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NUTS AND BOLTS OF MANAGED-CARE PROVIDER NETWORKS

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- Organizing networks -- if we build it, will they come?
- Information needs
- Monitoring utilization
- Risk/reward methodologies

MS. NANCY F. NELSON: I am a consultant with Tillinghast in the firm's Minneapolis office. Our practice in Minneapolis is heavily focused on managed-care products and the organizations that deliver those products. I have experience in developing compensation arrangements for providers in these types of arrangements, and also product development and pricing for health-care organizations. My co-instructor is Mr. Richard Kaplan.

MR. RICHARD W. KAPLAN: I am a consultant with Tillinghast. My background is the design, pricing and the administration of managed-care products. Prior to joining Tillinghast, I was with CIGNA.

MS. NELSON: Provider networks are featured in a number of different types of products. These include HMOs, PPOs, point-of-service (POS) products, and exclusive provider organizations (EPOs). Most of our comments will be applicable to the range of these products. Where there are differences, we will try to point them out.

OVERVIEW

I would like to give you an overview of our presentation. To set the stage, I am going to provide some facts about network products today. Then, Richard will talk about the steps of organizing networks. Many of these steps will also apply to either maintaining or expanding a network. We will then talk about the techniques that are currently used in network products to manage utilization and those that are likely to be used in the future. I will then discuss risk and reward methodologies used to compensate providers. Then, I will review the information and data needs associated with network-based managed-care products. We will conclude with a discussion of future uses of provider networks.

CURRENT ENVIRONMENT

Managed-care network products have become very important to health insurers, employers, employees, and providers.

In September 1992, Towers Perrin conducted a survey of health insurance industry CEOs.[1] The survey was directed to all commercial insurance companies with health

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[1] Towers Perrin, "1992 Health Insurance Industry CEO Survey -- Report"

premiums exceeding $10 million, and to all Blue/Cross Blue Shield plans. Some 71 responses to the survey were received for a response rate of about 28%. The results of the survey indicate that network-based products will continue to grow, with the more heavily managed products growing most quickly.

The survey respondents identified what cost-control initiatives they had in place or planned to introduce. Essentially, all of the companies used coordination of benefits, utilization review, cost sharing with employees, and precertification of hospitalization. Limiting access to providers and use of negotiated provider reimbursement or risk-sharing arrangements are keys to network-based products. More than 70% of the survey respondents had some sort of a limited access product. Almost 70% stated they have or want to introduce provider reimbursement and risk-sharing arrangements.

Other approaches to cost control noted in the survey were subscriber education, proposals for regulatory change, centers of excellence such as those that might be used for transplants, reduction or elimination of mandated benefits, control of cost shifting, and outcomes management. Some of these control initiatives are really beyond the control of the company (i.e., regulatory change, changes in mandated benefits, and cost shifting). The other initiatives are probably only going to be workable in a network-based product (i.e., the centers of excellence, use of subscriber education, and outcome management).

The companies identified what they thought were the most effective cost-control initiatives. The number one category was shared by provider reimbursement and risk-sharing arrangements. The third most common response was limiting access to providers. This was indicated to be more important by the Blues plans than by the commercial plans. Other responses included cost sharing with employees, control of cost shifting, and outcome management.

The executives were asked to project the predominant managed-health-care product in two years and five years. Answers to this question indicated a trend to maximize control, while allowing some choice. PPOs were ranked number one in two years, but dropped to the number two spot in five years. POS products were projected to be number two in two years, and to then gain in popularity to become number one in five years. Independent practice associations (IPAs) were in third place for both two and five years in the future. Managed indemnity was anticipated to lose ground relative to group and staff model HMOs.

The executives were asked to comment on anticipated competitive strategies. The number one response was to focus on a network-based product. That was followed by better customer service, containment of claim costs, improvement in operational efficiency, improved information, and target/niche marketing.

Towers Perrin asked the executives to identify opportunities for profitable growth. Almost 80% indicated that network-based managed care was their first, second, or third choice for profitable growth. Sixty percent indicated network products as their first choice. Other choices were price control, growth of managed workers' compensation, and small-group products.

The executives were asked to comment on employer demands. For large accounts, the most common response was network-based, managed-care capabilities. This was followed by customized solutions, better ways to control claim costs, better customer service, and best price. The answers are different for small accounts. However, I do not think that the conclusion that network products are extremely important changed. The most common answer for small accounts was best price. This was followed by better ways to control claim costs and better customer service. Network-based managed care was ranked fourth for small employers.

According to surveys by HIAA and KPMG,[2] the number of employers offering conventional products has dropped from 89% in 1988 to 62% in 1992. The number of companies offering HMOs has remained fairly constant at about 72%. PPOs have had dramatic growth from 12% in 1988 to 41% in 1992.

From 1989-90 there was a drop from 18% to 5% in the number of people enrolled in products without any utilization management (i.e., very traditional indemnity-type products). This is offset by a growth in membership for products with utilization management and POS products.

From 1976-91, total HMO membership, including dependents, grew from 6 million to nearly 39 million members. An estimate at year-end 1992 was that there are over 40 million persons enrolled in HMOs.

From 1987-91, PPO growth was from 12.2-37 million covered employees, excluding dependents. That is equivalent to about 85 million individuals enrolled in PPOs in 1991. A few other facts about PPOs are of interest. There were almost a thousand PPOs at the end of 1991; 25% of these were started in 1989 or later. Insurance companies owned 36% of the PPOs, and 45% of the PPOs offered an EPO, with 6 million persons enrolled.

A survey of over 300 hospital executives was conducted by the American Hospital Association Society of Healthcare Planning and Marketing.[3] The executives contacted were from hospitals with over 100 beds. Ninety-six percent of these companies anticipated an increase in managed-care activity. Within the managed-care arena, 33% said that financial concerns were their biggest worry; 16% said that physician relationships and participation were their biggest concern; and 14% said that competitive positioning was most important.

A few additional statistics indicate how important contracting has to be to the hospitals. Seventy-five percent had HMO contracts, and 28% contracted with 6 or more HMOs. Eighty-four percent had PPO contracts; 20% had 6 or more PPO contracts. Thirty-seven percent of these hospitals reported that they were doing direct contracting with employers without having a PPO or HMO in between.

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[2] KPMG Surveys and Health Insurance Association of America Surveys, Washington.

[3] Society of Healthcare Planning and Marketing, "1993 Managed Care Study," March 26, 1993, Page 3.

ORGANIZING NETWORKS

MR. KAPLAN: Many people are in the business of building networks. However, when they started thinking about a network, they built the network that they thought was most appropriate, and lo and behold, when they were done, no one signed up.

Networks are first and foremost customer focused. If you are not customer focused in building your network, you might have the best network money could buy and no one would join. So, customer focus is a very critical factor in network building.

What are the considerations for building a network that someone wants to buy? The three major considerations are the types of providers in the network, the quality of the network, and the access to the network.

Networks need to include primary-care physicians, specialty-care physicians, hospitals, and ancillary-service providers. When we talk about ancillary services, we are really considering the full range of specialty services. These ancillary services include durable medical equipment, home health services, therapy services, and prescription drug programs. Unless we have the right mix of providers, the network will not be successful.

People ask, "How many of each of these providers should there be?" "Is there a rule of thumb in terms of building networks?" "Is 20% of the primary-care physicians in the market enough?" "Is 80% of the specialists enough?" "Can I have one hospital?" "Do I need every hospital in the community?" "What do I have to do about my pharmacy program?"

I can think of a couple of rules of thumb for building networks that may be successful in some markets and less successful in others. Some of this is by happenstance, but primarily is because medicine is practiced locally. The way doctors practice medicine in Hartford or San Francisco is not the way it is practiced in Nashville or in South Florida. However, there are some general rules of thumb that I feel are applicable throughout the U.S.

With regard to physicians, a network ought to have about one-third primary-care physicians and two-thirds specialists, assuming that the primary-care physician provides a gatekeeper function. I do not think open access to a network by members will deliver the medical cost levels needed to actively compete and succeed in the marketplace in the long term.

In terms of physicians in the marketplace, preferably 20% of the primary-care physicians in any one market should be included at your network. Maybe that number is 25% or maybe 30%, but, it certainly is not 50% and it certainly is not 10%. However, if an employer came to the network and said, "We need 95% of the primary-care physicians in the marketplace," an appropriate response from the network is, "That has a price attached to it." It is interesting to see how quickly the employer that is paying the bill will understand that access has an associated cost. The more quickly employers understand that broader access has an implication of higher costs, the more quickly they are able to realize that a smaller network delivers what they really want.

Hospitals are both a market issue and a medical service delivery issue. Since we need to cover all the services, you clearly want to go with hospitals that provide a full range of service rather than to pick and choose among a lot of different hospitals. If specific services are broken up among several hospitals, your physicians will be confused. For example, they may be uncertain which hospital they can use for what services; they may be in the practice of admitting to only one hospital for all services; or they may never use a specific hospital. Obvious exceptions to this "full service hospital" rule are those high-quality specialty hospitals in your marketplace (i.e., a children's hospital or a specialty cancer institution). For the most part, though, the community-based institutions that have a full range of services should be featured in the network.

Ancillary services are market driven. The prescription drug problem, from a network-building perspective, is only critical with regard to price. Low costs are important. People are willing to travel to have a prescription filled. I would not be overly concerned about people saying, "Oh, but now I have to drive fifteen minutes to the pharmacy." People will drive fifteen minutes to a local pharmacy. Formulary and rebate programs are two good cost savers for drug programs. Another is to move away from a card program to a deductible program. It is amazing what that shoe box does to reduce drug costs.

I think network quality will become the differentiating factor long term, because, I think everyone is going to be smart enough in the long term to figure out how to get costs down. If the cost differential between networks is 10-15%, good sales people will be able to sell a differential cost, and quality will become the indicator. I think, as Jack Welsh said at General Electric, "If you cannot be number two long term, or number one in the marketplace, you probably do not have a place in the market." Quality will become the indicator that will make a network number one or two in the market. In the indemnity market, anyone can get the high-quality/high-cost physician. We have freedom to choose. We always pick what we think, personally, to be the high-quality provider. I would say that people associate high quality with high cost: "If it does not cost a lot, it probably is not good." The object in building a network, however, is to pick the high-quality/low-cost provider. That will be the trick long term in assessing the quality of physicians.

How do we evaluate quality? We need to look at the perceptions of our prospective members. Community recognition and hospital affiliation are very important. You want to get the brand-name physicians in your marketplace in your network. There are costs associated with that. You have to understand what those costs are, but these providers are very important as more people are driven toward network-based products. You need to begin with more quantitative evaluations. This is difficult. No one knows how to quantitatively evaluate the quality of physicians, although we are getting a better handle on that.

There are better tools in the marketplace to evaluate physician quality than whether they have an active license to practice, meet the continuing medical education (CME) requirements, etc. These are not enough and will not cut it long term. The better managed-care networks are much more aggressive in their credentialing and include economic credentialing, especially when it comes to high-cost services.

Hospital credentialing, the economic credentialing of an institution, is very important. I think that is an issue we are just beginning to understand both with regard to importance and how to do it. But, if you do not do it, you could be left with high-quality hospitals that are just too expensive in the long term. Obviously, a 30% discount from a hospital that is 30% more expensive than the average community hospital does not provide any advantage.

Product requirements are another issue. Consider total replacement products for an employer. This might include total replacement for the existing indemnity plan and two or three HMOs that have been offered or replacement of the five or six HMOs an employer has previously used. In these cases, each product requires different things of your network. In the second case, your network will need to be broader based and more accessible to the membership.

Another issue is the use of carve-out approaches. Mental health and substance abuse services are often carved out from the network. This type of carve-out arrangement has been in the marketplace for a long time. There are a number of very large and successful companies that have built their reputation on carve-out products. These include direct contracts with employers as well as contracts with HMOs and other managed-care network organizations. Prescription drug carve-out products are offered by prescription drug administrators that are beginning to offer good reporting capabilities to the network manager. Carve-out prescription drug plans are clearly a growing portion of the market, and they are affecting an area where costs have been increasing rapidly. Another carve-out product is transplants, which should be effective in the long term.

Access is the third critical issue for a network product. What are we talking about? We are talking about the customer's needs. I keep going back to the customer. I do not think there is anything that should drive a network more than what the customer wants.

Consider the geographic needs of the customer. That means, "How far do I have to travel to get to a physician regardless of where I work or live?" "How long does it take to get there?" "How long do I have to wait for an initial appointment?" "How long do I have to wait for a subsequent appointment?" "How long do I wait for an appointment with my primary-care physician versus my specialty physician?" "Is it a follow-up visit?" "Is it an emergency visit?" "What is the capacity for a new patient?"

These are all issues that should be evaluated as the network is built. Again, the more physicians in the network, the more difficult it is to manage the network as the likelihood of including some physicians that have higher cost increases. These higher costs may take more time to manage. You have to expend more energy to manage these physicians. They deliver a medical cost that is not quite the same as your first-choice provider. These are not the physicians wanted for the high-quality/low-cost network.

UTILIZATION MANAGEMENT

Utilization management is not new. We have done lots of these things for a long time. Preadmission certification is something that has been around in the indemnity

world and is not a new issue for us, but the referral process is. A managed-care network without a referral process will deliver a price that is much different than one with a good referral process. That assumes one very important factor: the right primary-care physician is in the network. I do not care whether you have a referral process or not; if you did not pick the right physician, this is not going to work. You cannot be a policeman often enough to deliver some benefits to the network in terms of price.

The jury is now out on concurrent review. There are a number of Blues plans, regional and national carriers, which are among the more sophisticated network managers, that are now backing away from concurrent review. As procedure and medical-care guidelines are implemented, the necessity for concurrent review decreases dramatically because treatment guidelines are established up-front. Treatment guidelines have to be appropriately set for a geographic area to deliver the right product. Concurrent review is now held out as a "punishment" for those physicians whose performance is not where it should be, or for that hospital that is not delivering the expected level of service.

Overall, I think there is a trend away from 100% concurrent review, once there is enough information on the network to know how to manage it. Clearly, this issue relates to the maturity of the network.

Networks that have an aggressive case management program for selected diagnoses (by either diagnostic category or cost) will begin to address the outliers. Case management is really an outlier phenomenon. It does not address the bulk of the service provided within the network.

What do I think tomorrow's approaches to utilization are going to be? Quality is probably the single factor that will affect the way networks perform more than anything else. Outcome measurement is a function of a quality measurement. There are more large employers that want to develop sound relationships with their networks. They want to absolutely know what is happening. Towers Perrin's Benefit Consultants are looking at a program called "Partnership for Quality," which is basically an agreement between the employer and the network that establishes a time frame for developing quality measurements and outcome measurements. The employer works with the network manager to decide the outcome measurements to be monitored. Towers Perrin expects those outcomes to change over a 12-, 18- or 24-month period and then it works together with the employer to reach that goal. It becomes a very important issue, and I think an important sales piece for network-based care. And, if we look at what is happening in Washington, outcome measurement is a key indicator being discussed in all of the health care reform proposals.

Risk transfer is one approach that I think we are going to see used more. In fact, there is a plan we just finished evaluating that had a sophisticated risk-transfer program that delivered the quality of service that people wanted. The plan just started this program; we think it is going to deliver the right quality. The plan does not have enough members yet to know, but it is a very interesting way to begin looking at physician and provider behavior. Risk does do that. People do sit up and

take notice when appropriate risk is delivered when the appropriate level of reward is also offered by the network.

Finally, I mentioned credentialing. I think more is going to happen in the credentialing area. It is becoming a much more sophisticated process and, in fact, a product. There are products out there that help networks to credential physicians and hospitals.

MR. BERNARD RABINOWITZ: Could you please explain risk transfer?

MR. KAPLAN: In a risk transfer, the network transfers a fair amount of the financial risk for delivering a service to the network provider. This may be accomplished through use of either capitation or per diem arrangements.

FROM THE FLOOR: You indicated that the referral process was very important, but that it is also essential to pick the right primary-care physicians. Particularly in a noncapitated, non-HMO-type of environment, how do you select the right primary-care physicians, and how do you really make them behave as capitated gatekeeper physicians?

MR. KAPLAN: I am not convinced that capitation for primary-care physicians is necessarily the only way to go. I think I have worked in enough networks to know that fee-for-service models can make money where the primary-care physicians are paid on a fee-for-service basis, as long as the right primary-care physicians are in that network. Again, we are talking about network-based care, and not about the indemnity world. In a traditional Blue Cross plan, for instance, where there is a participating network, which includes essentially every physician in the community, there is no real selection of physicians. The issue of credentialing physicians is very critical in terms of selecting the right, cost-effective, primary-care physician.

FROM THE FLOOR: How do you make the primary physician meet your expectations?

MR. KAPLAN: I think that if you look at a physician population in any community and have enough data to tell you something about the efficiency of the physicians, you will be able to identify what I call the low-cost and high-cost physicians in the marketplace. There are both efficient and inefficient providers of care. The object is to include as many of the efficient providers in your network so that the bulk of your physicians are or become efficient providers of care.

I can tell you that there are doctors in New York who practice similarly to the low-cost physicians who practice in California or Minneapolis. The problem is that there are more low-cost providers in Minneapolis than in New York. What you really need to do is move the practice style toward that of the more efficient providers in a marketplace and away from the style of less efficient providers. It has a lot to do with the physicians' training, the hospital they admit to, and their peers.

When you look closely at a primary-care physician, you are not just looking at that primary-care physician. You are also getting the specialists to whom the primary-care physician refers; you are getting a network that goes together. The object is in the

credentialing process to have as much information about those providers as possible, including economic information.

MR. KERRY A. KRANTZ: What reasons contribute to turnover among physician providers?

MR. KAPLAN: As we judge networks, I would say that a network that has more than a 10% turnover rate in any one year is a red flag. I would want to know who disenrolled and why. For example, is the 10% made up mostly of voluntary disenrollment by the provider through retirement, because the physician moved away, or because the physician is no longer affiliated with a network hospital? These reasons would probably include 70-80% of the 10%.

The remaining 1-2%, or maybe 3% on the outside, is likely to relate to a physician realizing that he did not belong in managed care. For example, managed care was not the physician's practice, the network decides that despite high quality the physician's costs are too high, or the physician is just not cooperating with the network, because he does not follow directions or did not understand what the basic premises were in working in a managed-care network.

Benefit consultants ask networks, "What is your turnover rate?" all the time. People are afraid that, if they do not have a high enough turnover rate, there is a negative reflection on the network. I would say turnover is not a key indicator. The issue is the ability to get rid of a physician in your network who is not behaving if you need to. This really is the key indicator.

MR. DOUGLAS O. SANDERS, JR.: Who should be responsible for current physician review?

MR. KAPLAN: It should be the responsibility of the network.

MR. SANDERS: Does having physicians doing current review facilitate higher utilization?

MR. KAPLAN: I think that hits the issue of medical-society-sponsored networks or organized physician-sponsored networks. I know of one in a large northeastern city that was a nightmare. It was organized around the physician community. In those instances, where you have a fox watching the chicken coop, you need a balance and need to be very careful. In most instances, the networks that we are familiar with today are really independent of that and deliver. Those that deliver the best product and price have a very fair evaluation process for picking their physicians.

PROVIDER REIMBURSEMENT

MS. NELSON: Let us go on to risk and reward. We will talk about physician compensation, hospital inpatient and hospital outpatient reimbursements.

The physician compensation approaches we will talk about are fee-for-service, discounted fee-for-service, negotiated fee schedules, the fee schedule with a withhold capitation, incentive risk payments, and salary.

You may be wondering why fee-for-service was included in the list. There are a couple of situations where you might actually end up with fee-for-service. One would be a case where there is a specialist whom you want in your network. He is the best or maybe the only one in town. You would rather have him agree to be part of your network, comply with your utilization management, and be a team player and pay him fee-for-service, rather than have him outside of the network.

In the other situation involving fee-for-service, by contract the doctors are going to be paid the lesser of what they submit or the amount specified by a negotiated fee schedule. Now, you would think that the idea in setting a fee schedule would be to cut fees so that no physician is paid at charges, but it happens. I work with one HMO that has had its physician costs increase year after year. They have not had a fee schedule increase in years, but average costs per service keep marching up.

With discounted fee-for-service, the doctor agrees to accept a flat percentage off of his fees. The network pays different amounts depending on the doctor. This is most likely to happen in a PPO network. I am not aware of an HMO that uses a straight discount from charges for physicians.

A negotiated fee schedule establishes fees for all services. The doctors agree to be paid according to that particular fee schedule for services provided to network members. This might be done by establishing one fee schedule for all physicians, or by using multiple fee schedules. For example, one fee schedule might be for primary-care physicians while a second is used for specialties.

Higher fee schedules are used sometimes for specialists to recognize that they are specialists, have more training and should be paid more. On the other hand, sometimes an approach of rewarding primary-care physicians through a higher fee schedule is used.

A negotiated fee schedule with a withhold might be used. This approach is most likely to occur with an HMO. In this situation, the doctor agrees to put a portion of fees at risk, with a settlement at some later date. A variety of approaches can be used to do the settlement. For example, the settlement might be based on the physician's own performance relative to some budget targets, or relative to utilization target, or on total plan experience.

Capitation arrangements involve prepayment (usually monthly) of a fixed amount to a physician for agreeing to provide a certain set of services to a certain set of members. Capitation is very commonly used for primary-care services in an IPA model HMO. In this case, the capitation rate is likely to vary by the age and sex of the member. Some HMOs use an approach of a global capitation. A global capitation might be paid to an IPA or a group model medical practice. Then, while the organization is getting a total capitation, the physicians within the organization are most likely being paid on some sort of a fee-for-service arrangement.

Another approach is capitation of specialty physician services. For example, an HMO might negotiate a fixed rate for all allergy services.

Capitations can also have a withhold. Again, under a withhold, the HMO retains part of the capitation with a settlement based on some formula at a later date.

Incentive risk payments are ways to get additional income to the physician. Withholds can be considered as a type of incentive provision. Incentive arrangements that provide payments that are strictly on the upside are also possible. The plan does not know which doctors are going to get a payment up-front, but does know that some providers will. The amount of the incentive payments might be preset in the budget as a fixed amount per member. Alternatively, the payment might be set as a function of the plan's operating results relative to budget.

A staff model HMO might use a salary approach plus a bonus to pay its physicians. The bonus is probably going to reflect some sort of a productive formula or factor.

According to the 1992 *Marion Merrell Dow Managed Care Digest – PPO Edition*, 86% of PPOs reported using some kind of negotiated fee schedule or fee cap in 1991. Eight percent reported using a package price per episode. An example of a package price would be a global fee for maternity. In this case, a range of current procedural terminology (CPT) codes would be grouped and a maximum paid for the range of codes. Forty-three percent of PPOs reported using a discount from charges, and 31% reported some combination of a fee schedule and discounted charges. The survey also reported that in 1990 the average physician PPO discount was 17% of charges, increasing to 20% in 1991.

There are five types of inpatient reimbursement methods that will be reviewed: full charges, discounted charges, per diems, per case or diagnostic related group (DRG), and fee schedule. Obviously, you would rather not pay full charges. But, as on the physician side, you might end up in a situation with no other choice. For example, an HMO may need a particular hospital in its network in order to meet its geographic requirements. I am aware of a situation where this happened. The hospital did not have significant excess capacity. It did not need the HMO, but the HMO needed it because the state insurance department wanted a hold harmless agreement from all providers so that the HMO's members would not be balance billed.

Discounted charges are a percentage reduction from full charges. A per diem arrangement involves paying a flat dollar amount per day. It might vary by type of admission. Per case or DRG-based fee schedules are also possible. These may be considered a type of global fee. They are most commonly used for cardiology surgery, obstetrics, and transplants. It is also possible to have groups of DRGs where a series of payment levels are established, with a number of DRGs falling into different payment rate categories. A fee schedule might be used for some charges. An example of services where a fee schedule might apply would include services provided by hospital-based physicians, and certain therapy services.

PPOs sometimes use a mix of per diem and discount reimbursement arrangements. They may have a formula that guarantees a per diem, if a certain level of volume is reached. If it is not reached, then a discount applies. I have also seen situations where a PPO varies discounts and per diem arrangements depending on the purchaser. For example, a very large employer might be able to get a better deal through that PPO than a smaller employer. Discounts also are often applied to catastrophic

expenses. In this case, per diem rates may be specified, but a discount from charges will apply once charges exceed some minimum threshold.

PPO hospital reimbursement arrangements have shifted from charges to risk-based arrangements over the last few years. According to the 1991 and 1992 *Marion Merrell Dow Managed Care Digest – PPO Edition*, in 1991, 81% of the PPOs reported using discounted charge arrangements, 71% used per diem arrangements, 6% used usual/customary charges, 31% used DRG-based arrangements, and 71% used a combination of approaches. The average discount reported by PPOs was 16% of charges in 1990, and 17% in 1991.

Information on managed-care contracts between hospitals and HMOs, PPOs, etc., reported in the Society for Healthcare Planning and Marketing's "1993 Managed-care Study" reports 80% of the hospitals used a discount from charges, 69% used per diems, 56% used a DRG or other perspective basis, 23% used capitation arrangements, and 11% used a percent of premium arrangement. The capitation arrangements would involve payment of a flat rate similar to a physician capitation. Percent of premium can be thought of as a capitation arrangement that varies with changes in premium. I would speculate that, in cases where there is a capitation arrangement or a percentage of premium arrangement, the hospital is either a part owner or at risk in some other way for the plan's experience. I do not think they are common unless the hospital is an interested party.

The levels of discount for outpatient services have lagged behind discounts for inpatient services and physician services. I have seen some HMOs be very careful to analyze the relative costs of providing services on an inpatient versus an outpatient basis. While there has been a lot of push to move things to an outpatient setting, some HMOs are finding that they have such favorable inpatient arrangements that it might be cheaper to do a particular surgery on an inpatient basis rather than outpatient.

On the outpatient side, you might use charges, discounted charges, a per case approach, or a fee schedule. Per case for outpatient is usually going to involve setting rates for groupings of outpatient surgeries. For example, all common surgeries might be grouped into one of five or six categories. A fee schedule is likely to be used for X-rays, diagnostic tests, or therapy.

The percent of hospital CEOs responding to the Society for Healthcare Planning and Marketing's survey indicated the following types of managed-care contracts for outpatient services: 87% used discounts from charges, 33% used a per case rate, and 21% used a capitated arrangement.

MR. KAPLAN: The discount off of billed charges can be a real problem in the long term. If you are not controlling the level of billed charges, the true savings of the discount can quickly evaporate. So, Nancy was absolutely right that, unfortunately, the networks have paid a lot of attention to their inpatient services without paying appropriate attention to their outpatient services. They have been willing to buy lower inpatient costs for higher outpatient costs. It really gets to be a balancing act between these two and how one is played against the other in your network.

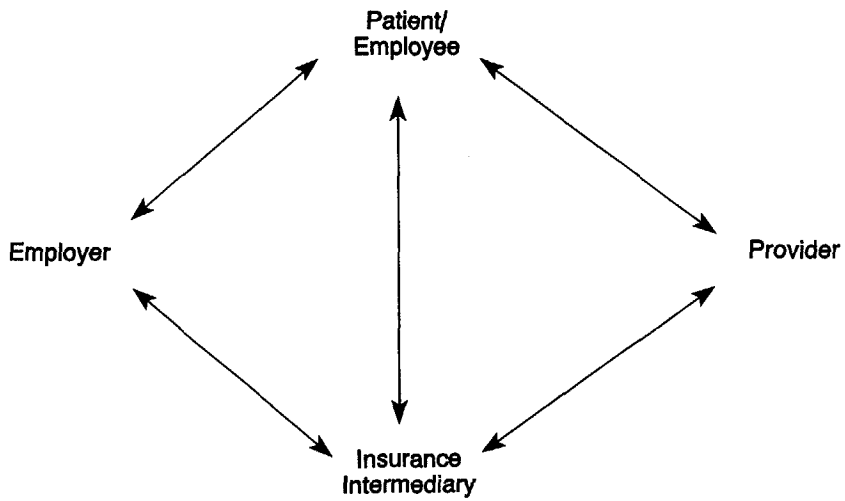
MS. NELSON: Access charges for PPOs are sort of a cousin to provider reimbursement, and I think are of interest in this discussion.

According to the 1992 *Marion Merrell Dow Managed Care Digest – PPO Edition*, the average PPO charges to employers on a per employee per month basis are an access fee of $1.96, a utilization management fee of $1.41, and other services of $1.06; with a total average of $3.16. Now, that does not add, does it? It is a little troublesome. The survey noted that there is considerable inconsistency among the types of services included in the PPO's access charges, and the parts are not directly correlated to the total. But, I wanted to present them to you to give you a feeling for the range of costs. The types of services that might be included in the "other" category would be prepricing or repricing of claims. In some cases, pricing or repricing may be included under the access charge category as well. Another interesting piece of information from this survey is that the fees charged vary tremendously by type of sponsoring organizations, with fees charged by TPAs being the highest.

INFORMATION NEEDS

With the advent of managed-care products, the amount and need for good information has increased compared to the needs of a traditional indemnity product. Chart 1 presents the entities, (patient/employee, providers, insurer or intermediary, and employers) who need to communicate and receive information effectively. The arrows indicate the directions that the information will flow.

CHART 1
Flow of Information



The employee gets information from his employer, who in turn gets information from an intermediary, which might be an insurance company, a PPO, a TPA, or an HMO,

which in turn gets information from the providers. The employer and the intermediary have information exchanges, and the provider and the intermediary are also going to share information.

Now, I am going to compare the information needs for a nonnetwork product and for a network product. My lists of information are not intended to be exclusive, but contain the key elements.

For the employer and employee, the information flow is very similar in a network and a nonnetwork situation. The employer needs to let the employee know his choice of plans. Information about the employee premium and the contract selected needs to be communicated. The difference with regard to contracts is that for a network product the employer probably needs to know exactly what dependents are going to be covered. We need to know what their names are, how old they are, their sex, and so forth. This is particularly important in situations where capitation payments are involved.

Between the employee and the provider under a nonnetwork product, the provider will want to know something about whether the patient has insurance or not. After the provider has a claim paid by the intermediary, the provider is going to send a bill for the deductible and coinsurance amount to the patient.

On the network side, we are still going to have the question of insurance coverage, but we are also probably going to have copayments made at the point of service, with a membership card identifying that copayment. If we have a POS or PPO product with both a network and out-of-network option, bills will be submitted by the nonnetwork physicians. There might be balance billing to the employee after the nonnetwork physicians have been paid by the network.

Utilization management information is also needed for the network product. That information is a little bit of a two-way street. In some managed-care organizations, the responsibility falls on the provider. It might be the primary-care physician's responsibility to know what the member ought to do. However, in other situations, it will be the member's responsibility to be telling the doctor, "This is what you need to do before you can admit me to the hospital," and so forth.

Between employers and intermediaries, information about premiums needs to be communicated. This is the same both on the network side and on the nonnetwork side. Both will need information about eligibility, but on the network side we have to know about dependents.

The network will want to know more detail about the claim. For example, a large employer with a nonnetwork product would historically get information on hospital claims, physician claims, or maybe claims in total. For a Blue plan, data might be sorted into Blue Cross claims, Blue Shield claims, and major medical claims. If it is a commercial company, only information on monthly claims paid might be provided. But, once the employer has invested in a network product, he wants to know more. For example, "If I am putting my people into this product, what am I getting out of it?" "What do my cost trends look like?" "What kind of utilization do I have?" "Am I really getting the bang for the buck that I was promised?"

Also, it is very common with POS products that an insurance company will offer a performance guarantee to the employer that decides to offer the POS product. Now, if there is this kind of guarantee, information to manage and settle it is needed. This might include information like: "Did we get the identification (ID) cards out on time?" "Are we answering the phone in a timely manner?" "Are people happy?" And, the employer is also going to want to know something about quality. For example, "Is the network meeting its requirements in terms of board certification and turnaround time?"

The employee and the intermediary need to know what benefits are covered. The intermediary will want to know something about coordination of benefits so that, if there is another insurer involved, that money can be collected. Also, information on claims will need to be communicated: an employee's claim must be sent to the intermediary, with an explanation of benefits (EOB) sent back to the employee.

On top of those things, a network will need to have a provider directory. If an employee is going to sign up to have a network doctor, he or she needs to know what doctors are in the network. The intermediary needs to keep the directory current and make it readily available to the employee.

There are utilization management requirements. If the program has a gatekeeper, we need to know which gatekeeper physician the employee has selected. Membership cards have to be issued. If the employee changes his gatekeeper physician, the change will have to be noted and updated on a new card. Newsletters to educate people on the network and its advantages are often used. In general, for the intermediary, the member services function is increased a great deal by adding a network.

The area that changes the most dramatically with the introduction of a network is the information shared between the provider and the intermediary. Before, without a network, only claim information and maybe a little bit of utilization management data were needed. With a network provider, a reimbursement arrangement with provider contracts is needed. If there is an incentive compensation arrangement, the information needed to settle up on that arrangement must be tracked. For HMO networks, the providers need to know who is eligible. The doctors and the hospitals need to understand the utilization management requirements, meet credentialing requirements both initially and on an ongoing basis, and keep up with quality assurance programs. If a primary-care gatekeeper arrangement is used, the providers need to keep communicating information on capacity for additional members to the intermediary. Particularly in an HMO, telling the doctors something about how they are doing relative to their peers with regard to cost, utilization management, and quality is important.

To sum things up, the flow of information for a nonnetwork product is fairly simple. Once a network is added, there will be additional informational needs between the employee and intermediary, the employee and the employer, the employee and his provider, the employer and the intermediary, and the provider and the intermediary.

MR. KRANTZ: In communicating all these things, how much will be communicated using computers?

MS. NELSON: Between the employee and the intermediary, claim data can be transferred back and forth on a computerized basis, and a self-funded employer would have access to that information. Some information on claims might be communicated between the providers and intermediary on a computerized basis, and we are certainly headed in that direction, long term. But, I think much of the remaining information will be paper based. Certainly, provider directories will be. You could update directories on a computer database, so that somebody could call in and find out the current status of a physician.

MR. KRANTZ: Several years ago there was talk about smart membership cards where patient information would be stored on a chip. Are we still a long way away from that?

MR. KAPLAN: It is certainly being considered. Many networks are using smart cards in terms of magnetic strip cards and readers for eligibility to transmit information from physicians' offices through the claim system for referral authorization and things of that nature. The more sophisticated networks are doing that now, and they are doing a fairly good job with it. Paperless referral processes are here. I think the networks that do not have them are clearly behind the time.

Having an ID card with your medical history on the back of it, or when we talk about health care reform, health security cards with your medical history on the back of it are things that are not really part of the delivery system today and are probably a number of years away. The issue for those networks that are much more advanced technologically is to get rid of the paper. Paper is a very expensive proposition. It is cumbersome to manage, it is not always accurate, and it is not always timely. Those networks that are more computer literate or more high tech are really delivering a product with a lower distribution cost. And once the delivery system costs are basically equal, we want to be able to deliver services for the lowest cost.

MR. JEFFREY L. JOHNSON: Can you comment on case law with regard to malpractice law suits against networks?

MR. KAPLAN: I will make some comments on that in the next section on future trends. I think there was a lot of fear a number of years ago, with a number of potential cases for malpractice against the network itself and for third party liability. The networks have done a generally good job in writing their contracts to isolate themselves from the direct line of malpractice, although networks do find themselves in the third party position.

There have been very few successful lawsuits that have included the deep pocket carrier in the settlement process. I, personally, was involved in a few of them with my previous employer, and we were not severely scarred. I think the issue is isolating the network from the independent, contracted physician. It is a much different issue, however, in a staff model where you are, in fact, responsible for a physician who is part of your organization.

FROM THE FLOOR: How can the network educate its patients so that they will more effectively use the network versus continuing to use the system as they had under an indemnity policy?

MR. KAPLAN: If you look at those networks that work better, they are also the ones that educate their members better. Member education should be a big part of any network. Those employees and their dependents who understand why they are in a network are better members. They understand how to navigate the system and utilize the system appropriately.

MS. NELSON: I also think that employers try to sell employees on the idea that the network system will benefit them by being more efficient and resulting in a better quality of care.

FUTURE DIRECTIONS FOR NETWORKS

MR. KAPLAN: To conclude our discussion, we will discuss marketing the network, managed competition, workers' compensation, Medicare, Medicaid, and Physician Hospital Organizations (PHOs).

Things are getting very sophisticated in the marketplace. There was a Blue/Cross Blue Shield ad that appeared in the Minneapolis paper a while ago that specifically addressed outcome measurement. This is a way to market your network. The ad addressed the quality of cardiac services within the network. It basically said, "This is for Minnesota's first quality based cardiac network. This is a network within the network. Cardiac care includes some of the most critical, complex, and costly of all health-care services. That is why access to the highest-quality care is so important, and why as the benefits manager you want your employees to go to the best possible facility for that care. There has never been a truly effective way to measure the quality of care they receive until now."

There are two charts on the left-hand side of the ad. The first chart shows that, for cardiac bypass postoperative heart attacks, nonnetwork providers experienced rates of 105 per 1,000, while the cardiac network provides experience rates of 29.4 per 1,000. The second chart provides cardiac bypass mortality rates. For nonnetwork providers, the mortality rate is 52.8 per 1,000, while the cardiac network's rate is 14.7 per 1,000.

Now, the ad does not state at what stage the people were when they presented themselves. We do not know a lot about the severity. We do not know anything about the patient population. Not age. Not sex. Things that all of you would certainly want to know before you set a price.

This is used in the marketplace and is becoming a very effective tool in marketing networks. Now, Minneapolis is clearly somewhat ahead of other parts of the country in terms of managed-care and the proportion of the population enrolled in managed care, but be that as it may, we will all be looking at this much more closely in the future.

How do we market networks? We look at quality and cost savings for both the employer and the employees. Although the ad appeared to be directed toward the employer and his benefit managers, rest assured there was not one person who saw the ad and said, "Oh, this is not for me. This is for my benefits manager." Everybody read that ad. I would care about it if I or my father or my mother or some friend of mine was going to have cardiac surgery. So these ads might appear to be

directed to a particular audience, but be assured, they are directed to the entire buying population.

Let us consider what states are doing to reform their Medicaid programs. For example, in New York, HMOs who enroll Medicaid recipients get more favorable hospital DRG levels. There is a clear movement to get more Medicaid recipients into managed-care networks. If states do not have the money to spend in the fee-for-service segment of the marketplace, they are going to want to push more recipients into networks. If states do not do this, they will likely have to move toward Oregon's system in terms of rationing.

You will also see Medicaid pushing for carve-out programs within existing Medicaid programs. They might have fee-for-service or some network-based care for medical and surgical services but a carve-out program for mental health and substance abuse.

Medicare risk contracts have been around for a long time and will continue to be. Medicare Select is a demonstration program available in certain states for Medicare supplement network products. Medicare issues are also going to change a bit, given what is happening with retiree health benefits.

An article in the April 9, 1993, *Managed Care Outlook* provided summary results of Towers Perrin's recent survey on workers' compensation. A vast majority of the employers (75%) who responded believe cost-cutting measures are effective. More than half of the respondents are now using some form of managed-care network for their workers' compensation. Clearly, some of that is driven by the states in which they find themselves and whether they can use managed-care or not.

I think workers' compensation has been the last bastion of fee-for-service medicine, and it is drying up very quickly. Some say if an employee goes out on workers' compensation, that it is like winning the lottery. That is, the check comes in every month. By hook or by crook, it is there. This is one item that employers do not want to pay for anymore. Others say that providers can win the lottery as well by getting a lot of workers' compensation cases.

I think we are going to see some real changes in state laws. Florida was one of the first states that moved towards managed workers' compensation, and that is happening more and more. So, network-based managed workers' compensation is critical.

For a managed-care network to cover workers' compensation, it needs to have different providers than the traditional network. The medical or surgical networks do not have chiropractors. They avoid chiropractors like the plague. Workers' compensation networks need chiropractors. The chiropractors' lobby is strong in almost every state. They make sure that they are written into the workers' compensation laws. Therefore, you need to figure out how to use chiropractic services within your workers' compensation network. Their focus is a little different, but the basic management techniques will be the same.

Another issue is that the product is basically on the property and casualty side rather than the employee benefit side. The property and casualty side has a different perspective on benefits with a distinct lexicon. It is a major change when workers'

compensation is dealt with and communicated when presented as an employee benefit.

Over the past four weeks I have had fourteen phone calls from hospitals that have suddenly awakened to the imminent possibility of health care reform and its possible implications for them. "If we have affordable health plans within the health alliance, where does that put our hospital?" "Where does it put the physicians associated with our hospital?" "How can I play in this crazy world?" I do not know whether this is an offensive or a defensive measure. To be honest, I do not think the hospitals know. All they know is that they have to do something. PHOs appear to be the darling of the hospital industry today. I do not know whether they will be the darling of the hospital industry even three weeks from now.

Hospitals are very worried. They do not know how to respond. They are becoming a very large force in the marketplace that needs to be addressed as we begin to look at networks going forward. If that hospital and its physicians are successful in organizing themselves to be a low-cost medical engine driving this train, they will have a lot more leverage in the system, but that is far away from where we are today. Their ability to come together around a coordinated and comprehensive set of objectives is difficult at best.

I always felt in managing networks that my biggest competitor was my provider group. If these provider groups are successful, I would say that the network itself, or the carrier, or the Blues plan could find itself out in the cold quite quickly because, if the providers organize themselves in an appropriate way, they can have a very effective provider network. The network is where the real savings are. It is not processing the claims, it is not doing utilization management in a niche world. It is not delivering directories or ID cards. It is the network. So, the more we focus on the network, the more we will see changes in the delivery system. This is where managed competition is going.

Every day we wait to read the newest and latest and greatest from Washington. But, in fact, whatever happens and it makes no difference whether we call them health alliances or health plan purchasing cooperatives (HPPCs) or affordable health plans, networks will be at the base of these programs in some way. It may not be tomorrow, but it will be over time. We are talking about some major overhauls in the system. It does not happen overnight. Clearly, the trend in the use of networks will accelerate.

So we go into a brave new world and what do we find? We are going to face the same set of circumstances just put together a little differently and more effectively in a network system.

MR. MICHAEL I. WIESNER: My question concerns using risk/reward relationships to manage mental health. There seems to be a basic tension between the needs and reducing costs. The process of outpatient mental health care seems to be one which many people are acknowledging does not really work in the short term. You have recidivism and other problems. Longer-term-type processes are the best, but then you have cost issues. What do you see among the risk/reward relationships that work? Or are there any? Where is it heading with Tipper Gore and Hillary Clinton's efforts?

MR. KAPLAN: I think the issue you raised has become critical. However, the literature is basically clear. If you read literature that speaks to outcome measurements in mental health and substance abuse, outpatient therapy works as well in almost all instances as inpatient care with the traditional 28-day stay for detoxification and rehabilitation. No one pays for those anymore. If you read the literature, the outcome measurement studies will tell you that recidivism rates are no higher with structured outpatients and Alcoholics Anonymous or any of the 12-step programs than for inpatient care.

Therefore, this is clearly an issue of revenue. You have less people able to receive inpatient services from the same number or more providers. Providers, in this case, are psychiatrists, psychologists, social workers, and inpatient facility companies. Some of these large national chains are finding themselves in a very difficult position. They have empty beds. And so it really is, I think, a financial issue more than it is a quality of care issue. The tension is there, and the tension will not go away.

I would tell you that the literature does sustain the managed-care network belief that outpatient works as well, in most instances, as inpatient. That is not to say that you do not need to use inpatient services for certain diagnoses. You can read about the treatment guidelines developed by Van Doyle at Milliman & Robertson. He is a physician who is very active in developing treatment guidelines. According to him, for those cases that are fairly severe, inpatient stays are very appropriate.

MR. WIESNER: Apparently, many networks like to limit outpatient mental health services to five or eight visits and will penalize providers who might have longer treatment patterns than average. Are there changes you see occurring on the outpatient side in terms of risk/reward as opposed to focusing on the inpatient?

MR. KAPLAN: One of the things you see now is trading inpatient days for outpatient visits. For every inpatient day you did not use, you would get two outpatient visits. That is generally common. The issue you raise is really a benefit issue. What is the employer willing to pay for? If an employer wants to cap liability, he will limit the number of visits. That is not developed in terms of a medical appropriateness guideline. That is a benefit guideline that is separate and apart from what the appropriate treatment guideline is. There is a clear tension between what the chief financial officer of the corporation decided and what the network manager would say is appropriate medicine. There are lots of instances where the network approves benefits over and above the benefit limit because it just makes sense. The benefit limitations that exist on almost all services are made at the employer side, not at the network.

MR. ROBERT M. DUNCAN, JR.: Even though we have more people moving into HMOs and PPOs, medical inflation continues at three to four times greater than CPI. Is it therefore likely that we will be forced into rationing health care? Are we moving toward a Canadian plan where we are going to start cutting back on the quality and quantity of health care delivered?

MR. KAPLAN: My crystal ball is not any clearer than yours. No matter how many people are in networks, and it grows every year, we have not seen a decrease in the inflation for overall health-care expenditures. In fact, some of what we have heard

out of Washington is that managed competition carries no weight with the Office of the Chief Actuary. That office considers that there are no savings associated with moving people into managed-care from an actuarial perspective. I think that you really do see improved quality. Someone looking at the quality of the care you get in a network would find it better managed. If you were in the indemnity world and you had a problem with a physician, who did you call? What did you do? There was no one to call. There was no one to help you weave your way through the system.

MR. DUNCAN: Well, that is certainly an improvement, but it will trigger utilization. If I went to my primary-care doctor and said I needed a service that he cannot provide, he will tell me where I can have it, whereas prior to that, I would have had to go and hunt and search for something.

MR. KAPLAN: So what is better?

MR. DUNCAN: Where are the savings in utilization or cost that either have been or will be achieved by putting all of these network procedures into place?

MR. KAPLAN: Well, I think if you look at utilization in a managed-care setting versus the indemnity setting, the savings are clearly there. For example, consider inpatient utilization in the indemnity world versus the managed-care world.

MR. DUNCAN: That is a demographic shift. You have brought a lot of healthy lives into a system with a promise that you would cut costs for them. Now, their cost is rising just like everybody else.

MR. KAPLAN: No, I disagree. I think trend increases on the managed-care side are clearly less than trend increases on the indemnity side. I think that any of you who are pricing both managed-care products and indemnity products see a vast difference in medical trend increases, and I am assuming that you see this on a regular basis.

MR. DUNCAN: Clearly, the indemnity is rising faster, but that is a matter of selection.

MR. KAPLAN: I think that if you look carefully, the selection issue is kind of a false argument. In fact, there are some studies that show that. If I look at the number of HMOs that have lost money over the past five years, they would certainly tell me that they do not have a healthy population. In fact, they have a basically sick population because there are no waiting periods and no preexisting condition requirements. HMOs are probably getting folks who are just as sick if not sicker than the same population on the indemnity side.

MR. IRWIN J. STRICKER: I have heard comments that one of the suggestions to reduce health-care costs is to shift the physician population from 20% primary-care physicians and 80% specialists to 80% primary-care physicians and 20% specialists. Your ideal model had one-third primary-care physicians and two-thirds specialists in the network. I wonder if you would comment.

MR. KAPLAN: Your comment, I think, addresses the issue that we need more primary-care physicians providing service to the general population. I do not disagree with that. I am talking about a managed-care network perspective.

MS. NELSON: The reason for networks to have 70% of its physicians as specialists is because specialists can take care of a greater number of patients relative to a primary-care physician. They are going to be seeing patients for a much shorter term, and more specialists are needed just to cover the range of specialists. Proportionally, dollars for that HMO might be 80%/20% in terms of time or dollars inside of your network. But, the number of specialists is going to be different.

MR. WALTER WESLEY WELLER: My provider people tell me that in many communities there is a shortage of primary-care doctors and a surplus of specialists. I guess I do not understand the one-third/two-third rule.

MR. KAPLAN: That gets to the issue that we need to train more primary-care physicians than specialists, and that we have too many specialists and not enough primary-care physicians. In terms of managing a network, you will have many more specialties in a geographical area than you can use in your network, while the opposite can be true for the primary-care physicians. Therefore, it will be beneficial to networks as well as the whole health-care community to have more physicians wanting to go into primary care.