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Session 6PD
Provider Contracting In a Consumer-Driven World

Track: Health

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Summary: Consumerism is affecting provider contracting for health plans and managed care networks. This session addresses contracting to support various defined-contribution, employee-choice and consumer-choice plans. The panelists also discuss current issues and activity in provider contracting specific to hospital inpatient, hospital outpatient and physician services, including tiered network approaches. Session participants learn about several new areas of provider contracting for various types of services covered by health plans.

MR. RANDALL PAUL HERMAN: Jay Coldwell is product director at Wausau Benefits, the fifth largest third party administrator (TPA) in the United States and was recently acquired by Fiserv. He has worked extensively with my company, Patient Choice, in the implementation of a tiered network program. Jay also has worked on Wausau Benefit's Health Reimbursement Account (HRA) program and other product initiatives. Jay will be talking about various provider-contracting issues that he's encountered relating to those products. Arnie Paulson is the vice president of actuarial services at PacifiCare, and in that capacity has worked on a number of their various product initiatives, including some interesting tiered network products that he's going to talk about. I'm Randy Herman, CEO of Patient Choice Healthcare. Our company manages the tiered network program that the large employer coalition in Minnesota, the Buyer's Health Care Action Group, which was put in place in 1998. I've had a lot of experience in provider contracting as a consultant for many years with Reden & Anders. In today's panel we're going to

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

cover not only some case study information, but also some specific contracting issues that have come up in our collective experience.

Ten years ago, we were in a period with substantially higher inflation in benefit costs versus salary and wage costs. The employer response to this was a movement toward defined-contribution pension plans and the dramatic growth of managed care. Managed care health care programs brought benefit increases down to a point where they were below wage increases for a number of years.

Managed care introduced a key weapon in the fight against benefit inflation—the provider contract. The provider contract allowed a number of things to happen that weren't happening in the health care benefits arena before. First, provider contracts introduced negotiated discounts, creating immediate cost savings. Second, provider contracts required participation in medical management programs, causing a reduction in utilization of unnecessary medical services. Third, provider contracts incorporated capitation or other risk–pooling approaches creating financial incentive for providers to control utilization. Finally, you saw consolidation of resources and a rationalization of service delivery, such as fewer hospitals and fewer beds, and fewer specialists in overstaffed areas.

As a result, getting to the late 1990s, we have a situation where many of the components of the moderation in the health care trend that came out of provider contracting had run their course. As we're all aware right now, we're right back to where we were 10 years ago in terms of the dramatic relative increase in benefit costs versus salary and wage costs. This has really prompted the hope that if we can put the consumer in the purchasing equation, we can create market forces that will help reduce costs.

Before we start, I want to ask the group two questions. First, how many of you work for organizations that don't contract themselves primarily, but rent provider contracts from PPOs or rental networks? We've got a handful here. How many of you work for organizations that contract directly with providers? That's the large majority. Jay's organization rents their provider contracts, as do many of the new Health Reimbursement Account programs offered by companies such as Definity, Lumenos and other companies that he's going to mention. Then Arnie's organization, PacifiCare, contracts directly with providers. My organization, Patient Choice does both.

MR. E. JAY COLDWELL: I'm with Wausau Benefits, which Randy referred to as a TPA. However, now that we're part of Fiserv, we've started to refer to ourselves as a health plan manager rather than a TPA. We do rent our networks. Our primary issue is helping folks understand their benefit plan and to understand how to work with the new consumer-driven products that are out in the market today.

There are two flavors of consumer-driven products: the tiered networks and HRA plans. With regard to tiered networks, we've primarily worked with Patient Choice.

We've got about 90,000 members in the Patient Choice network under our administration, and there are other PPO choice products and "company store" products out there that we manage. With the HRA plans, we're starting to see the creation of the "impatient patient", a termed coined by Regina Herzlinger of Harvard Business School. As people start to pay more out of their own pockets and start to become more empowered with information, they are starting to expect to be treated like customers and also expect some customer service from their benefit payer as well as from their provider.

A lot of what Randy was mentioning with benefit costs accelerating has really driven employers to start to shift costs to members through HRA products and other vehicles, and that cost shifting makes members more financially responsible. There are other ways that employers have worked to make members more financially responsible as well, such as reducing double coverage, delisting some covered services and turning some covered services from a third party payer paradigm to a retail paradigm, but we'll talk more about that later. Also some employers are starting to offer a program with very low lifetime maximums, which is something that the employer as well as the employee can afford. All of these things are starting to drive more consumerism out into the networks.

As we move into a paradigm of retail versus a third party payer, the members have to be equipped with tools to help them answer several questions. What do I need to buy? Who do I buy it from? How much should it cost? How do I shop around?

What do I need to buy? There are a lot of supportive services that payers are providing that help members understand what to buy, such as disease management, nurse help lines and patient advocate programs. As the member becomes more financially responsible for his or her own health care and as the managed care organization becomes less directive, the member now needs to take more responsibility in deciding what health care he needs to buy. To do this he needs access to services over the Web as well as professional people on the other end of the telephone line helping him figure this out.

There are a lot of Web tools out there that provide information along these lines—personal health Web pages that might be based on a health risk assessment that help prompt people with the things they should be concerned about. There might be an event diary for someone with asthma or diabetes so that person can record what's happened in the last day or two. If the patient keeps that up, it really helps the nurse case manager or the health advocate understand what's going on with this patient so that they can help the patient figure out what services he or she needs to be looking for.

Who should I buy from? Of course with a PPO, you would buy from a preferred provider. But since most broad-based PPO networks include almost all providers, that doesn't provide much guidance. One of the most effective ways of helping to control costs and improve quality is by getting people to use the right providers,

and so the tiered network is the push that we're seeing. I believe that eventually all provider networks are going to be tiered, with cost and quality parameters driving the tiering. Today, we are seeing price tiering. Eventually, we will start to see more quality tiering and total cost of care tiering, which will be much more effective than price tiering. There is significant resistance from providers. Providers are saying if you're going to tier me, I'm out of this network. The networks are pushing back and saying, well, we've got to tier you, although some networks are pretty slow on the uptake. They're not getting the importance of the whole paradigm shift.

As I mentioned, there are Web tools to help consumers. We'll look at one on the hospital side. They're really all based in data from CMS or from state hospital databases. There's not a lot of physician-quality information out there. There are "rate-a-doc" things addressing what type of member service was provided, but not information on medical outcomes. For pharmacy, there are some real exciting things out there. I think pharmacy really is ready for retail, and we'll talk a little bit more about that.

In terms of hospital report cards, there are several vendors out there who provide summaries of the CMS data that show differences in hospitals. One example I bring up over and over again is that in the area where I'm from, central Wisconsin, there's a local hospital that, if you look under obstetric care, you find that this hospital has a 37 percent complication rate for normal deliveries. If that's very widely known, you just stay in the car a few more minutes and go to another hospital, or even have the baby in the car on the way there. As that information becomes more widely used, it'll start to drive changes in provider behavior and in consumer behavior, and obviously will impact network contracting.

There are similar tools for pharmacy. Consumerism is really ready in pharmacy. There's obviously consumer advertising, but the information is now available on the Web so that people can understand the various drugs that are available within a class of medications, what that class of medications is used for and what the retail price is for each of those medications. They now have ammunition to take to the doctor and ask, "Why can't I take one drug versus another? It's coming out of my pocket now. I'm making that decision. It's not costing me $10 anymore, so help me pick a reasonable point on the cost/benefit continuum."

How much should it cost? We're seeing very limited availability of price transparency with regard to hospital and physician costs. Some of the Web vendors are displaying CMS costs. I think the interpretation of those costs is very difficult, especially in a retail environment. I think the pharmacy costs are more useful and will be helpful to folks in that area. Typical costs for typical procedures are becoming more and more available so that people can pick a procedure and ask how much it really costs to go to the doctor Not $10. Now it's $120. That's what the real fee is. People want to know the other services that might be involved with the

procedure, but not costs specific to Dr. Smith and Dr. Jones, so they can't pick between the two.

How do I shop around? Where is the price tag on this? Again, the difference between a third-party reimbursement paradigm and a retail paradigm as we try to move to more of a consumer-directed area is problematic. In the third-party reimbursement paradigm, costs are insulated from the member. The managed-care company probably makes a lot of the decisions, and providers are not really rewarded for caring for the sickest patients in the most efficient way. In a retail paradigm, on the other hand, costs are exposed to the member who's paying the cost more directly, and there are consequences to that member for the decisions that he or she makes.

A couple of services that might be illustrative of this are comparing a Lasik surgery to a cataract surgery. With the Lasik surgery, you see billboards that say it costs $499 per eye. You see how it's easy to shop this. People know how to shop it. There's one bill. There might be a common procedural technology (CPT) code with it, but nobody cares. They understand what they're buying. Lasik surgery was typically not covered by insurance, and that's why it evolved that way. You might expect cataract surgery to be similar, but, of course, it's in a third-party payment paradigm. You have quite a few line-item CPT codes that the average consumer is going to have no idea about.

With surgery today, you may have several providers and several bills. The insurance company will pay the bills at different times. There's really no way for this person to shop this particular procedure. There's just no global fee connected with it, and the patient probably doesn't picks the physician doing the surgery, but the primary care physician (PCP) who directed them to use a particular physician. The patient probably should have looked at what facility does this procedure so the patient gets the best outcome. There's a huge scale of change to deliver this kind of consumerism in a typical rental network situation.

As Randy mentioned, the major consumer-driven health plans where these two things intersect, the HRA benefit and the network issues, are using rental networks. The proprietary plans use their own networks. No real surprises here. But local networks are a little bit more responsive. Randy will talk about Patient Choice, the plan we've worked with quite a lot, a very advanced tiered network system. The Vivius product has been able to work in local areas to develop differentiated cost tiers within a locally established PPO, but it's still really a third-party payment-driven kind of process. Several years ago one of the national networks we work with quite a lot, PHCS, brought out a narrow network product, which was one of the first tiered network situations available nationally on a rental basis. However, it really fell on its face. It was discount driven and was very narrowly focused. It wasn't consumer driven and just didn't really go anywhere.

Price transparency is generally contractually prohibited on a specific doctor-by-doctor basis or facility-by-facility basis. There are some initiatives to expose individual fees and promote transparency on a very localized basis, but without having a global fee, how much good does that really do for people? We find that higher priced providers are not always more expensive. There's significant provider resistance to fee transparency. It's causing some turnover in networks.

There's also a drive by the providers, as they've gained more power in recent years, to move back to discounted fee-for-service payments. Networks are pushing back on that again, causing some provider turnover. So there's some dislocation out there in the provider network world.

With Vivius, the per employee per month cost is imputed by the selection of the providers that the member makes, so there is a degree of transparency there, but it's translated into the amount the employee pays out every month rather than the amount he or she pays at point of service. So it's still not really a consumer economic kind of paradigm. One interesting thing that was announced a couple months ago is that HealthGrades and PHCS were working together to use HealthGrades' hospital quality information to start to influence the PHCS contracts. We'll see if that actually takes root and produces some fruit. Networks are starting to publish member surveys on provider service quality, so that may have some impact as well.

One area that is already in the retail space is alternative medicine. Most of these services have never been covered by medical plans, and huge amounts of money are paid out-of-pocket by members. So, these folks are already in the retail space, and as medical plans start to pare back the number of services that are provided or pare back the coverage, there's a little bit more direct competition now between traditional medical providers and alternative medicine, and it may help drive some of this change as well. There are discount networks that are being promoted as part of consumer-driven packages that put the alternative medicine folks on a little bit more even footing as well there.

To summarize my remarks, the cost shift to employees is really driving a paradigm shift to retail behavior, and it's enabled by information that's provided over the Web and by nurse lines. It is driving localized change to the paradigm and driving tiering on a very localized basis on price, quality and cost.

MR. ARNOLD PAULSON: I'm vice president of actuarial services at PacifiCare Health Systems, and part of my job there is to oversee all the provider contract financial modeling that we do throughout the company. So, every time we're proposing a new contract with a hospital or medical group or an individual practice association (IPA), we're doing a financial analysis before that proposal goes out quantifying the economic impact of the proposed deal in terms of a percentage increase compared to their existing deal. I also oversee the modeling that'll go on

around our entire network. So, anything that we're doing with narrow networks or tiered networks, I'll be involved in.

I'll give you a couple of case studies of consumer-driven products that are actually up and running in PacifiCare's California HMO operation. Before I go into details here about this product, I should give you a little bit of background about our California network. On the physician side, the vast majority of the network (about 95 percent) is organized in California into IPAs and medical groups. Those IPAs and medical groups take capitation for professional services in every case; they're getting capitation for both primary care and specialty services. Then there's another 5 percent that's contracted directly on a fee-for-service basis on the physician side. On the hospital side of the network, it's split about 50-50 between capitated reimbursement and fee-for-service reimbursement.

There are two consumer-driven products that we have out now in California. One is the select network product, which is essentially a tiered hospital network where we will tier hospitals into a select tier versus a standard tier based entirely on quality. We also, and this is critically important, publish quality information so that members can make a decision based on a combination of cost and quality when they're deciding how to access the network and which pieces of the network to access. In the select network product, they have access to the entire HMO, but depending on which hospitals they access, they have different cost sharing. There is relatively low cost sharing in the select part of the network, and higher cost sharing in the non-select part of the network. The member is making a determination at point of service as to which way to go.

There's also some decision-making on the select product at point of enrollment. The way that works is that we publish a list of medical groups and IPAs in our select network directory that are likely to admit to select network hospitals. So, at the time the member enrolls with the medical group or IPA, he or she can decide if they want to pick one that's identified as highly likely to admit to a select hospital, and, as a result, have lower cost sharing. The value-network product is the other product I'm going to talk to you about. This is really a narrow HMO network. It's a subset of our full HMO network that contains the low-cost, high-quality providers. So, this value-network product is typically sold dual choice alongside the full HMO network. There is a consumer decision at point of enrollment: whether he or she wants to opt into the full HMO network at typically a higher contribution level out of each paycheck, which also has typically a leaner set of benefits, or opt into the value network for a lower per-pay-period contribution and typically richer benefits.

I'll talk to you about the criteria for the construction of these two networks; give you some information about cost, relative price points; and discuss our target market for these two products. I'll also show you a little bit about PacifiCare's published quality data, which again is an essential component of both of these products, so as to ensure that consumers are making a decision based on a

combination of cost and quality as opposed to just cost. We'll also review some contracting experience from the field around these two products.

With the select network product, which again is our tiered product, hospitals are divided into select tiers, which are the low-cost hospitals, and a standard tier, which are your relatively high-cost hospitals. The standard tier hospitals will carry incremental co-payments per service compared to the select tier hospitals. For inpatient services, those incremental co-pays range from $100 a day up to $400 a day, and for outpatient surgeries the incremental co-payments are going to range from $50 per surgery to $200 per surgery.

This particular product was launched in January 2002 in California. Again, one of the critical components is that the select network directory is identifying medical groups and IPAs that are likely to submit to a select hospital, so that the member can make a decision at the point where they enroll with the medical group or IPA. This will ultimately help drive whether they end up in a select hospital or a standard hospital. Members also have Web access to our quality index profiles for both hospitals and for medical groups and IPAs to help to guide this whole decision-making process.

Member education on both products is absolutely critical. If your consumers don't understand these products, they're not going to buy them, and that's the bottom line. You've got to have good enrollment materials. Test them ahead of time. Make sure your average employee can understand them. It's also critical that you train your customer service staff on what these products are and how they work.

I'll give you an anecdote. Part of what I get to do at PacifiCare is periodically listen in on customer service calls. So, we've got the customer service person taking live calls, and I'm on a headset listening in. There was one call in particular in which a member had enrolled in the select product, and he said, "When I was choosing my medical group I looked in your directory and I picked one of the ones that said they're likely to admit to select network hospitals. Now I'm getting ready to go into a hospital, and my physician wants to admit me to a standard hospital. It's going to cost me $500 a day, and I'm going to be there for three to five days. It could be $2,000 in cost sharing. What's going on here?" The customer service rep was really good. She was educated the customer on the product, and explained, "Well, your physician has admitting privileges at both hospitals. We can't direct you ourselves to the select hospital versus a standard hospital, but what you can do is go back to your physician and have a discussion with him about your cost-sharing dilemma and ask him whether the select hospital may be an appropriate one for you for the condition that you have and the service that you need at the hospital."

In terms of composition of the network, the select hospital network is made up of roughly 50 percent of our hospitals throughout the network, and those hospitals represent roughly two-thirds of the HMO admissions. The price points that we were able to achieve on the select product are 2 percent to 6 percent below a standard,

non-tiered, HMO product. That variability is a function of where the employer is located geographically, how much spread there is in cost between hospitals in that geographic area and the actual benefit design and how big your co-pay differentials are. Our target market for the select product is mid-size and large employers, or 50 or more employees. The vast majority of the 20,000 members that we have enrolled at this time are from the mid-size market.

Let me tell you about the selection criteria for the select network product. All of our capitated hospitals are in the select network, and if you go through and evaluate cost of these capitated hospitals, they almost always end up being relatively low cost compared to the fee-for-service hospital network. That's why they're in. On the fee-for-service hospitals, which in California represent roughly half the volume, we're looking at hospitals with below-median expected cost per day to determine whether they're in or out. Expected cost is important here. You want to make sure that you're looking at future costs when you're setting up your selected network. It's critically important to distinguish between a historical cost per day, and what you expect that the future cost per day is going to be based on the contract you have in place for next year, or the contract that you're negotiating for next year. Ideally, you want to set up the timing of decisions about constructing these networks to coincide with the provider contract negotiation process so that you can get some leverage from these products during your contract negotiations.

Let me make some technical comments about methodology. On the fee-for-service side, we're doing some catastrophic smoothing so that a hospital is not unduly impacted by a large random catastrophic claim. Also, while our original version looked only at inpatient hospital cost per day, the latest version has added outpatient reimbursement, where the comparison metric there is 100 percent of Medicare allowed. In future versions of this, instead of looking at cost per day, we're going to be looking at severity-adjusted cost per admit. This is the right way to go here so that you're not unduly dinging a hospital because it happens to treat more severe patients.

Now I'll move onto the value network, which again is our narrow network product. On the cost side, we're going to look at total per member per month (PMPM) costs for members that are paneled to a particular medical group or IPA. We'll add up their physician expenses, hospital expenses and pharmacy expenses, then compare those from medical group to medical group. Again, it's critical that you're looking at expected future cost for reasons I've already articulated. For some of the details for capitation and claims, we're normalizing those cost expectations for differences in age, sex and plan mix. We're again doing catastrophic smoothing on the hospital claims expense. In future versions of this we will be adjusting all of the expected cost PMPMs for risk adjustment. It's important to head in that direction because every medical group or IPA that I've come across thinks that it has a sicker population than everyone else, so you hope to diffuse that argument. Plus, for half of them, it's really true, so you should theoretically do this.

We've got an awful lot of capitation. We're not always sure that we get good encounter data where we're capitated, so we've got to make sure that our risk adjustment methodology is fairly robust and doesn't unduly penalize or credit a delivery system for having good data or bad data.

As I mentioned, there are really two criteria for being in the value network: cost and quality. On the quality side, we're looking at both hospital quality and medical group quality. For hospital quality, right now we're using a combination of leapfrog measures and patient satisfaction from the Patient's Evaluation of Performance in California (PEP-C) report. As for future versions of the product, we're going to dramatically expand the range of quality metrics that we're looking at to be more closely aligned with PacifiCare's published hospital quality index. On the medical group and IPA sides, the quality metrics include a combination of member satisfaction data, some preventative screening rates that we go in and collect ourselves, and then also childhood immunization rates.

I'll now discuss some of the details of network selection for the value product. We go through a point system where points are assigned to each medical group and IPA based on a combination of cost and quality. Then, the value network is created with the medical groups or IPAs that end up with the most points within each submarket. It's critical that when you're going through this exercise and comparing medical groups that you define geographic submarkets. The submarkets should be set up so that they contain providers that are geographically close to each other and could realistically compete with each other for membership. Our very first cut at this was interesting. We rated the providers on cost and quality throughout the state of California, and found that everyone in southern California was in the value network and everyone in northern California wasn't. So, it's obviously not a realistic product. Just to give you an example, we've divided L.A. County, which is a fairly large county, into five geographic submarkets.

You want to make sure that you've got reasonable network coverage in each of those submarkets. We may end up adding providers to achieve those coverage standards, even if they didn't meet our strict points criteria. The other constraint is we'll look at the price differential provider by provider within each submarket, and if we don't have a minimum price differential across the providers, then we just won't create the value network in that submarket. Currently we've got the value network set up in eight southern California counties. The selected provider groups represent 60 percent of PacifiCare's HMO membership in those value network markets.

Chart 1 shows you a numerical example of why this concept works. Each of these dots represents the total health care cost PMPM for physician, hospital and pharmacy of a medical group in L.A. County. You can see the mean is roughly $150, and the 105 providers are arrayed along this line from a low of about $110 PMPM up to a high of almost $300 PMPM. You have some opportunity there for tiering the network and coming up with the low-cost, high-quality subset.

The average PMPM cost for value network providers is roughly 15 percent below non-value providers in our eight-county area. The price points we're able to achieve on this product are up to 10 percent below PacifiCare's full network, and that really is a function of how many of the employer's members are already enrolled in value network providers. So, if you're switching an employer group from a standard HMO network to value network, and they already happen to be all enrolled in the value network, you're not going to have any cost savings relative to your current product. That's rarely the case, but that is certainly something we look at.

The price point differential is also a function of whether the product is sold stand-alone or dual choice. Obviously, if it's stand-alone, you're going to get full penetration into the value network, and if it's dual choice, you'll have something less than that. When it is sold dual choice, the underwriter looks at the magnitude of the contribution differential and benefit differential between the full HMO network and the value network. So, it's important to have some minimum contribution differentials and benefit differentials, so that you can drive membership into the value network.

Our target market for this product includes large and national employers. The employee benefit consultants love the concept of building a narrow network based not only on cost but also on quality, and PacifiCare was one of the first to do this. We brought the product to market in fall of 2002, and we had six large employers enrolled effective January 2003, which, if you think about the national account sales cycles, is pretty amazing. The sales cycles start in March and April, so we were able to get six large employers to conceptually sign up for this product without knowing any of the details about exactly how the product was going to work and which providers were in or out. Now that the product is well-defined, we think we have a huge enrollment potential.

We tell those in the value network that we reserve the right to add providers to this later, but we won't be subtracting any. This really helps you preserve contracting leverage with medical groups and IPAs where you haven't locked in on the next year's contract by September. If you end up signing a great deal with one of them, you can add them to the value network later. The select network is updated twice year, in January and July.

Chart 2 gives you a flavor for what is included in our quality index of hospitals. This information is also accessible to members on the Web. We roll these results up and give people aggregate quality metrics for people who want one score for the entire hospital, but then we also give detailed access to all this detail for people who are interested more in the detail. So, you can differentiate on hospital quality depending on why you're going to the hospital. If you're going in for cardiac surgery, you can look at the cardiac surgery quality metrics. If you're going in for a delivery, you can look at the obstetrics quality metrics.

We also have a quality report card for medical groups and IPAs, which is much more physician-focused in terms of the things that you're measuring quality on. You've got to make this stuff as simple as you can for people who just want an aggregate score, but you also want to give them the capability to drill down into more detail for your more sophisticated users.

Let me close with a little bit of contracting experience from the field. The first category is barriers to ideal network selection. Sometimes, a system of medical groups or IPAs wants to be evaluated together. You want to consider the contracting approach with that network. Do you contract separately with each site and have a separate rate for each site, or do you have a single rate for the whole system? If it's the latter, and there's only one capitation rate for the whole system, then there's a lot of logic for saying they're either in or out as an entire group. You can ask the same question about quality initiatives. Are the quality initiatives for this medical group system generally corporate initiatives that are rolled out uniformly across all their sites, or do they have a lot of site-specific quality initiatives?

The second barrier, which is a little more thorny and hard to get around, is a large hospital system that will allow assignment of any of their sites to the standard network. You must ask yourself, how much do you need this hospital system in your full HMO network? I would say that one consideration is, how many members do you have in your narrow and tiered networks versus your full HMO network? As that starts to shift, and you get more and more enrollment in your tiered and narrow networks, I think your answer to the first question will start to change, as you'll get more and more leverage in these discussions.

Our new products have led to some contracting successes, based on conversations I had with our California network managers, the people who are out negotiating deals with medical groups, IPAs and hospitals. In one case, a large hospital system granted substantial contract rate concessions to ensure that all the medical groups that admit to their hospitals were included in the value network. That's a huge win in the hospital negotiation with that system.

Finally, although we don't have much membership in this product, the select hospital product has provided leverage in the hospital contract negotiations. Hospitals really do believe that differential and patient co-pays will shift market share. So, we're actually seeing some significant traction on this, and even though these products are both still in their infancy, we're starting to see them help us gain leverage in the hospital and medical group negotiation process.

MR. HERMAN: I want to talk about two things today. First, I'll talk about the specific experience we had in Minnesota in re-contracting and creating the tiered program there, and then I'll touch on some other specific issues and open it up for questions.

By way of background, the Buyer's Health Care Action Group is a group of large employers in Minnesota who got together in 1990 to develop their own health care program. The program that they came out with initially in 1993 was a self-insured, point-of-service program built around primary care selection and administered by one of the local health plans. In 1998, the coalition rolled out a tiered network program. I was a consultant to that program, and in 2001, Patient Choice took over managing the program. It's been an interesting experience because we not only re-contracted, but we've gathered data on price elasticity of consumers and provider performance. Members selected primary care physicians, but they had an out-of-network benefit option available to them. It was a PCP gatekeeper model, and the health plan that administered it required referral authorizations. The plan featured health-plan-driven medical management.

We experimented between 1993 and 1998 with various partial capitation approaches, since most of the primary care groups that we were dealing with were used to some form of capitation. The employers in our program didn't like the pooling of risk under capitation; they preferred pure self-funding.

The program, like many managed care programs, periodically excluded providers that wouldn't meet the economic terms of the program. Like most health programs, employees paid the same monthly contribution amount no matter which providers they chose to see within the program. Every year the health plan would come back and say they were having trouble negotiating with one or more medical groups and ask the coalition leaders if they wanted to keep the providers in the program. The HR professionals who ran the coalition would ask why they couldn't leave these providers in the program and just charge the member more to see them. The answer was always, well, it doesn't work that way.

The second thing employers were questioning was why we pay the administrator to manage care when that was really supposed to be the job of the providers themselves. They wanted to find an approach that empowered the providers or, at least, gave more economic rationale for them to control cost. So we maintained the self-insured point-of-service benefit program, but we went out and re-contracted directly, instead of through the health plan, with entities that we call care systems. These were basically the IPAs, physician hospital organizations (PHOs) or the medical groups that we had contracted with us through the health plan. We created a program that featured open access within these care systems. We got rid of a lot of the primary care gatekeeper approach that existed in the previous program.

As I mentioned before, within certain parameters, we allowed these care systems to manage their care. We got rid of a lot of routine utilization management requirements such as specialist referrals, concurrent review for routine hospital stays and so forth. We got rid of every aspect of capitation that was in the program and moved to fee-for-service. We went to resource-based relative value schedule) (RBRVS) physician reimbursement. We also created a relative value unit (RVU) hospital reimbursement approach that was based on classes of per diems with a

differential for the first day and second day of the stay, with the categories of per diems grouped by the DRG of the admission. So it's a fairly sophisticated approach, but it also gave us a single relative value unit that we could compare across services.

We opened the program up to all providers, and we let all providers bid their rates. If their bid rates were too high, the provider would be in the high-cost tier. Employees could still access these providers them, but it was going to cost them money to do so. That's the program we rolled out in 1998.

The way the program looks to the consumer is fairly straightforward. They can select among the primary care physicians in Tier 1 for the lowest monthly contribution rate, for example, $50 for a single employee as their monthly contribution. Or, they can choose to select a primary care physician in the next cost tier, reserving the right to use primary care docs in the lower tier as well. So they've bought into an expanded layer of access. It costs an additional $15, approximately, for a single employee if they want to choose primary care docs in the highest tier system, again reserving the right to switch to anybody that is lower cost. For the families, we allowed each individual family member to select different care systems.

The $15 or so differential represents the actuarial value of the differential between these tiers. Our commitment to the providers was to pass the actuarial value of the difference between tiers on to the providers. On an optional basis we offer a PPO network side-by-side, usually as the highest cost option. We also allow employers to differ benefits by tier instead of employee contributions. Under this approach, an employee who wants the richest benefit plan for the entire plan year again would select the lowest cost tier providers and stay within that tier. If the employee wanted higher cost providers, they would have less rich benefits for the year.

Our care systems look a lot like the medical groups that Arnie was talking about with PacifiCare. We allowed these care systems to self-organize. We initially started with the networks with which the health plan was contracting. We asked them to first define their network for us. They didn't have to have a contract with every specialist in every hospital that they planned on using; they just declared who was in their care system. We then present to the consumer a mini-directory of providers for each care system that they can access on an open-access basis. Each of our care systems looks like a miniature network.

We also allowed them to look at and define their own health care protocol, which means some of them manage themselves fairly tightly while some of them manage themselves fairly loosely. We put some information in front of the consumers on how that occurs, and then we let them set pricing for those contracts or providers that they directly control. We made a blanket set of contracts available to care systems that we maintain at a Patient Choice level, so if they don't have a contract

with a facility or a certain provider, they can access that provider through our contracts.

Each year when we receive the fee bids from care systems we evaluate the performance. We do a risk-adjusted and catastrophically-adjusted projection of what the cost would be based on the fees that the care systems bid. In the Minnesota program we use the ambulatory care group (ACG) system for risk adjustment. We've been using that since 1997. In markets where we don't have experience data, we might use actuarial assumptions while we phase in the actual claims experience. The result presented to the consumer is the tiered network.

One of the key things about our program that I think we did right from the beginning, and I'm going to show you the numerical results after this, is we tiered based on expected total cost, not simply based on the price that the providers were submitting. In Chart 3 we're showing, for each care system, the relative cost index and the relative price index. The gradual line represents the relative price index of each care system arrayed from low to high. This shows how the care systems compared based on price without regard for utilization. The jagged line shows what the total cost index on a risk-adjusted and catastrophically-adjusted basis was for those care systems.

Had we tiered our network on price alone, we would have taken the groups that were on the left side of the gradual line and put them in the low-cost tier, and we would have taken the groups on the right side and put them in the high-cost tier. But instead, we look at the expected total cost and tier based on that expected total cost. In Chart 4, the groups on the upper part of the graph would be high cost and those on the low part of the chart would be low cost. Some of our low-cost groups get there because they're low-price groups. Some of our low-cost groups get there because are efficient from a utilization perspective, and they may actually get paid higher-than-average prices.

Each year we evaluate the bids from the care systems, group them into tiers and estimate the differential cost between tiers. A key issue is, whether or not we picked the right providers in the low-cost tier. If we didn't, and clearly if we had tiered based on price alone we wouldn't have, the differential by cost tier wouldn't translate into actual experience differentials.

Chart 5 shows the actual experience differentials by tier for each program year with and without considering risk and catastrophic adjustment. What this table shows is that our predicted low-cost tier providers have always ended up being low-cost based.

When we developed this program, one of the questions of many of the employers and providers was whether employees would select their providers and change provider relationships based on a $10- or $15-a-month contribution differential. For each year of the program, we've evaluated the migration of the members from the

high-cost providers to the low-cost providers, and in Chart 6 we're showing the enrollment change in 2003 over 2002. The year 2003 was interesting because we had more care systems shift cost tiers than we have had in previous tiers, but this illustrates fairly consistent results with our previous years, and a couple things come out.

First off, as a general rule, high-cost providers lose patients. They'll migrate at open enrollment to the middle- or low-cost providers. Similarly, low-cost providers tend to gain patients. Secondly, which is just as striking, is those providers who move up a tier lose a lot more patients. A provider that moves from the middle tier to the high-cost tier will lose a substantial amount of its business. Providers that settle into a tier and stay there for a while can expect a relative amount of stability. If they're middle-cost tier, they might maintain where they're at or they might actually pick up. But I think the takeaway that's been eye-opening for our providers is that changing the tiers and being in the high-cost tier has had an impact on their patients. People have made decisions to move away.

We've found that providers react to the program. For instance, Park Nicollet Medical Center, which was in the high-cost tier, migrated over time into our lowest-cost tier because they found many of their patients wouldn't pay extra to access them. As a result, they improved their pricing and improved utilization in order to move into the low-cost tier. Another example of a provider's reaction was in 2003, when one of our big hospital systems gave us a reduction in the price to keep their group from creeping up a tier because they had had a high utilization year. So we've seen the kinds of results we were hoping for in terms of provider behavior in this Minnesota program.

The program itself has been studied a fair amount, and the results that I think have been fairly well-documented are, as I was showing before, that consumers will migrate to the better-performing systems. We have had care systems respond. We've had improved quality of care that's been documented. We have had improved service. We've had care systems that have improved their phone systems and appointment systems, and we've seen results from a patient perspective. Our trend experience has generally been 2 percent to 6 percent below the local HMOs, so the performance for the employers has been good, and we get that trend experience by the migration out of the high cost into the lower cost tier. That's generally the experience that we've had with the Minnesota program.

While in our program we are not negotiating price since we let the care systems bid their fees, we are asking to identify their care system panel of specialists and facilities, we are asking them to perform their own routing medical management, and we are asking that they participate in the catastrophic case management performed by the TPAs. The other thing that we are looking at requiring in the future is their participation in providing quality data. Like PacifiCare, we are providing more information to consumers and will be incorporating quality into our tiering next year.

MR. PETER REILLY: Arnie, you mentioned that you achieve 2 percent to 6percent lower rates through your select product. MHave you analyzed how much of that was due to benefit differential and how much of it was due to steerage into the lower-cost providers?

MR. PAULSON: No, we haven't looked at that. It'd be an interesting study to see for the select network. For the employers who have picked the select network, what was their distribution of admissions by facility before they selected the select product versus after? We have not done that particular study. The pricing turns out to be based on the size of the benefit differentials. How much movement do we think we're going to have? How much variability is there from provider to provider within the particular geographic area that the employer's in? That's exactly the right study to do, I think, to see how much movement do we really get, and what was it worth? How does it vary by geographic area? Also, how does it vary by plan design and the co-pay differentials that you implement?

MR. REILLY: Mr. Herman, you showed expected differentials among the tiers versus actual and then actual adjusted for large claims and for risk adjustment. I thought it was striking not only due to how much the adjusted-tier relationships were and how close they were to actual, but also that apparently your risk adjustment explained a tremendous amount of variation, because you looked at the relationships before risk adjustment and after, and they're very different. How much of that explanation came from just traditional large claim adjustment, and how much came from more sophisticated risk adjustment methodologies?

MR. HERMAN: I don't know if I have the exact answer. I can say that the risk adjustment factor that was going into individual care systems probably ranges anywhere from about 0.9 to about 1.2. My sense is that it's probably about two-thirds risk adjustment, one-third catastrophic.

FROM THE FLOOR: Can anyone comment on how often the seemingly reasonable advances in managed care have been met with litigation or threats of litigation by physician or hospital groups?

MR. HERMAN: When we're talking about the tiering of providers, we really have two kinds of litigation risks that we have to deal with. One relates to the contracts, since many contracts prohibit disclosing price, the question will be whether tiering exposes that price. This will be especially challenging to some of the HRA programs that are putting prices on the Web to promote "shopping" by consumers. The other risk, and I've always found it interesting that it hasn't been more of an issue, is that we have had this quality data, including health grades, hospital safety statistics, etc. showing poor performance on the part of some providers, yet we keep them in our panels. I am surprised this issue hasn't caused more litigation.

MR. PAULSON: For PacifiCare, we certainly have some contractual language that would bar pure price transparency, but if you think back on the particular products

that we're involved in now, we're not directly revealing any of our specific provider contracts. The current products don't have that element of litigation risk. What typically happens instead is that we have some heated discussions during contract negotiations. It turns into more of a contract negotiation issue as opposed to a litigation issue.

MR. PETER DAGGETT: One of the problems that we've had in working in this environment is specifically around emergent care, radiologists and pathologists. I'm interested to know, from either the contracting side or from the product side, how you have dealt with this in your different situations.

MR. HERMAN: I can start from the contract side. Those are the types of providers we knew in our program that we had to go out on a plan-wide basis and contract with. You end up getting whatever kind of contract you can, given the community dynamics. For example, in the Twin Cities nearly all anesthesiologists are in one group. We ended up contracting as best we could with the anesthesiology groups, and then our care systems just piggyback off of those contracts. I don't know that we found any solution to some of these monopoly or near-monopoly groups.

MR. PAULSON: Yes, I would echo that. If you think back on the product design for PacifiCare and the construction of the networks, where we're capitated on both hospital and physician sides, those reimbursements to urgent care radiology and anesthesiology are going to be handled by either the capitated hospital or the capitated medical group. They'll want higher or lower overall aggregate capitation for us, and it will impact where they fall in value networks versus non-value networks. Where we're reimbursing for these services on a fee-for-service basis, we haven't really cracked that one. We're out there just trying to sign the best deals that we can, and then when we're constructing the value network, those costs are considered along with all the other costs in a particular network's aggregate PMPM to determine whether they're a value network provider or not.

MR. COLDWELL: Just briefly from a TPA's point of view, that problem has been around ever since PPOs have been around, and we're just handling them the same as you would with any PPO.

FROM THE FLOOR: This is a question for Arnold. Looking at the value network versus the select, it seems like the value network had some measures of quality and some of cost that went into the selection of the hospitals, but it looked like the select, if I understood you correctly, was only on cost. If that's true, what is the reason for that, and is that expected to change in future years?

MR. PAULSON: It is true, but the driver or the answer to that question is what our target market is. On the value network, our target market was more the large national accounts where typically the sales process involves an employee benefit consultant, and setting up your narrow network based on a combination of cost and quality is critical. The consultants also share PacifiCare's vision that that is critical.

On the select network, by contrast, the market there has been more of a mid-market target that's more broker-driven as opposed to consultant-driven, and that crowd tends to be a lot more price sensitive, so incorporating quality isn't as critical there. The other comment I would add is that even though quality is not an explicit driver in determining whether a hospital is select or standard in the select product, quality information is still published, and it's accessible to the consumer. So, the consumer is ultimately making a decision in the select network based not only on the co-pay differentials, which is a cost metric obviously, but also based on the published quality information that we supply to them.

FROM THE FLOOR: After you decide which tier a provider is in, do you tell them about that and give them a chance to change anything to go to a lower tier, or do you just wait for a year?

MR. HERMAN: We do a combination of things. I think when we initially created the program, you fell where you fell. It was a blind bidding process. But more recently there have been certain care systems where, as we get their bids, we'll go back to them and say, "this seems kind of high." We've evolved into an approach where if somebody's an outlier, we'll go back to them and talk to them about what they've bid, if we think they're going to be moving tiers and so forth.

MR. KENNY KAN: I have a question for Randall. I'm curious about some of the processes that went into establishing the employee contributions and the plan co-pays. At first glance, $50, $65, $85 for contributions and $10, $15, $20 for co-pays don't seem to differentiate providers enough to be able to empower employees to achieve the results of a tier network. What do you think ultimately drove the success of the tier network?

MR. HERMAN: The original idea was that we wanted to pass the actuarial value of the differential between tiers. The $15 or $12 monthly contribution differential that we recommend is the actuarial value of the difference between the tiers. So the basic premise was if we expect a 5 percent differential in claim costs between the tiers, we're going to pass that on in the form of an employee contribution. That level of differential has shown significant consumer migration to lower cost care systems.

Chart 1

Normalized Cost PMPM for LA County Medical Groups - Projected 2004

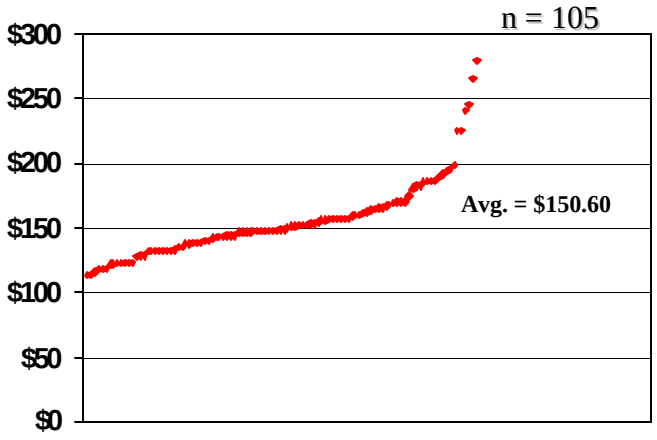

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Chart 2

QUALITY INDEX profile of Hospitals

- **55 measures**
  - Medical, surgical, OB, peds
  - Risk-adjusted
- **Appropriate care**
  - Risk-adjusted complication rates
  - Cardiac, OB/GYN, peds, pulmonary, elective surgery, ortho, ICU, stroke
- **Patient Safety**
  - Risk-adjusted mortality rates
  - Cardiac, OB/GYN, peds, pulmonary, elective surgery, ortho, ICU, stroke
  - National Quality Forum metrics
- **Leapfrog measures**
  - Self-certified reports to Leapfrog website
  - Volume thresholds for CABG, PTCA, CEA, AAA, esophageal ca, neonatal
  - CPOE
  - Intensivist staffing
- **Patient Satisfaction (Calif)**
  - PEP-C survey (113 hospitals)
- **Utilization**
  - Hospital length of stay - cardiac, OB, pulmonary, general surgery, ortho, peds, ICU, stroke
- **Aggregated grades**
- **Best Practice "stars"**

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Chart 3

Patient Choice Encourages Provider Choice Based on Total Costs and Quality

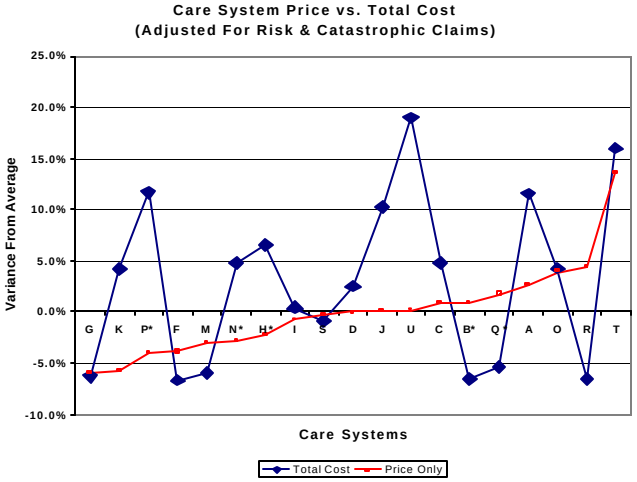

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Chart 4

Patient Choice Encourages Provider Choice Based on Total Costs and Quality

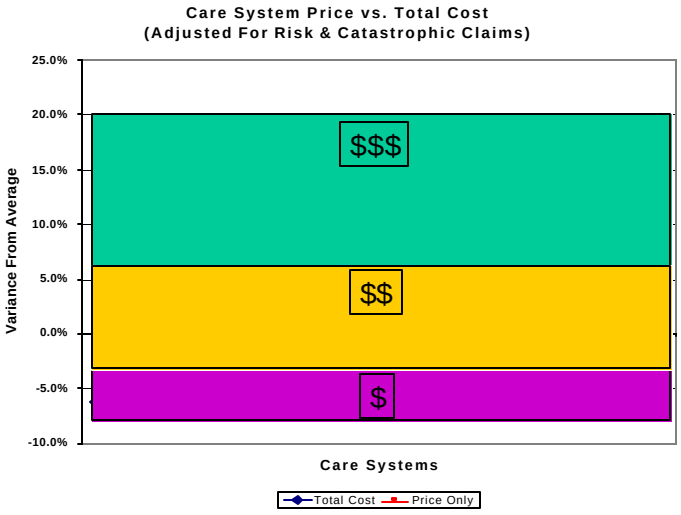

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Chart 5

Minnesota Experience

Actual to Expected Variation By Tier

	Expected Based On Bids [1]	*Actual Without Adjustment*	*Actual With Risk / Catastrophic Adjustment*
1998 Experience			
Tier I vs Tier II	- 7.1%	-12.7%	-7.7%
Tier III vs Tier II	9.6%	11.5%	4.9%
Tier I vs Tier III	-15.2%	-21.7%	-12.0%
1999 Experience			
Tier I vs Tier II	- 4.6%	-17.3%	-8.5%
Tier III vs Tier II	2.9%	5.7%	2.7%
Tier I vs Tier III	- 7.3%	-21.8%	-10.9%
2000 Experience			
Tier I vs Tier II	- 6.8%	-19.7%	-4.0%
Tier III vs Tier II	12.8%	-0.4%	9.4%
Tier I vs Tier III	-17.4%	-19.4%	-12.3%
2001 Experience			
Tier I vs Tier II	- 4.7%	-5.7%	-6.2%
Tier III vs Tier II	6.7%	19.4%	5.9%
Tier I vs Tier III	-10.7%	-21.0%	-11.5%
2002 Experience			
Tier I vs Tier II	- 6.1%	NA	NA
Tier III vs Tier II	9.0%	NA	NA
Tier I vs Tier III	-13.9%	NA	NA
2003 Experience			
Tier I vs Tier II	- 5.7%	NA	NA
Tier III vs Tier II	8.4%	NA	NA
Tier I vs Tier III	-13.0%	NA	NA

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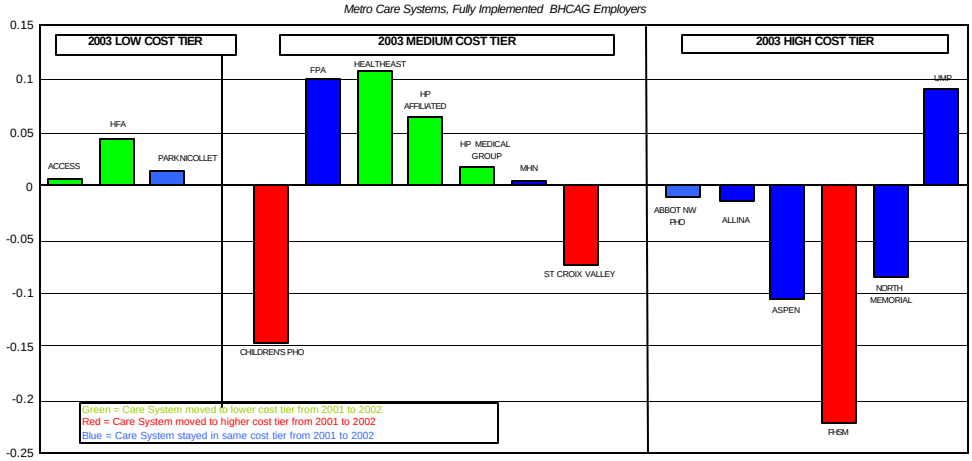
Chart 6

Relatively Small Differentials Produce Substantial Migration

PATIENT CHOICE CARE SYSTEM PERCENT CHANGE IN MEMBER MARKET SHARE: 2003 OVER 2002

Metro Care Systems, Fully Implemented BHCAG Employers



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