RECORD OF SOCIETY OF ACTUARIES
1990 VOL. 16 NO. 1

OPEN ENDED MANAGED CARE PLANS

Moderator: WILLIAM F. BLUHM
Panelists: MARY K. BRAINERD*
GREGORY N. HERRLE
TED WISE**
Recorder: DAVID E. SCARLETT

- Open ended managed care plans from various perspectives:
  - -- IPA/Staff/Commercial
  - -- Marketing/Operations/Actuarial
  - -- Hints

MR. WILLIAM F. BLUHM: Greg Herrle, who is a consulting actuary with M&R in the Milwaukee office, specializes in managed care plans. His clients include HMOs, PPOs, insurers and medical groups. Greg has also written a paper on designing open ended managed care plans.

Ted Wise is the Director of Marketing at Group Health Inc. in Minneapolis. Ted has been with Group Health since 1983 and has been responsible for developing and introducing Medicare Risk Programs, HMO and indemnity choice products, and the management of individual and group products. Ted has an MBA from the University of Minnesota.

Mary Brainerd is Vice President of HMO Operations at Blue Cross and Blue Shield in Minnesota. She's also the Chief Operating Officer of HMO Minnesota, a subsidiary of Blue Cross. Prior positions have included Vice President of Health Services at HMO Minnesota, and she was an instructor of Marketing at Metro State University. Mary also has an MBA from the College of St. Thomas and is the Chair-Elect of the Minnesota Council of HMOs.

MR. GREGORY N. HERRLE: I'd like to lead off with some general characteristics about open ended HMOs; then I will comment on some experience and surveys that have been done on the characteristics of open ended HMOs, and some of the average benefit designs, some of the out-of-plan leakage statistics that *InterStudy Edge* has recently put out. Also I'd like to add to that some of my own experiences in plans that I have dealt with in terms of some of the key issues that come up in marketing strategy, benefit design, providing a reimbursement, and rating.

* Ms. Brainerd, not a member of the sponsoring organizations, is Chief Operating Officer at Blue Plus and Vice President of Blue Cross and Blue Shield of Minnesota in St. Paul, Minnesota.

** Mr. Wise, not a member of the sponsoring organizations, is Director of Marketing at Group Health, Inc. in Minneapolis, Minnesota.

I'd like to start out with some general characteristics. Some of the information that I'll be showing you in the beginning was taken from Volume 1 of the 1990 edition of the *InterStudy Edge*, which is a publication put out periodically in the Twin Cities. A survey was sent last August to most of the HMOs in the country regarding their experience and feelings about open ended HMO plans.

I'd like to first show you some of the results from the survey. There were about 85 open ended HMO products in the marketplace, or plans that had open ended products in the marketplace as of last July, according to the surveys. A lot of averaging was done on this. I don't know how a lot of this was averaged, but they were trying to come up with some common characteristics. It might say that the typical open ended HMO plan was developed by an IPA model HMO, had more than 25,000 members, was a not-for-profit plan, was federally qualified, located in the Midwest and was affiliated with the national HMO firm. I'm not sure any of those jived exactly, but that's apparently what the common characteristic is.

In terms of where open ended HMO plans seemed to be concentrated, they are, at this point, in California and Minnesota. Six or more plans reported having open ended products. Colorado, Texas, Wisconsin, Missouri, Ohio, and some northeastern states reported having three to five plans. New York and New Jersey had the next most open ended HMO plans last year, and the rest of the nation had very limited experience.

I want to show the factors, and kind of get into the marketing strategy. Why are open ended HMO plans being offered? Why are HMOs moving in this direction? The response from most of the HMOs was the appeal to small and mid-sized employers. That was the most often indicated response to why they offered an open ended HMO product, or why they were going to. Other reasons include: employer pressure to offer such a product, their future growth was impeded by the lock-in in their traditional HMO program and they saw it as a means to expand membership, and competition was a reason whether it was from other open ended products in their area, whether it was from PPOs, or whether it was from other managed health care plans.

Now there are a couple of marketing strategies that I've seen HMOs take. One is as a complete replacement product, where it does a whole case underwriting. It has the whole group; there are no other carriers or health plans involved. Another situation is using the open ended product in the typical dual choice environment, replacing the traditional HMO plan, or where it's one of many plans being offered with an open ended product instead.

The HMOs were asked as to whether they plan to, over the next one to two years, offer an open ended product, and 64% of the respondents said they were not going to offer or were not planning to offer an open ended product in the next one to two years, 26% said they were, and 10% weren't sure.

Now a commonly asked question is do you reinsure or who reinsures the risk for out-of-network services? Many HMOs are very risk adverse, not wanting to offer or provide that coverage, take the risk for the out-of-network, while many others certainly do but cannot do it because of state regulations that prohibit the HMO from taking insurance

risk. In addition, the federally qualified HMOs have certain regulations that deal with the percentage of services that can be provided outside of the network. So 80% of the out-of-network coverage is being provided by affiliated companies, which seems to make sense in light of the response to the rest of the survey in that most of the activity in the open ended products was with some of the larger national carriers like CIGNA, and so I think that's being reflected, where it's very easy for them to offer that kind of an arrangement. Another 5% indicated that the out-of-plan risk was being picked up by the Blues. About 10% indicated that it was the HMO itself taking that risk. A very small percentage indicated that out-of-network risk was being taken by an unaffiliated insurance company.

My experience has been, in a lot of plans, there are a lot of independent HMOs looking to do this product, even though 64% apparently said that they weren't interested in doing it. But, they're having real trouble in states where there are regulations prohibiting -- where they can't find a player to take the risk. There's a number, a small number, of insurers out there, some of the HMO reinsurers, who will provide coverage for out-of-plan risk if they have the reinsurance coverage, but there aren't a lot of players in the market right now or a lot of insurers, who will join up with the HMO or front for the HMO in this kind of a product.

Moving on to benefit design, the key question that usually comes up in discussing this product with an HMO manager is the out-of-plan usage. The big fear everyone has is what's going to go outside the network and how much is going to go outside the network. We can't manage the plan as well as we did before because we can't control cost once they're outside of the network. So when it comes to benefit design, one of the top priorities most HMOs will have is to design a benefit package to limit out-of-plan use.

Now, there are a number of variables that are going to influence out-of-plan use, and again, getting back to a very common question, the question we'll hear a lot is: What percentage of costs can I assume to go outside of the network? And unfortunately, the answer is usually: It depends on a lot of variables in your marketplace. What works well in one area of the country, or the experience from one area of the country, is not likely to be appropriate for a lot of other areas of the country. Benefit differences are one of the key variables, and I think most people in designing these products ideally try to get a 20% to 30% benefit differential between in-plan benefits and out-of-plan benefits. At that level, it's a strong enough encouragement to use the network, or strong enough disincentive not to use the network, but in many areas it's very difficult to design a competitive benefit plan with that much spread if the employer requests are for something much richer. For example, if your in-plan benefits start to mirror a low-option package, it's a lot harder to get a 20% or 30% differential if your high benefits, or in-plan benefits, are already quite low, but that's a typical target that many people will strive for. Another factor affecting out-of-plan use is certainly the network size of the model type. Those HMOs that have all the hospitals and physician providers in an area certainly are going to have a lot less out-of-plan use than a very limited staff model, perhaps, that does not have a lot of fee-for-service providers in the community. The perceived network quality goes right along with that. Does the HMO network have a lot of the highly thought of quality providers in the community, or the high profile providers in the community, the referral centers, whatever? That has a big influence on who is

going to go out and who is going to go in. It can also significantly influence the risk status of people going in and out of the network or who are going to join the plan.

High profile providers is an issue that seems to come up a lot. The main concern in a number of areas where I've dealt with plans was not so much that people were going to go to other providers in the area, because they already had good coverage, but the concern was that people were going to go outside the service area and go to a large referral center, like Mayo Clinic, or the University of Pittsburgh, or some referral center in New York. Even those HMOs that have a very high penetration of providers in their market area are very concerned about people going outside the community for care. I personally think, in most situations that's probably not as big an issue as people are worried about. I think most people go for care in their community, and if you have that network covered pretty well, most of the time you're reasonably safe. The next two panelists are from the Twin Cities, and the Mayo Clinic is certainly very convenient there. I'd be interested to hear their comments on, perhaps, if they knew how much of their outside care was going to the Mayo Clinic?

Another issue is the sales strategy that one employs. If the open ended HMO product is going to be offered on a replacement basis on groups that maybe had 20% HMO penetration in the past, you'd expect more out-of-plan usage for awhile until people got used to using the system and understanding how the HMO network and the providers in it worked. On the other hand, if the product is being offered as a dual choice to replace your current dual choice product to groups that already have your HMO, you might expect to have quite a bit lower out-of-plan usage.

If you look at the experience in the Twin Cities, the out-of-plan network usage is extremely low and it really doesn't vary that much across all the different HMOs that are in the Twin Cities. But, I think, the Twin Cities are very unique in that respect and HMO penetration is quite large, 60% penetration perhaps in HMOs already.

I think the perception of managed care in the community has a big impact on the use of network providers. I think the conclusion to the benefit design and the variables that affect out-of-plan use is: Each area is going to be quite a bit different. An HMO network is going to be different if the competitors are different in each area and if the products that employers want are different. So, I don't think it's very easy to generalize on either the design, necessarily, or the out-of-plan usage from HMO to HMO.

Now, as recorded in the *InterStudy Edge* survey, the typical in and out benefits for an open ended product were ones where the HMO benefits or in-plan benefits were pretty much covered in full, no deductible and co-insurance, as would be expected. But there were copayments on the office visits, and generally you see $5 or $10 copayments on office visits, copayments on prescription drugs, and no out-of-pocket limits. Contrasting that is the indemnity benefit which would have a significant comprehensive major/ medical-type deductible. In this case they show a $350 deductible, 25% coinsurance, no copays, but an out-of-pocket limit of $3,000. So vastly different benefits.

We're trying to get into the alphabet game with all these different plans in the market-place. For example, what's an HMO, what's a PPO, what's a point-of-service plan? I

think it's very difficult to classify a lot of these as one or the other. A PPO is based on the same concept as an HMO. I think one of the differentiations is product design. A lot of PPOs are, perhaps, developed by insurance companies outside of their HMO networks or not by HMOs themselves. They have a more insurance comprehensive major/medical-type plan design. The HMOs seems to be going more the route of copays on the in-plan stuff and deductibles for the out-of-plan in coinsurance. I think there's much more, from a benefit design standpoint. The open ended HMO is structured to look more like an HMO product on the in-plan benefits. In terms of the services that generally are covered within the network as opposed to outside of the network, the common ones are all the well-care types of services: physicals, well child care, vision, hearing, other types of preventive care. It's the main additive benefit that most open ended products have for using in-plan services. They generally won't provide those types of services if you go outside the network.

In terms of services received outside the network, getting back to the concern of how much is going to go out and where it is going to go, and for what services, a lot depends on the breadth of your network, the quality of the providers in your network and how much you've limited access to certain types of specialties within your network. About 20% of the plans indicate that less than 10% of costs are performed outside of the network, and another 10% of the plans reported that 10% to 25% of the costs are performed outside the network, and a smaller percentage reported a very significant portion of costs are outside the network. What was interesting, I thought, was that 65% of the respondents said they didn't know what percentage of costs were going outside the network, and giving people the benefit of the doubt, I'm assuming that means that they just started the program and it's too early to look at anything, not that they have no means of measuring, showing, or reporting in and out usage, though I think that really may be the case for a number of people.

So I guess the big question now in everyone's experience is, what's happening to that 65% who do not know what's going on? Typical services most likely to be sought outside the HMO network include such things as OB/GYN services, which isn't surprising, and mental health and chemical-dependency-type services. Again, those are areas where many HMOs have quite limited networks. Cardiac services, other types of specialty care -- a lot of these things aren't too surprising. According to the response, very little primary care seems to be going outside the network. You can certainly guess that some of these kinds of surveys can be very misleading if they're influenced a lot by certain types of plans. For example, in a capitated plan you have to pick a primary care doctor; that certainly can influence the use of physicians in a network. So it's hard to know exactly who all is in the survey and how much it's influenced by certain areas of the country, certain types of reimbursement, or delivery system structures.

In terms of getting back to benefit design, one opinion that I have, or strongly believe in, is that we spend far too much time trying to design the benefit plans to be of a specific basis and get into discussions like: Well if we have this kind of copay on this service relative to that, more people will go in or out; or if we have an out-of-pocket limit, once people go out and hit that, there's no incentive to come back into the network. I think we get very detailed because we tend to understand the benefit design better than the typical person. I think we make it overly complicated.

My opinion is, most people don't look at their benefits quite that way. I think a lot of people receive care and then find out what their benefits are. I think there's certainly an incentive or disincentive after the fact at that point. From a marketing standpoint, I feel, you can accomplish a lot of these things without getting extremely complicated.

Other uses that come up are whether to have out-of-pocket limits on the out-of-network services. A number of HMOs did not want to have any out-of-pocket limits for the reason I mentioned earlier, there's no incentive to ever go back into the network once you hit your out of pocket. From a marketing standpoint again, I think that's a tough sell -- to have someone totally exposed, especially if your out-of-pocket cost sharing is extremely high and people don't know about it ahead of time. If they're paying 30% or 40% coinsurance and they have a pretty huge bill, you can have some pretty significant PR problems on your hands. I have seen people start to limit those benefits. Instead of an out of pocket they've gone the other way and just said, "we'll provide $3,000 of coverage outside the network and after that, we're not covering anything," which is kind of the opposite end of the spectrum.

Other issues are maximum allowable charges. Some HMOs have said that anything outside the system would be paid at a maximum fee schedule whether you go in the service area somewhere or whether you go to a referral center in New York when the plan is in Wisconsin. Rather than using usual and customary screen, they would limit it to a fee schedule. One plan that was in a two-hospital town, where the other hospital was a university hospital and the costs were two and three times higher than the contracted cost, wanted to limit the reimbursement to what they paid their own hospital, again leaving significant out-of-pocket costs to the enrollee.

I think the typical benefit exclusions for going outside the network are preventive, and then after that, some plans exclude mental health and chemical dependency. Some people I've seen exclude lab and a number of other things where they've had very good contracts in network. But typically preventive is probably the most common one excluded from out-of-network services. Utilization review (UR) penalties vary. A lot of people use differential coinsurance percentages. Normally, if you require preauthorization even if you go outside the network, and you don't comply, instead of paying 20% or 30% coinsurance, you might get billed for 50% coinsurance. Again, my personal opinion is that this gets to be complicated. I'm not sure most people can figure out the difference in the coinsurance percentages to begin with or know what the bill is going to be to apply it to the coinsurance and figure out the penalty. I would like to have flat dollar penalties for that.

Out-of-plan definition gets to be an issue as does the definition of when the benefits kick in as out-of-plan service or in-plan service, especially if you have a primary care model where you have to get a referral to a network specialist. What happens if you go to a network specialist without a referral? Then is it an in-plan benefit or an out-of-plan benefit and how do you pay the specialist on that basis? That gets to be complicated for a number of plans with that kind of model.

On provider reimbursement, there are mainly capitation strategies for those plans that in their typical HMO either capitate primary care, or perhaps, in a more extensive basis

capitate medical groups for all services. Some of the common strategies, or at least considerations that I've seen, are with this new product. For example, you maintain the capitation and exclude the out-of-plan services from the cap; or you maintain the capitation that you had on the HMO, obviously adjust it for benefits and the like, but include all the out-of-plan services as part of the cap so that the risk taker, the physician group, is responsible for out-of-plan services; or keep prepayment, but reduce the capitation for what you expect to go outside the network, or eliminate the capitation altogether because you can't figure out what to do with it, or negotiate something with your providers and go to a fee schedule, which certainly has a number of risk implications.

An example of capitation strategies would be to maintain the cap at where it was and exclude out-of-plan services from it. What that tends to do is just increase costs. If the capitation was $30 on the HMO and out-of-pocket costs are now expected to be $3 on the out-of-plan side, then that capitation would stay at $30 and you'd have to pay $3 in out-of-plan costs and it would increase the cost of the plan. Now primary care isn't that big a deal. If you want to keep your primary care network and you're paying $10 per member per month, it might not be worth worrying about whether the members should be at risk for primary care, or you could get by at least paying the extra amount; but if you're capitating a lot of services, it's hard to keep the cap at the full level knowing that everything is not going to be provided by the capitated providers, but the providers are going to like that one.

Another example is to maintain the cap and include the services. There you keep the cap at $30, but if $3 goes outside, the net cap to the providers essentially is going to be $27, but your costs as the insurer are the same.

A third example is to reduce the cap, that would be paid by the expected $3 outside. You would then pay them $27 and you can take the risk for the $3.

Finally, eliminate the cap altogether and if all the assumptions work out, that isn't going to impact anything. But if you think of the cap impact of medical management and the use of services and you can get your fee schedule tied exactly to what you are capitating, good luck.

Just a couple last issues. Premium differentials as reported in the *InterStudy* surveys, 37% of the respondents indicated that their point of service product, or their open ended product, was at least 16% higher in cost than their HMO product, 20% indicated it was about 6-15% higher, another 20% reported less than 5% higher, and about 20% indicated it was the same cost or less cost than the HMO product. Again, it's hard to tell how much of an apples-to-apples comparison we have in this situation and what the HMO product really is and what the point of service product really is.

My last comment is on rating issues, and the big question I get from HMO clients, the big concern I see, is defined as one of risk versus uncertainty. I think HMO managers, especially those who don't have much insurance background, really get concerned about this stuff going outside -- I don't know what it is, it's uncertain, I can't measure it -- as opposed to risk. Yes, it is riskier, but you should be able to measure what's going

outside, and I think there are ways you can quantify and at least model what the potential impact of the product is. Out-of-plan usage from the HMO standpoint is the big issue in predicting that. So a lot of HMOs that aren't affiliated with insurance companies don't have the insurance background. Pricing comprehensive major medical products is difficult. They don't have the data and expertise to do that.

A big issue on the relevance of their own experience, the traditional HMO experience, may not be a good base or the only base to use in going forward when introducing this new product, especially if it is used as a replacement product. You now have the whole group. Before you maybe only had 20% of a given group. If selection was present in the marketplace, you could have a big change in the risk characteristics you're taking with this type of product. Again, it makes the relevance of your own experience less meaningful than it would be if you were going forward with a typical HMO product.

I wanted to go over just the general characteristics. Very common questions asked in the industry are: What's going outside the network? What are the pricing differentials? What are the premium differentials, benefit differentials?

MR. TED WISE: To set the context, one of the questions some of you may be wondering, and I don't know the perspective you come from exactly, is if, in fact, open ended managed care is sort of an oxymoron. We've been in this business now for about 30 years, and I guess from our experience -- it doesn't necessarily have to be, but I think we have had over the years many of the same issues which Greg has identified, and I'm sure this question is running around in your heads if you consider this for your clients or for your companies.

I really want to try and address three broad questions. The first one being, what is it about our market, why are we doing this, why did we start doing this? Put into context the remarks that I make, as well as Mary's, because you'll have to translate in your own minds what your market places look like. They may be different than the Twin Cities. Second, I'd like to give you a summary of what I believe are the keys to how we at Group Health have been successful with these kinds of programs over the years. Again, this is our perspective and there are some unique aspects of Group Health. I'll give you a sense of those when I get to it, but you'll have to translate to your own experience. Finally, I'll close with some of the key questions you might want to ask yourselves as you set about trying to design one of these programs, if that's in fact, the way you want to go.

I'll start out setting the context in the Twin Cities. I think what you've heard is true. The managed care up in the Twin Cities is very interesting. In recent years, I'd characterize it as sort of wild and wooly. There has been dramatic growth in managed care. Greg mentioned the figure earlier about 50% to 60% in HMOs. There's another 25% in PPOs and practically nobody is in traditional indemnity insurance, at least without some form of what you might call managed care features, utilization review and some of those kinds of things. I think what this has done is forced all of the HMO organizations to begin offering a much broader range of products and, hence, choice. It's kind of interesting trying to keep up with what these programs are called, open ended, point of service choice, or combination plans. I used to like choice, but it seems open ended is becoming the term of choice.

So what are the purchasers up to in the Twin Cities? They are probably not unique, maybe a little bit more intense than they are in some parts of the country, but absolutely cost is the biggest issue. Some research I've seen just recently that was done in the Twin Cities says, not surprisingly, all major employers say that cost is the key issue as they look ahead over the next several years. I'm sure that's the same thing that you would find in your market. What it is leading them to do is take much more of, what I call, a purchasing approach. They want to start purchasing health care and health care plans the way they've been purchasing sheet metal or components or wire or whatever it is they use as a raw material in the products that they manufacture. This really means specifying benefits, specifying how they want to pay for those plans, how much risk they want to pass off, what sort of service standard they want to hold the carrier to, and what kinds of reports they want to see from them. The combination of those two issues, concern about cost and this purchasing approach, really is leading them to focus on consolidating the number of plans they offer. They cut it down to one, two or a handful of plans that can really respond to all of those needs.

With a purchaser overview, what about consumers? The situation we see in the Twin Cities with consumers is that they are incredibly confused about the whole thing. We see something on that order in some research we've been doing, and we've been doing this every six months for the last six years, asking questions like: Do you intend to change plans? About 20-25% of members of HMOs are intending to change health plans in the next year or two. So they're sort of saying, "I'm not sure what I want, I'm not happy where I am, I'm going to change to something." Interestingly, over half of those people who intend to change don't have a clue where they're going to change to. So it's an interesting challenge, and I think what's contributing to this are the name changes and new plans that are offered. (Mary, for example, keeps changing the names of her plans periodically, from HMO Minnesota to Blue Plus.) Even beyond that, it's confusing because the industry talks about PPOs and HMOs. As a consumer, I don't know whether that's important to me or not. I'm just very confused about what my choices are when open enrollment time comes around.

I think it's safe to say that we're certainly seeing a purchaser backlash. Absolutely, that's it. I can't afford anymore kind of a stance. I think we're seeing the same thing starting to happen with purchasers and with consumers as well.

A large percentage of the strikes in this country were primarily over health benefit issues, which is fairly remarkable. It's not salary, it's not working rules, it's health benefit issues. We just finished with a strike that was absolutely over the issue of who gets to choose the health plan that is offered to the employees. So I think all of those things together keep the pot stirred up a little bit as we look at our environment.

The health plans are doing some things about that. We are all changing the kinds of offerings we make. A closed model plan, the traditional kind of HMO, while it's still an important part of the market, is a shrinking share. We've seen that in our business. Virtually every HMO in the Twin Cities with one exception offers some sort of a choice product. It may play a different role in their strategy but there is a choice product out there from all but one carrier, and the choice plans that are offered are offered in a variety of different ways: HMOs, insured and self-insured PPOs, all kinds of different

financing options. It's really a candy store for the purchasers right now, and I'd say they have a fair amount of say in the way those plans are going to be offered. I think it is causing all of us to get quicker on our feet in how we deal with the people that send us money every month.

To give you just a couple of specifics before I talk about how it is we happen to be, I think, as successful as we have in this business, I'll tell you a little bit about Group Health. We've been around since 1957. We are primarily a staff model, and I'd like to say that we do most of the things that Dr. Enthoven was talking about earlier. We probably don't do them quite to the extent that he would like, but we are primarily a staff model. We have 15 medical centers around the Twin Cities with two more under construction. We are a large multispecialty group, over 300 physicians are on our staff. We also contract with 33, what we call, affiliated medical centers, which looks like a lot in terms of number of sites. In reality, it's a very small part of the care we deliver. Under 15% of our members use affiliated sites. They are there primarily to fill in peripheral geographic areas. Our 1989 membership was about 280,000. It's now up to just under 300,000 after the first three months of this year.

So, what's our choice product experience? We got into this back in 1961 with a product called Instant Choice. It's interesting, if any of you went to the HMO Myth-versus-Reality seminar. Earlier they talked about how some carriers in some areas, because of the issue of risk selection, are starting to say that once HMO penetration reaches a certain level, as an indemnity insurer, they are going to drop groups. Well, that's what happened to us in 1961. At that time, we were the communists and the only way we stayed in business was to invent a program that would allow us to serve the needs of an entire group because the insurance company just pulled out. So we've been at that for a long time. We were forced into it. Fortunately, it happens to have worked out for us as well.

We have several other programs that we developed more recently. GroupCare is a small group product primarily sold on a total replacement basis. CareSpan is a joint venture product we do with The Prudential, which is either dual choice or total replacement. Since 1987, we also have a PPO product combined with a TPA group of health administrators. In total, we have about 75,000 people covered under one of these options, with the smallest number being in the PPO option.

There are a couple of areas which I'd like to touch on which hopefully will begin to give you an idea of what you might want to be looking at if you're considering these kinds of programs in your own operations. The first of those is operations. One of the things we've discovered as we've gotten bigger in this business is absolutely internal communications. By that, I mean not only to administrative areas but also to physician staff. I think the same thing would apply if there were contractual relationships with physicians. This is a new type of program. Members come into this program with a different set of expectations. I think what we've seen is that people who never would have considered an HMO before are sticking their toe in it for the first time and they're coming in with a challenge. "Okay, now I'm here and I never thought this was a good idea but I'm going to give it a try." I think that's a different kind of approach that the providers and the service delivery people need to take.

Obviously, there's a need for a much more sophisticated claims system. We have done this program for a long time, but still our claims payment was for the most part, this is probably true of a lot of HMOs, really an accounts payable function. It wasn't really a claims payment function, there was not particularly much sophistication there. Clearly, when you've got choice and nonchoice people, you've got in and out-of-plan providers. All those bills are coming in together, it really necessitates a whole new level of expertise on the part of claims payment and other kinds of administrative systems.

Another thing which we found is that the whole area of member services changes a lot too, -- I don't know whether this is true in your area if you're in the HMO business, but the state looks very closely at how we handle member services issues. We have all kinds of standards we have to meet on resolving complaints. We start to get a lot of complaints now from people who are using doctors who aren't even on our staff, doctors we've never heard of before, which really adds a whole complexity to the member services function that we've had to deal with.

On the delivery side, we really think, and I'll touch on this again in terms of promotion, the absolute key to success for this is the core delivery system. We think that a staff model or a very tightly managed and well-managed delivery system is key to success, with all of the efficiencies and potential advantages that come along with that, because that's really what we're selling. This product is a vehicle to get more people to come into that care delivery system and that's the way we look at it. Absolutely, broad geographic access is critical, getting at the point at which Greg touched on, and we try to position some of the advantages of our system similar to other staff model systems, like full-service medical centers. While we do have some managed care features, they are managed care and outside the network. I'd say that is an oxymoron. Obviously, there's not a lot we can do for people who aren't using our care providers, and so the key is to have a system in place that really yields a very high percentage of services being delivered inside the network. Our overall experience has been very good in this. It really depends on the nature of the service, but it's somewhere between 85-95% of the services inside the network. We've seen a bit higher percentage outside in areas like mental health, which I think was on the list that Greg had, not so much in the area of OB, though, surprisingly, but mental health and maybe some catastrophic cases that just were outside. That's really where most of the expenses have been going.

The good news is, there is a role for actuaries. There is a new need for expertise that we haven't had before. So there's a role for consulting actuaries as well, and that is to monitor trends very closely. We've gotten pretty good at projecting what our in-network costs are going to be. We're not at all familiar with what's happening out of the insurance world, and because people have the opportunity to go in and go out, trying to keep track of that and assess what that might mean to our future rate need, we've had to develop some expertise.

We think field underwriting is critical. We spend a lot of time with our sales people convincing them that not every group is a good candidate for this kind of product. There are questions to be asked: Where is the group geographically? What has its experience been, not just claims experience, but what has its experience been with HMOs? If it's a group we've had, what has our experience been in that group? The last thing we want to

do is take over a group, enroll members, and really discover that what we sold them was an insurance plan, that there aren't people coming into out network. So we put a lot of responsibility for that on the part of our sales people to try and screen those things before they get enrolled, and obviously maintain strong benefit incentives to use the network. I really want to underscore what Greg said. We think that a simple benefit design is the best way to go. We have spent hours getting coddled up on some obscure case that might yield a slight advantage to go outside the network versus inside the network, and I think that gets so esoteric that it's really not worth the extra effort. We try to maintain at least a 20% coinsurance difference plus a deductible. Our typical plan is a $200 deductible, not $350 as found in the InterStudy work. In fact, we have very few that have a deductible that high, but it is an area that we look at very closely.

In terms of promotion, and again, depending upon where you're coming from, if it's an insurance company starting up one of these plans, I think this will be a tough one to grapple with. We feel going in that what we're really selling is an HMO product. It happens to have an option, a safety valve, if you will. We're not selling an insurance plan that happens to have an HMO available, and I think that's an important distinction. We spend virtually all of our time talking about the network, talking about the advantages of using the network. We try to simplify the whole program as much as possible.

It's kind of interesting. We did a piece of research about a year ago, and this may just tell you something about how effective or ineffective we've been in communicating, but we did a survey of our choice product members, and only about 20% of them even knew they had a choice option. Most of them thought it was an HMO and they didn't know they had this indemnity plan. So that's sort of a good news, bad news, thing. It may also suggest that we missed some opportunities because people didn't know that was the nature of the beast, but it also may contribute to the fact that there are so few people using outside the network.

Again, the final point, which I touched on already, is a tough one. You know, it is not for every group, and I think there is a need to be somewhat selective. We've had to say, "I'm sorry, we won't go that far." If an employer wants us absolutely to match a current indemnity benefit, which might be a $50 deductible for the out-of-network piece, we will say, "No, we won't bid on that basis." That's part of, I think, the recognition that with that little benefit difference there would probably not be the kind of long-term experience that would be good for us or good for the purchaser.

To summarize, a helpful hints list, if you will. I think one of the first questions is almost a philosophical one. It was a question of survival, I guess, originally, but as we developed some programs a little more recently, it is now philosophical question. Is this type of product really consistent with our mission, or your mission, as an organization? I'm aware of some discussions among some of the large HMOs, that are primarily staff model, going on around the country right now that suggest that many of the physicians don't think this is a consistent approach to the HMO business, and I wouldn't minimize the significance of that. We were lucky because we had a lot of experience, but we also spent a long time with our doctors as we expanded in the early 1980s with these types of programs, explaining to them some of the issues about the market place and why this

was absolutely critical for our survival, but I think you need to build some of that in, some of that internal soul searching.

A second issue, also very important, is know your market. I have seen some choice plans designed around the country that really were clearly designed to satisfy some system issue, satisfy the doctors. I would argue they didn't satisfy any market needs that I could identify, and based on some of the experience they've had, any of the market needs that their market could identify either. So make sure you're putting together a product that really is going to meet somebody's needs. Just because it's a "choice product" does not mean there will be people flocking to buy it.

Make sure you aren't just really selling indemnity insurance. Probably our highest out-of-network usage group is only about 20%. We're worried about that. We think that if you get up that high or any higher than that, you're really much more in the insurance business than you are in the HMO business and there's a limit to what you're going to be able to do to manage the costs of that group.

Don't underestimate the system requirements. I don't think we did, but in fact it's tough to keep up with claims sometimes and it's tough to keep up with membership and enrollment issues and things like that. This is a different kind of business. Now, for those of you who are with insurance companies, this is probably going to be a piece of cake. The hard part is going to be putting together a managed care component that actually is able to manage care. The systems part will be easier for you than it will be for most HMOs. This is a big nut to crack, though, but I think it's one that we've managed to overcome, and I think you can as well.

Finally, the core HMO network must be strong. Choice really should be a safety valve, and that's the way, again, we sell it to people, but I think it's the way it's perceived by people. Those people who have never tried an HMO before now have this comfort of knowing that there is a safety valve available, but it shouldn't be a flood gate. If your HMO has tightly limited access, has long wait times, and all kinds of nasty service problems, and you put in a product like this because you think it's going to solve some of those problems, what will happen is you're going to find all those people going out in the fee-for-service world, and once they're out there, even with benefit differences, it will be hard to get them back.

Just to underscore and do the bottom line, as they say, I think we found it meets a market need. It's not our whole strategy though, but it does meet an important market need. Members like this kind of thing, the ones who know they have it and the ones who have taken advantage of it, like it. Administration is tough but I think it's doable, and I think the financials can work. It's the way we survived 30 years ago, but it does well for us now as well.

MS. MARY K. BRAINERD: I'm in the mop-up position on this panel, which makes me want to say, "me too," to a lot of the comments that have been made. It has also been interesting to hear the other panelists because there are some things that are distinctive about what we've done with our open ended HMO plan, which we call Preferred Gold, that bring a little different perspective than particularly the staff model experience.

The first thing I want to do is give you a little background on the organization. We're part of Blue Cross and Blue Shield of Minnesota, and we've created a tremendously complex organization to respond to what we see as employer interest and needs. Blue Plus is the largest of the HMO corporations that is an affiliate of Blue Cross and Blue Shield. We are a federally qualified plan. Minnesota Health Plans Inc. is a small state-certified HMO. HMO Midwest is another corporation of ours that does a little bit of business in Wisconsin, and very importantly, there is a corporation called Employer Provider Network Inc., which is the organization that we use to write our open ended HMO for self-insured corporations. So essentially right now, we have four different corporations writing the same health plan in order to accommodate some unique employer marketing strategies that we have.

We've talked about what to call these plans -- PPOs, open ended plans, choice plans -- but I guess my preference is combination plan, and the reason that I would use that term is we've really used the open ended HMO model to accommodate some of the concerns and business interests that we've had for both our HMO and for Blue Cross and Blue Shield of Minnesota. HMO Minnesota, as the plan was known in the past, was one of the smaller actors in the Twin Cities market place. So when employers started to look at the health plan they might choose to eliminate as they consolidated offerings, HMO Minnesota would have been at the top of the list for many of the larger employer groups in our state. So from the HMO standpoint we had not, in the past, been as successful in marketing ourselves. We had had a lot of instability in the physician network up through about 1985. We were an individual practice association (IPA) model plan. We had had difficulty in managing our costs. We had a lot of trouble becoming an effective player in Minnesota. At the same time, Blue Cross and Blue Shield had marketed a tremendously popular plan called Aware Gold. Aware Gold was one of the early leading PPO offerings. We had at one point about 450,000 people involved in that program, but because it included more than 90% of the physicians in the state, cost control was a tremendous problem. So offering an open ended HMO which allowed us to direct people to a better managed network solved some of the business problems we had for Blue Cross and Blue Shield, and it also solved some of the marketing problems, nitch player problems that we had for our HMO corporation. We began offering Preferred Gold in 1987. We currently have 110,000 people in the open ended HMO plan out of a total of about 170,000 people that are in our HMO offering today. We are still not the largest HMO in the state by any means, but we are a much stronger player than we have been in the past. We really view the open ended HMO as our primary product offering for Blue Cross and Blue Shield today.

Just to summarize what we offer through Blue Cross and Blue Shield, we have Blue Plus, and Minnesota Health Plan Inc., which we had organized specifically to allow ourselves some greater underwriting flexibility for the small group and individual market. We have EPNI, which is a corporation that houses our self-insured offerings, and HMO Midwest, which operates in a portion of Wisconsin.

Preferred Gold is the point of service offering which offers people an option of choosing networks. We have primary care designation in the core network for Preferred Gold.

Those primary care providers are either members of multispecialty clinics, family practice clinics, pediatric clinics, or general internal medicine clinics. We don't offer direct access specifically to OB/GYN groups.

There are three network options available in the plan, also called a triple option plan. The primary network, or specialty care referrals made through that primary network, is really the core offering. The extended network is made available through Blue Cross and Blue Shield participating providers. In addition, we have non-network benefits. I think one of the greater advantages that we have in combining our HMO program with Blue Cross and Blue Shield is, first of all, a relatively easy time dealing with some of the administrative issues that were identified earlier. We have some good expertise in claims processing and data reporting that's been very valuable to us. Another thing that's very important to us is that we're able to take advantage of the payment arrangements that are already in place for Blue Cross and Blue Shield. We have a better buy of care even in the outside core network plan. We have our HMO payment arrangements, which are most advantageous in the core network, and even in the extended network, we have the Blue Cross and Blue Shield agreements. We also can take advantage of utilization management programs that are in place for Blue Cross and Blue Shield when someone goes outside the network. So it gives us a broader managed care system than some of the other choice plans nationally have available.

The benefit design that's usually used for Preferred Gold is 100% coverage or, more frequently now, a 10% office visit copayment for physician services, 100% coverage or sometimes 90% coverage for in-patient hospital care. In the extended network, we generally use a $200 deductible, 20% coinsurance kind of program. For the non-network, we have a higher deductible in place. We have a good deal of flexibility in this benefit design, but in our experience since 1987, we very much believe that $200 is the minimum deductible that we like to see on that second level and, in fact, we are urging groups to put in higher deductibles whenever possible. That's a change for us, because when we began offering the program, we had the second tier of coverage available with no deductible and 20% coinsurance. So we've learned some lessons about directing care in the primary network since we began offering the program.

The primary network is the core, or the heart of the program; a $200 deductible, 80/20 coinsurance is the second level; and a $300 deductible is for the nonnetwork services.

I'm going to talk about the physician payment features of the program. Because we are an IPA model program, we've had some challenges to deal with in trying to figure out appropriate ways of attracting physicians to managed care, getting some cost control in the program and yet still operating as an IPA model alternative. We have 1,200 primary physicians in our program and we're the HMO probably most active outside the immediate Twin Cities area in Minnesota of any of the health plan offerings. So we have about 30% of our business outside Minneapolis and St. Paul. What we have done is really take a network that was at one time capitated and move it to a fee for service system. I like to think that we've managed to maintain many of the incentives that we had under the capitated arrangement, but we have had a good deal of network stability since 1985 or 1986. So we have many of the same players who may have learned some behaviors under capitation and who have incorporated them into their practice style now. We've

developed utilization targets to accompany the fee-for-service payment system, and I'll talk a little bit in more detail about those. We have some long-term agreements with key clinics that are part of our program. We have contractual requirements for quality assessment and care management and very significantly, we have a care management/quality assurance capitation that we make. It's minimal. It's $1 per member per month, but it starts to show the primary clinics that we work with that we value the time and effort that they put purely into care management. So it's been a very attractive feature of our program from the standpoint of the physicians. We have a fee- for-service payment mechanism and we use a fee schedule.

We use a withhold system. Our general withhold is 20%. Our withholding in future years is based on the past year's performance. So we do have clinics we work with that have a 30% withhold because they have had little success in managing cost, and we have a number of clinics we work with that have been eligible for 10% withhold. The withholding is return based on the actual clinic performance. We've had plans in the Twin Cities market place that have based withholding return on plan performance, and having had some rough years financially in the HMO market in Minnesota, many physicians are unwilling to accept agreements that tie their financial results to plan performance. We feel we've been much more successful at tying withhold return purely to the physician's performance independently. So that's a better motivator for them, and also an agreement that they're much more willing to accept in our market today.

Our utilization targets are defined as average monthly costs per enrollee for all health services. Now this should start to sound familiar to you because essentially it's the same as a capitation. So the dollars that we have as performance targets are virtually synonymous with what physicians might view as an amount they would receive in capitation. So for most physicians, as I mentioned, who are already familiar with capitated models, it is a performance target they're easily able to orient to. Dollars and cents per member per month is something they feel they can judge, measure, and they're familiar with it. We include in that performance target all health care costs except scripts, and that's something we're going to be reconsidering. We exclude the expensive medical supplies, abortions and sterilizations. We have a special arrangement for mental health and chemical dependency. We do not include self-referred mental health and chemical dependency and chiropractic, and we have a stop loss, but we do include the cost of self-referred medical and institutional care. So not only the hospital and physician services delivered within the system but their target also includes the cost of care delivered outside the system. Age and sex adjusts the performance targets because we think that age and sex is at least one surrogate for projected utilization, and our targets are based on our plan experience adjusted for what we think reasonable trends are in use and cost.

The hospitals under our Preferred Gold program are paid at Blue Plus per diems, so we use a per diem payment mechanism with the hospital. There are some incentives built in to the hospital payment arrangements as well, but where we don't have Blue Plus payment arrangements, we're able to use our Blue Cross and Blue Shield payment option.

We offer advantages to physicians in dealing with us. First, a committed payment patient population due to primary care designation is a very strong feature of our

program. Limited risk in our market is very important. We have two health plans still in arbitration with their major physician clinic groups due to misunderstandings about risk arrangements. So we feel that our limited risk arrangement leaves us in pretty good shape. There's an opportunity to share in gains. We do have a bonus system in the program. We have good case management and quality assurance programs, and I'll talk briefly about case management programs. We believe that we offer good access to key markets and particularly, right now we see many of the large national accounts looking for consolidation of health plans across the country, and so we market heavily to our physicians the advantage of working with a plan sponsored by Blue Cross and Blue Shield because of the access it provides to some national accounts.

We use a fee schedule that is based on a conversion factor and a unit value. It was internally developed and managed by us arbitrarily over the years. Last year, we became what we think is the first plan to actually take the Harvard work value data base, build it into our own payment system, do some comparisons to what we were paying for services as opposed to what our system would indicate was appropriate payment, and we've adjusted already in 1990 our payment to physicians. Because we're a primary-care-oriented plan, it's easy for us to decide to make adjustments that are rewarding to primary physicians, but in making those changes, we felt it appropriate to start reflecting on some areas where payment reductions were in order. So as you would expect, some of the procedurally-oriented specialty groups are actually receiving payment reductions from us in 1990. Interestingly enough, we've had no difficulty at all maintaining our specialty care network in those areas. In fact, we've attempted to reduce our specialty care network and receive great opposition to our attempts to cancel some specialty care contracts. So the ophthalmologists, pathologists, surgeons and ear, nose and throat physicians are those where we've had the most significant reductions, and as you would expect, pediatrics and family practice are those groups that benefit most from the changes that we've made in our fee schedule.

We developed cost-per-member information and services-per-member information that we provide the clinics. We provide it in very, very detailed high piles of data, but we also provide it in graphic form. We have metropolitan area averages, but we have found that many clinics are more sophisticated than that. Managers say, "So what if everybody else in the Twin Cities is operating like this, we either deal with a different patient population or we are a different kind of practice." So we've developed peer practice clinics to do some comparisons of utilization. Table 1 shows the metropolitan area average of office visit costs per member per month. We would be presenting this information to clinic B, and clinic C and D would be examples of two clinics that we would interpret to be peers of clinic B. So in other words, it gives us one more way, when a clinic is operating outside of what we would see to be expected performance, of giving them that information and seeking some behavior change.

We would provide the same kind of information on X-ray costs (Table 2). In this example, clinic B management says, "Well wait a minute, I have an in-office mammogram, I am simply much more effective at doing my mammography screening than some of the other clinics in the network might be." So we take a look at its costs in comparison to clinics that have like facilities and like capabilities.

TABLE 1

MEDICAL CLINIC
9 Months 1989: Home/Office Costs

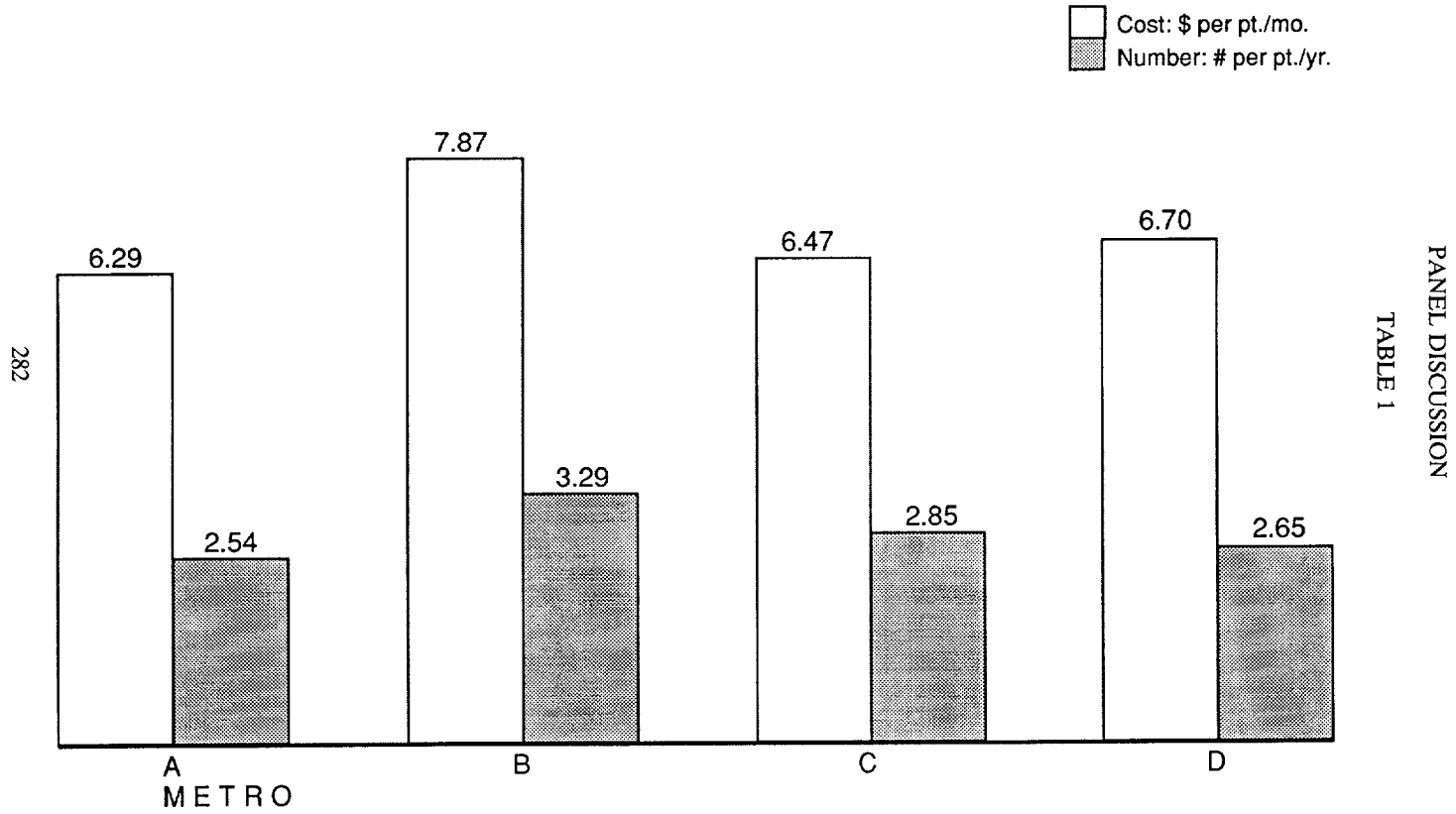
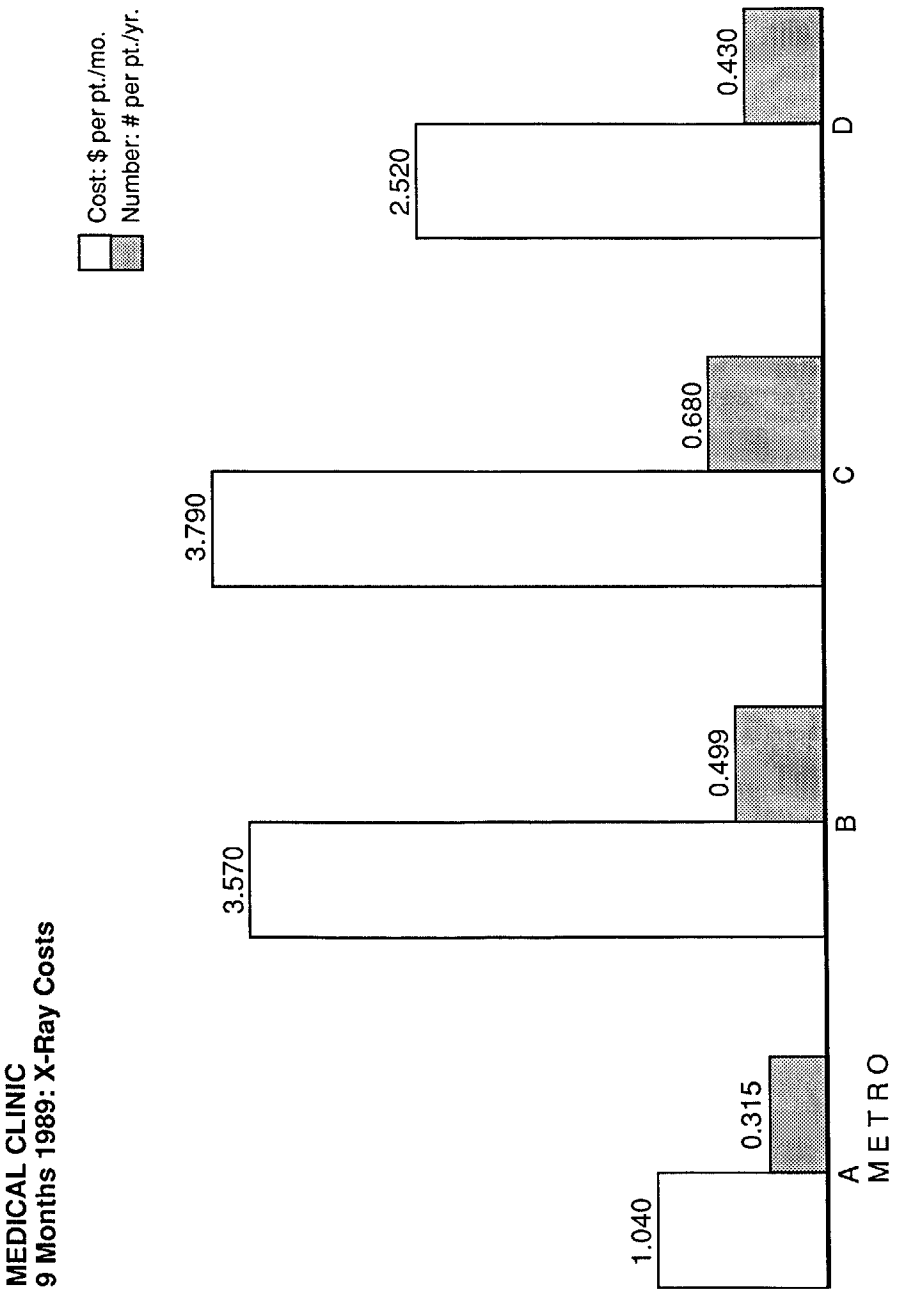


TABLE 2


MEDICAL CLINIC
9 Months 1989: X-Ray Costs
Cost: $ per pt./mo.
Number: # per pt./yr.
1.040
0.315
3.570
0.499
3.790
0.680
2.520
0.430
A
METRO
B
C
D

Tables 3 and 4 show lab costs, emergency room costs. We generally follow up this kind of analysis with some very specific recommendations about how to deal with areas where clinics clearly seem to be operating in a way that we would expect to be outside the norm. Tables 5 and 6 show surgical costs and in-patient utilization, acute care, days per thousand. We would be sitting down in our current system of care management with the physicians in a group dealing with this kind of information with our medical director and then agreeing to some specific follow-up.

As I mentioned, another kind of problem or challenge that we're faced with in dealing with our primary care groups is: Managers might say, "Well, wait a minute. I have a lot of older and sicker patients, or I have a lot more neonates which are costly to care for." So we've started to develop age distribution information for clinics as well to show what their population is and how it may differ from that of other clinics. A year ago I probably would have said, "Gee, I think it's pretty tough in an IPA model plan to effectively manage care and costs." Through some of the work we've done in utilization management, we've seen some very effective results in dealing with clinics that have had high costs in the past.

We forecasted rate increases to be in the neighborhood of 16% for our Preferred Gold and our traditional HMO products. We experience rate groups, and we had much higher than expected rate increases. We're seeing that number come down, but I think it says two things. One is we calculated a larger rate increase for Preferred Gold than we did for our traditional HMO business. In our market rate, increases have generally been 20% or above in the last year, and when I say calculated rate increases, many groups that had higher rate increases modified benefits as a result of having the high rate increases. So we're having many more groups either put in the $200 deductible, original groups that didn't want to have that on the second tier, or an increased deductible or coinsurance are put in office visit copayments on the primary care level. So higher than we would like to see rate increases have resulted in some benefit modifications in the past year.

What's been our experience in the issue of use for the open ended plans versus traditional plans? For 1987, 1988, and 1989, we had somewhat higher use in the combination plan than we had in our traditional offering, but I think part of that is due to the fact that we had positioned it as a total replacement program. We are very reluctant to offer Preferred Gold as an alternative in a multiple choice environment. So if we go to a group and they already offer two plans and want to add a third, we are unlikely to bid in that kind of a situation. We are most likely to place this program with employers that are willing to replace all of their previous offerings with Preferred Gold. I think one area in which I might differ a little bit from some of the previous speakers is, we've found a pretty accepting market among the larger self-insured groups. Many of those employers, while they want to maintain some level of choice, are willing to believe that this kind of a plan offers them all the choice they need to make available to their employees. So we have a good deal of our business currently with the self-insured employers and virtually all of that is replacement, total replacement, business. We have 57,000 people on a self-insured basis and 53,000 on a fully insured basis in Preferred Gold. So we see the self-insured market as a very particularly strong one for us.

TABLE 3

MEDICAL CLINIC
9 Months 1989: Laboratory Costs

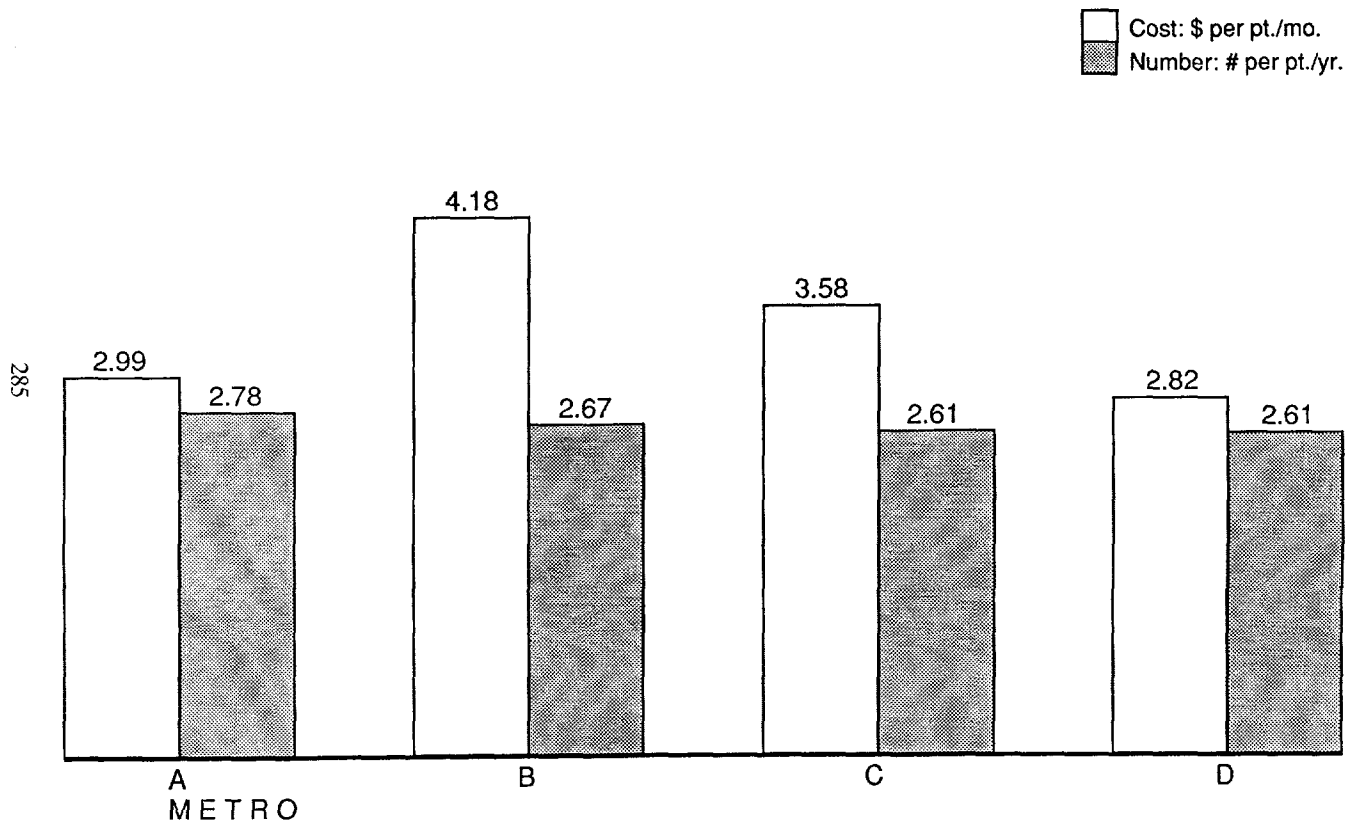


TABLE 4

MEDICAL CLINIC
9 Months 1989: Emergency Room Costs

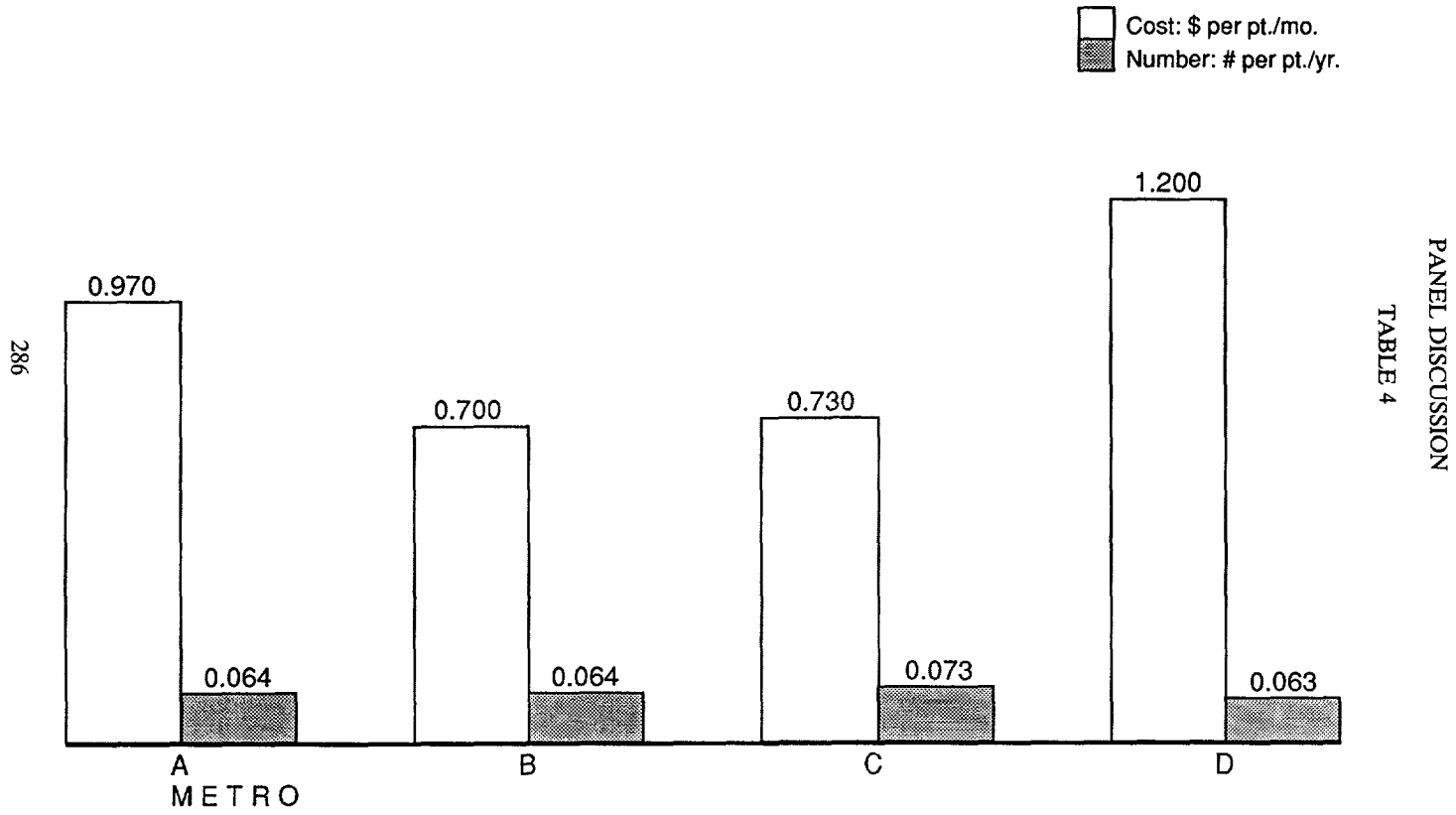


TABLE 5

MEDICAL CLINIC
9 Months 1989: Surgical Costs

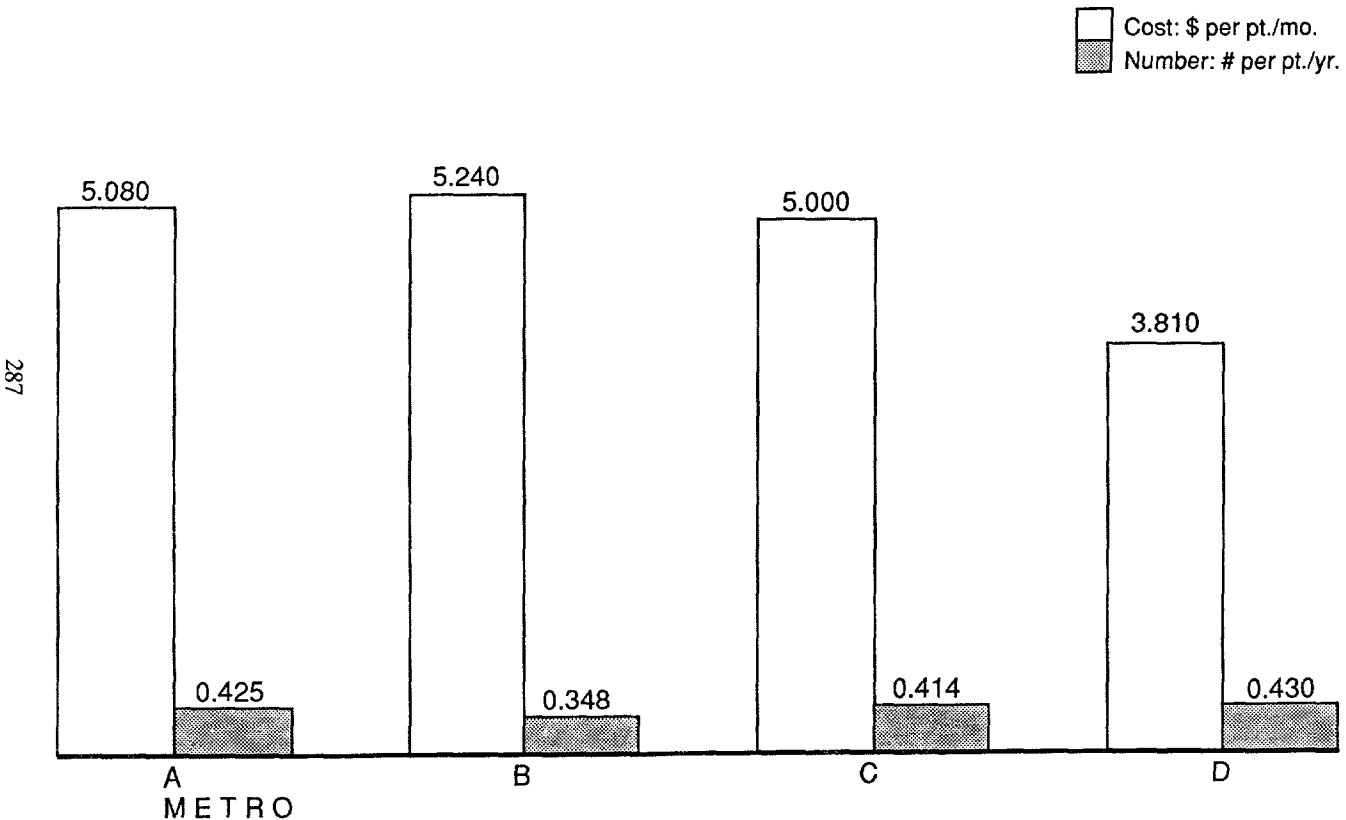
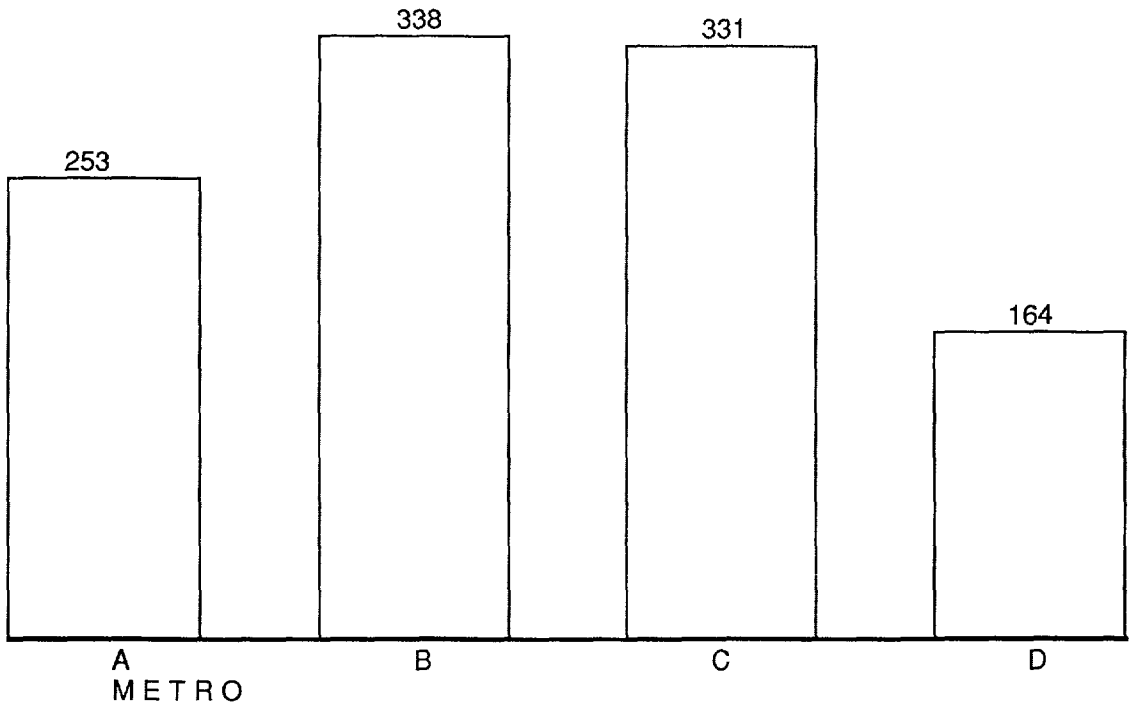


TABLE 6

MEDICAL CLINIC
9 Months 1989: Hospital Utilization
Days: Hospital days/1,000



As I mentioned, I think that we see the data on Preferred Gold as being about what we would expect and had predicted in out-of-plan use, and I'll show you what we are seeing in the way of cost as well. Cost per member for our traditional plan and the open ended plan show about a 5% difference. That's sort of comforting to us because we've been rating that product at about 5% higher than our traditional HMO offering. We had expected most of the use out of plan to be somewhere between 10% and 15%, and we're a little bit over 10%. Less than 6% of the medical care is delivered outside of our medical delivery system, but a lot of mental health, chemical dependency, and for our plan, chiropractic care is going on outside the network. In the kind of system that we have, where primary physicians must refer to specialists, not very many people get to the chiropractor. So their access to chiropractic is almost entirely at the second level of the program, and we're seeing the chiropractic, mental health, and chemical dependency as areas where we would like to see greater control or greater direction of that care within the plan.

In summary, what are the tips to the wise from having offered this kind of program for at least three years? I think, like the other speakers, we believe it is extremely important to have a significant benefit deterrent to using outside-the-network benefits. As I mentioned earlier, we started with a lower level deterrent without the deductible in place. We won't sell that program that way anymore. We think it's important to have payment limits outside the network. We've been fortunate in having our Blue Cross and Blue Shield payment limitations in place, but I think that's extremely important. It's also important to have some measure of cost containment when care does go outside the system through utilization management. We think it's very important to retain enough of a financial incentive in the physician agreements that the physicians in the core network manage the care. So if that means moving away from capitation as it did to us, we made the move primarily in order to make ourselves more attractive to the self-insured employer who is oftentimes disenchanted with capitated systems. Nonetheless, we think it's important to maintain a significant withhold and to have financial results based on clinics' own performances. I think that's key. I also think it's important to avoid multiple choice environments. We found over the years it's too difficult, at least in a market like ours, to enter and be offered alongside other health plan offerings if yours is among the most liberal in terms of benefit choices and also where the other plans have been in place. So we really view our strategy as a replacement strategy. We think data reporting is key. It's key to us in managing this program from a financial standpoint, and I would in no way want to underestimate the importance of providing data reporting to providers in an IPA model plan. There's no other way for them to know how they're doing other than through a good level of data reporting.

We're concerned about the future of consumer incentives. In our market, we're seeing much more employer interest in higher copayments and deductibles. We're sort of limited because our state regulators will not allow us to put in copayments on preventive services, yet we see the employer market increasingly interested in cost sharing. So we've got a unique market challenge, I think, to deal with in our plan. We're also concerned in an IPA model about managing specialty care. I don't think we have any very good answers right now about effective management of specialty care, but as more care is delivered outside of the hands of primary physicians or as more primary

physicians become uncomfortable in trying to manage the care through subspecialists, that's a challenge for the future.

Finally, I think it's an extremely worthwhile product to pursue. We have enrollment. We've had good financial success in offering this program. We had a small net gain in our plan this year. About a half million dollars worth of gain was due to this product offering. So we have found it to be a profitable program for us to make available. I think that the marketing success of the program is dependent on offering people more choices, particularly in extremely competitive markets like ours.

MR. ANTHONY T. BATORY: Mary, did you say that in determining the targets for a disposition of withholds that you include the out-of-network claims in that target determination?

MS. BRAINERD: Yes, we do.

MR. BATORY: How do you get the physicians to agree to that? The physicians are accepting the risk of out-of-network utilization. Now, given that I don't have enough market share to have that kind of leverage with the physicians, how am I going to set a target for an out-of-network situation?

MS. BRAINERD: It continues to be probably the single element of our contract with physicians that causes them the most concern. They're most reluctant about accepting it. However, on the other side, they can understand the crazy incentive you can create by not having it included; if the physicians' costs are high and it's excluded, they can start directing people outside the network. I think most of them understand that that's a problem. We've tried to address it by having a relatively low level of stop loss in our physician contracts for out-of-network costs. So that's the way we've bought ourselves some time, but I know that will come up when we renew agreements this fall.

MR. NEIL Y. YANG: I'm from a company called U.S. Healthcare. We operate mainly on the East Coast -- Pennsylvania, New Jersey -- and last year we reached one million members. The question of benefit design came up when we designed the open ended HMO. A subdivision of the State Insurance Department brought up the point that there's a 10% limit on out-of-network usage and that's only allowed on physicians. Can any of you comment on that?

MR. HERRLE: I'll be happy to comment. I'm not sure what the question is, other than it becomes a problem when the regulatory environment doesn't allow you to do that?

MR. YANG: Somebody told us that there is a 10% limit on out-of-network usage and when you design your plan, if that's the case, how do you get around it? Have you encountered a situation like that?

MR. HERRLE: Yes. I don't know if that was a federally qualified issue, but with federally qualified HMOs, the HMO amendments last year indicated that they would allow HMOs to take insurance risks but it was on a very limited basis, and I know Pennsylvania isn't thrilled about letting HMOs do any of this regardless of what the feds

say. In talking to them, they didn't want to set a precedent, I don't think, for allowing HMOs to get into this project. I think they'd just as soon leave them out. The feds haven't come out with details on a lot of these amendments. It doesn't apply to each group, at least in my understanding, and you're not offering that product to every group, presumably, and so I think whatever the restriction is -- like 10% would at least be on your total book of business which could be a problem if you rolled all your business into this product, but it might not be as big an issue if it's limited.

MS. BRAINERD: The way that we've dealt with the feds is, Blue Cross and Blue Shield underwrites the risk for the out-of-plan use. So they don't consider that out-of-plan use to be ours. So it would depend on how you structure it. If within your state, you're writing it all within your HMO corporation, it's probably at least a question mark, but if you're using an insurance company to underwrite the out of plan, then it's no issue at all. So those would be the two ways I'd look at it.

MR. JEFFREY L. SMITH: We talked about some of the out of panel reimbursement issues. I guess I have to start with an assumption before I ask my question. If my assumption is wrong, then the question shouldn't follow. I'm assuming that on the in-plan entry to the managed care system, the impetus and responsibility is on the provider versus out-of-plan entry into the system, which is a covered person or subscriber-initiated process. If that's the case for out-of-plan utilization, are there any problems in imposing the rules and regulations of your managed care process on out-of-plan or noncontracting providers in effective financial management of care?

MR. WISE: Let me try and address that. Relative to the out-of-network utilization -- the utilization controls, I think is what you're talking about, cost containment measures -- the elements that we have are fairly standard. I'm sure most of you are familiar with them -- preadmission certification and a second opinion program, and something which we call concurrent review, but there really isn't very much of that.

FROM THE FLOOR: Approval of number of days?

MR. WISE: Yes, approval of number of days. And that is provider initiated, but you're right, if there is noncompliance, the penalty is on the member, the benefit reduction happens to the member. We don't do those kinds of things inside the network with our providers.

MS. BRAINERD: In our plan right now, we can't force the out-of-plan providers to comply with our HMO kinds of utilization requirements. We do force them to comply with Blue Cross and Blue Shield requirements which include preauthorization and concurrent review. There are still some exceptions in our state, big exceptions like the Mayo Clinic, who participates essentially with no one, and there we do what we can.

MR. HERRLE: Yes, I think one key issue there is that if you're having a medical management program on a point-of-service product, it's important that you have consistent standards for treating in and out. Penalties are different, but when you're precertifying days, it's certainly a lot easier to do it within your network if you have a group of providers who have been around and who know how it works, and who know

the stick doesn't need to be there quite as much. Out of network, it is a lot harder to control. You might not be able to do on-site things anymore. You might have to have a call-in number, especially if it's out of the service area. So it is harder to control, but there are a lot of insurance company managed care programs with call in, and so you still have to have consistent standards. You don't want different people doing different things. I think you'd have a certain legal issue at that point.

MS. ALICE ROSENBLATT: I have two questions for Mary. Question one is: Have you run into any regulatory problems as a result of marketing the product as a total replacement product? Question two is: The gain that you mentioned, was that on the HMO or did that include the out-of-network portion of the plan?

MS. BRAINERD: Those are good questions. We have not run into regulatory issues in using a total replacement approach. In our state, health plans mandating employers ended about three or four years ago, and so, while I think there are challenges to total replacement, they're primarily in situations with union negotiation as opposed to other regulatory activities. So I would say negotiated agreements where the union is reluctant to move to a single consolidated plan is a greater obstacle than any other.

Answering the second question, we did okay on the HMO side of the in-plan use, and we did just fine in out-of-plan use. Actually, it's a source of irritation to me that Blue Cross and Blue Shield did better on its program than we did, which says we thought the out-of-plan use might be a little higher than it turned out to be.

MR. BLUHM: I'd like to add one thing, Alice, as well, which is that in Minnesota, HMOs are regulated by the Health Department not by the Insurance Department, and they tend to have their regulations biased more like a health department than an insurance department as well.

MR. HARRY L. SUTTON, JR.: A couple of questions. One of the things that came up earlier from both Ted and Mary was with Mayo being such an outstanding referral center. Are the costs, if they go to Mayo, out of line with what you pay locally? I'm just kind of curious. Also, how many people want to opt out with these plans to go to a place like Mayo Clinic?

MR. WISE: Our experience, actually, has been we get a lot of questions during open enrollment: Does this mean I can go to the Mayo Clinic if I need to or want to? Our experience has been that very few people do that, and I also think our experience here has been that the Mayo Clinic is, in fact, a very cost-effective provider of care.

MS. BRAINERD: I guess I'd answer the first part of the question the same way, which is we have very few people who have wanted to go to the Mayo. I'd answer the second part a little differently. I don't know how cost-effective the Mayo is. It may be, if you look at the total package, but their charges are a lot higher than the other providers we deal with.

MR. SUTTON: They also don't discount anything.

MR. HERRLE: Of course, only 20% of Ted's people knew they could go there. Fortunately, none of them have been sick yet.

MR. SUTTON: Another question. This is for Ted, or maybe Mary too -- a question about the need to educate your marketing force on how to explain these contracts. Now, Ted mentioned specifically trying to market the network. In Mary's case, you have three different or two networks. My guess is, you must have a tremendous training problem with marketing people being sure they understand what your objectives are and how to market it. Could you comment on the extent of that problem or what you do to solve it?

MR. WISE: Sure. Yes, we recognized a few years ago that a couple of things happen when you get into these programs. One, it is a different ball game and so it does take some different kinds of explaining when you have an open enrollment meeting. You get different kinds of questions, and getting the sales representatives up to speed on how to address that kind of thing is very important and takes a fair amount of commitment from training time and resources. The other thing that happens is, as Mary said, total replacement becomes much more a strategy and a logical strategy with these kinds of programs, which gets you into issues of dealing in an environment which is a typical traditional HMO sales rep you didn't have, where you were just talking about dual choice offerings. We've had to make them conversant in things like self insurance, and funding mechanisms, and different risk transfer issues, and risk pool consolidation issues, and things like that, that they have never really been faced with as much in the past. What we've done is really just dramatically revamped how we do training and committed just a lot more resources to that. I think it's been necessary to do that given these kinds of programs and the way the market environment has changed as well.

MS. BRAINERD: It's been very difficult for us to get our marketing people up to speed, and I can almost say that our sales results reflect where our marketing staff is up to speed, which is in the large group, self insured, more consultant-like sales representatives. It's a difficult challenge to sell three markets, or three different networks, and it's a product that's more complex than I would like to see. We've done some things to try to address that problem. We've worked hard with clinics so that when we do have people in a total replacement environment who may not have been to a clinic before, we try to get them to that clinic and try to get the clinic to introduce itself to that new member. We also are doing videos which is something we've never done before as educational tools on how the health plan works, and we have redesigned all of our written material. We aren't there yet because when we look at satisfaction, our plan's greatest level of dissatisfaction is with members who have been with us less than nine months. So it's a big, big challenge.

MR. BLUHM: Do both of you use brokerage systems primarily for your deliveries?

MR. WISE: I wouldn't say primarily, but I'd say we probably use less of it than Mary does.

FROM THE FLOOR: A question about benefit plan design. Ted talked earlier and Mary talked about putting in the $200 deductible in their middle network because it wasn't enough of a barrier with just coinsurance. How do you evaluate the underwriting

problems? You go in with a replacement product, but your middle network, for Mary's case, or your out-of-plan network with the $200 deductible, 80%, is the same as the benefit plan that the employer had before. My own personal feeling is that that's going to encourage a lot of out-of-plan use, because the benefits aren't any worse than the employer was already used to. It's going to take some educating that he's losing money to get him into your network if you do that. Do you consider that a problem?

MR. WISE: I think that has been a concern, and it's maybe been more of a concern for our underwriters and our actuaries than for our sales people, but I think what we've tried to do in that case is, we've absolutely said we will not go -- they're probably granting an exception as we speak -- less than a $200 deductible, and we certainly don't want to give a richer out-of-network plan than what they've been having as an indemnity plan. What we've tried to do is make the case to the employer, or in many cases it's to a union group or someone else who is very influential, that, in fact, what they want to do is acknowledge the fact that there are now full benefits available inside the network and that outside of the network we can give a higher deductible than what they have been offering, but if we're unable to do that, we will go in with a $200 deductible but we will do some of the things which Mary just talked about, spend a lot of time doing work site orientations, getting people into clinics, doing some extra education of people, explaining the benefits of coming inside the network, and really encouraging them to try that network system. In some groups where we have taken over an entire group in that kind of scenario we've seen that we get about half of the people who had been in the indemnity world to come inside the network right off, and then we need to work on that other half.

MS. BRAINERD: Me, too.

MR. ALLEN J. SORBO: This question is just related to what you were talking about, Ted, but I'd like you and Mary to both elaborate on it. How much of a problem do you have getting people to select this site in these options? We see it all the time, even in the HMOs that run the problem with people selecting a site. How do you adjust your physician incentives accordingly for that sort of issue?

MS. BRAINERD: Interestingly enough, we have not had a difficult time getting people to select a site. We have a pretty broad primary care network, at least in the Twin Cities metropolitan area, and when people have come from an indemnity plan, at a minimum, I think, they figure they might as well select the site even if they never use it. So then the trick is how to get them into that site as their choice when they use care, and that's really sort of the same issue, getting those clinics to get them in, making sure that when we educate them, we educate them on the advantages of using those primary physicians, and using the physicians when we can to help us make some of that sale at the employee level. Those are strategies we've been working on. We do not have a lot of people who go outside of our system for medical care. Our problem has been mental health and chemical dependencies, where we have a very limited network. There, there's almost more of a tendency for people to go by reputation, recommendations of friends, the names of the treatment centers or mental health providers that they see in the newspapers and in *People* magazine, and we've had more difficulty changing that kind of pattern of access than we have for medical care.

MR. WISE: Yes, I think the issue of selecting sites has been one that as a staff model HMO we used to have a major problem with years ago. It is trying to get people to identify with a personal physician. Somehow when they came into our type of system, they completely changed the way they went about getting medical care, and we would have more than half of the people not indicate a clinic site. We've been working on that over the years, and we now have something on the order of 85% designate a site. For those who don't, we have a slightly different situation because as a staff model if people don't select a site, we will assign them to one of the staff model sites. We don't start shipping capitation payments out the door for those people. So the only way they go to an affiliate is if they designated that site. But we've had good luck, I think, in getting a very high percentage to designate clinic locations.

FROM THE FLOOR: Mary talked about the fact that in her early days with HMO they used capitated plans and the physicians were trained to the incentives involved in the capitation. You also mention now you have fee for service with the withhold but you would like to pay the physicians back the withhold based on their own experience. Now, is that statistically reliable because you have mostly groups, and maybe it's not really an IPA with a bunch of solo physicians floating around, for the most part. Is that statistically reliable for you to pay the withhold back based on their own experience? Second, what would you think about doing that fee for service with a system that had never been under the constraints of capitation so they were never well managed before you started it?

MS. BRAINERD: The question, is it statistically reliable to do it on the physicians' own experience, we do sign our contracts at the clinic level. So there is not an option for an individual physician within a clinic to participate with us. So almost all our agreements are with clinics of physicians, and I can't think of a solo practitioner that we contract with. So almost all of our clinics have at least 1,000 members. Many more have 2,500 or 3,000, or up to 20,000 members, which makes it a little easier to do. If enrollment is very small or if we have a start-up clinic, we do pool experience for medical groups that have fewer than 500 members with us. So we use that system to accommodate some of that problem.

Do I have concerns about contracting or would I have concerns about contracting with a network that didn't have the experience with capitation? We found that when we signed agreements with medical groups who have not been part of a managed care plan before, either our own or in our market med centers or share group health, which are all capitated models, they tend to have worse experience coming in. They even have a worse experience if they've contracted with other fee-for-service managed care plans before. I believe that there is a discipline and an attention to care management that comes with capitation as a payment mechanism. So I would be more reluctant and more concerned about costs getting out of control without having had that experience.

FROM THE FLOOR: What was your stop loss point for the risk pools?

MS. BRAINERD: Do you mean at what point do we take costly cases out? At $18,000.