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PROVIDER NETWORK BUILDING IN NONMETROPOLITAN AREAS

Moderator: JAMES T. O'CONNOR
Panelists: ROY H. FLAHERTY*
DOUGLAS FREEMAN†
THOMAS L. WILEY‡
Recorder: JAMES T. O'CONNOR

How can an effective delivery system be built to serve rural areas? What influence will health care reform have on such systems? Does a single-payer system make sense for such populations? These are just a few questions that will be debated in this session.

MR. JAMES T. O'CONNOR: As many of you know, one of the perceived challenges of health care reform is to establish a system to provide efficient and quality health care in both rural and metropolitan areas. But what works in a big city may not work in a rural area and vice versa.

We have three panelists experienced in health care financing and managed care who are going to share their ideas about developing health care delivery systems in nonmetropolitan areas. One of the things that I think is key in terms of this issue, particularly in terms of actuaries addressing these issues, is what is a nonmetropolitan area? Each of the speakers will, in part, address what he is defining as his nonmetropolitan area.

Our first speaker is Roy Flaherty, who is the president and chief executive of Southeastern Indiana Health Organization (SIHO) in Columbus, Indiana. Mr. Flaherty has over 18 years experience in managed care, spending eight of those years with Kaiser Permanente Medical Care Programs. Previous to his current position, Mr. Flaherty was vice president of health services and operations for HEALS Health Plan, an individual practice association (IPA)-model health maintenance organization (HMO) in the San Francisco area. He is past president of the Indiana Association of HMOs in prepaid health plans and serves on the Indiana Senate health care task force on health communities counsel for the city of Columbus. He's also very active in civic affairs.

MR. ROY H. FLAHERTY: The first question that I was asked was, what is a rural health plan or what is a rural area. I'll try to answer that in two ways. One, I'll show you what the health plan that I work with entails, and two, I'll give you demographics of our local area.

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*Mr. Flaherty, not a member of the sponsoring organizations, is Chief Executive Officer of Southeastern Indiana Health Organization in Columbus, IN.

†Mr. Freeman, not a member of the sponsoring organizations, is President of Medical Benefits Mutual Life Insurance in Newark, OH.

‡Mr. Wiley, not a member of the sponsoring organizations, is President and CEO of Health Service Review Inc. in Franklin, OH.

If you look in the literature, the Group Health Association's March 1994 *HMO Magazine* defines rural as counties whose major cities have populations smaller than 50,000. In our particular area, the southeast central Indiana area, there are about 18 counties that are equal distances from Indianapolis, Louisville, and Cincinnati. A major part of our tertiary care looks towards Indianapolis, some to Louisville, and very little to Cincinnati. SIHO's service area is 18 counties in southeast central Indiana, with a total population of 620,000. About 76,000 are on Medicare, 7,000 are on Medicaid, and about 6,300 are uninsured. The net population for the market area for our network is about 475,000. The average county size, including metropolitan areas, is 35,000. There are no major metropolitan areas in this particular area of Indiana. Approximately 65% of our market is self-funded, and it is heavily manufacturing oriented. There are a few major insurance players. Blue Cross/Blue Shield has a statewide preferred provider organization (PPO). A smattering of large insurance companies have self-funded arrangements with groups of 200–500 employees. By and large, I'm describing a rural market. Our program has a little over 8% market share, mostly concentrated in the northern part of the service area. Our membership is 40,000 lives. We have groups of 50–5,000 employees, and we're here primarily because of two Fortune 500 companies.

My presentation is going to be a little bit of the "Yellow Brick Road." You're not going to find that many rural areas with this type and level of program. It's been my experience that few areas have had the "patient capital" to allow the development of a network program that allows a rural area to thrive.

Even though we are a prepaid health plan, 98% of our product is self-funded managed care. There are 14 hospitals in our network which includes every hospital in the service area. Of the 905 physicians in our area, 351 are in our network, with an even balance between primary and specialist physicians, which gives us a real strength. Reimbursement is fee-for-service discounts on the seventy-fifth percentile of usual and customary. That doesn't sound much like managed care, and it certainly doesn't sound like what you would find in a large metropolitan area.

The network organization itself is an IPA model, which has individual contracts with our health plan. Providers represent one-half of the health plan board of directors and all the committees. The other half are the payers (employers). The IPA elects the positions to the IPA board, and the IPA board appoints physician members to the health plan board of directors. The quality assessment committee approves medical policy and, again, is half providers and half employers. The medical advisory committee, which is a cross section of specialties by geography, recommends and reviews medical policies through a full-time medical director of the health plan.

Our performance in the rural area, measured in bed-days per thousand, ranges from 285 to 310 inpatient days per thousand. Our average annual trend for health care costs for the past three years is 4.2%, and you can track down Art Wilmes from Milliman & Robertson to validate, and this is an old population. In fact, our largest employer, Cummins Engine Company, heavy-duty metal benders, just signed a contract, and in 11 years, every one of their line employees will be retired. The youngest that you can be on that production line today is 42. Our population is not young married families with lots of kids.

We have based our costs on an "effective premium," which is my way of calculating paid claims plus administration, plus reinsurance. In 1993, our "effective premium" was $112 per member per month. And year-to-date in 1994 it has been $106 per member per month.

What are the key issues? I'm going to be talking about philosophy more than anything, and then getting down to the basics, the hands-on involvement. Being there, understanding the market, is important. Most of the sales in the market, and most of the network development in our market, are done face to face, sitting down working with individuals. They want to see your face, know who you are, know who you are married to, know your kids, know where you bank, know where you go to school. All the issues that are important in a rural area. Balance in ownership and governance between payers and providers has been very important. It's held both sides together in tough times.

Payer recognition of the network's financial requirements is very important. I don't think anybody understood what cost-shifting was three years ago. When the board, and particularly the employer members of the board, began to understand that "hidden tax," they began to appreciate more of the issues involved in financing health care. Network recognition of payer limitations in national and global competition is also important. We only had to go through a couple of recessions in the early 1980s and the early 1990s for the physician population, in particular, to realize how devastating it can be on the population and their business if the local employers were not competitive. Because we have two Fortune 500 companies, we are in global competition. It has been very important that providers recognize that issue.

I can't overemphasize the issue of data. In our plan, like most plans and most networks, it is limited. It's not very good, but our use of it is important. Its primary purpose is education, not punitive; and if you don't do that in a rural environment, you won't last. That's the case in our rural environment.

The most critical issue is our future ability to attract primary-care physicians. We have to compete with every other market in the U.S. We are beginning to see multiple ways of practices developing. They are developing along lines of multispecial group practices, PHOs, foundation models, marketing services officers (MSOs), and even a staff model clinic that one of our Fortune 500 companies wants to start. I can't overemphasize enough that if we don't have primary care, we are not going to survive in our market.

My last issue is time. The development of a rural network is not a quick process, it is based on building a foundation of mutual respect and accountability between the payers and providers. As I have said earlier, in this type of ideal environment it takes a lot of "patient capital." If you have to have a certain level of membership and a certain level of administrative fee in order to survive and develop and have reimbursement adequate to attract the physicians, it takes money.

MR. O'CONNOR: Our second speaker is Doug Freeman. Doug is currently the president and CEO of Medical Benefits Mutual Life Insurance located in Ohio. It's a multistate employee benefits insurer. He has held executive positions with Blue

Cross/Blue Shield, American Physicians Life, Physicians Insurance Company of Ohio, and the Ohio State Medical Association. Doug is actively involved in health care reform, serving as an appointed member of several Ohio state task forces. He is also a board member of Health Insurance Association of America (HIAA), a member of its vision committee, and a member of the board's health care reform strategy committee.

I want to talk first about the influence of health care reform on nonmetropolitan markets. When I refer to nonmetropolitan, I'm talking in terms of Medical Benefits' experience, which is nonmetropolitan to be sure, but I don't think I would classify it as rural. There's a distinction between those two. The nonmetropolitan markets that we deal in are mostly towns that have between 15,000–20,000 citizens or 60,000–80,000. We do some work in some metropolitan markets. I would say that in terms of our long-range plan, that's not in it. Most of my comments will be related to doing business in communities like Orrville, Ohio, or Zaneville, Ohio, or Portsmouth, Ohio, or Quincy, Illinois, or places like that.

In terms of the outcome of reform, I think the likely outcome is not going to be a single-payor system. Yet we should see a lot of things happening, particularly in the area of insurance reforms. HIAA's President, Bill Gradison, gave a good feel for what seems to be coming down the pike in terms of insurance reforms. Some of us are a little nervous about that because when we started out, when I came from Blue Cross to the company that I'm with now, our strategy was to get licensed in as many states as we could and then set out to do what some of the other small group carriers do; in other words, cherry pick. When I became a board member of HIAA in 1990, I began to see early reform efforts, primarily the small-group reforms at HIAA, that passed in many states. It became evident to me that the strategy of underwriting, selecting risk, and having the "oil slick" marketing strategy wasn't a very long-term strategy. So we rapidly changed our focus to building significant market shares in communities in which we felt we could have an impact and actually have the capital necessary to do that.

I should tell you that Medical Benefits is a company with about 55,000 members. That translates to about $40 million in annual revenue, and we have about $8 million in surplus. Obviously, we're not one of the major players in town, and so it's very important that we find a niche. And our niche, as I have started to explain to you, is markets in the 20,000–60,000 population range. The kind of environment that we deal in is what I referred to in a speech that I gave a while back called Clinton's Sort of Rural Environment (SORE) point. It's not metropolitan. It's not Wyoming. It's kind of somewhere in the middle. There are a few characteristics about SORE kinds of places. They typically have a well organized health care delivery system. They usually have one hospital, sometimes two. They have a physician staff or a physician population that numbers anywhere from 20 to 60. Many of them are primary-care physicians, maybe as many as half. And there's a lot of things going on there, which make it relatively easy to bring some level of "managed care" to them.

I think there's a great deal of nonacceptance in the areas of capitated plans, HMOs, etc. People went to those markets because they wanted to be independent. They like the small town, and there's a very close-knit kind of dynamic there.

Reform in terms of capitation or vertical integration, buying family physicians, or plugging "doc in the boxes" out in places, probably works well enough in metropolitan markets, or maybe some rural markets where there aren't any physicians there to begin with. But I can tell you from experience that it's probably going to be a while before there's a great deal of acceptance for advanced stages of managed care in our kind of nonmetropolitan marketplaces.

There are a lot of things going on in terms of reform initiatives. The influence on reform today in a state like Ohio has been widely varied. And in any state, I think a lot depends on the local government activity. Obviously, we're going to get some kind of federal reform. It's impossible to tell exactly which direction, but assume it's going to be some form of insurance reform.

I'm sure many of you are aware of Tennessee and TennCare, and that emerging disaster. Ohio is rushing headlong to repeat that disaster with its Ohio Care plan. And there are some major players in the state of Ohio, which are positioning themselves to take part in Ohio Care, which in its first iteration is a Medicaid privatization scheme. Of course, Ohio and Tennessee are behind states like California and the HMO managed care-oriented states. But the general view that we see out in rural Ohio, or this sort of rural environment sector of Ohio and the states that we do business in, is one of great anxiety. Physicians, and particularly hospital administrators, are trying to be at every table and trying to network with as many people as they can.

There are a number of different kinds of networks beginning to develop. There are existing for-profit systems of hospitals, such as the Alliant Management Group, which manages about 24 or 25 hospitals in rural Kentucky, Illinois, and Indiana. They're very anxious to integrate themselves and create some kind of managed care environment. There are nonownership kinds of systems scurrying about. They are typically characterized by a group of rural hospitals that have been organized by a metropolitan hospital, because the metropolitan hospital wants to draw in that marginal revenue or tertiary referrals. VHA is doing a lot of this. And then there are some new networks out there forming, whose common bond is not a metropolitan hospital, but just that they're rural and they want to be able to create some level of clout in their market, and then organize around their own chosen metropolitan hospitals. Self-preservation is definitely the common thread.

The new player that we see in terms of rural network building is the primary-care physician. It used to be that primary-care physicians were, of course, at the bottom of the pyramid. And what's happening now, after the hospitals are trying to buy them up and the insurance companies are trying to buy them up, they realize now that they are a scarce and valuable resource, and they themselves are organizing to develop internally created primary-care networks.

There are different kinds of variations of those. But it's a very interesting dynamic in markets, because once a primary-care physician network is in a real market, is organized and becomes an entity, it is amazing to see how the hospitals and the specialists scurry about trying to position themselves to be the chosen ones for referrals. That's going to add a whole different layer of interest to this whole process. There's a lot of creation of rural networks going on. You have seen one example,

SIHO, which is an HMO type of organization. There are big players trying to go out and buy physicians, that is, vertically integrate.

And then there's companies like Medical Benefits out there, my company, dealing in rural markets that are trying to do it a bit differently. I will share with you, at the expense of being somewhat mushy, our principles in developing these sorts of relationships. And these may seem a little bit contrived, but believe me, it's something that we've learned the hard way. Relationships in rural communities, that is, relationships between a payer and a provider, can't succeed unless they're based on mutual respect and cooperation. I think Bud was getting at this same issue. You can't go out there and jam things down their throats.

Again, it's not a sustainable relationship, if the provider community thinks that something is being jammed down their throats. The community that I'm from, Newark, Ohio, is a classic example of that. There's a hospital-owned HMO there, which is capitated and has about 20% of the Newark, Ohio market, and then there's us. And we market a more or less open panel PPO, but it's heavily primary-care oriented. Our relationship with the physicians is great, and the HMO's relationship with the physicians stinks.

I was talking to a friend with Prudential who was on the HIAA board. We were talking about sharing networks and looking at their tertiary system in Columbus, which is a good one. I made the comment that, "We have a really good relationship with all the physicians in Newark," and he said without a hitch, "That's because you haven't done anything to them yet." If that is the kind of technique the big companies use, it's no surprise to me why Medical Benefits is successful in small towns and certain other companies aren't.

I think you also have to recognize that managed care, to a large degree, already exists in many rural markets. I mentioned earlier that maybe as many as half of the local physicians are primary-care physicians, and they already control a great deal of care. They know everybody. Everybody calls them Doc. It's one of those situations where they wouldn't dream of self-referring themselves to a specialist because Doc would be angry with them. That's just the way it is. The challenge is to bring a system to them that helps them organize it better and feed data back to them. And the way to do that is to go out and offer yourself as somebody with a lot of tools that can be used to create an integrated health system, but not necessarily pretend to be an expert in their delivery system, because they know their delivery system willfully. There's a saying that we've been using, "if you've seen one local delivery system, you've seen one local delivery system."

The best that I think a payer can do is develop some expertise in managed care techniques, which would primarily be, as Bud said, in the area of data. I'd like to contrast for you the experience. We have compared ourselves statistically to the local HMO. We have a very similar type of population base. Theirs is primarily larger companies and ours is small business, but the age mix is relatively similar. It helps that they've been producing their utilization data for the last couple of years, so we got an opportunity to compare our data to theirs in certain key areas.

This capitated HMO, based on fourth-quarter 1993, had 285 days per thousand, which I guess is a good HMO statistic. But look at our fee-for-service PPO at 229.4. They had 60 admissions per thousand; we had 54.3. Their average length of stay was 4.7 days compared to our 4.2. Our first-quarter 1994 continued a downward trend in that area as we began to add some more managed care techniques and tried to drive people toward primary-care physicians.

Why does rural care cost less in general? I don't know, you guys may have the answer to that because you have all the data. There are some obvious answers. I think there's less technology in rural markets. There's less tendency to use specialists. Farmers just fall off the tractor and die because they don't go to physicians until they get really sick. These may be some of the wives' tales, but I think much of it is probably true. But then you get into that area and you compare a very tightly managed system to a nonmanaged, or somewhat of a nonmanaged system, (and I would not say that our system is tightly managed). However, we let the physicians do what they like to do, which is practice medicine.

I asked some of our physicians why, for example, the days per thousand were higher for the HMO than for us because we're talking about the exact same group of physicians. They're either capitated with the HMO or they're a fee for service with us. Their answer was quick and simple. If somebody gets sick with the HMO on a capitated basis, I'm sticking that guy in the hospital as fast as I can because the HMO is not paying me $7 a month to take care of somebody who's really sick. So the moral of the story there is, you've got to build relationships with the physicians or they will go out of their way to make your life miserable as a payer. That's basically our experience in terms of rural network delivery.

In closing, I would say that in our view, the key to building an effective delivery system in a rural marketplace is being totally flexible and being able to wrap around whatever delivery system exists there. Create an infrastructure that you can start wherever they are, in terms of their managed care awareness, and begin then to move them across the continuum of managed care. Medical Benefits has been working at this for a couple of years now, and has learned many lessons. But I think we've raised this issue of being friendly to some kind of an art form, and it works very well.

MR. O'CONNOR: Our third speaker is Mr. Tom Wiley. Tom is president, CEO, and founder of Health Service Review, which has over 300 clients throughout the 50 states. Tom has been in the business of hospital administration and health care management for over 22 years.

MR. THOMAS L. WILEY: Provider network building in nonmetropolitan areas—I suppose our definition would be somewhat different, by the nature of how we are approaching it, based on our experience in providing health care at the best possible cost to our clients in rural or nonmetropolitan areas. As I describe what we have done, I think the definition will take care of itself. We quite often use the cliché "big fish in a small pond." Well, that can be a huge fish in a rather sizable pond, or it can be a much smaller fish in a much smaller pond. The key is for this type of network development to have a business, industry, or company that is large enough to have relationships and clout in any particular given smaller community.

I spent 22 years in hospital administration, and then I left to form health service review (HSR), which is now 11 years old. Quite frankly, I left hospital administration because I was feeling the frustration of the health care cost prices that started to emerge 15 years ago. Of course, now we've seen the devastating effects of the escalation in health care costs. I left with that frustration because I thought my experience in hospital administration put us in a good position to know what things could be done to help us alleviate the health care cost problem. We've taken that background experience to clients across the country and formed what we call partnerships. It would be very easy for these large corporate clients to be very dictatorial in the small communities where some of them are located, but we've taken exactly the opposite approach.

Along with what you've heard from both Doug and Bud, and what you will hear from us, I think that what you're listening to right now could and should be the model for the country. I'm not sure, based on what we heard from Bill Gradison and what we see on the nightly news, that that's what we're going to get. But if networks are put together in the fashion that I'm going to describe to you now, I'm not sure we have a health care cost crisis. We think that this exact situation that we're looking at here represents the model for very effective health care cost management.

Thus far I see no problem or drawbacks to regions. We have effectively done this in Farmington, Missouri with tertiary care being delivered out of St. Louis. We've done it in Dyersburg, Tennessee with tertiary care being delivered in Memphis; Siloam Springs, Arkansas with tertiary care coming out of both Tulsa, Oklahoma and Fayetteville; Kingstree, South Carolina with tertiary care provided in Florence and Charleston; Bluffton, Indiana, with tertiary care being delivered out of Ft. Wayne; New Bremen, Ohio, with tertiary care being delivered from Dayton, Ohio; and Salina, Ohio with tertiary care being delivered from both Dayton and Ft. Wayne. We are currently finishing up two projects in Kentucky and Georgia.

One thing we're all going to agree on: each one of these networks is independent. It has its own group of providers. They can be, and usually are, quite different in makeup. One of the companies, the one in Salina, Ohio, we use in some of our marketing with permission. It's the Huffy Corporation in Salina, Ohio, the largest domestic maker of bicycles. Huffy has locations in about seven locations in the U.S. The network we put together, however, was in Salina, Ohio. It gives you a typical corporation that we're working with.

Each one being different, one of the first things that you will note if you could look across the breadth of all these, we have only one primary-care hospital and only one tertiary-care hospital in one of the networks. In another, we have five primary-care hospitals, and a whole host, probably as many as 15, 18 tertiary-care institutions. The community itself will dictate that. As we've indicated, they're all going to be different, but we actually accomplished this with an employer of only 500 employees who has some very outstanding rates. The largest has over 5,000 employees, therefore size of the corporation is clearly important, but it can happen in that range as far as employee size.

Demographics and employer relation considerations are of the utmost importance, along with, obviously, accurate data, and as much data as you're able to obtain about

that local area. With that information, HSR's first step is to sit down with the employer, look at all of that information, and along with them, cooperatively, try to determine the very best basic makeup for the PPO or network. We don't dictate that. We don't tell them what it should be. We listen to their employer relations concerns, look at previous patterns, where their employees have historically gone for care, and then, of course, start eliminating; and finally we have what appears to be the network we'd like to put together.

In establishing the network, there's one thing that cannot be overemphasized in the nonmetropolitan and rural markets. Our approach, saying the same thing a little differently, is to develop partnerships, and trust.

We're negotiating with hospitals and with doctors, and we want this to be a long-lasting relationship. The Huffy Plan is now 11 years old, and we've been back to negotiate with the same hospitals four times now. If you're going to be successful the second time, the third time, and the fourth time, then it's imperative that you did it right, and you did it together the first time.

There are a lot of folks putting together PPOs who are being very demanding and telling hospitals and doctors what they want, or what they're insisting upon. I don't think that's going to get us where we want to be on health care costs. The business community has a huge stake in health care cost prices, a huge stake, and they should be a part of it. But if they want results, I don't think they can demand. I think they need to go to their community hospitals and doctors and work cooperatively if we're going to achieve the results we all want.

There are three major components to putting together an effective network in these types of markets: negotiated rates with providers, which I'll come back to, monitoring of care (precertification utilization, etc.), and reviewing your plan summary. Not completely redoing it, but primarily to get disincentives included that will make the other two parts of the plan work.

Let's talk about negotiated rates with providers. Many, many PPOs, which I'm going to call "off-the-shelf," operate as follows.

A salesperson walks in the door to the company and says, "we'd like you to join this network." Lots and lots of providers. One of the important things to them is being able to say to the human resource person, we've got every physician and every hospital in the area signed up.

The commitment these clients have made is that they will narrow. They will talk to their employees, and help them understand that to have effective health care cost and quality, they need to do this together, and they're going to have to narrow the providers.

Once the company has made that decision, we have the tool that we need to negotiate with the providers, and thus far, we have been able to negotiate frozen three-year contracts in every single instance.

Now I want you to think about that. For the most part, national PPOs get a 12%, 15%, or 20% discount. Walk out the door and the hospital raises their rates 18%, and the client effectively has 2%. These discounts are frozen for three years. The methodology, very simply, is for inpatient, either per diem reimbursement or diagnostic related group (DRGs).

Before we'll settle on either payment method for the client, we reassure ourselves that in the final analysis, the net cost to the employer is going to be the same in either case. I'm ashamed to say this of my own profession, but the client in HSR will, more often than not, know what those numbers are going to be, and the hospital won't. We have actually negotiated rates and raised them after the negotiations to make sure that the hospital couldn't get hurt.

For outpatient rates, we use one of two approaches. We either tier the discount over the period of three years, trying to estimate as best we can how much their rates might go up. So you could end up with an 18% discount the first year, 25% the second, and 32% the third. More often than not, we have been successful in negotiating perhaps a 25% discount, or 20% discount, and then any time during the course of the three-year contract, if the hospital raises its rates, the outpatient discount goes up in the same amount. We try not to make that into some administrative monster. Once again we're working towards gross final cost. There is some trust involved in this, and when the hospitals raise rates, they do not necessarily raise them 10% across the board. Some will raise rates 20% and some 2%. But we take the average increase, and that's what we use then to adjust the outpatient cost.

The other area for negotiated rates is an obvious one, if we are to be successful, and that's physicians. In almost all cases we have gone to fee schedules and frozen those for three years, and then reissued or renegotiated schedules at the end of that period. More and more, we're seeing acceptance of some much lower percentile of usual, customary and reasonable (UCR), either HIAA's, McGraw Hill, or whoever the third party administrator or plan administrator may use. But in either case we're trying to eliminate or freeze for a fairly extensive period. Depending on the makeup of the particular project that we're talking about, some have extended this concept to pharmacies, and even into other ancillary services such as therapy, etc. Two have pharmacy networks, where the rates were negotiated with local pharmacists, and that's where they get all of their prescriptions.

The second big area is utilization review, and I'm going to touch on this more than the other two because I believe it's firmly coming out of hospital administration. These seven projects, the locations that I described to you, came to us with inpatient utilization figures of over 500 patient days per thousand. One of them was 800. I think most of you will recognize the current national average is about 400. You've already seen some of the figures that these two gentlemen presented to you. And in every case, through a good independent utilization review process, for all these clients, inpatient hospital days were cut in half or better.

Go to those companies today and ask their employers, ask their human resources people, their benefit manager, but most importantly, ask the employees themselves whether they feel their quality of care has gone down. You're welcome to do that. I think the quality of care has improved.

There's an inherent risk to going into a hospital, and when you eliminate that risk when it's unnecessary, we've done everyone a favor. I think there's something today that maybe you all are aware of. I'm not, and I should be if it exists. But I will admit my ignorance. If it doesn't exist, it would be a wonderful project for some of you in this room. One of the reasons utilization review has been accepted is that the government and the Clintons are patronizing. They're not that interested. It will give you huge savings and reductions in your health care cost.

One of the mistakes we've made when we review the utilization review process is that we lump all of it together. Who does utilization review? We've got three groups who do utilization. Who did it first? Who started utilization review? Well, I started the utilization review department back when I was an administrator in the hospital. It started with Medicare. Hospitals still do it today, and when all the figures are reported, the utilization review being done by hospitals is included in there. I'm not going to put those numbers up on the board, but I think most of you can guess what they are.

Large insurance companies, as a sideline or as a marketing effort, offer utilization review. Utilization review is also offered by independent utilization review firms, including those who you are hearing from today. It would be an interesting study to see the results and the difference in inpatient days among those three categories, instead of all lumped together, and then compared to those who do not have utilization review. If such a study has been done, you probably would know about it before I would and I'd love to hear about it. I really think I know the results, but I'd like to see it confirmed.

For large case management, on a national scale, the figures that we hear are that you save $11 for every one you spend. We are seeing something closer to 28 to one. The huge savings involved in large cases is monitoring and finding alternative treatment for these patients rather than leaving them in the hospital.

Finally, the third thing we alluded to is plan summary and disincentives. If the networks are to work, based on our experience, there's something magic about 20%. You can put a network together and put in a 10% disincentive. In other words, if the employee goes to someone outside the network, the penalty is 10%, and it won't work. You can put in 15% and it won't work. Once you get to 20%, it becomes your own. We have 20% penalties, and we have 30%. We actually have one that is a 100%. If you don't stay in the network, it's a 100% penalty. But we have found the 20% is indeed some magic point at which our public and our employees respond and say, I'm not willing to go outside the network if I have to pay that much more. The same would be true for making sure that a qualified and good utilization precertification process takes place. You've got to have at least a 20% disincentive in your plan to make sure that the precertification gets accomplished, and gets accomplished the way it should.

In at least two of our networks, interestingly enough, instead of the disincentives being applied to the employee as a part of our negotiations with the providers, the 20% penalty is applied to the provider. So the hospital and the doctor would be paid 20% less than what was negotiated with them if there is failure to go through the precertification process. The end result is this. We're working with some people

who have some very rich plans, and what we told them 11 years ago is, before you start applying huge copayments or huge deductibles, let's try the things that we're talking about here. Let's see if we can take the waste out of the system.

And if we can achieve the savings for you through that methodology, then you can think about deductibles and copayments. The deductibles and copayments don't help us, as a country, solve our health care problem. The burden simply shifts back to you and to me. And what we're trying to do, and what I feel we've done successfully with these corporations who have adopted this philosophy, is not only save them dollars, but also have an effect on their entire community.

There's far better cost management in the hospitals in those communities today because the business who was paying a primary share insisted. Is that unfair? I think not. We all live under controls, and the health care profession went without cost control for years.

When I was still in hospital administration, the HIAA tried the old voluntary effort. Let's not judge whether it was right or wrong. It happened 15 years ago, during our period of extremely high inflation. Everybody was giving 12% wage increases, and inflation was at 17%.

The hospitals started doing that, along with everyone else, for a two- or three-year period. Then everybody else stopped. Many corporations have cut back, but those things that were applied or became necessary in the rest of our society, did not continue to take place in the health care industry. And thus, we went from 7.5% of gross national products to what? What are we at today? About 17%? That's exactly when it happened. We did not have a health care cost problem prior to that.

You decide for yourself whether or not we need controls. And if we do, I would rather have business and industry, through our free enterprise system, applying those controls cooperatively with the providers than having our government do it for us.

MR. O'CONNOR: We have a few minutes to field some questions from you.

FROM THE FLOOR: I have a couple of questions. Mr. Flaherty, how influential are the large employers that are included in your HMO in developing the network and maintaining the relationships? And do you think that there are any conflicts in having the larger employers as one of your groups and thinking that it was the company's HMO instead of being able to market to all size employers?

MR. FLAHERTY: That's a good question. I think the larger companies were very influential in creating the crisis, or at least identifying the crisis, and bringing it to the community. I think the way the program was set up, they did not have a nominee on the board, which answers your second question. They have a continuing commitment to the program, initially through capital and subsequently staying with us in times that I don't know whether I would have stayed, but it has worked out. Does that answer the question? Are there any conflicts in terms of having large employers on the board? I don't see the conflict, if there is any.

FROM THE FLOOR: This is to all three. When you talk about building a network, are you ever concerned about how many hospitals and how many providers you actually have in the network? Do you feel you need 50% in the area? Ten percent? It's something that I've always struggled with whenever I look to analyze a network, about what the proper amount should be, to have a proper network to cover a wide range of employees in that area.

MR. DOUGLAS FREEMAN: I'll answer it the third way, and it gets back to the issue of primary-care networks. I think it's safe to say that you need as many primary-care physicians as you can get in a network, because they're all very busy and you want to encourage people to use them exclusively, if possible. But I suppose someone will get really sick sooner or later, and then you leave it up to the primary-care physicians to determine which specialists are the good ones and which aren't. And it turns it around on them. If they want to control the system, which many of them now want to do, then they need to pursue that to its final end point, which is to create the rest of the network, the specialty and tertiary care.

There was also a study done; I think it was published in *The New England Journal of Medicine* several months ago. It talked about managed competition and how it would only work in communities with at least 180,000 people, because in order to have competition you need to have preferably three plans to prevent oligarchy or monopoly. And then it had some ratios of how many cardiovascular surgeons you need, etc. I don't remember those numbers, but clearly you don't need 14 cardiovascular surgeons in a city the size of Columbus, Ohio. How many are there? Four maybe, but those numbers are, I think, readily available in terms of some of the studies that have been done.

MR. FLAHERTY: I think if you approach that problem in the sense that if you're an off-the-shelf PPO, and you're going into leverage of market, obviously there is a percentage that will work for you in terms of volume and shifting volume. That just doesn't happen, at least in the rural areas I'm familiar with.

As Doug said, you need all the primary care you can get. And many places, like our area, we need all the physicians we can find. There is only one hospital in each population area, so you don't go in and start to leverage negotiations if they're the only game in town. There's no percentage that works with that.

And Doug's answer was more sophisticated in the sense of beginning to develop how many specialists you may or may not need, and how the primary care drives it. But in reality, the market itself, long before managed care got there, was driving how many could survive. And we're having more problems attracting physicians than selecting.

MR. WILEY: I've probably already answered your question from our perspective. But I think the different circumstances, as I indicated earlier, dictate that. That's what's important to the employer who's buying this product. And in some cases, employer relations will dictate a very broad-based network.

In the case of one primary-care hospital, there is only one because we got the employee group to accept our rate. Would you like to have a $650 per diem for

medical, surgical, or an intensive care unit, that is effective for the next three years? The next 36 months?

The other two hospitals that were under consideration for primary care in this small community would not get even close to that. And this company was willing to go to the employees and share the importance of a very narrow network. Now the hospital, in this case, came first and then the physician issue took care of itself because, in all cases, if you don't have a match between the hospitals and the physicians, you've obviously got problems. And your referral network to the tertiary-care hospital also has to be there. That's just good planning in putting the network together. But some of our very best negotiated agreements, which are supplying the client with wonderful rates, per diem rates, are coming from very small and very narrow provider groups.

MR. EDWARD W. O'NEIL: This question is directed to Doug Freeman. But I'd be interested in what you other gentlemen think about it because you've each talked about primary-care physicians and their part, in particular, in the rural environment. You had shared some information, Doug, about the number of days per thousand and the difference in your plan and the capitated plan, and so forth. If that seemed to go down, what do you think of the other half of the health care cost, the physician's cost? Do you see an increase in the physician component? Both the utilization of primary physicians and the cost, and how close does that come to offsetting any reduced cost that you're getting out of the hospital part of the health care cost?

MR. FREEMAN: I think a lot of it gets offset by outpatient. What you don't see there is any kind of outpatient data, so obviously a lot of it goes there. Primary-care physicians, at least in our data, have occupied somewhere around 6% to 8% of the cost for some time. It never seems to move very much. Specialists tend to get a larger and larger piece of the pie with each passing year. I think one of the big components or one of the big sells, at least to me personally, of a primary-care network is that primary-care physicians tend not to rely heavily on diagnostic technology, as do some of the specialists who are trained in that regard, like gastroenterology, and things like that. There's a lot offset in outpatient, and I think the answer to your question is, yes, there is. It would be great if everything else stayed the same and we saw that reduction in the outpatient for days per thousand, but obviously we don't.

MS. JOAN P. OGDEN: A question for all three of you. Each of you have spoken of primary-care physicians. Into which camp do you put OB/GYNs? The second question is, when you are dealing with a reasonably small community, what do you do about the physician who everybody loves, but provides a lousy quality of care?

MR. FLAHERTY: I can only answer for our community on OBs. We put them anywhere they want to be because we have only four, and we have many babies delivered by family practice physicians. But in general plans, putting them in a specialty is happening more and more.

The small community with the second- or third-generation physician and his or her father is getting old. This and any number of impaired physician issues are not handled any differently than they have been in the context from working with the

hospital and their credentialing process and our credentialing process. That has not been a problem. People are not shy and retiring when that's common knowledge on the street. As we have said, everybody knows each other by their first name. If somebody is having a problem, let him speak up.

MR. WILEY: Let's talk about the family physician that everybody likes, but the quality of his work is poor. Our approach is a very simple one. It's been successful in every case but one, and that is to take the pattern's practice of that physician. We have two possible situations. There could be poor diagnostic quality, or poor quality of how they're functioning within the network. Obviously with the precertification program you still have to precertify an emergency, but if a physician wants to play games with you, he can do a lot of one-day admissions. And we've had a physician who played that game. Everyone in the community liked him. We took our medical director to visit him and had the data with us to lay in front of him. We wanted to make sure that he knew we were aware, that we had already made the hospital aware, and chastised the hospital for not taking care of the problem. And if we had to go the employer group or his patients, we would.

In every instance we've had that turn into a success story. We had a couple backslide, so we had to go back to visit and remind them. In most cases, these employers are committed. And in the one case where we just couldn't get it done, we did indeed dismiss the physician from the panel.

MR. SCOTT R. HILDEBRANDT: My question is directed primarily to Doug Freeman. You mentioned the TennCare and Ohio Care as being impending disasters. I guess in keeping with your goal of being controversial, could you elaborate on those?

MR. FREEMAN: Let me start with TennCare because it's actually in operation, sort of. TennCare was rushed into. I don't know all the details, but I don't know that anyone does. I think part of the reason why TennCare got off the ground so fast is because we had a governor that wanted to be the model in the example, and they put all this in place with absolutely no existing provider infrastructure. Some of the other horror stories were that they had 14 or so HMOs that weren't yet licensed out there marketing. And there were incentive premiums given by some of these health plans to potential Medicaid customers, like toasters and microwave ovens, if they would sign up for a certain plan. It was basically an implementation fiasco, and I suppose it may yet work itself out. The reimbursement rates were unrealistically low, and many of the physicians simply said, forget it, we're not doing this. So they immediately had an access problem.

Ohio believes that they've studied the Tennessee experience long and hard, and are now rushing to send out requests for proposal (RFPs) to HMOs, in certain areas of the state, to begin taking Medicaid people. And it's planned that by the end of this year they would send out RFPs to other managed care organizations, or HMOs, for the rest of the state to begin July 1, 1995. And they haven't even heard yet whether or not they're going to get the Medicaid waiver, which is the thing that has to come first.

Again, it's another situation where, because they're rushing to save money, or they're rushing to do something, the organizational aspect is spaghetti, and it will become a bureaucratic nightmare. That's my read on it.

FROM THE FLOOR: Do any of you encourage the use of ancillary providers, nurse practitioners, or physicians' assistants? Do you find that effective?

MR. O'CONNOR: How we encourage it is simply in the context of working with the IPA board on a number of issues, but we're not a staff model. There's no way that I'm aware that we can encourage it any longer any more than that.

MR. ALAN N. FERGUSON: What about capitation? I got the impression from Mr. Flaherty that you have some capitation in your plan.

MR. FLAHERTY: No.

MR. FERGUSON: None of you have. Any of you moving towards capitation?

MR. FLAHERTY: Probably in a Medicaid environment, yes.

FROM THE FLOOR: Mr. Wiley, it seems the plans that you're developing, the networks that you're developing, are for the benefit of a single or maybe a group of large employers. What access, in the areas that you're covering, do small employers have to any of these plans? Is there any extension to the small employers? And if so, how?

MR. WILEY: That has been talked about. In fact, one of the companies talked about marketing. We call them closed networks. And to date, those plans have not been shared with any other employee groups.

MR. O'CONNOR: We have one final question here.

FROM THE FLOOR: The question is about the movement of PHOs in rural areas, and whether or not you think that they're going to catch on, or whether they'll be achieving serious development?

Certain communities have a tertiary-care hospital, which traditionally have effectively built the PHO because they had to. They do everything anyway. They were vertically integrated. Are we going to see this moving out of the metropolitan areas into the rural areas? Do you want to answer that, Mr. Wiley, from the hospital administrative point of view?

MR. WILEY: I think you already have the last three that we've done. The tertiary-care networks were coming after us. Once we went to the rural community, there was a big enough array of referral patterns that a lot of the tertiary-care hospitals came to us. For example, there are two alliances that are packaged in St. Louis, and when they heard we were putting a network together in Farmington, they came after us in a hurry. So I think the answer to your question is yes, and of course the biggest thing we see that's more due to what's going on at the federal level is everybody seems to be in a mood to put together an alliance. I'm not sure, once it's

all said and done, that that's going to make a whole lot of sense. Hospitals are aligning themselves with other hospitals. And St. Louis was fighting over the two childrens' hospitals, which one was going with which alliance. I can't make much sense out of that, but very clearly that's what the activity is at the moment, at least in all the locations that we're servicing.