set up their own HMO and PPO programs. In terms of putting this program together, VHA and Aetna each combined $40 million to initially capitalize Partners National Health Plan. There will be continual capitalization from the participating hospitals through VHA Enterprises with an estimation of spending anywhere between $100 million and $250 million over the next year or two for HMO and PPO development.

Forming this relationship was one of facilitating local efforts and did not entail a very close relationship between Aetna as an insurer and VHA as a representative of the hospitals in the program. There's no sharing of risk at the Partners level since both entities have come together in the PPO products that Aetna is selling. The participation is in the sense that a certain percent of the premium from the Aetna product goes to the Partners National Health Plan. There is no risk participation per se of the PPO products that Aetna will be selling.

Probably the best characterization of the experience to date with this program entails a lot of fits and starts. There were some difficulties in the programs that they designed. They had come up with a new idea in terms of a PPO product that would have guaranteed savings. If savings were greater than what

was planned, there was going to be sharing of those savings between the providers and the employer. In trying to implement that product, there were a number of legal problems and those products couldn't be delivered in a number of states. There was also a problem in that the providers, once they understood the program, were not interested in participating in that kind of risk at the local provider level through that kind of a program.

Another problem this program is encountering right now is the difficulty of trying to obtain the right kind of management expertise. VHA partners have run into problems providing the management capabilities at the level of the regional health care system. The plan is still plugging along but is running into some problems that will delay it from meeting many of its goals.

Leaving 1985 and moving into 1986, the major events entailed the providers faltering in terms of their insurance initiative and insurers retaking the lead. An example of provider faltering was American Medical International (AMI) pulling out of its PPO insurance product. They had spent $50 million to obtain 65,000 members. They were facing losses of about $25 million in 1986 and an estimated $100 million in 1987 if they continued the program. They decided to get out of their insurance activities. National Medical Enterprises (NME) not having been that active and seeing what was happening with other hospital companies, pulled out very quickly. Humana, unlike AMI, was very successful in recruiting enrollees for their program. Over a very short period of time, in 40 markets they were able to enroll 650,000 people into their program. They enrolled many members but they didn't run the program very well. They didn't understand how to run an insurance program. They essentially started it out as strictly a hospital discount model and ran into very severe problems. They did not have a sufficient shift of patients into the preferred provider discounted hospitals. They anticipated about 80% participation and the PPO hospitals only experienced 50%. They also did not involve physicians in the PPO program, which caused problems in channeling patients to the appropriate hospital. They did not have utilization components in the program either. The result was a loss of $25 million in 1985 and an additional $100 million in 1986.

AMI is sticking with their program and will be instituting utilization management controls, pulling back out of markets where they do not have strong provider presence. In terms of what happened with VHA, by the end of 1986 they had

HMOs in about 15 cities and they had PPOs in 22 cities. That was still a far cry from what many of their original projections had been. AHS is just beginning to get their program organized and is still working on getting the top level of the structure organized.

What we see is a pulling back of the provider dominated PPO initiatives and the shift to the insurer's leadership. In that transition, we begin to see more of a refinement of that national strategy. I think the grand strategy back in 1985 was for the big insurers to find relationships with major provider groups. By having a relationship with the provider group, the problem of setting up provider networks for your programs would all be solved. I think results have shown that it's not as easy as just establishing a single relationship. What we begin to see now with the national strategies is more of a refinement in terms of trying to look for relationships across the country that make more sense for the individual insurer. What we see now is that the dominant strategies are acquisition by insurers, horizontal joint venture relationships, and vertical joint venture relationships.

In terms of acquisition, the Travelers' major activity was to acquire Whittaker Health Plans which was a beginning HMO national company. The Travelers spent approximately $48 million to acquire 19 HMOs where there were only 25,000 enrollees. In addition, they are going to be investing about $25 million to establish 25 PPOs in various cities throughout the country. By the end of 1987, it is reported that they anticipate being in 18 markets for their HMOs and as many as 40 markets for their PPOs. Essentially, at the Travelers, you see not so much a move to acquire members for their program, as much as a move into key locations to buy some of the expertise that Whittaker, although a young company, would still be able to provide in the managed care area.

Another major acquisition during 1986 was the purchase by American International Group (AIG) of Jurgovan & Blair. Jurgovan & Blair is a unique company in the managed care area. Their HMO systems company accounts for about 45% of their revenues. Another 45% of their revenues is from managing HMOs. In addition to that, they do some management consulting in the Alternative Delivery Systems (ADS) area. They also have begun administrative services by going into self-funded plans and running the whole program for them. In AIG acquiring Jurgovan & Blair, they didn't so much acquire members as much as

they bought expertise. The acquisition strategy was to get expertise that the insurers did not possess.

Another kind of arrangement we saw in 1986 was the beginning of horizontal relationships between insurers, as a way of their gaining a certain mass and a certain amount of expertise to implement their PPO programs. Heading the list, is a top-down strategy. I call it that in the sense that it was started by eight insurers and has now expanded to 18 insurers, coming together to develop a national network of PPOs. Essentially they will be spending about $20 million in 40 cities. My understanding is that they are currently in all 40 cities in terms of hospital discount and are making very good progress in getting the physician networks in place. The combination of these 18 insurers puts this organization as the equivalent of the third or fourth largest insurer in the country. They begin to get a certain mass that is important in contracting relationships. In addition to that, they are beginning to achieve economies of scale that would not be available to the individual insurer, by working with Health Data Institute (HDI) to go into all of the cities, evaluate the providers and make the selection profile. It's through that organization that they are also doing the utilization management. Also, through Private Health Care Systems (PHS) there is brand development, national advertising, and collateral that go with the program. All of those costs are shared across all of the programs.

In working with some of the insurers in evaluating their participation in PHS, there are many disadvantages in that it's not going to take us all the way we want to go. One of the problems seems to be that there may not be just the right match between the insurer's markets and those that PHS is in. PHS may not be meshing and serving exactly all of the markets they need to be in. In many respects the insurers have been participating in PHS to take advantage of the defensive opportunities. The other problem with PHS is that, for some insurers, it is not providing the competitive advantage they had hoped for. In a particular marketplace to get the desired clout, they have joined with 18 insurers, thus diluting the competitive advantage they have in participating in the program.

Another example of a top-down strategy is Equicor. Equicor is a joint venture between Equitable and Hospital Corporation of America (HCA). Essentially, at

those levels, what you are seeing is a putting together of some programs at the corporate level.

I identify another item as more a bottom-up strategy. This is another kind of networking joint venture relationship that is not being organized at the top, such as PHS, but rather it is being organized in Chicago by Preferred Care Network. They are currently working with a number of self-funded plans, as well as Third Party Administrators (TPAs) and carriers. What they are doing is expanding the PPO they have in Chicago into other marketplaces. The vehicle they are going to be using for that is a local joint venture arrangement where they will be joining with a very selective group of insurers, possibly a TPA, to set up a particular PPO in a community. They are going to be realizing economies of scale because the program already has in operation the standardized provider selection criteria, the contractual arrangements, the utilization review, and the data processing. All has been placed and sold as a license to the local joint venture arrangement. Also, for a limited fee, they will be able to participate not only in the program in which they sponsor, but will be able to network other joint venture relationships that are being set up in other parts of the country. Another added feature of this particular program is that they are also folding in a PPO for workers' compensation. They are working with a utilization management company that specializes in workers' compensation cases by providing the discounted PPO network to handle the workers' compensation cases. In contrasting it to PHS, it is a very different approach in that it works with the insurer in markets that makes sense to them. It works by trying to provide more of a competitive advantage to the participating insurers by limiting the number that can be owners of that particular program.

Another strategy we were seeing in 1986 is what I call vertical joint ventures; vertical meaning the insurer was joint venturing with some form of health care delivery to develop their managed care programs. HealthWin was formed by Lincoln National and United States Health Care, a major HMO company.

The bottom-up strategy is not trying to organize something at the corporate level, but pursuing strategies from market to market that make sense and picking out the right kind of partners. Lincoln National has been doing quite a bit of that in addition to the HealthWin Program. Lincoln National right now is in the position of implementing HMO programs in 19 states. They are using the

individual practice association (IPA) group network models. The primary strategy is to take a minority investment position in those particular plans. They are essentially working through 12 different partners. In some cases it is an individual HMO; in other cases, such as their joint venture with Peak, it is taking them into a number of markets. They are getting a foothold in the markets that are key for their customer base. They are also at the corporate level through Peak. Through United Health Care, a partner they have recently become involved with, they will be tapping into more HMO expertise than they have been able to acquire up to now.

MetLife's strategy has been a market-by-market basis. Instead of joint venturing or working with HMOs, they have been predominantly setting up their wholly owned IPAs or had initially been working on joint venture relationships with providers. Over the year, they were able to get into 17 markets and accumulate 250,000 enrollees. The major challenge in the MetLife program will be how to integrate their MetLife program with their PPO program to make that a successful, integrated provider network for a triple option product.

I want to use HealthWin as an example of an organizational arrangement, even though it is not with us today. HealthWin can best be characterized as a shotgun marriage and a quick divorce. It was a massive joint venture that was established and dissolved in just one year's time. This was Lincoln National coming together with U.S. Health Care, not at the corporate level but at the market level, consolidating their books of business into one organization called HealthWin. What Lincoln National brought to the deal was about 420,000 lives and about $15 million. U.S. Health Care brought in about 150 members and about $15 million also. By consolidating at the market level what these two companies were trying to do, the relationship had a lot of potential. The program did run into a number of problems. One was in terms of making HealthWin work as an operation. There were a number of problems in terms of that organization relating to its parents and still needing to rely on certain systems to make it work. Another problem involved cultural differences between an insurance company and a fast growing, very young, entrepreneurial HMO company. Another problem had to deal with economics. Lincoln National was doing very well in its health business. Once the relationship was whetted, it ran into a lot of financial problems with the book of business, which probably soured the relationship. We saw that relationship dissolve, but at least it begins to show how,

in a sense, some of these joint ventures could begin to move closer towards making these entities a viable, organizational structure.

I think we began to see a real evolution when we saw Equicor come into being. Equicor is the joint venture relationship between Hospital Corporation of America and Equitable. What's different here is that there has been a true consolidation at the corporate level of the essential components from the two companies and the setting up of a very distinct corporate entity. It is very different from the kinds of joint venture relationships I have been describing. The emphasis is on being a free-standing company. The plan is to take the company public to reinforce the autonomy of the company from its two parents. It was probably a good match in that both HCA and Equitable had needs to be met before moving ahead in the managed care arena. HCA had already invested quite a bit of money acquiring an insurance company and in acquiring HMOs. They were going to be looking at a lot of losses to bring those HMOs up into big, healthy plans. On the Equitable side, they were looking for opportunities to bring their health insurance into the mid-1980s by moving ahead in the area of HMOs and PPOs. It seemed to make good sense in terms of matching mutual needs. We'll have to watch very closely to see how these two organizations work it out.

What are some of the lessons we have learned from the organizational arrangements we have been seeing? First of all, it is pretty clear that the grand, national strategies with providers may not match the market needs of insurers. The simple solution of trying to find a large multihospital system to work with in order to get the provider network is not the simple solution many insurance companies initially thought. Another lesson is that being part of a network may not provide the competitive advantage many insurers desired. Companies were tapping into and participating in a program without looking at exactly what specific market needs they wanted to meet. The third point is that joint ventures may be easier to set up than operate. We have seen a rocky road in getting these programs organized, and I think we will still see a lot of trial and error in making them work. The other last point is that the emphasis and the attention in terms of putting these megastructures together has really been at the corporate level.

This emphasis is very far away from getting down to the service delivery level and really affecting health care. What lies ahead? I think the future strategies

can best be characterized by less dating around and more settling down. I think we will begin to see insureds learning a lot from their experimentation with the different kinds of relationships they've had. We will also see insurers getting a better sense of how those relationships do and do not work, becoming much more focused in where the insurer is going to try to work on PPO arrangements. This is going to involve an increased attention to local market strategy, again selecting the markets that make most sense to the insurer to really invest their energies in developing a PPO program.

Stronger provider relationships must be developed. In many markets today, most providers have multiple relationships with PPOs, insurers, HMOs, etc. Over the next year or two, we are going to begin to see some sorting out of these relationships. The insurers need to begin to work on a closer relationship with providers in a more selected way. There are going to be attempts to improve the PPO product itself. In terms of local market strategy, the effort's going to be on developing more local market clout -- greater selectivity in markets, going after markets that make sense, that are attractive, and that aren't saturated with PPO activity.

Insurers will also look at markets that are making sense from their perspectives, in terms of where they have a good book of business or a good distribution system. In terms of local markets, the insurers will be looking for partnerships that really yield market share strength in the communities that they are targeting. It's not just important to be in a community, but it is important to have the market clout to be able to wield some power with the health care delivery system. It is important that those relationships or partnerships represent complimentary relationships, so that the payors that come together can work more closely since they do not have conflicting problems in terms of working out product definitions. It is also important that the relationship will be serving complimentary market segments.

In terms of future PPO arrangements, insurers have to deal with a physician hospital organization (PHO) which is evolving in the marketplace. I think there has been a reluctance on the part of insurers to encourage the development of these organizations, with the fear that you diminish your bargaining power if you have to deal with one single entity as opposed to a hospital and many physicians. There are advantages though to a more formalized delivery system

and insurers should really begin to consider working with these organizations. In addition, the providers now are spending a lot of effort in terms of putting these organizations together. An advantage of a PHO is that it brings together the physicians with the hospital. It is the physicians who really drive the costs. The alliance enhances your opportunity to gain greater cost savings. In addition, by bringing the two groups together, you have a vehicle to work on reinforcing financial incentives in terms of risk sharing. Also as a larger entity, the provider can take on greater risk and manage it. A lot of these PHOs are making minor investments in terms of administrative support information systems, which are going to allow them to take on more risk assumption types of contracts than they have been historically.

Another thing we will be seeing is a movement away from just a strict discount arrangement; instead groups will be trying to look for contracting arrangements that look at the full spectrum of care. What we are talking about here is contracting arrangements which allow the purchaser not to just get a discount on that hospital fee, but a discount arrangement that coordinates care across the spectrum and prices that care to bring about greater cost savings. Here is an example of what we are seeing in the Chicago marketplace in terms of what insurers or anyone right now in the retail market, would be paying for open heart surgery. Let's say it is $40,000 when you add up all of the components that go into it -- the cardiologist, the anesthesiologist, the actual hospital stay and aftercare. A number of programs in Chicago right now are packaging that for $22,000. A number of corporations are actually sending their employees down to the Texas Medical Center to buy that kind of care for $18,000. That's the kind of contractual relationships we think will be evolving to get greater cost savings versus just the simple hospital discount arrangements. We will also be seeing a closer relationship between the insurer and the provider. The insurer will work more closely with the provider to obtain cost savings. That will entail providing administrative support, providing them with information so they understand what's driving their costs up and how they might be able to manage them, and even working in a much closer partnership in terms of marketing those providers and, therefore, providing the volume they need.

We will also see opportunities to improve the PPO product. As insurers get more experienced, they'll have more opportunities to learn how to develop those

incentives within the program, improve the pricing of it, and begin looking more like an HMO product in terms of moving towards paperless claims.

In conclusion, we have seen a lot of different kinds of arrangements being tried in terms of insurers coming together with providers. Clearly it's a strategy to try to broaden product lines and it is a way of reducing medical costs. As insurers become much more selective in the markets they go into, it will be an opportunity to increase market penetration and provide the opportunity for much more growth in their products than they may have experienced in the past.

MR. FLEISCHACKER: Our next speaker is George Orros. George leads the health care consulting practice in Tillinghast's London office. He was previously the chief actuary for the largest private health insurance company in the United Kingdom. This company owns and manages hospitals, as well as being an insurance carrier. George consults with health insurance companies, hospital groups, and large employers in the U.K. He has been in the health care business for most of his professional career.

MR. GEORGE C. ORROS: I would like to share with you some of the recent PPO developments in the United Kingdom (UK). I must say, however, that the state of the art with PPOs is far less advanced than here in the United States. Nevertheless, some of the developments in the UK will be of interest to health actuaries on this side of the Atlantic. You might even feel that you can learn from some of our experiences in the UK.

The subjects I intend to cover are public and private health care, PPO concepts in the National Health Service, private health insurance, private hospitals, and future developments with PPO structures

Let me begin, however, by setting the scene, and very briefly contrasting the health care environment in the United States and the UK, from the point of view of PPO networks.

In the United States PPOs receive pressure from hospitals with low occupancy; pressure from doctors with low patient volume; and pressure from self-insured large employers.

PPO developments in the United States have been characterized by pressure from the health care providers to direct patients towards their facilities, at the expense of other health care providers. There is also a large number of self-insured groups, many of whom have had the financial muscle to negotiate attractive deals with PPO networks. In this environment, most major health insurers have had to respond positively to PPOs, or else face a decline in their fortunes.

In the United Kingdom, hospitals need to attract noninsured patients, and large employers, and the National Health Service (NHS) needs to collaborate with private hospitals

PPO developments in the UK are still in their infancy. Some private hospital groups have taken a keen interest in US developments and have sought to move in a similar direction, by means of limited experiments. These moves, which were largely prompted by low bed occupancy, have included fixed price surgery to noninsured patients and corporate discounts on bed prices. There has also been collaboration between private hospitals and the public NHS, which has led to experimental PPO developments.

Now that we have briefly contrasted the United States and the UK, let me move back to the main body of my presentation.

Public and Private Health Care -- Public health care is provided by the NHS, which has been in existence since 1948. The private health care sector has been in existence for even longer, but accounts for only 3% of national health care revenues. Nevertheless, it is expanding rapidly and is always a topical issue in the public eye.

PPO concepts in the National Health Service -- The current Thatcher Government has been encouraging the NHS to privatize more and more of its services. It has even been argued that its role should progressively switch from one of delivering health care services to one providing the finance but not the delivery of services. The idea here is that the delivery of most health care services should be privatized, with preferred providers having the responsibility for the delivery of services. It will be interesting to see whether Margaret Thatcher will get a chance to implement some of these ideas after the next general election, which may only be a few weeks away.

PPO Concepts in Private Health Insurance -- Discussions about potential PPOs are becoming increasingly commonplace with very large employer paid groups. Some have recently entered into PPO arrangements, along with their reluctant private health insurers. Some health insurers have sought to develop PPO based products for introduction at some point in the future, when the time is right for the launch of PPOs. There is also scope for attracting new individual business through PPOs, perhaps through direct marketing methods.

PPO Concepts in Private Hospitals -- An interesting development here has been direct agreements between large employers and local hospitals, whereby the employer receives preferential terms in respect of hospital charges and the specialist fees charged by the participating doctors. Future developments could be based on fixed cost surgery, whereby the hospital offers a fixed price list for some of the more common surgical procedures. These developments could attract both individual and group business.

Future Developments with PPO Structures -- We do not have real PPO legislation or regulations. Nevertheless, some of the recent PPO type developments in the UK have parallels in the United States. Perhaps the message is that PPOs come in all types and forms, and just because we do not call them PPOs does not mean that they do not have components similar to those found in PPOs in the United States.

Let me say a few words of introduction about public and private health care in the UK. A useful starting point is the NHS, which is funded by general taxation and is provided free of charge at the point of service to all of the population. The difficulty is, however, that you might have to wait for treatment, perhaps for a long time, perhaps forever.

The cost of providing the NHS has increased in real terms since its inception. The architects of the NHS originally thought that there was a backlog of untreated cases of illness which would soon be cleared up by adequate care from a free NHS. It was felt that thereafter the load of medical work and its cost to the NHS would decline as the national population became healthier. It was soon found, however, that this pious hope was unrealistic. We now have a situation where the state can no longer support the rising health care expectations of the population. Politicians want to allocate more resources to the NHS, which has

now become the largest employer in Western Europe. There is also a growing realization that the NHS cannot survive in its current form for very much longer, which has led to calls for privatizing more of its services and encouraging taxpayers to partially opt out, by insuring against the need for nonemergency treatment.

In spite of many difficulties, the NHS still provides an excellent accident and emergency service. It is also well geared up to provide high quality primary care, maternity care, pediatric care and a reasonable level of geriatric care. The problem areas lie with nonemergency treatment for chronic and acute medical conditions. In some parts of the country, one now has to wait months, or even years, for nonemergency treatment. For example, the waiting list for hip replacements is often two years or longer.

On the brighter side, we have also witnessed encouraging signs of positive collaboration between some public health authorities and the private hospital groups. This collaboration can take the form of one or more of the following arrangements.

1. Sharing Expensive Equipment -- Specialists in NHS hospitals have traditionally seen their private patients in NHS hospitals, although this is now becoming less common. More recently, private funding has enabled public hospitals to purchase expensive high technology equipment, which has then been shared by both public and private patients. This has enabled productive use to be made of expensive equipment, in situations where the private patient usage would have been insufficient to justify the purchase.

2. Sharing Pathology and Laboratory Services -- Specialists in NHS hospitals have traditionally purchased pathology services, blood supplies, x-rays and laboratory tests on behalf of their private patients from the NHS. The provision of these services gives the NHS additional revenues, which can be used to improve public facilities. Some would argue that it also reduces the burden on the NHS, by removing a patient from the waiting list for treatment.

3. Privatizing Pay Beds in NHS Hospitals -- There have been instances of management contracts for NHS pay beds being awarded to private hospital

groups, rather than being managed by NHS hospital administrators. The NHS health authority can rent out its pay beds to a private hospital group for a guaranteed income, thereby relieving itself of NHS pay bed management responsibilities, and using the additional revenue to improve its services to NHS public patients. NHS pay beds will increase rapidly over the next few years, due to the efficiency of the private hospital management companies.

4. Privatizing NHS Waiting Lists -- In recent times some NHS administrators have realized that the waiting lists for nonemergency treatment have become unacceptably long for the local population. Some have sought the ways and means to use the private sector to reduce waiting lists, by negotiating bulk prices with private hospitals for a guaranteed volume of specific surgical procedures. It has been found that the private hospitals were often cheaper than the NHS hospitals, due to competition between private hospitals for additional patients. It also emerged that most NHS administrators had little idea of the true cost of specific surgical procedures. In recent weeks the Thatcher Government, with an eye on the date of the next general election, has allocated funds to reduce NHS waiting lists, with an encouragement to use the private hospital sector. In other words, as far as reducing NHS waiting lists is concerned, private hospitals and their participating specialists have become the preferred provider.

The private health care industry has grown rapidly during the 1980s. One measure of this has been the rapid growth in acute private facilities. During the past seven years the number of hospitals has increased from 149 to 212, an increase of 42%. The increase in the number of hospital beds was even more dramatic, from 6,578 to 10,876, an increase of 65%. We have seen many hospitals expanding their facilities, as well as new hospital constructions.

There is now evidence of imbalance in the geographical spread of private hospital facilities. The geographic variation in the number of beds per unit population is now significantly wider than the geographic variation in private health insurance coverage. One consequence of this has been low occupancy rates in many private hospitals, which has in turn made the hospitals more amenable to discussions on preferred provider arrangements.

We have also seen a rapid increase in the number of private health screening centers. These establishments have in turn diversified from providing health checkups for senior executives to providing a wide range of facilities, from basic cancer screening for women to fitness assessment units for athletes (and joggers) and mobile screening units for occupational health programs.

Alongside this rapid growth in private hospital facilities, we have also seen growth in the size of the private health insurance industry. One measure of this has been the growth in the number of persons insured. During the past six years they have grown from 2.9 million to 5.3 million, an increase of about 80%. The proportion of the overall UK population with comprehensive private health insurance coverage has risen from 5.2% to 9.3%, an increase of approximately 80%. Annual premium income has increased from $131 to $350 million, an increase of over 300%. Much of the growth has been in the large group market, rather than in the individual market.

This rapid growth in premium income and the insured population has been accompanied by the market entry of new commercial insurance carriers, some of whom are the UK subsidiaries of North American health insurers. Most of the business, however, is still being written by the medical provident associations, who are similar to the Blue Cross and Blue Shield organizations in the United States. The market has recently become receptive to new products and new ideas, such as preferred provider arrangements. Much of the impetus for new ideas has come from large group clients, many of whom have demanded a proactive role from their health insurance carriers.

In recent years there has been considerable interest in the PPO developments in the United States, and many UK observers have speculated on the potential PPO market in the UK. Some of this discussion has even taken place within the NHS.

National Health Service

Encouraging Use of the NHS Pay Beds -- The benefit schedules used by the private health insurers have traditionally been linked to NHS pay bed charges. Typically, there have been provincial teaching and general hospitals. Claimants who exceed their chosen level of coverage suffer a financial penalty, which is

generally equal to 100% of the shortfall. We have also seen the private health insurers negotiating with the private hospitals on their bed prices, and then including these private hospital beds in the same hospital price bands as the NHS pay bed hospitals. It could also be argued that the financial penalties imposed on claimants who do not use NHS pay beds, or an approved private hospital bed, within their level of coverage amount is a form of PPO.

A more highly developed form of PPO has been discussed within specific district health authorities, as a means of improving their revenue from NHS pay beds. One such proposal was a local private health insurance plan which gave first refusal to the local NHS pay beds. Claimants who choose not to use the pay beds when they are available and are deemed appropriate on medical grounds would have a financial penalty imposed in the form of coinsurance payments and/or front-end deductibles.

Reducing NHS Waiting Lists -- The need to reduce NHS waiting lists is an emotive political issue. One method of achieving this is to encourage the healthy population to purchase minimal private health insurance protection, which will at least cover the cost of local NHS pay beds. The theory is that the privately insured population will not join the NHS waiting lists, since they will instead have the funds to use the NHS pay beds, which will have preferred provider status.

Privatizing NHS Waiting Lists -- As mentioned earlier, the government now feels that the waiting lists have become unacceptably long, and is encouraging NHS administrators to use the private health care sector to reduce the waiting lists. Provided that the funds can be made available, this can be a cost effective method of subcontracting the waiting lists for specific surgical procedures to the private sector.

Private Health Insurance

Hospital Agreement Plans -- In recent years the private health insurers have negotiated annual agreements on prices with the private hospital groups. These agreements have often taken the form of discounts off the retail price list for hospital accommodation charges. They can also take the form of overall per diem charges for all hospital charges. Another method has been for the hospital to

choose which of the three hospital price levels it wishes to operate within, and therefore be identified as such in the promotional material of the insurer.

The cost effectiveness of hospital agreement plans has not yet been proven. In many cases they have merely resulted in the private hospitals increasing their charges up to the maximum set by the hospital price band.

Plan Design Based on Preferred Providers -- Most private health insurers now classify hospital groups into three (and occasionally four) hospital pricing bands. Claims at the participating hospitals within the chosen hospital price band are usually fully reimbursed, often by direct settlement of bills between the private health insurer and the health care provider. Claimants who use hospital facilities that are not on the list of participating facilities for the chosen hospital price band receive an "out-of-band" benefit, which is a fixed monetary amount for each day in the hospital. The financial penalty on such claimants is usually 100% of the amounts in excess of the out-of-band benefit.

Very large employers can often arrange insured administrative services only ASO plans with the health insurers, which are similar to ASO plans but are written by an insurer. These plans are experience rated with explicit administration charges and risk charges. Some of these involve PPO networks in the local community of the large employer, on the basis that the large employer can encourage a large number of employees to arrange their inpatient treatment at the local preferred hospital. One large nationwide employer has recently arranged a nationwide PPO type deal with a major private hospital group.

There is also a PPO development for individual business. This arises from using a private hospital group as the PPO, with financial penalties if the claimant chooses not to use the PPO when appropriate treatment was available on a timely basis. The financial penalties can take the form of coinsurance and/or deductibles. Although such plans are still relatively rare, there is considerable interest and public demand for such products.

Plan Design Based on NHS Waiting Lists -- These benefit plan designs provide conditional access to private hospital facilities, the condition being that treatment required was not available in NHS public beds within a reasonable time period of (say) six weeks. Such plans use the NHS public beds as a form of a PPO.

Such plans are relatively inexpensive, since most claims do not involve a six or more week waiting list for inpatient treatment.

It has also been argued that such plans are politically more acceptable than traditional full reimbursement plans, since the NHS is in effect given first refusal in providing appropriate treatment within a reasonable time period. It can also be argued that such plans satisfy the patient's need for treatment (whether public or private) at a reasonable cost, rather than luxury treatment at a luxury price.

Plan Design Based on NHS Pay Beds -- As mentioned earlier, benefit schedules for insurance coverage have traditionally been linked to NHS pay bed charges. Claimants who exceed their level of coverage suffer a financial penalty, which is generally equal to 100% of the shortfall. It could be argued that the financial penalties imposed on claimants who do not use NHS pay beds within their level of coverage amount is a form of a PPO.

Private Hospitals

Fixed Cost Surgery -- During the past year or two, a major hospital group has introduced the concept of fixed cost surgery. It was originally introduced in order to attract noninsured patients for surgical operations subject to NHS waiting lists. It was soon found, however, that there was considerable interest in fixed cost surgery from large employer paid insured groups. In recent months, two other hospital groups have followed the lead and have also introduced fixed cost surgery. It is anticipated that the other private hospital groups will follow during the next few months.

Fixed cost surgery means that the hospital publishes a fixed price list for a wide range of surgical operations. These prices are guaranteed to the patient, irrespective of the length of stay in the hospital. The plan covers a wide range of selected operations and a guarantee is given to the patient that, if any unforeseen development occurs to the condition being treated, no extra costs -- either specialist fees or hospital charges -- will be incurred by the patient.

The financing mechanism underlying fixed cost surgery plans is transparent to the patient. The hospital group protects itself by contracting with the

specialists to perform the surgical operations at fixed prices, irrespective of any medical complications. The hospital group accepts the risk that the length of hospital stay will not be longer than originally forecast, in the knowledge that some patients will be discharged earlier than originally forecast. The fixed hospital charges include accommodations and meals, nursing, drugs and dressings, theatre fees, prosthesis, pathology and radiology. The other fixed prices include surgeon fees, anesthesiologist fees, and physiotherapy. The price guarantees given are thus quite extensive.

The introduction of fixed cost surgery by hospital groups places them into the insurance business. They are providing financial guarantees to patients not as extensive as those offered by the private health insurers. There may also be a contractual obligation to accept the professional liability risks associated with the medical hospital as being the principal in the fixed price contract. The specialist could argue that he was subcontracted at a price which was too low to ensure the highest standards of independent professional care, and that he was not responsible for the supporting services provided by the hospital.

It could be argued that the introduction of fixed cost surgery products by major hospital groups will inevitably lead to innovative PPOs. Bulk purchasers of health care services will want to negotiate preferential prices for fixed cost surgery products. They will also want to see the hospital groups upgrading their professional standards by monitoring the cost effectiveness of participating doctors and weeding out the inefficient or ineffective ones.

Procedural Pricing -- This is a similar concept to fixed cost surgery, but is more comprehensive. It means fixing the prices for the great majority of surgical procedures, rather than the most popular 30 or so procedures and then marketing these to noninsured patients. Procedural pricing represents a fundamental shift in strategy, from fee-for-service to contractual prices for all surgical procedures. It also lends itself to preferred provider arrangements, whereby the preferred providers are those who have contracted with the PPO to provide their services at a fixed price for all surgical procedures within their specialty. A major advantage of procedural pricing is that treatment costs are guaranteed, once the necessary surgical procedure has been identified. This moves medical insurance away from being a contract of indemnity to one of cash contingencies, where the insured contingency is the surgical procedure.

PPOs With Local Communities -- Most major hospital groups in the UK would like to develop PPOs in the local communities in which their hospitals are situated. The reasons for this include the need to increase occupancy rates and to smooth out the peaks and troughs in bed occupancy. One solution is to have a captive market of insured patients in the locality who have both an affinity with the local PPO and a financial incentive to use it.

The local PPO would have a structure based on the local hospital and its participating doctors. The PPO would market its services to the local community, probably as a branded product underwritten by a health insurance company. The benefit plan design would involve full reimbursement of medical bills if the patient uses the local PPO services. In practice, there would be direct settlement between the health insurer and the local PPO, so the patient would not even see the bills. There would, however, be a financial penalty imposed when the patient chooses not to use the local PPO services, except in cases of emergency or the unavailability of appropriate treatment through the local PPO.

PPOs With the National Health Service -- There is already extensive collaboration between many private hospitals and the NHS. This collaboration has included the sharing of expensive equipment, the sharing of pathology services and the purchase of blood from the National Blood Transfusion Service. There have also been management contracts awarded to private hospital groups for the management of NHS pay beds.

The extent of collaboration with the NHS depends on political as well as on commercial considerations. The political opposition by the Labor Party and the NHS trade unions to private medicine has led to considerable geographic variation in the extent of any collaboration. One positive factor in favor of collaboration has been the recent introduction into the NHS of district general managers, many of whom were recruited from commercial organizations outside of the NHS.

This speculation about future developments naturally leads to the final part of my presentation.

National Health Service Plans

Future PPO developments could include insurance plans which give preferred provider status to using NHS pay beds. This could be achieved by benefit plan designs which have full reimbursement for NHS pay beds and relatively low out-of-band limits for private hospitals. Although such a plan might be sponsored by some private health insurers, it is unlikely to receive support from the private hospital groups.

A more marketable option would be to offer a PPO plan which provides full reimbursement for the PPO approved hospitals and any NHS pay bed. Such a plan would have the advantage of being a nationwide PPO network. The majority of specialists are likely to prefer their patients to be admitted to a modern private hospital, rather than to an NHS pay bed, many of which provide less amenities to patients. Consequently, the inclusion of NHS pay beds in the PPO network is unlikely to be financially significant to the PPO network. One implication of this is that, in order for PPO networks based on NHS pay beds to be commercially viable, they need to include a network of modern private hospitals.

Private Health Insurance Plans

Future PPO developments could include insurance plans which give preferred provider status to health care providers on a nationwide basis. There is already one health care company which owns both a health insurance company and some private hospitals, and which offers a discounted price to patients insured by the associated health insurance company. In the future there could be linkages between health insurers and major hospital groups, whereby insured patients using the PPO network obtain full reimbursement, and those using nonparticipating health care providers have a financial penalty.

Much of the interest in PPO networks is likely to come from large employers who are becoming increasingly concerned about cost control and are expecting the health insurance companies to take positive steps to negotiate with the health care providers on cost control issues. The introduction of PPOs is likely to receive a warm reception by many large employers, who will view it primarily as a method of cost control.

It is also anticipated that local PPO networks will generate considerable volume of individual sales, even if they are initially set up to cater to the needs of large employers. The local distribution channels are likely to include direct marketing methods, including local radio and local newspapers. There would also be strong links with the local community, including hospital open days, local advertising and high profile local events. The local PPO would also attract a large number of individuals as a result of those leaving large employer group plans. Most who have left group plans would be offered continuity of membership at discounted premium rates from the group health insurer.

It is likely that the insurance company based PPOs will be based on a network of favored acute private hospitals, with financial penalties if these preferred hospitals are not used. It is unlikely that the private health insurers will be able to negotiate directly with the medical profession. A more likely scenario is that private hospitals will negotiate directly with the specialists who wish to use their hospital facilities. It is probable, therefore, that the most effective PPO networks will be hospital based, rather than insurance company based.

Private Hospital Plans

The greatest potential with PPO developments probably lies with the private hospital groups. They have a primary interest in directing patients towards their facilities, in order to improve bed occupancy rates and, hence, profitability.

The private hospital groups also have considerable potential influence over the doctors and other medical professionals who use their facilities. The major private hospital groups could potentially play a central role in setting up nationwide PPO networks. In the meantime, it is likely that some private hospitals will attempt to set up local PPOs for their communities.

It is also likely that the hospital based PPO networks will wish to broaden their services to include limited forms of health screening, primary care and occupational health. Such a move would reduce the significance of medical expense insurance against acute treatment by specialists, so it is likely to be resisted by some of the private health insurers. Nevertheless, this broadly based health

care package is likely to have considerable market appeal, particularly to large employers.

Finally, I have a message for the major PPO networks in the United States. The UK has a growing private health care market. The current political and economic environment is such that a cost-effective PPO could obtain a large share of a growing market. Perhaps we could learn something from the PPO networks in the United States, and vice versa.