Selective Contracting

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The Twenty-seventh Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Health Administration and Center for Health Administration Studies of the Graduate School of Business, Division of Biological Sciences, University of Chicago, was held at the Ambassador West Hotel, Chicago on May 10, 1985. These symposia are a reflection of strong concern of the Graduate Program in Health Administration with complex current issues in health care management.

The topic for this, the Twenty-seventh Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

Special thanks are due Mrs. Margarita O'Connell and Mrs. June Veenstra, who staffed the symposium.

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WELCOME

RONALD ANDERSEN. Welcome to the Twenty-Seventh Annual George Bugbee Symposium. The symposium is sponsored by the Center for Health Administration Studies and the Graduate Program in Health Administration at the University of Chicago. This symposium is directed toward alumni and students of the Program, and friends and colleagues of the Center. It's dedicated toward the exploration of significant issues, current and long-term, faced in the organization, finance, and delivery of health services. The symposium was originated by Ray Brown, well-known statesman in the health care field, during his term as director of the Program in 1958. It's been nurtured and developed, and later named in honor of George Bugbee, who directed the Center from 1962 to 1970.

The symposium is most appropriately named after George, who has a style that we try to emulate here. The style I refer to is critical analysis. George is well-known for his careful and detailed review of the pros and cons of policies and programs for health services finance and delivery. This style probably had a lot to do with his successful career as administrator of a large teaching hospital; executive director of the American Hospital Association; and key actor in the development of the Hill-Burton program, accreditation of health care institutions, and maturation of professional education in health care administration.

The Symposium Program is planned jointly by the alumni of the association and the faculty of the Program. On the Program side it's coordinated by Odin Anderson, with Reed Morton's assistance. On the alumni side we've had considerable input from Chet Minkalis, president of the Alumni Association, and a number of council members, including Phil Haas, Don Oder, and Phyllis Levens. We thank them for their contribution. The implementation is largely in the hands of Margarita O'Connell and June Veenstra.

Selective contracting is emerging as perhaps the most significant element among pro-competitive strategies in health care financing today. We define it as arrangements between insurers, employers, and their agents, entering into agreement with designated providers of medical care to provide services to enrolled populations, often times at discount prices.

This developing bargaining process brings to mind the report about the hospital administrator who was invited for a fishing outing by the chief of his medical staff and the chairman of his board. They had not been out in the boat very long when the chairman of the board said, "I forgot my

the lake, walked across the water to the shore, retrieved his lure, walked back across the water, and got into the boat. A few minutes later, the chief of the medical staff said, "With all the fish we're going to catch, we really should have a fish net." He stepped out of the boat, walked across the water, got the fish net, and came back. The hospital administrator thought, "In this company of equals I ought to have some reason for going back to shore." He said, "You know, it's very sunny out here; I think I need my sunglasses." He stepped out of the boat and promptly sank to the bottom of the lake. The chief of staff turned to the chairman of the board and said, "Do you think we should have told him where the stones were?"

There are a number of additional people in the boat today, including employers, insurers, and state and federal officials. What we hope to do today is to find a few of those stones in selective contracting. More particularly, we'll look at types of selective contracting and their growth, various actors in the process, and implications for planning.

SELECTIVE CONTRACTING: AN OVERVIEW

RON ANDERSEN. Leading off for us today is David Dranove, who is assistant professor of business economics in the Graduate School of Business. David did his doctoral work at Stanford; he also has an M.B.A. from Cornell with a specialization in health administration. He's been doing studies of rate-setting legislation and investigations of alternative delivery systems, such as PPOs and HMOs. We are pleased to have him associated with the Graduate Program in Health Administration and to speak to us today.

DAVID DRANOVE. I'd like to thank Odin Anderson and Ron Andersen for asking me to speak here today. I'm honored to have the opportunity to set the table for the distinguished speakers who will follow. What I'd like to do is to present an overview, from an economist's perspective, of selective contracting for health services. In addition to summarizing the limited data about the performance of selective contracting arrangements, I will discuss why these arrangements are becoming so popular, what employers and providers stand to gain from these arrangements, and the implications of these arrangements for the long-term structure of the market for health services. I will try not to sound like another "Doctor Doom-and-gloom," as they often call Henry Kaufmann, but at times I may suggest that perhaps this trend is not the best thing that could ever happen to providers. Those of you who are providers may have that feeling already. On the other hand, I plan to argue that selective contracting will generally improve the performance of the health care delivery system.

If you were to look at the market for health services over the past few years, you would observe several remarkable, related developments. I will give you a few examples. To start with, consider group-model HMOs, which for many years have been very successful in contracting with individual hospitals to admit their patients at a favorable rate. As a second example, we are now seeing employers such as Hewlett-Packard and General Motors offering health insurance options to their employees that are somewhat unlike their traditional health insurance options. In particular, these employers are negotiating directly with area providers to continue providing fee-for-service medical care, but at discounted prices. Providers who agree to attractive price-service packages are being rewarded with increased utilization by employees of these firms; the employees might otherwise have gone to other

providers, but now they are being directed to the contracting providers.

As another example, consider the Medicaid programs in California and Illinois. These programs are now soliciting bids from hospitals for the rights to admit and to treat Medicaid recipients. Most hospitals are receiving contracts, but at discounted prices. A few high bidders are being excluded from treating recipients and are suffering the consequences of reduced utilization.

The Teamsters union was in the news recently. The Teamsters union purchases group insurance for its members, and the Teamsters have entered into a contractual agreement with the Voluntary Hospitals of America, a loosely affiliated group of large, non-profit hospitals spread across the United States. These hospitals will offer discounts on services for union members.

Finally, consider the Blue Cross programs in California and Illinois. These programs are now negotiating favorable rates from many hospitals and are offering separate Blue Cross plans that direct enrollees to those hospitals with the lowest prices.

These events all have, I believe, one common thread. In every case, the organization that pays the medical bill is shopping around, rewarding what it perceives to be good buys in the marketplace with high volume, and punishing what it perceives to be bad buys with low volume. These arrangements all fall under the rubric of "selective contracting." Selective contracting is something that virtually every business does when it buys productive inputs; for the first time businesses are doing this in their purchase of health services.

The fact that purchasers of health services are shopping around, contracting with only a select group of providers--those providers offering the most attractive price, service, quality, and so forth--is the reason these arrangements are called "selective contracting." Selective contracting for health services is not really a new phenomenon. As far back as the turn of the century, it was not uncommon for employers to contract with a group or groups of physicians to provide medical care to their workers. The precedent for insurers' selectively choosing providers also dates very far back. The very first Blue Cross plans contracted with a limited number of providers

to provide services to Blue Cross enrollees. However, many states, shortly after the formation of these Blue Cross plans, passed laws requiring insurers to contract with all providers in the state; and in many states such laws still provide a barrier to selective contracting.

Selective contracting, whether initiated by employer, insurer, or, in some cases, provider, soon disappeared. The mold that employers and insurers then followed is now a very familiar one: the employers would typically purchase insurance through Blue Cross or through some other commercial insurer; the insurer would reimburse providers for either the charges from providers, or perhaps the reasonable costs of care; all accredited or licensed providers would be covered by the insurer; and employees would have free choice of provider. Within the world of fee-for-service medicine this particular mold remained unbroken until the 1970s.

In the late 1970s the first crack appeared. It is generally agreed that the first significant departure from this mold occurred in California in 1978, with a firm called "Admar". Admar aids employers that self-insure their employees for health care benefits. In 1978 Admar began contracting with providers on a selective basis on behalf of its employer groups. In 1980, the consulting firm InterStudy dubbed such an arrangement a "PPO," or preferred provider organization, and the moniker has stuck. (It often seems when I teach material like this to my class that the only time I mention InterStudy is for its ability to come up with acronyms. Apparently this has a great value in the marketplace, and this acronym is one of many that Interstudy is responsible for.)

Although selective contracting does take many forms, "PPO" is now the generic term for most such arrangements, and I will use the two terms interchangeably. The growth of PPOs has been quite staggering. By 1984 there were roughly 150 PPOs operating in the United States, with 51 in California alone. Another major center of PPO activity is Denver, Colorado; and here in Chicago there's been quite a bit of activity in PPOs. The number of PPOs in the formative stages is also in the hundreds, and today hardly a week goes by without a newspaper announcing the formation of another PPO. Some of the most important developments in selective contracting have been the recent decisions by certain Blue Cross and Medicaid programs to turn to selective contracting. I would like to discuss those briefly.

In 1983, after the California legislature enacted laws allowing such selective contracts, Blue Cross of California formed a network of preferred providers. This large PPO, called the "Prudent Buyer Plan," attracted 500,000 enrollees in its first year. Leona Butler will tell us much more about the plan this afternoon. Blue Cross of Illinois will soon implement a similar plan, starting here in Cook County; it has had a plan on an experimental basis in Peoria for a year. Over half of Cook County's hospitals have contracts to participate in what Blue Cross of Illinois is calling its "participating provider option."

California in 1983 was the scene of another important precedent, when the state's Medicaid program (which is called "MediCal") made a very radical change in the way it would reimburse hospitals for the care of recipients. Rather than paying what it deemed to be reasonable cost or "cost-plus" or "cost-minus," as is done in some states, or setting rates prospectively, as is done in other states, MediCal held, in effect, an auction. Hospitals that wished to continue treating recipients had to submit bids to provide in-patient services at fixed per diem rates. The low bidders won contracts; in many cases, hospitals that would be in financial straits if they lost a contract but submitted a bid that MediCal deemed too high were allowed to enter a second, lower bid. But in general you could think of this as an auction, occasionally followed by negotiations. In the first year, 1983, 60 percent of the state's hospitals received contracts; last year 70 percent received contracts. I think one would be justified in calling MediCal "the nation's largest PPO."

This year, as many of you know, Illinois Medicaid is negotiating contracts with hospitals. As in California, the hospitals are submitting per diem rates, but they can further distinguish between what Illinois is calling "general" care and "specialized" care. It's not exactly clear that this categorization really distinguishes less expensive from more expensive patients, and I imagine some fine-tuning will be required. It appears that most hospitals in the state will be securing these contracts, but, again, at discounted prices.

In 1982--and this actually predates California--Arizona instituted a somewhat different sort of arrangement for the care of its indigent population. Prior to 1982, Arizona had no Medicaid program at all, so it went all out by not

only introducing Medicaid but using quite an experimental plan. Nelda McCall described this plan in yesterday's workshop. Arizona's approach has been to contract with what are in effect health maintenance organizations: it contracts on a prospective, per capita basis with these contractors. The plans that receive contracts are then free to deliver care in any way they wish, and some plans that have run into problems are delivering care on a fee-for-service basis even though they are getting a fixed capitation payment.

Whether it is an arrangement between an employer and a provider, one between a Medicaid program and providers, or one between Blue Cross and providers, I do not really consider the PPO to be a new organizational form. I think it is better to think of the PPO as a contract between existing organizations. The contract calls for a set of fees and a service package. Providers are still reimbursed on a fee-for-service basis; this is one of the most important distinctions between a PPO and an HMO. The fees, however, are usually discounted from the provider's customary fees, and it is these discounts, contractually arranged in advance of utilization, that some people consider to be the real new innovation of PPOs. The contract may call for utilization review, or perhaps quality assurance, and these can be quite crucial to the success of the PPO as well.

The contract usually specifies financial incentives that employers must provide to encourage employees to seek care from participating providers. After all, if employers extract reduced rates from the providers, providers expect something in return. What they expect is higher volume. The incentives that the employers can provide are not limited to their telling their employees, "Look, these guys have lower fees, so your 20 percent co-payment will be 20 percent of a lower number." Employers actually lower co-insurance rates and deductibles, substantially reducing out-of-pocket payments by employees who visit preferred providers. As an extreme example, consider the Illinois or California Medicaid program. The co-insurance rate if you visit a preferred provider in Illinois is zero; the co-insurance rate if you visit a provider who's not on the preferred provider network is one hundred percent. So you can easily see how Medicaid encourages recipients to go to the preferred providers.

During the negotiation process, the employer may play off

one provider against another. In fact, many providers are realizing that they might have a competitive edge in the marketplace. Rather than waiting for employers to come to them, they are initiating the PPO negotiations themselves. In this way providers who believe they have an attractive package for employers are pre-empting the market. Currently, about one-half of the new PPOs are started by providers. I think that it is correct to view this, however, as a direct response to the employers' and the insurance companies' letting it be known that they are willing to negotiate selectively. If the employers had not taken the initiative, I do not think that you would have seen the providers making this response.

If you consider lower fees to be the goal of PPOs, then PPOs have been quite successful. Price discounts of 10-25 percent are the norm; discounts of 30 percent are not unheard-of. Blue Cross of California is now achieving average discounts of 23 percent. Blue Cross of Illinois expects 10-18 percent discounts in its first year. (One reason Illinois is not doing as well as California is that Blue Cross of Illinois does not cover physician groups, but Blue Cross of California does.) MediCal estimates that its discounts are about 12 percent; Illinois Medicaid appears to be getting substantial discounts as well, and these discounts are what many people considered to be bare-bones rates.

Even if no discount is obtained, it is often the case that the preferred provider was already offering prices twenty or thirty percent below the market average; so again employers can gain by directing employees to low-cost providers. For example, one Silicon Valley firm went out into the market and found a local hospital's prices to be 30 percent below the market average. It found the quality of care at that hospital to be acceptable as well. It contracted with that hospital without obtaining a further discount, and saved substantially.

To the extent that there are providers in the marketplace offering low prices and high quality, participation in PPOs may offer very valuable means for these providers to publicize this fact. When employers and insurers decide to contract with providers, they evaluate not just the price differential, but also the quality of care, the service offerings, and so forth. Because of the large numbers of people they are negotiating on behalf of, the dollar expenditure they are going to make, and the expertise they

may call into play, employers or insurers can very often do a better job of this evaluation than could an employee, who often has to make the decision of which hospital to go to with very limited information. Winning a PPO contract would enable a low-priced provider to announce credibly to all individuals in the marketplace that it had withstood the scrutiny of this contracting process. Such a provider could effectively announce, "Blue Cross of California has said that our low prices, coupled with our quality of care, meet their selective criteria." If a provider could gain that sort of publicity, then consumers who previously feared that low prices were a signal of low quality--something that might be a reasonable response in the marketplace--need no longer hold such fears. In this way, PPO negotiations allow consumers to make more reasonable choices about their options in the marketplace, even if the consumers themselves were not in the PPO.

The explosive growth of selective contracting seems to have taken the market by surprise. To an economist, the biggest surprise may be what took so long. Allow me to explain. Until recently, the individuals who had chosen providers--the employees--had obviously been very interested in quality, amenities, and so forth. However, because they had insurance, employees had been insulated from price differentials and had not shopped around on the basis of price. As a result, hospitals have historically competed on the basis of quality, amenities, and so forth, but much less on the basis of price. In fact, if a provider had lowered its price, it would not have anticipated a marked increase in volume. Employers are certainly concerned with the quality of care provided to their employees, and the amenities, and so forth, but because employers are paying the medical bill, they are concerned about price as well. The old arrangement therefore worked to the detriment of employees, who paid for high prices through high insurance payments. Suddenly, employers, and other purchasers, such as Medicaid and Blue Cross, are finding that if they can credibly offer increased volume in exchange for lower prices, providers will, in fact, lower their prices.

The economic term for the price-volume tradeoff is the "price elasticity of demand," as I'm sure all of my students could tell you at a moment's notice. By shopping around on the basis of price, employers are effectively increasing the price elasticity of demand for medical services. Hospitals are responding in the way we expect

just about any seller to respond to an increase in price elasticity: they are lowering their prices. I believe that this simple elasticity argument is at the heart of the success of many PPOs.

The willingness of providers to offer low prices is greater when they have excess capacity. Most hospitals run at occupancy rates of 75 percent or less, and the extra cost of increasing utilization in these hospitals is very low. To these hospitals, the gain from increasing volume can be quite substantial. It is no coincidence that PPOs have been most successful in California, where the hospital occupancy rate is just 66 percent, one of the lowest in the United States. The Illinois occupancy rate of 70 percent is also below the national average; and on the south side of Chicago we have several hospitals operating with occupancy rates of 50 percent or less. I will return to the issue of excess capacity later.

I would like to spend the remainder of my time in discussing, first, what the firm must do to be successful in implementing a PPO, and then what will happen to providers if this new competitiveness in the market for health services continues to grow in importance. The idea that shopping around will generate discounts is so simple that one must ask why employers waited so long. I can offer two possible explanations. First, the negotiation process can be time-consuming and costly, and until now employers did not know that they could successfully complete these negotiations, so they were not willing to incur this cost. Second, employees value free choice of provider and they must often be offered large inducements before they agree to visit preferred providers only. It is only recently that employers have learned that financial inducements can be offered that will get employees to agree to visit preferred providers.

These two explanations offer some guidance about what employers must do in order to have successful PPOs. First, consider the amount of employee participation. There are several ways that it can be increased. If employers offer two plans, a standard plan and a PPO plan (as is often the case), they can reduce the co-payments in the PPO plan. In fact, deductibles in the regular plan are usually several hundred dollars higher than deductibles in the PPO plan, and the co-insurance rates in the regular plan are often ten or twenty percent higher than the co-insurance rates in the PPO plan--perhaps 20 percent, versus no co-payments if

you join the PPO. To encourage enrollment further, some plans, such as Blue Cross of Illinois, allow free choice of provider within the preferred provider plan. In order for this really to be a preferred provider plan, they also make the co-insurance rates for the preferred provider much lower than the co-insurance rates for everybody else. In the Blue Cross of Illinois plan, there is typically a 20 percent co-insurance rate for visits to a preferred provider and a 40 percent rate for visits to a non-preferred provider. In this case employees might be able to get most of their care from preferred providers and enjoy the benefit of the price discounts, but if there is a particular provider not in the network to whom they owe some allegiance, they can still get some insurance coverage for care from that provider.

There are other things that employers can do to increase employee participation. If they want to get their employees involved, they ought to be shopping around as if they were employees. This means that the providers they choose should be suitably located, offer a diverse array of services, and guarantee a reasonable quality of care. In fact, third-party quality assurance may be a very desirable aspect of these contracts. Employees' participation will be further enhanced if they perceive that the preferred provider arrangement is a long-term arrangement, offering the prospect of continuous care from the preferred provider.

Of course, providers who understand these incentives can use this understanding to their advantage during the negotiations. For example, suppose that the PPO contract is for just one year. At the end of the year the contracting providers are surely going to have a competitive edge in new negotiations. They can offer higher fees in the second period, maybe only a little bit discounted from their regular fees. If they do this the employer faces three choices, none of which is as desirable as the choices it faced the year before. The employer can switch to another provider, but that will jeopardize employee participation: employees will not want to get involved with a plan in which they must seek care from a different provider every year. The employer can abandon the PPO completely, losing all discounts. Or it can acquiesce to the now-smaller discount of the provider group that received the contract in the first year. Of course, employers can avoid this unfortunate situation if they anticipate future arrangements in the initial contract. For example, Blue Cross of Illinois is negotiating two-to-

three-year contracts, and I think such long-term arrangements are desirable.

Of course, before employees' participation becomes a key factor, the employer must choose its preferred providers wisely. It must be sure that expenditures per employee are really going to fall after it starts directing its employees to these providers. Employers should therefore take note that price discounts do not per se translate into reduced expenditures. There are at least three factors that might stand in the way.

First, when prices fall, total utilization can increase, mitigating the benefits of the discounts. A clear example of this is the experience of hospitals in the states that have comprehensive rate-setting. In the state of New York, for example, after a prospective rate-setting plan was put in place in 1970, lengths of stay went up by 10-20 percent. The effect of the plan on total expenditures was much less than one would think just by looking at the price discount. This problem of increased utilization can be exacerbated if employers attract employees into PPOs with low co-payments, because then the employees will have no objections to the increased utilization. Some remedies include provisions for utilization review. This is already a standard feature of most private insurance coverage, and to the extent that discounted prices encourage further abuses it becomes a much more important element of the PPO contract. Employers may also want to have coverage for out-patient care and other low-cost substitutes for in-patient care. Employers may want to have written into the contract the opportunity to cancel the PPO arrangement if utilization proves to be unsatisfactorily high, though that begins to sound like an HMO. Finally, employers might prefer to offer direct cash incentives to employees who choose the PPO option rather than reducing the co-payments: rather than offering zero percent co-payments, employers can offer a lump-sum cash payment instead. This maintains employees' incentive to lower utilization.

The second factor suggesting that price discounts by themselves do not guarantee success is that discounted prices do not always mean low prices. For example, suppose a PPO contract calls for a blanket charge of $800 a day, as opposed to an average charge of $1,000 a day. For a particular, relatively healthy payer group, the average actual charge might only be $750 a day, lower than the discounted price. So the preferred price is no discount at

all. An employer may gain if it gets a tailor-made PPO contract specific to the risk pool of its employees.

The final factor suggesting that price discounts are not enough to guarantee lower expenditures is the wide variance in practice styles amongst providers. Some providers are higher-utilization providers than others, and lower per diem rates do not ensure lower expenditures. Employers need to do some shopping around, perhaps with the expertise of some consultants. Employers need to identify the efficient providers as well as the low-priced providers.

If employers are successful in their efforts, then selective contracting should generate not just substantial price discounts, but also reductions in expenditures. It does not take too much thinking about the health care industry, in which profits for many hospitals are already scant, to realize that further expenditure reductions are surely going to have a profound impact upon providers. In my remaining time I would like to examine how this new competitiveness for health services, as exemplified by selective contracting, is likely to affect the market.

Consider where the market is today. This is a market that many consider to be over-capitalized. As I stated earlier, the average hospital occupancy rate nation-wide is 74 percent, yet many hospitals have shown that they can operate effectively and efficiently at 85 percent of capacity or higher. As a second example, consider open-heart surgery. This is a procedure with a substantial fixed cost, and cost-effective provision involves doing many procedures per institution. But evidence from several states suggests that most hospitals that do open-heart surgery perform fewer than 100 procedures a year, far too few to be doing them efficiently.

These two examples are symptomatic of an entire market problem: the market has large, fixed-capital investments that are not always being used efficiently. This excess capacity has been supported in the past by high price-marginal cost differentials. This markup allows hospitals to pay for fixed capital costs, but the new competitiveness will force hospitals into making Hobson's choice. They can lower their prices, thereby reducing their markups and reducing the amount of capacity that can be funded. They can maintain their prices; but then they lose volume, and this also reduces the resources available for supporting excess capacity.

Clearly, as consumer price sensitivity increases, providers as a whole are going to be forced to cut back on capacity. To the extent that capacity is truly duplicative, this is a good thing. It is better that our resources go elsewhere than that we provide a second open-heart surgery unit in a community where one unit is already not providing its full capacity of care. But this capacity may also serve to reduce waiting time, guarantee access to care, and so forth, and in this sense reductions in capacity may be a bad thing. There are other ways in which reductions in expenditures may be harmful, and I'll return to these shortly.

As an aside, it is worth noting that the elimination of excess capacity may have some dramatic implications for pricing and marketing strategies of health care providers. Once excess capacity is eliminated, the market consists of what may be considered "lean and mean" hospitals. If a new hospital comes into the neighborhood and steals away patients, the response of a lean and mean hospital may be, "Well, we didn't have empty beds before but we've got some now. It may not have made sense to cut price before, but it does make sense to cut price now." The response to a future entry in the market may be price reductions. Currently, if somebody enters the market we do not observe such reductions. After all, hospitals had empty beds already; if cutting price were the best way to fill those beds they would have done so already. Instead, hospitals try to improve the quality of service and amenities.

That means that the entrant to the market is not going to expect a price reduction. In "marketing" its product it emphasizes its hours, its location, and the quality of the medical staff, but not the price. In the future, when this new provider enters the market, the provider next door will lower its price. The future entrant must recognize that it is not marketing just amenities and quality; it has to market price as well. That may lead hospitals into price wars. Price wars are foreign to the market for health services, but quite common in other markets where providers have capacity constraints, such as air travel.

Let me return to provider responses to consumer price sensitivity. If the excess capacity is eliminated from the market, so that fixed capital costs are spread over more patients, the market will be operating more efficiently, at a lower average cost per patient. In fact, in a

competitive market price-sensitive shoppers reward such improvements in efficiency. Other improvements in efficiency will also be rewarded in a price-sensitive market. For example, many providers differ in their intensity of care, with perhaps no appreciable difference in quality. The efficient, low-cost providers will be rewarded more and more often, and this may cause many providers to re-examine their styles of practice. Within a particular hospital this can create conflict, as physicians, who are responsible for the intensity of care, are usually not directly subject to financial constraints. I think this will be a healthy conflict, one that will eventually eliminate many unnecessary tests and treatments. Other methods of achieving economies of scale and other economies will also be rewarded in the marketplace. To the extent that there are economies of scale, there will be continued mergers and joint ventures. Let me point out that the magnitude of these economies is questionable, and conglomeration is therefore not inevitable.

What all these changes reflect is a process that occurs in all competitive markets: the search for the most efficient method of bringing the product to market. The benefits of this competition are quite clear: providers are driven to the lowest average cost possible, and price is driven towards marginal cost. In some cases this can take the health care market on a rather bizarre turn. Many hospital services are what economists call "natural monopolies." They involve high fixed costs and low marginal costs, so the average cost is continually falling as volume increases. From a cost standpoint, it makes the most sense to have only one provider per market area offering such services. If competition between providers rewards only the most efficient, in the end only one provider will survive. But then the survivor would have a monopoly on that service. The goal of preferred provider organizations is increased competition, and the result is that only one provider survives, and you end at exactly the opposite point that you started from. You get the perverse outcome of a monopoly provider with high prices, when what you were searching for was competitive pricing among many providers.

There may be some long-term implications of selective contracting that many people may find undesirable. It is probably incorrect to argue that most providers, be they hospitals, community health centers, or even physicians, are pure profit-maximizers. Most providers offer many

unprofitable services as well as charity care: many high-tech services, such as burn centers, lose money; teaching services lose money. Just like expensive capital equipment, these services are supported by high markups from charge-paying patients. This cross-subsidization is known as "cost-shifting." Cost-shifting persists because most charge-paying patients have not been price-sensitive, and the markups have been large enough to support the cost-shifting. This clearly will not be the case if selective contracting grows. Providers who have used these hidden subsidies to support unprofitable services are going to have to find new sources of income. This can include offering profitable health services that do not otherwise fulfill the provider's mission, and possibly even going into non-health-related ventures. We can expect even larger cost-shifts to groups that do not get involved in the PPOs; and if worse comes to worst, providers may have to dump their unprofitable cases on county hospitals.

These selective contracting effects are probably going to be selective. The hospitals with the most charitable care, such as inner city hospitals and hospitals that have a teaching function, are the ones that need most the markups to support these money-losing propositions. I do not believe that elimination of these subsidies in their present form is a bad thing, though some of you may differ. I think that those who support these subsidies, saying that we really ought to subsidize these money-losers, will have to come forward. Instead of having covert subsidization through cost-shifting, hospitals will have to seek overt financial support for what they think are justifiable causes. This is going to provoke a healthy debate, one which has in fact started here in Illinois, as many hospitals are complaining that the low prices of Medicaid are forcing them to push their non-insured population into the county hospitals. Some argue that this is going to create a two- or even three-tiered medical system. I counter that this is going to happen only if, as a result of public debate, the public decides that it wants this to be the case. And if that is the outcome, at least it is the one that the public debated openly.

Finally, I'd like to address the issue of quality of care. With the increased concern about the price of medical services, will quality be sacrificed? This will depend crucially upon the goals of the individual or group purchasing health care. By shopping around for low prices employers are not necessarily discounting quality and

amenities as desirable features. In fact, as I have said, doing so would greatly inhibit the success of the PPO, as enrollment would be diminished. This is the way it should be. After all, the winners in the competitive market are not the ones with the lowest prices; the winners are those who offer the best value at a reasonable price. If employees make their feelings about their preferences for quality and amenities known, employers will in fact seek out the best value, not just the best prices.

What worries me most about selective contracting, though, is the attitude that's been adopted by MediCal and may be adopted by Illinois Medicaid. The constituency here is not employees, not a group that can make its displeasure with the contract felt by not selecting the option or perhaps by organizing to protest the benefits package. Public aid recipients are a relatively powerless constituency. Moreover, the pressures on state public aid departments from state legislatures are purely financial pressures. In these cases one can easily envision price becoming the only important variable of choice. In fact, when asked about allegations that the MediCal bidding process had produced lower-quality care for the poor in California, the czar of the MediCal program responded, "I am not a licensing agency; I was hired to negotiate a rate." I think that this single-minded pursuit of low prices brings the market no closer to the spirit or to the benefits of competition than does the single-minded pursuit of high quality. It may be this price-above-all mentality that is the greatest cause for fear of the phenomenon called "selective contracting."

THE DEVELOPMENT OF THE STATE OF WISCONSIN HMO OPTIONS PROGRAM AND EXPERIENCE

RON ANDERSEN. Our second speaker is Tom Korpady, a graduate of the University of Wisconsin and director of health and disability benefits for the state of Wisconsin. Tom directs one of the most comprehensive and diverse state programs. The elements of selective contracting are an important component of his work. Tom, we're very pleased to have you.

THOMAS KORPADY. Several months ago, when I first spoke to Odin Anderson about this symposium, I gave little thought to the professional composition of the audience. A few weeks ago, Odin told me that a significant portion of the group would consist of senior hospital administrators. This fascinated me, since no segment of the health care delivery system has been more profoundly affected by the changes in the Wisconsin state employee health insurance plan than the hospitals. In August 1984, after the new state employee health insurance program had been in place for only eight months, one of the local hospitals put out a bulletin to its employees announcing the elimination of eight full-time positions. Additional staff cuts were to take place by January 1985. The reason given for these cuts was the hospital's "continued efforts to remain cost competitive in the Madison health care marketplace." The memo went on to say that in July of 1983, the hospital had an average length of stay of 5.3 days, but by July of 1984, the average length of stay had fallen to 4.4 days. Further, the projected number of in-patient days for the year had dropped by 4,500 days. These changes took place in the space of only one year. All three of the other Madison hospitals experienced amazingly similar census drops.

Our utilization statistics on state employees in the Madison area mirror these reports from the hospitals. It is estimated that the Wisconsin state employee health insurance program pays for one out of every four health care dollars expended in the Madison area. Of the approximately 350,000 people in the greater Madison metropolitan area, almost 80,000 are insured by the state employee plan. In 1983, for Madison-area state employees, the average length of stay was 5.4 days and there were 760 in-patient days per thousand in the covered population. In 1984, those figures had dropped to a 4.4 day average length of stay and 339 in-patient days per thousand. Our preliminary information for 1985 indicates that these levels are remaining fairly constant.

It should be obvious that changes of this magnitude represent not a mild aberration in hospital utilization, but rather a major shift in the patterns of practice of Madison's health care providers. As hospital administrators, I believe, you should have an intense interest in the dynamics of the changes behind this shift.

To understand what happened and why, it is probably necessary to have some background on our program. The state of Wisconsin, under authority granted to the state's Group Insurance Board, provides a health insurance plan for its 60,000 active and retired state employees. In addition, approximately 100,000 dependents are covered, giving a total insured population of about 160,000 people. The plan currently has an annual premium income of $96,000,000. Almost half of the group is in the Madison area, with the other half scattered throughout the state and, to a far lesser degree, the world. The plan was predominantly a Blue Cross-Blue Shield fee-for-service type of plan up until 1983. The state as an employer was statutorily and contractually required to pay 90 percent of the monthly premium for each enrolled employee.

Historically, premiums for the plan had risen 8-10 percent per year since the early 1970s despite our attempts at some of the more traditional health care cost-containment strategies. In 1982, premiums jumped 30 percent, and in 1983 they rose another 22 percent. Alarmed over these tremendous cost increases, then-governor Lee Sherman Dreyfus convened a blue-ribbon panel to discuss what would be done to reverse this trend. Our agency's part in this panel was primarily to advance an idea that we had been considering for several years, the concept of direct provider contracting. In December of 1982, the panel issued its findings. The foremost conclusion presented from the group was that the health care reimbursement system then predominantly in place did not provide meaningful incentives to hospitals and physicians for cost-containment. The group recommended shifting the economic risk from the state to the providers through a competition-based health program called "direct provider contracting." This could be accomplished, the report said, through encouraging the development and growth of HMOs, and changing the basis on which the state contribution toward the premium was determined.

In 1983, newly elected governor Anthony Earl focused on health care cost-containment as a major issue in his 1983-85

biennial budget bill (Senate Bill 83). Among the changes this bill sought were mandatory hospital rate-setting, restrictions on the certificate-of-need program for hospitals and nursing homes, limitations on medical school enrollment, and provisions relating to cost-containment for the state's Medicaid program. In addition, the bill contained several provisions that incorporated the suggestions from the blue-ribbon panel. In its final form, this legislation permitted us to put in place our direct provider contracting program. The final obstacle that remained was the collective bargaining agreement with the state's 25,000 unionized employees. Although initially opposed to the program, one union, the American Federation of State, County, and Municipal Employees (AFSCME), which represents over 22,000 of the state's active employees, came to accept the idea and eventually played a major role in the program's success.

Direct provider contracting is a comprehensive system of providing health insurance benefits to the state's employees. There are three major components to the system: the use of competing, prepaid, comprehensive health plans (HMOs); the competitive bidding system; and an equalized employer contribution towards the premium. Each of the components is a sound strategy in its own right, the use of which will produce some cost-containment. However, when all three strategies are combined, they complement and reinforce one another to produce a cost-containment system that is far more effective than the mere sum of its parts. I would like to review each of these components in detail, and then to try to pull them all together later.

The first component is the competing health plans, the HMOs. SB 83 enacted several changes to state law relating to health insurance plans. Of paramount importance was the removal of provisions that prohibited insurance plans from selectively contracting with a closed panel of health care providers. HMOs depend on their ability to allow access to only those providers that the plan has chosen. But the law in effect prior to SB 83 provided that any provider that wished to participate in a health plan must be allowed to do so--the open panel concept.

The revision of this statute created an environment in which HMOs could effectively and legally form and compete. After the effective date of the law, the number of HMOs in the state almost tripled, from eight in 1983 to over twenty-one in 1985. All of the new HMOs formed around existing provider groups, and for the most part they were not sponsored by

large, multi-state insurance companies. In the Madison area, where the state employee program has the most financial clout, it is particularly interesting to examine what happened.

Madison's health care delivery system is dominated by several large, multi-specialty clinics. These clinics have firmly established referral patterns to each of the four hospitals. The hospitals are critically dependent on these referral patterns. For instance, one hospital receives 90 percent of its total admissions from a single clinic group, and another hospital receives over 80 percent of its total admissions from a different clinic. This dependency fostered an intense need for the hospitals to be willing to bargain with the physician groups, because for the first time, the physicians were re-examining their long-standing referral patterns. Further, hospitals that, until then, had competed for physicians' business on the basis of the amenities they could offer, found themselves competing on the basis of price. To date, we have seen no major disruptions in the established patterns, but there are signs that these ties are beginning to erode.

The HMO movement in Madison has affected other provider interrelationships as well. Primary-care physicians have begun negotiating with their colleagues for secondary and specialty care. Because HMOs place so much emphasis on primary care and physician-controlled patient access, the primary-care specialties have attained a new preeminence in the health care delivery system. The outcome of these negotiations has been a significant shift on post-primary-care referrals.

We recently had an opportunity to witness a major breakdown in a long-established referral relationship that occurred as a direct result of the HMOs' competitive pressure. In Madison, most anesthesiology services had been provided by a single group of about twenty anesthesiologists. Because of its monopoly on these services, this group had steadfastly refused to negotiate either price or utilization review with the HMOs, despite the fact that all their colleagues in other specialties had been required to do so. One clinic administrator complained to me that the anesthesiologists had even warned of retaliatory boycott actions if one of the HMOs employed a nurse-anesthetist to administer a simple shot of pentothal for uncomplicated out-patient minor surgeries. He said that his clinic had done a good job in controlling its costs, but whenever anesthesia was needed, the clinic was "taking a beating." Finally, in a desperate move to solve

this problem, the clinic hired away eight of the group's anesthesiologists and made plans to hire twelve nurse-anesthetists. The age-old anesthesia monopoly had been broken virtually overnight.

On an even more individual level, we're also beginning to see changes in the physicians' individual practices. Earl Thayer, secretary of the Wisconsin State Medical Society, estimated last year that over 50 percent of the state's physicians belonged to HMOs. That percentage has increased in 1985. Mr. Thayer said that independent physicians are feeling the pinch of the clinics and the HMOs, and, as a result, feel they have to join an HMO or be run out of business. He reported last year that roughly a dozen physicians were facing bankruptcy or having to move out of the state, merely because they were unwilling to join an HMO or couldn't get into one.

It is also interesting to note the backlash that has developed as a result of the HMO growth. Many ancillary providers have been adversely affected and have banded together to seek legislative remedy. Last year, for instance, the optometrists, dentists, podiatrists, and pharmacists allied with one another to sponsor a bill that would mandate open panels in HMOs for those specialties. They orchestrated a massive letter-writing campaign to the legislature in support of their bill. In response, a group formed to oppose this effort. It comprised even stranger bedfellows: the Wisconsin State Medical Society, the Wisconsin Hospital Association, several large labor unions, the Wisconsin Association of Manufacturers and Commerce, several state government agencies, and the insurance industry. This loose and informal coalition took an active part in the ultimate defeat of the open-panel bill, and it has been steadfast in its support of the HMOs. It is particularly surprising to see the state medical society and the hospital association so supportive of the HMOs, since members of these two groups have suffered the greatest financial impact from the increased competitive pressure.

The HMOs, in the meantime, have prospered. Though most of the HMOs are less than two years old, almost all of them have met or exceeded their most optimistic enrollment projections, and most have shown operating gains in both of their first two years of existence.

As an administrator of a large benefit plan, one of my primary concerns is, of course, financial. HMOs in Madison have shown that they can be amazingly effective at controlling

health care costs. But we have seen other very positive signs that the HMO industry is changing other aspects of the health care delivery system. All of the HMOs have begun to emphasize preventive health care to their members. One plan provides financial incentives to complete stress-reduction or stop-smoking programs; others provide health club discounts to their members; and still others provide health screening. Some of the HMOs' cost-containment efforts have actually produced increased benefits for their members. For example, to combat inappropriate hospital emergency room utilization, many of the clinics now provide after-hours urgent care centers that make it easier for patients to get to physicians during the evenings and on weekends.

In retrospect, the HMOs have forced providers to become price-conscious, and responsive to consumer pressures. Traditional patterns of practice and referral ties are being re-examined, and the industry in general is being forced to look at itself to see if there are better ways of doing things.

The second major component of the direct provider contracting program is the competitive bidding system. For the state program, each HMO is required to submit a sealed premium rate quotation by September 1st for the following coverage year. These bids remain sealed until about September 7th, when the Group Insurance Board meets to establish the premium rate for the standard fee-for-service plan. After the standard plan's premium rate has been set, the bids are opened and accepted without further negotiation. This bid process is double-blind: the HMOs do not know what the standard plan rate will be, nor do they know what the competing HMOs will bid, and the Group insurance Board has no knowledge of the HMO rates when it sets the standard plan rate. At this point our procedure deviates from a traditional winner-take-all bid process, for the board accepts all HMOs that have submitted a bid. The reason we accept all bidders will become clear when I tie all three components of the direct provider contracting system together.

To be eligible to submit a bid, a health plan must meet certain guidelines that have been established by the Group Insurance Board. Each plan submits a proposal to the board that outlines its benefit structure, its financial stability, and its coverage and service areas. The plans must, at a minimum, substantially equal the benefit level of the standard fee-for-service plan. The standard plan has a very rich benefit structure, so we eliminate the situation where a

catastrophic type of plan is competing against a comprehensive plan. By doing this we have minimized the effects of adverse selection and we have isolated the factor that we hope will be the focal point of the competitive pressure, to wit, the efficient delivery of services. Further, plans are not allowed to target specific populations through benefit design. We have apparently been successful in preventing this, because when we conducted an age-sex analysis of the program in 1984, it revealed that our HMO enrollment is fairly representative of the state employee group as a whole.

In addition, we have taken steps to eliminate the possibility of unfair competition through intentional price-fixing. Our system has several small, independent HMOs competing against each other and against a few HMOs that are sponsored by very large insurance companies. It is obvious that if a large insurance company were to use its massive reserves to deflate its premium rates artificially for a couple of years, it would in all likelihood drive its smaller competitors out of business. Therefore, the board requires that each bid be accompanied by utilization statistics and rate-making information. This information is submitted to a consulting actuary for analysis after the bids have been opened. If a bid is not supported by the information, the board will accept the bid but consider it non-qualifying for the purposes of the employer contribution rate formula. The importance of this qualification will also become clearer after I have explained the whole system, but suffice it to say that the low-ball bid will have backfired on the company that submitted it.

The final major component of the direct provider contracting program is the equalized employer contribution to the premium. Prior to direct provider contracting, the state was required by law to pay 90 percent of the standard fee-for-service plan's monthly premium, or an equal amount to whichever HMO the employee chose. Employees then paid the remainder of the premium out-of-pocket. Now the state pays up to 105 percent of the lowest HMO premium within a county or 90 percent of the standard-plan premium, whichever is less, but not more than 100 percent of the premium of the plan selected. The employee pays the remainder of the premium, if any, out of pocket. This formula is used to determine the employer contribution rate in each county, and this set dollar amount does not vary by whatever plan is chosen.

An example will serve to illustrate this. In LaCrosse County there are two HMOs available in addition to the

standard plan. During the annual bid process, the standard plan's premium rate for single coverage was set at $79.12 per month. When the HMO bids were opened, one HMO, CompCare, submitted a bid of $76.41 per month, and the other HMO, Q-Care, submitted a bid of $62.46 per month. We now plug these rates into the statutory formula and compare them.

The lower HMO premium was from Q-Care, so 105 percent of its rate equals $65.58. Ninety percent of the standard plan equals $71.21. Now, 105 percent of the Q-care rate is lower than 90 percent of the standard plan's rate, so the state is obligated to pay up to $65.58 per month for whichever plan the employee chooses to join. If the employee chooses to enroll in Q-Care, the lowest-cost plan, the state pays the entire monthly premium of $62.46. If the employee chooses the CompCare plan the state pays $65.58 and the employee makes up the $10.83 per month difference out-of-pocket. And if the employee chooses the standard plan, the state again pays $65.58 per month and the employee must make up the difference of $13.54 per month out-of-pocket. The maximum contribution from the state for every single employee in LaCrosse County is $65.58 per month, regardless of the plan that is chosen. Additional savings accrue to the state for every employee that chooses Q-Care because its total premium of $62.46 is $3.21 per month less than the mandatory contribution rate of $65.58.

I should mention that this formula is somewhat complicated because it is a by-product of the collective bargaining process. In its purest theoretical form, the contribution rate should be 100 percent of its lowest-priced plan. But even so, the important concept here is that the amount contributed by the employer is the same no matter what plan the employee chooses. This component of the system really accomplishes two things. First, it places competitive pressure on the HMOs and makes the bidding process more meaningful. And, second, it places the employees in the position of examining their health insurance plan vis-a-vis their out-of-pocket costs. They must then make enrollment decisions during the annual open season that are based on rational economic considerations.

Both of these phenomena have been demonstrated during the first two years of the program. Prior to the change in the employer's contribution rate, there were a few HMOs that were available to state employees. The bidding process was almost identical to the current one, but without the final step of the employer contribution formula, the bids always seemed to cluster around 90 percent of the standard plan. It was a

classic case of premium-following. While the HMOs did not know exactly what the standard plan would cost, they became adept at guessing the amount. When we changed the contribution rate formula, the HMOs had to compete not only with the standard plan but also with each other. The disparity between the rates began to widen, and in some instances we saw HMOs submit bids that were actually lower than their bids of the preceding year. The premium-following which we saw in the past has disappeared.

Employees have also responded to the financial incentives of the new system. Prior to the program's inception, HMO penetration for active employees had hovered around 12-15 percent. After implementation in 1984, that figure soared to 65 percent. The HMOs with the lowest employee out-of-pocket premium costs gained the most new enrollees, while those with higher costs fared less well. In 1985, the out-of-pocket cost of the standard plan increased in comparison to the out-of-pocket cost of the HMOs, and as a result, we are now experiencing a 70 percent HMO penetration rate for active employees.

When one considers the importance of the contribution rate formula, it becomes clear why the board safeguards the system by requiring rate-making information with the premium bids. If this safeguard were not in place, a plan could submit an artificially low premium bid, thereby establishing a very low employer contribution rate and, given the price sensitivity that the state employee group has exhibited, driving the other plans out of business. With the qualification safeguard, however, the low-ball rate would be non-qualifying, and the second-lowest rate would be plugged into the formula. Thus the employees would have only a limited financial incentive to join the plan with the artificially low rate, but the plan would be stuck with that low rate for one year. To date we have not had to invoke this sanction, and we hope that the mere threat of its existence will deter any plan from attempting such unfair competitive practices.

Simply stated, direct provider contracting is a comprehensive system in which employees are given the choice, once each year, of enrolling in competing, pre-paid health benefit plans. The plans compete with each other and the standard fee-for-service plan on the basis of their premium rates and, to a lesser degree, their benefit structures. The premium rate of the lowest-cost plan is used to determine the employer's contribution rate, and employees who choose a plan

other than the lowest-priced one must make up the difference in premium out-of-pocket.

Because of the size of the state employee group, the direct provider contracting program has had a significant impact on Wisconsin's health care delivery system. And because of the success of the program, it is likely that there will be continued ramifications for Wisconsin's health care providers. It has been estimated that the program saved the state over $35,000,000 in expected health care expenditures over the last two years. The state had budgeted health care cost increases of 15-17 percent for those two years, and instead the actual increases were only 2-4 percent each year. These savings were not at the expense of the state employees, who, on the average, are paying approximately 25 percent less than they were two years ago when the program began. We did not alter the benefit structure of the standard plan at all, and the benefits of the HMOs in each case are better than the standard plan.

Employee satisfaction with the HMOs has been extremely high. The disenrollment rate from the HMOs has been only about 4 percent, and the number of complaints from employees has actually dropped to one-third of the level before the change. Nor have we seen a diminution in the quality of care from the HMOs. It was once popular to say that quality would suffer in an HMO, but this argument has become very shallow. On a subjective level, I argue that our employees seem, on the average, to be very satisfied with their HMOs. If the lower complaint rate is any indication, then they seem to feel that the quality is better. On an objective level, no one has produced proof that free-access, fee-for-service medicine is of higher quality than HMO medicine. There are no mortality studies, no comparisons of successful hospital discharge rates that have been calibrated for intensity of service, no group-specific morbidity comparisons; there is nothing that would prove that fee-for-service medicine is of higher quality. In the absence of this proof to the contrary, we have to conclude that our HMO enrollees are receiving health care of quality at least equal to what those in the standard plan get, and at lower cost.

There even appear to be some benefits from HMOs for those enrolled in the standard fee-for-service plan. Traditional theory has it that providers will shift costs onto the private-pay fee-for-service plans when they begin to feel the pinch of constraints from HMOs. So far, we have not seen this occur. In fact, the opposite has been true. From admittedly

premature utilization statistics from our standard plan, it appears that providers have embraced the more conservative patterns of practice of the HMOs and are not differentiating between their HMO and fee-for-service patients. This halo effect has resulted in lower average lengths of stay and fewer in-patient days per thousand in the standard plan, although the cutbacks have not been as dramatic as in the HMOs.

It must be fairly obvious that not every party is a winner under this system. While the state and its employees have enjoyed better benefits at lower costs, hospitals and physicians have borne the brunt of lower utilization and constraints on their income. The constraints on hospital income have been so pronounced that the assistant senate majority leader, John Norquist, has introduced an amendment to a current law to abolish the recently created Hospital Rate Setting Commission. The commission was established in the same legislation that permitted the enactment of the direct provider contracting program, but the commission was not to begin operation until July 1, 1985. Citing the success of the competitive program in holding down hospital rate increases, Senator Norquist convinced the legislature's joint finance committee that the new rate-setting commission not only was not needed, but could in fact prevent the HMOs from negotiating innovative contractual reimbursement agreements with the hospitals if it were allowed to operate as originally envisioned. Supporting this, the Wisconsin Hospital Association testified before a subcommittee of the joint finance committee that in its opinion, the new competition had done more to hold down hospital costs in the last two years than all the regulatory measures that preceded it. Should Senator Norquist's proposal pass the full legislature, the commission will become a health care cost-containment information-gathering agency with absolutely no regulatory authority over hospital rates.

Hospital administrators in Wisconsin are facing new challenges. Many hospitals have begun to sponsor their own HMOs, and the Rural Hospital Cooperative is operating an IPA-model HMO based on the participating rural hospitals and their admitting rural physicians. These hospitals have become active participants in the competitive health care market, not as a means to expand their census, but rather as a means to keep their current patient base from being eroded. Physician-hospital relationships are becoming more formally defined through selective contracting arrangements. More and more, the physicians are demanding that hospitals share financial risk and that they be willing to negotiate rate discounts or

flat per diem reimbursement.

For a research paper by the Center for Public Representation, a Madison public advocacy law firm, nine HMOs were surveyed about their contractual arrangements with their providers. This survey found that physician reimbursement methods varied from modified fee-for-service to salary, with capitation being the predominant method. All HMOs have some risk-sharing or bonus fund holdback arrangement. The hospital reimbursement arrangements also vary. Some HMOs receive discounts on the hospital's fee structure or flat per diem rates, others have arranged capitation payments, some use DRG reimbursement, and one HMO negotiated a flat fee per admission. As the HMOs become more aware of the financial clout they yield, I expect, the reimbursement arrangements will become more innovative. And as this happens, health care providers will feel increasing peer pressure to justify every expenditure.

In Wisconsin, health care delivery is finally beginning to operate as it should and is: a business. It is a business that must, like other businesses, become more sensitive to traditional market pressures. The successful administrators within the system have been able to adapt to the changes in their environment. To continue to be successful, they will have to remain willing to explore new reimbursement arrangements, and to be able to anticipate the needs of their consumers. In Wisconsin, we are not so naive as to expect that health care costs will diminish. An aging population, new technology, and a litigious society have probably eliminated that possibility. I think we can expect, however, health care providers to become more aware of the cost of their services and to deliver them in the most efficient manner.

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QUESTIONS AND ANSWERS FOLLOWING THE TALKS BY MESSRS. DRANOVE AND KORPADY

RON ANDERSEN. Thank you, Tom. We do have considerable time now for questions, so the floor is open.

QUESTION. I had a question about the HMO that is at the lowest end. Does the enrollee get the additional 5 percent in his paycheck?

THOMAS KORPADY. No, those savings accrue to the state. The 105 percent was negotiated by the union, presumably to protect its employees who didn't want to join the lowest-cost HMO; they would have a little bit extra to go towards the next HMO of their choice. But they never negotiated for, nor would we have negotiated to allow, the employees to receive it. The result is to drive up your health care costs because the three or four percent of the state employees currently without health insurance will join the lowest-cost HMO. That also encourages adverse selection, because those three or four presumably now are not using much health care and probably will not use the HMO health plan either. They have joined primarily to receive the five percent extra kickback. So the cost of that lowest HMO will continue to go down while the HMOs that are getting stuck with higher-utilization patients will be unable to compete. We don't want that to happen.

QUESTION. What percent of the medical community participates in the HMO?

THOMAS KORPADY. In Madison, 90 percent. Statewide that's significantly lower.

QUESTION. Do you think that the reason it's been so successful is that they've continued to see the same physician?

THOMAS KORPADY. Absolutely. In fact, in a study that was conducted it was determined that only about twenty or thirty percent of the people had to change a physician to join the HMO. I think that's one of the major reasons for the success and satisfaction with the HMOs.

QUESTION. Sounds as if it's been a total success, and there aren't too many flies, but there's always a fly. What would you have done differently if you were doing the whole thing over again?

THOMAS KORPADY. I would have negotiated a hundred percent of the lowest-priced plan, period, and that's it. But I guess right now we're not naive enough to think that there's not going to be something happening down the road. We haven't seen a flaw yet, and it doesn't mean it's not there; it just means it's too early in the program's history to find one, maybe.

QUESTION. I have two questions. One, how do you test the financial stability of the HMOs that have sprung up as a result of your program? And two, how do you get HMOs or employees to limit access to emergency care?

THOMAS KORPADY. Let me answer your second question first. We give the plans flexibility in their benefit structure. One of the perceived problems that the HMOs have seen is inappropriate emergency room utilization. So what we've seen are some very innovative ways of attacking that. For example, the HMOs will provide most services at 100 percent coverage, but if you use an emergency room it's going to cost you $50 out-of-pocket, unless that emergency room is followed within 24 hours by a hospital in-patient admission. The employee unions were concerned that there was going to be excessive limitations on hospital emergency room admissions. However, we haven't seen a problem; there haven't been a lot of complaints. I have a feeling that because the program is new and the HMOs are trying to be responsive to their consumers, they're being liberal with that particular provision; they're not denying charges.

Concerning the financial stability question, all the HMOs that we contract with are required to be regulated by the insurance commissioner's office. They have a very good history of financial review on HMOs, with one or two minor exceptions. In addition, we require financial information from them--prior to submitting their initial proposal and then on an annual basis--which is reviewed by our finance administrator.

QUESTION. If an HMO goes down the tubes, would you pick up the tab for what's left outstanding?

THOMAS KORPADY. Because of the way our program is set up, with the standard fee-for-service plan, it is self-insured with a third-party administrator. So if an HMO were to go belly-up, we could take all the people right then into the standard fee-for-service plan. That's a luxury that a lot of people may not have, but it is possible for Wisconsin,

since we run the show.

QUESTION. Have you had any flak to speak of about the patients' being limited to the doctors in the group for referral outside?

THOMAS KORPADY. The complaints that we've had on the HMOs--and they have been very limited, by the way--do seem to relate to that. When one explores some of those complaints, one finds that often they are provider-generated. In fact, at the insurance commissioner's office, providers are complaining that their traditional referral patterns have been broken.

QUESTION. At the beginning of your talk you gave us some pretty impressive figures on decreases in hospital utilization rates and lengths of stay. That represents an erosion of the charge-based or Blue Cross-Blue Shield or cost-plus-based market. I was wondering if you had any sense of what's happening to hospitals, particularly those that carry a load of indigent or Medicaid populations. Has there been a kind of thrust to get overt subsidization for those patients?

THOMAS KORPADY. I don't administer the program, but in Madison, Milwaukee, and one other spot in the state, the Medicaid population is in fact enrolled in a similar HMO experiment. It's not the same thing, but Madison has a very small Medicaid population; there are only about ten or twelve thousand recipients in the Madison area. And of those ten to twelve thousand I think nearly 95 percent of them are enrolled in an HMO and therefore have access to the system through an HMO. So it hasn't been a problem that way. The hospitals are very definitely scrambling; there's no question about it.

QUESTION. HMOs start with the physicians and then work through the physician groups and contract with the hospitals. My question is, can a PPO accomplish anything if it doesn't follow the same route? For example, in the state of Illinois, the PPO approach is definitely to contract with hospitals. Of course, there are fewer hospitals than there are physicians. It creates an interesting problem for the employee, who for an initial visit perceives no financial incentives to choose one physician over another one. He only learns about the financial incentive after he's developed a relationship with the physician, who says, "You need the following surgery." The patient responds, "Can you put me in Hospital X?" The physician says, "I'm sorry, I'm not on staff at any of the hospitals in your PPO." Might that sort of disincentive destroy the PPO, because most employees develop relationships

with the physicians which they will not give up if their physicians are not in the PPO.

DAVID DRANOVE. The success of the PPO arrangement will in part depend on the assortment of providers that can be contracted into the system. Let's consider the difference between a PPO and an HMO. In the HMO system in Wisconsin the enrollees will get the full dollar benefit for whichever plan they choose. If they opt into the plan with limited choice of provider they'll get the initial dollar reward. They will encounter a problem in Wisconsin similar to the problem you describe if the low-cost provider doesn't happen to be the provider that they would want to be contracting with. Whether it involves both physicians and hospitals, or hospitals alone (which is what Blue Cross is doing), in order to get your dollar savings you may be forced to change your provider. I'm not sure there is much of a difference between an HMO and a PPO. In order to provide the reward, you may have to limit the choice.

PPOs probably will have a problem in Illinois where the physicians are not being involved at all. At first glance it appears as if a patient is not constrained about whom his physician should be; it's only later that he realizes to get the dollar savings a choice is necessary. Hopefully, the enrollees will realize that before they sign up for the plan, they should ask their physicians, "Can I stay with you if I have this plan?"

THOMAS KORPADY. That is, in fact, what we're seeing. Most access to the health care delivery system is, of course, through the physician, and what we've found is that state employees were going to their primary care physicians and saying, "What plan are you going to be in?" Some enrollers considered price but most simply selected the plan in which their current physicians participated.

QUESTION. Why did the state not consider PPOs?

THOMAS KORPADY. Because frankly the state does not think they're going to work. PPOs, by their very nature, have to be open-panel. You cannot place accountability on the plan or on the physician in a fee-for-service arrangement in an open-panel arrangement that you can through HMOs in a closed-panel system. So basically that's why we went only to HMOs.

DAVID DRANOVE. If I could speak perhaps in rebuttal, the fact that we don't have a hundred percent enrollment in HMOs in areas in which they're available suggests that there are some people in the marketplace who either are not being offered the financial incentives to join, which may be true, or don't like the HMO arrangement, for whatever reason. They may feel that capitation payments will translate into diminished quality or diminished access or diminished accountability of the individual physician. Rightly or wrongly these are perceptions in the market. So the PPO represents an opportunity to obtain, at lower prices, the traditional type of medical care service. I think it's just going to be a matter of seeing what the market will support in the long run. As a Chicago economist, I don't approve of denying anyone the option of any type of health plan that can be offered in the marketplace.

QUESTION. I have a question regarding the future quality of the service delivered by HMOs. More HMOs are going into the for-profit sector, with Wall Street financing and expectations of a 30 percent return on investment. In order to retain that capital return the providers are going to have to reduce cost in order to return profits, or the people who advanced the money will withdraw their investments as profits come down. My question is, what do you see in the long run? We're seeing decreasing numbers and ratios of providers to subscribers and decreasing numbers of ancillary service personnel. I see quality suffering as pressures increase to maintain profits.

THOMAS KORPADY. First of all, in Madison we're probably a lot more provincial than you are here in Chicago. Maybe we don't have as intense a profit motive as you do here. We're not seeing the problem yet. In our system the providers are quite similar with respect to price and quality. If you look at a marketplace, generally there are going to be prevailing rates for health care reimbursement in that area that every plan has to deal with. Also the employees have and make use of the opportunity once each year to switch plans. If quality does suffer too much the employees will recognize that and switch to another plan.

We have a very active employee union. They took an active role in making the system go. They are watching the HMOs very closely. We used to meet with them just about every other week to try to field any complaints that were coming in. In the beginning, people were dissatisfied because they couldn't get the referral they wanted; they weren't going to

the right place. Now we don't meet with them at all because they're not receiving that many complaints. Admittedly, it's very tough to do. It's tough to define quality. But if a plan does really start to suffer, I think that people will know it and move away.

QUESTION. How many people are involved and what's the budget for coordinating this process?

THOMAS KORPADY. Our department has about 150 people, but we administer retirement funds, and life insurance programs, and disability programs as well. Only two are directly involved in this program. Obviously there are other people involved in an administrative capacity in different areas--collecting premiums, doing accounting and auditing.

COMMENT. I would say that's very efficient, and your observation about the profit motive in Wisconsin is appropriate.

QUESTION. I'm curious about the price sensitivity of these plans. For the Madison example that you gave us, what proportion of your employees choose each plan; particularly once they chose the HMO option, what proportion went into the zero cost option?

THOMAS KORPADY. The split right now is very equal. Two groups have around 120 physicians each. Another clinic group that formed an HMO on its own was a little bit smaller to begin with--about 60 physicians. The latter one has fewer patients. In Madison we have 90 percent of the state employees enrolled in an HMO. Statewide, even including some areas where there is no HMO available, the figure is 70 percent. In Madison HMOs are very popular. Almost all the physicians are members. The disenrollment rate in Madison is somewhere around 4-6 percent.

QUESTION. What I'm trying to determine is what advantage the plan has for being the low-cost bidder.

THOMAS KORPADY. There was a very interesting true-life experiment this last year. One plan decided to add a dental benefit and raised its cost; it had been the low-priced plan. The other plan considered adding dental benefits but decided to hold down their price. When the bids came out the one that had decided not to add the dental benefit was now the lowest-priced plan; the one that had been the lowest-priced plan and added the dental benefit now started costing more money. The

clear-cut winner was the plan that kept the price lower. They got about 800 new enrollees; the plan that added dental got about 600 new enrollees.

DAVID DRANOVE. The 5 percent differential should have wiped out most of the cost differential.

THOMAS KORPADY. It wiped out a portion of it.

DAVID DRANOVE. It was a relatively small price increase for the dental plan, and they didn't go for it.

THOMAS KORPADY. That's right: about eight dollars a month, I guess, out-of-pocket.

COMMENTS. I have two comments. One is on the ratcheting down issue. Maybe our next year's symposium topic ought to be to have Wennberg come here and talk about regional practice variation. When I lived in Chicago, I worried a lot about the ratcheting factor and what would happen. Now I live in Washington state where the Medicare days per thousand are 17 percent below the national mean. Washington has a very different style of medical practice but the people live just as long, maybe even longer. So I think that there are different styles of practice that must be taken into account when we consider market changes.

The second thing that makes the critical difference is the act of competitive bidding. That brings to mind the story of the Rutgers University health plan. The Rutgers health plan went out for bids on open heart surgery, basically all-inclusive--doctor, hospital, etc. Their local bids, from the Philadelphia and New Jersey area, were all $19,000 plus or minus 5,000. The low bid from Houston was $7,700, including two first-class round-trip air fares to Houston. . . . That makes a big difference.

QUESTION. Over time, as the price differentials tend to become eliminated, are you going to see PPOs and HMOs start competing for enrollees on non-price conventions, re-starting the cycle of cost increases?

DAVID DRANOVE. Well, I'm not sure it's going to re-start the cycle. I hope that the arrangements for choosing these plans will continue to be what they are in Wisconsin, exposing the enrollees right at the beginning to the full price of their decision, so that all factors will be treated equally. I think HMOs and PPOs will continue to offer two very

different views of the way to deliver medical care: is it open-ended fee-for-service, or capitation? That's always going to be the prime method of competition. I should add that capitation allows you to do things that you couldn't do, with fee-for-service. You can offer certain services that are prone to moral hazard, such as eyeglass prescriptions. People consume more of these with open-ended payments. So capitation will give HMOs certain advantages in the marketplace. It remains to be seen whether the discount prices by themselves will be enough to keep fee-for-service medicine alive.

QUESTION. David, you mentioned that the two-tier medical class system is going to be prevented by some degree of public outcry. One of the problems we've been experiencing is that with the recent IDPA HMO in the state of Illinois, there's been a remarkable lack of patient education. People who are enrolling don't quite understand what the restrictions are. They still appear at our doorstep, although we're not a participant, wanting the same services. We have to spend a great deal of time educating them about what they really signed up for. The question that I have is, with the continuing conservative trend in the country, when is this outcry going to happen, and can we survive waiting that long until it does?

DAVID DRANOVE. I didn't say it would. If you characterize the conservative trend as meaning people get what they deserve, and those who are poor get what they deserve for being poor--if that's what turns out to be the view of the majority of this population--that's a sad way to go. As far as what's happening at individual hospitals, I'm curious about the media treatment of this in Illinois. If you read the newspapers in California, when big hospitals lost contracts or even just during the whole bidding, the newspapers were plastered with "UCSF to lose N million dollars because of bidding or Zion Hospital to lose 40 percent of patients because of bidding process." There was a tremendous outcry that this bidding process was going to cause great disruptions, and it provoked the type of public discussion that was necessary to see whether this was the thing we should have. The recipients could at least read the papers and find out what was happening to them. I don't think people know what's going on here. If it's really going to hurt, the people it's hurting are going to have to come out screaming and hollering.

QUESTION. Is there any evidence to show that the sicker patients have remained in the fee-for-service plan in

Wisconsin? And is there evidence at all that the premium contribution limits in the system result in a cost-shift to those sicker patients?

THOMAS KORPADY. We don't have data that are that finite to trace where people have gone and what their history has been. There was preliminary information in a survey that was conducted on about a thousand people in the state program. There was a tendencey for self identified sicker people to stay in the standard plan. That survey probably is not accurate for Madison, because in Madison the people who are in the Madison area can continue to see their own physician and join one of the health plans; it's over 90 percent in the Madison area. I don't think that there has been a cost-shift to sicker people; absolutely not. We go on a county-by-county basis. I didn't bring that out too much in the paper, but it helps the employees who are not in an area like Madison where the competition has kept the price down. You could have one employee in one county receiving a higher reimbursement from the state than one in the next county, and this compensates for higher prices. As Dave said before, there are going to be people who are never going to want to go into an HMO. We recognize that, and we will continue to run a standard plan for those people. Fortunately those people are predominantly in rural areas, where health care is usually less expensive. Consequently, the cost of the standard plan has not been skyrocketing either.

COMMENT. As a resident now of Madison, I've sat in on the Wisconsin department of health insurance. I'd like to say that the state has done a commendable job in my estimation of informing the employees of the state and the University of Wisconsin what their options were and spelled them out, and all you had to do was read. At the university club at lunchtime one of the professors was complaining about all the stuff he was getting. I said, "Well, do you believe in sovereignty? You're supposed to know." He'd like to have it simpler.

RONALD ANDERSEN. Thanks to David and to Tom for very orderly and stimulating presentations.

THE PPO: ONE SOLUTION TO A MULTIFACETED PROBLEM

RON ANDERSEN. Our next speaker is Tobie Miller. She has a background in the provision of care, as well as an M.S. in Health Administration from the University of Colorado. She's executive director of Mountain Medical Affiliates, a preferred provider organization associated with Presbyterian-St. Luke's Medical Center in Denver. The symposium planning committee looked for a PPO with a track record to share experiences with us. Apparently, there aren't too many around. Mountain Medical is one. Tobie has had a lot to do with establishing that record. We're pleased to have her here today.

TOBIE MILLER. Thank you so much. I'm really pleased that you asked me to speak with you today. I'm glad to be back home. I was born and raised in Rockford, Illinois, and went to the University of Illinois, and worked here in Chicago for five years until I moved to Denver in '70, and it's nice to come back home. I find from past experience that if I follow an economist I have nothing to say. So I surely hope that I don't bore you. I think that unfortunately, or fortunately in some cases, health care is becoming an issue of economics, and so I'll have to cover, very briefly, a few things to make a point.

We became operational October 1, 1980; I came on board in May of '80 to develop this organization. It's been a difficult but very exciting challenge over the last five years to be in a highly competitive market. The competition is much stiffer today than it was in 1979 and 1980. Just to make a point, we've really changed over the last forty years. We had it pretty well as providers of health care in the 'forties and the 'fifties when it was a seller's market. We didn't have to do much to get consumers to use our facilities; they were there, because of all the economic expansion due to the Hill-Burton Act. I'm not going to go into this, because I want to spend more time on the specific Denver experience. But it continued to be a seller's market in the 'sixties and in the early 'seventies, and I think that insurance has probably done a lot to give consumers of health care the feeling that health care was a right, as opposed to a privilege, and that it was free. As a result, there was use, and possibly overutilization, of health care--not that the providers haven't also contributed to that overutilization.

But into the 'eighties we've really seen a change. Now we are experiencing a buyer's market, and all of a sudden we have some very astute purchasers of health care who are

looking at their unbelievably skyrocketing health care costs. They've seen the excessive utilization that has occurred, whether it has been promoted by physicians, by hospitals, or by patients. We're all at fault, but now we're paying the price, and trying to figure out a way to resolve the situation so that we can establish a mutually beneficial system again.

Obviously, if it becomes a buyer's market, then it means that those buyers have a lot of power when they go to look for a health care product that will meet their needs. And we have tried over the last five years to develop a product to meet the demands of that marketplace. There are twenty-two hospitals in Denver, many of which are actually running at an occupancy rate now of approximately 60 percent (67 percent in 1980). There's a major, 400-bed hospital, managed by a Catholic system, that has a 37 percent occupancy rate today. And it so happens that we are in the process of bidding for a major employer group that has a contract with this particular hospital right now. If we get that contract, I think this hospital is going to go out of business, because it's $3,100,000 in hospital costs alone that we'll be taking away from them. They won't be able to survive. They're downtown, where there's a proliferation of hospitals in Denver.

There are so many physicians in Denver that there are some who are hungry. Kaiser is a successful system because physicians are guaranteed a salary, and that means a lot to them, because there are some doctors who are wondering what they're going to do, spending a whole day in an office with only a couple of patients coming in to see them. It's amazing what's going on in that city--mass chaos, mass paranoia, and fear. And I don't think I'm exaggerating.

There are ten PPOs in Denver, six operational ones. We're the biggest, we're the oldest and, I would love to say, the best; we try hard, and I think we try hardest, really to be what our employers want us to be, and that's a lot of hard work. But there are four PPOs in the developmental phase. The directory that I get every six months says that there are now 150 or 250 PPOs in the country. But I think there are probably about 10 percent of those that are really operational PPOs. They [the others] have set up a system to deliver health care, but they don't have any patients.

But we also have five HMOs in the city. Kaiser has 168,000 enrollees out of a population of 1,600,000 in metropolitan Denver. Kaiser is an extremely well managed system. It's doing very well. Kaiser is building its first

hospital, in the most rapidly growing section of Denver. It should be complete by 1988. Kaiser also just bought a plot of land on the west side of Denver near Lutheran Hospital, which is an excellent hospital, the "fattest" in Denver, with an 85 percent or 95 percent occupancy rate. And Kaiser has now bought a plot of land right next to Lutheran and is planning on building another hospital on the west side of the city in five years. That's going to make a major impact on the two major hospital systems on the west side of Denver.

Comprecare almost went bankrupt in 1980. Six hundred physicians out of the eight hundred who formed the IPA-model HMO left Comprecare and took most of Comprecare's debt with them. So they ate all of their losses. But the two hundred physicians that stayed with Comprecare now are happy to have made that decision, and Comprecare is a successful HMO now. It has just developed its for-profit management corporation. Comprecare is now apparently in the black, where it was in debt five years ago, and is building constantly, doing well; it is probably a major HMO force in the city. And it's a good system also.

HMO Colorado is the Blues' HMO: it has seen very slow growth, not as rapid as that of other HMOs. The Blues have basically adopted a group practice model to serve their HMO population in Denver, and Denver is not a city of large group practices. There is the Littleton Clinic, and there is the Denver Clinic, both multi-specialty clinics of fifty or sixty physicians practicing. The majority of Denver's group practices are small, single-specialty physician groups, with four or five physicians. There are a few solo practitioners, but not very many any more, because they can't afford to maintain practices alone.

Healthcare United has floundered for six years. It used to be Arapahoe Health Plan, changed its name to Healthcare South but couldn't make it, then changed to Healthcare United and expanded its service area. Healthcare went out and persuaded the county medical societies to develop IPAs to contract with it. This HMO should be a source of competition for us but just hasn't been able to do it.

Peak Health Plan is a for-profit corporation, started by Steve Hyde, the president, in Colorado Springs, Colorado, about four years ago, and he's a multimillionaire today. Peak has expanded to include Fort Collins, Colorado, Pueblo, and Denver, and is franchised; it went public about a year ago and is going into Ohio and Florida and doing very well: a for-

profit, group-practice, primary-care-based HMO product.

Lots of PPO products from an insurance standpoint are now being developed. Great West Life has its Stem program; it contracted with three hospitals in Denver, geographically dispersed, to provide a fully insured PPO product. Metropolitan is starting its Met-elect program; we will be a provider for Met-elect, for clients of theirs through a PPO mechanism. AMI, if you have read the papers recently, is acquiring our medical center. AMI is in the process of consummating the sale, $178,000,000, of Presbyterian-St. Luke's Medical Center, and I will be heavily involved in Amicare. It will be a fully insured PPO product. The VHA system, as someone mentioned earlier, also is developing a national PPO network. VHA just publicly announced that it has contracted with Aetna to develop a national network of PPOs around the country. Humana Care Plus has moved into Denver. I question how viable it will be; there are two Humana hospitals in Denver. (Humana was the first investor-owned to enter the market.) HCA, at the end of May 1985, is going to be contracting for management services of Rose Medical Center, which is a highly respected, quality-oriented health care medical center. And now with AMI in the city, the investor-owneds have moved in.

Adolf Coors' company, with 9,000 employees in the city of Denver, is one of the city's largest employers. We don't have a lot of large employers; we have a lot of small employer groups. Coors went out and decided it was going to develop its own EPO (exclusive provider organization). It was going to take the lead--and talk about purchasing power! This company is extremely impressive. I may not totally agree with all of its theories about hiring and salaries, but it is a progressive, astute, informed employer group. Coors has its own utilization review (UR) process, its own UR coordinators who go into every single hospital where its employees are hospitalized and review their records. The company has a beautiful, multi-million-dollar fitness center. It's developed very exciting, creative benefit plans for its employees. Coors has really, I think--more than any other employer that I've heard about, outside of maybe John Deere and Hewlett-Packard and a couple of others nationally--taken the lead in looking at health care, in reducing health care costs, in finding ways to develop a partnership with providers. We hope to develop some kind of partnership with Coors.

Our PPO has been seeing patients for almost five years.

We now have 525 participating providers. We started out with about 175 physicians who joined MMA by coercion. We capitalized on their paranoia. They were so fearful of breaking their referral patterns with other providers that they joined. Comprecare at that point was going broke. They [physicians] were losing money; they were seeing a decline in their patients; there were just so many empty beds, and they thought, "another delivery system that we know nothing about!"

Outside of anesthesiologists, we haven't actively recruited any more of those 350 or more who have joined since 1980. They have voluntarily applied for membership. Of the 525 physicians, 97 percent or 98 percent are M.D.s. Two or three percent are D.O.s; we have a few podiatrists; and we have a few allied health professionals. Our first Ph.D. psychologist joined two months ago. It took a long time before the credentialing committee (composed of a couple of psychiatrists) allowed the psychologists to become members of the allied health professional staff at Pres.-St. Luke's. We have two nurse-midwives. And we've had applications by M.S.W.s. It doesn't hurt to have providers of health care that don't have the M.D. letters behind their name; I think they can still be qualified as efficient, cost-effective practitioners.

We have forty-one specialties represented; we really do have a full-service component. I think that's one reason why we've been as successful as we have. I don't think that one-hospital systems, that don't provide all levels of care, should even get into the PPO business, unless it's going to be part of a network; "network" is the big term that we talk about today. We have three hospitals, one out east, two downtown; one probably will be closed in the next three years. We are planning on building a hospital in southeast Denver, if we can ever get a Certificate-of-Need to do it. AMI, with its ability to capitalize, I think, will be able to do it. We've developed all kinds of alternative health programs, again in response to employer demand. We really do have full-service facilities, outside of pediatrics, where we are weak, and transplants, which we don't do. But outside of that we just about do everything, so that an employer doesn't have to go shopping around and to worry about tons of contracts for services and facilities that may be needed in a full-service system.

A year ago we restructured our organization. We used to be a not-for-profit organization. We've always been MMA, but the old MMA was literally legally dissolved July 10, 1984.

The new MMA is now the "supercorp", or the administrative entity, for the PPO. And MMP is the physicians' membership corporation, a stockholding corporation. M.D.s and D.O.s are allowed to buy one share of stock, or if they so choose they can be member-providers only, for an annual membership fee. Two-thirds of our physicians are stockholders; one-third are not. Presbyterian-St. Luke's Health Care Corporation is the partner in joint ownership of MMA.

The old MMA had a board of directors of thirteen physicians. The new MMA has a board of directors of five: two physicians, two hospital administrators, and one community business leader. Obviously, one of the reasons we restructured was legal. We did not, because of the amount of visibility that we have received over the last few years, want to create cause for any kind of anti-trust action. But the way we were structured two or three years ago, with a physician board of thirteen negotiating fees with employers directly, could have been construed as price-fixing. We decided, for two reasons--the legal one and for flexibility in developing new joint ventures and new kinds of products--that we'd be able to achieve our goals as a for-profit corporation. We still don't make any money. The revenues go directly to the physicians and to the hospitals.

The contractual arrangement is simple. Simplicity is the key, I believe, to making a PPO successful. But, as Max Fine has said over the past few years, "If you've seen one PPO, you've seen one PPO." So I like to think of our PPO as a pure PPO, but we all know that other types and varieties are in operation. The concept is really very simple. There's a group of hospitals and there's a group of physicians. We are a provider-based [PPO], and when I say "provider-based" I mean both hospitals and physicians are a part of the PPO, and we go out and contract directly with self-insured trusts or with employer groups or with TPAs (third-party administrators) or with insurance companies.

We're probably now a third-generation PPO, in the sense that our clients, our customers, are changing. We used to have all union, self-insured trust funds. That was the beginning of the PPO movement. Then we moved into self-insured private employers. Then we moved into commercially insured employer groups. Now we have contracts with fully insured, multiple-employer trusts, to serve the small employers. So it's evolving constantly. We're developing lots of relationships; the commercial carriers are knocking on our door daily. They're afraid that they are losing health

care business. And they think, I believe, that they need to develop a partnership with providers so that they can have greater control and maintain, retain, and have access to new markets for health care. But it really is a very simple relationship. And it doesn't necessarily mean that there are going to be two contracts; there may be only a hospital contract; there may be only a physician contract; and there may be both.

We never contract for claim administration; the employer does. We do not do our own claim administration. We may eventually; I would have liked to, really, a couple of years ago, because it provides control of data and access to data that our TPAs, eleven of whom we do business with, have not been that cooperative in sharing. So we've had to develop our own data-base.

I think that one of the unique features is the "dual-option" plan. It means consumer choice, and that's where there's really a difference between an HMO and a PPO. Consumers want to feel as though they have choice. In the case of the PPO dual option, the patient always can go in and out of the system at any one time. In the morning I can go to my OB; in the afternoon I can go to an allergist who's not in the system, or vice versa. I am never locked in. Consumers love that. They must realize, however, that there are financial differentials or incentives. If employers are creative enough to develop good benefit designs, their plans will have a sufficient differential to encourage patients to use the PPO, but will also allow them to go to a provider of their choice, whether that means hospital or physician. It really does help to create good incentives; but they have to be good enough that the providers will benefit, or there's no reason in contracting.

There are some internal changes. Price competition was the major reason we entered the market, and it was our key factor in marketing, because employers perceived price discounts as an immediate saving to their health care costs. There were physician discounts; there were hospital discounts. But this is only a short-range solution to a long-range problem. It reduced medical pricing (which has stayed down), and there still has to be some kind of element of price competition, I believe, in the entire health care delivery system, whether it's HMOs or PPOs. There has to be some price sensitivity.

But I think that risk-sharing also is essential. Now,

you and I might define "risk-sharing" a little differently. It isn't necessarily risk by physicians, in the sense of pools, capitation, et cetera. A physician risks patients and we risk contracts if we aren't providing cost-effective, high-quality health care. But the element of risk-sharing needs to be there in order for us to survive. Surgeons have been on DRGs for years. That's not really anything new for them. But they are perceiving risk, in the form of discounts, and future prospective payments. Purchasers are seeing the risk in the level of premiums they're paying. The risk is being shifted to patients in the form of increased deductibles and co-insurance. With some type of risk-sharing, we will reduce medical costs as a whole, and that is our goal. That's where employers use the term "cost-containment" so widely now.

There's only one way we can do it, and that's by having access to information. I need information to make management decisions; I also need information to do utilization and peer review. This is an essential ingredient for success and viability of the PPO. You know, there are PPOs in Denver who aren't doing UR. As far as I am concerned, they should not even be there, and even though employers are much more astute today than they were two or three years ago, they still don't really know what high-quality medicine is. I don't think lay people know how to measure quality. If the doctor is good to the patient, the patient perceives that doctor as being a really good doc. I don't think that the consumer is that aware yet. The purchaser is much more aware than the consumer. I think that it is our obligation and responsibility, because we know what quality of care is; we've been spending years trying to measure quality of care. It's very difficult. But we as providers have an obligation to provide high-quality care to consumers, because we know what it is; they don't.

I'm lucky to have a very dedicated group of quality-oriented physicians. Over a period of five years, we have developed a UR process that has terminated physicians from our organization, put them on probation, educated them, performed behavior modification, and had a tremendous sentinel effect in how they deliver health care. They have changed their practices. I'm not saying that these physicians were poor-quality practitioners. Some of them were just trained in medical school to practice expensive, excessive medicine. And they're paying such huge malpractice insurance premiums that they're not going to take a chance, so they overutilize--as a matter of tradition, not because they really want to.

About five percent of those doctors care a little more about putting some money into their pockets than they do about producing high-quality care. That's where the discount phenomenon comes in. Doctors know how to do creative billing and creative coding. They will bring back a patient for a pharyngitis checkup instead of calling him on the phone to find out how he's doing, if the doctor is only receiving fifteen bucks for the visit instead of thirty. So a doctor can make up for it by excessive utilization.

We develop a profile on every single one of our physicians. We do that on in-patient and out-patient services: every single service that a physician provides must be documented on a claim form and sent to our office before the physician gets paid. That claim form is our source document, and all of that information is entered into our automated data-base. We've only been automated for a year and a half, I hate to say; I still am using fragmented computer systems in the hospital system. We're just purchasing our own PPO system. Though I like to think that we are a little more advanced than most of the PPOs in the country, we're still struggling with trying to get good data. It's amazing what you can do with data. We are looking at the quality of care, how the physician provides care or the efficiency of service; and when we have to, we determine if it's inappropriate or extravagant. We establish those utilization controls and intervention methods to complement the total UR process.

The process is simple, but it's time-consuming. We do individual claim case adjudication, when requested by all of our third-party administrators. We encourage them. We get an administrative service fee for doing UR for each of our contracts. We also pull claims at will in our office if we are suspicious of any particular physician. We do practice pattern analyses, as I said, both in-patient and out-patient, both concurrent and retrospective. It's amazing what you can see on out-patient review. People have accused us of nickel-and-dimeing the system to death, but I don't believe we are at all, because I think that physicians who practice and who depend on their revenues through office practice are going to develop the same kinds of habits we'll see in their hospital practices. So I think that we can eliminate some problems in hospitals if we can treat those problems on an out-patient basis.

I depend heavily on my staff to do UR, but my staff members work closely with the UR physicians. Those physicians have to be carefully selected: respected, influential

doctors, who are willing to risk their practices every time they make a decision and review one of their peers. But it does work. And as I mentioned before, we take action in the form of education and behavior modification and, if we have to, in the form of probation and termination or non-renewal. There are twelve physicians currently who will not be renewed come July. I thought that it was easier to get them out than to keep them out, but I'm beginning to change my mind. We now have a credentials committee that reviews the applications and looks very carefully at physicians' qualifications. We just turned down two physicians recently for membership, but we always have to be thinking about the legal ramifications every time we take action with a physician, keeping one out or removing one from the organization.

But, with all the action that we have taken, we've seen some good results. We have seen a decrease in excessive utilization. We've seen an amazing increase in out-patient procedures over in-patient procedures. We have surgery that must be done on an ambulatory basis. We've really seen an increase in quality of care, and a decrease in costs; we are saving our employers 18-20 percent of the previous year's costs.

The whole idea is that with the changes in utilization and peer review, there also has been a change in the way physicians practice medicine. Physicians are being scrutinized carefully.

We now have twenty-eight employer contracts. We started out with (I believe) ten, in 1980. We're serving 65,000 employees plus their dependents. We have a potential patient base of about 150,000 people in Denver. We share those contracts with anywhere from two to four PPOs in the city, but because we're the largest, we're seeing the majority of the PPO claims. We're getting 30-75 percent of all the PPO claims in the city, though that varies by contract: it depends on location, on the length of the contract, and on how long we've been involved with the employer.

From forty to eighty percent of any one group's employees are now utilizing the preferred option. Remember that dual option plan? There are the preferred option and the alternative option. It's only one plan, but it has two options or components. That's why we talk about the patient's never being locked in. If a woman has the PPO option available to her and her OB is not part of that plan, she can go to her own OB, but she'll pay a greater co-payment and

greater deductible and co-insurance amounts for the privilege of doing that. Only if we do our own claim administration or if the TPAs are a little nicer about sharing their data, however, will we have all the data on all services used, preferred and non-preferred.

In 1984 we were a $7,000,000 business. We contributed $4,100,000 in revenue to our three hospitals, and $2,850,000 in revenue to our physicians. You have to remember that that $4,100,000 represents sick people, and we're trying to keep as many people out of the hospital as possible, and to do more out-patient care. In fact, we've seen a decrease in our length of stay from 6.5 to 5.4 days, just a little over a day. It varies by hospital; this is the average over all three hospitals, so it's a bit deceiving, because we have an average length of stay of 3.3 or 3.4 days at Presbyterian Aurora Hospital, the smallest of our three hospitals.

I believe that we have to think about service as an essential component, in addition to the quality of the product that we provide. That's why we've maintained provider loyalty, employer satisfaction, and patient allegiance.

We've talked about the future. I think that networking is the key. People are going to have to establish greater geographic dispersion and distribution of providers in order to meet the needs of the marketplace. We haven't been able to touch Martin-Marietta, or Johns-Manville, two of the largest employers in the city of Denver, because they're located far away from our hospitals. There are going to be new health care alternatives that we don't even know about today. We're going to see increased purchasing power and even more creative benefit design. I'm hoping, though, that we can maintain the sense of competition in the city, because I think it will promote quality of care.

And last, John Naisbitt in Megatrends stated that trends, like horses, are easier to ride in the direction they are going. We've probably changed the saddle now about four times. This particular rider hasn't changed yet, but we're going to try to stay on that horse and go in the direction it's going, even though there are some Doubting Thomases out there who have said all along that PPOs will never make it. I still believe that PPOs and HMOs will be viable sources of competitive health care in the future.

QUESTION. Why don't you offer pediatrics? Why couldn't you recruit pediatricians?

TOBIE MILLER. The reason we couldn't recruit pediatricians is that we don't have pediatric facilities in two of our three hospitals. But the board passed a decision last month to allow recruitment of Children's Hospital physicians even though they do not have membership privileges at Pres.-St. Luke's. A major criterion for membership for physicians has been that they be on the medical staff. A lot of Children's Hospital physicians aren't. But we will be recruiting Children's Hospital physicians even though they don't have privileges. So we will be getting a lot more pediatricians soon.

QUESTION. Primary care physicians say that surgeons' fees are too high, and vice versa. How do you establish the discount in non-specialties?

TOBIE MILLER. We are revising our own relative value study this year to reflect that, and major changes are being made to promote the equity that is deserved between primary care and cognitive services, and surgical services.

QUESTION. What's the minimum amount of differential necessary to provide a financial incentive to use the program?

TOBIE MILLER. Well, if it's not done in the deductible, I think you need to have a 20 percent co-insurance differential; but if you go from a $100 to a $500 deductible, that $500 deductible will be enough of an incentive. You have to balance. If you have 90 percent-10 percent and 80 percent-20 percent, forget it, with a $100 or $200 deductible. That really isn't enough. But if you get to 90 percent-10 percent and 60 percent-40 percent, or a $500 deductible and a great enough co-insurance differential, you'll see major changes in consumer choice.

QUESTION. You gave the length of stay. What are your days per thousand?

TOBIE MILLER. If you know anything about PPOs, PPOs don't have that figure, because the employee, the patient, is never locked into the system and goes in and out. You never have a stable denominator to get that figure. What is your "thousand"?

COMMENT. Well, you could combine a thousand people, days when they're in the PPO and when they're out of the PPO.

TOBIE MILLER. No one that I know has ever been able to develop that figure, just because I can go back and forth at any time: I can use the system now and never use it again. Should I be included in the thousand? It's an inaccurate statistic. I wish I could develop a good one. But we can't; that's the unique nature of a PPO.

QUESTION. Wouldn't a social survey help?

TOBIE MILLER. Sure; I'm going to find out about that. I'm going to ask these people about the quality of care that they receive, in a social survey.

COMMENT. You could develop it if you made a decision between preferred and standard at the point of enrollment. That could be perceived as a lock-in.

TOBIE MILLER. That's called an "EPO."

QUESTION. First, have you ever used the dangling of preventive service coverage as part of the differential between preferred and standard? And second, your discussion of who contracts with whom had the hospital and the physician contracting with the client, if I recall correctly, rather than MMA or MMP contracting with the client?

TOBIE MILLER. MMA contracts with the client on behalf of the PPO. But if there are going to be both hospital and physician agreements, yes.

QUESTION. Is it the provider who holds the contracts, or your organization that contracts with the client?

TOBIE MILLER. It depends on the agreement. But it's generally our organization, the administrative entity for the PPO, that contracts with the client. For your first question, you have to remember we're not a benefit consultant; we're a provider of health care. We act only in an advisory capacity to benefit consultants in designing their plans. We don't want to step on employers' toes. If they want to build into the plan preventive health care, we'll be more than happy to oblige. But we're obligated to provide services according to what they consider our covered and non-covered benefits.

COMMENT. Days per thousand can easily be extracted from the claim data base, if that tape is available to either the employer or the carrier. That kind of work has been done.

TOBIE MILLER. You're absolutely right! They won't give it to us.

QUESTION. Do your physician members have an exclusive arrangement with you, or can they contract with other, alternative employers?

TOBIE MILLER. They have no exclusive arrangements with us. I would say that 85 percent of our physicians belong only to MMA, and the other 15 percent have affiliations with other PPOs in the city. It's called "protection of market share."

QUESTION. Do you have any evidence on a reduction in use of physician services or office visits? Is there a reduction there, of actual visits?

TOBIE MILLER. We're doing a lot of that now, because we just finally cleaned up all of the 1984 data-base, and we're doing some comparative analyses about what you're saying: we're looking at the number of follow-up visits per diagnosis, the number of ancillary services by diagnosis. And actually we are seeing a reduction, especially in follow-up visits per patient per physician. If we see an increase, then that physician is disciplined.

QUESTION. Could you give me a sense of what kinds of things fall into your wellness program?

TOBIE MILLER. The wellness program is through Pres.-St. Luke's Medical Center. They have a very active and now quite successful smoking management program, stress management programs, brown bag lunches for all employees to talk about proper utilization of the health care system, nutritional educational sessions, and so on. I'm not that closely involved with the wellness people any more.

RONALD ANDERSEN. Tobie, thank you very much.

THE EVOLVING INTERRELATIONSHIP OF HMOs AND HOSPITALS

REED MORTON. The conference on selective contracting continues with a presentation by Leonard Schaeffer, who is president of Group Health, Incorporated, in Minneapolis. Mr. Schaeffer has an illustrious history, and I suppose he's one of the individuals who may be closely identified with what became the hallmark of change in our field when it became noted that "He who has the gold plays the tune." That, I think, had a lot to do with health care financing administration's beginning to make its influence felt.

If you check the invitation you can see a number of the accomplishments; I just wanted to make note of two, one of which is his current capacity with Group Health, Inc., which has been an organization that has at times sponsored summer internships. It being an HMO, one expects to find unbelievable efficiency throughout, and we found this to be the case when one of the students came back last year and said, "Do you know that we had to go in on Labor Day and make presentations? They don't miss any time!" The other aspect, I guess, is that Mr. Schaeffer is a graduate of Princeton, a school known as the "Tigers," which permits one to say we now will hear about HMOs and hospitals in a tale by the Tiger.

Introduction

LEONARD SCHAEFFER. By definition, the hospital and the health maintenance organization (HMO) have conflicting objectives. The hospital's revenue is generated from in-patient volume. As a buyer of in-patient care the HMO's greatest cost saving is in reduced in-patient utilization. These opposing objectives result in a difficult, sometimes adversarial, relationship. The challenge facing the HMO and the hospital is to overcome this inherent conflict and to develop a win-win affiliation.

This discussion will review the interrelationship of HMOs and hospitals and how that relationship is changing. The perspective is that of an HMO, the buyer in this in-patient care transaction; more specifically, a staff-model HMO with an enrollment of more than 200,000 members, operating in a highly competitive market where almost 40 percent of the population is enrolled in an HMO. What follows is a description of an HMO's process of managing the purchase of hospital services and the dynamic environment under which that transaction takes

place. This includes a summary of the planning and strategic activities, the contracting process itself, and the development of joint operational and management efforts. The paper concludes with a prediction of how these relationships will evolve over time. First, a brief analysis of the marketplace within which the hospital and the HMO operate.

Current Situation

Twin Cities HMOs provide in-patient services to enrollees through contractual agreements with hospitals, to the near exclusion of other arrangements. There are twenty-seven community and specialty hospitals in the Twin Cities area. All are providing care to HMO enrollees, some more than others. Also, there is wide variation between HMOs as to which hospitals they contract with and how they contract for services.

Though only 33 percent of total expenses incurred by Twin Cities HMOs went toward in-patient services, the cost of those services approached $100,000,000 in 1983.[1] This was over 30 percent of the total revenue of Twin Cities hospitals for that year. HMO volume is no longer marginal business to a hospital. Contracting has become a major function within the HMO and the hospital, requiring more sophistication than ever before.

Low hospital occupancy rates continue to be a critical advantage to the HMOs in buying in-patient services. This increasing excess capacity is due to the changes in financing in-patient care, the success of HMOs, and the emergence of utilization review efforts. For example, the average 1984 occupancy rate for Twin Cities licensed hospital beds in the Twin Cites was 47.5 percent.[2]

If the market theorists are right, there should be a number of hospitals closing in the next few years. The hospital industry itself predicts that 1,000 hospitals will close by the year 2000.

In the Twin Cities some hospitals are learning to control costs despite lower utilization rates, owing in large part to pressure from HMOs and to the 1984 nurses' strike, which allowed Twin Cities hospitals to trim their labor force. In addition, some acute care hospitals have converted into specialty facilities, e.g., mental health and chemical dependency. The question is how much economic pressure it will take before hospitals begin to close. Such closures seem

inevitable from a financial point of view. However, community and political support of local hospitals cannot be underestimated.

Currently, no HMO in the Twin Cities owns or leases a hospital. There are a number of HMOs similar in size to those in the Twin Cities in other parts of the country that do operate in-patient facilities. The reasons an HMO chooses not to acquire a hospital are primarily economic. Because the hospitals are searching for greater efficiency and still have excess capacity, the HMO as purchaser has the ability to negotiate a good price. It is financially not in the HMO's interest to invest in hospital services. Coupled with the strong reputation of the quality of care provided by Twin Cities hospitals, this has resulted in the continued practice of HMOs' contracting for hospital services. As economic conditions change, HMOs must continue to assess whether to make or to buy in-patient services, or to do a combination of both.

One other important issue now surfacing in the Twin Cities, and soon to surface nationally, is location. Our market research shows that quality, access or location, and price are the critical factors in selecting a hospital. Therefore, those HMOs that have focused on one single hospital may get a good price, but their marketing efforts will suffer. If you contract with only one hospital, you will have problems.

Currently, the financial arrangement between an HMO and the hospital is primarily for acute, in-patient care--the hospital's traditional role. However, this role is changing and changing rapidly, which significantly affects the HMO-hospital relationship.

Hospitals have begun to diversify into non-institutional markets such as home health care, out-patient surgery, and occupational medicine, and into institutional long-term-care services. They have also entered into the health plan market by developing PPOs and HMOs, which represent a competitive threat to existing HMOs and other payers. The question is whether HMOs and hospitals work together or compete to develop these services and plans.

The current growth of multi-hospital systems enhances the hospitals' ability to diversify into these markets, traditionally controlled by third-party payers and other providers. Thirty-five percent of Twin Cities hospitals and

45 percent of the beds are in multi-hospital systems. These systems can support the horizontal integration of new services and products by providing financial and marketing support. A theory about where this may lead in terms of the impact on HMOs is presented later in this discussion.

In terms of the regulatory environment under which HMOs contract with hospitals, there is a strong emphasis in the state of Minnesota on the use of competitive forces to contain health care costs. The state of Minnesota has repealed the certificate-of-need law and has resisted rate-setting approaches in controlling costs. The flexibility required to achieve a win-win arrangement would be constrained under an all-payer rate-setting system. It is essential that the HMO and hospital be free of regulatory constraints when negotiating for in-patient services.

Contracting Strategy

In the early days of Group Health, the problem was finding a hospital that would be willing to take the professional risk of doing business with a staff-model HMO. Philosophical acceptance is no longer the issue. The key factors that Group Health now considers in selecting a hospital are quality of care, cost, and access, with quality being essential. Once quality is ensured, the challenge facing the HMO is the balancing of cost and access.

The decentralized use of hospitals subtracts from the economies of centralization. However, the market demands access to local, convenient hospitals. The question is, to what extent is decentralization necessary and for what type of service?

The financial assessment should not be restricted to the in-patient costs. There are also indirect costs, such as specialty consultation services, hospital-based physicians' services, and additional physician coverage, i.e., physician call, that must be taken into account when hospital services are decentralized. The other factors involved in developing a hospital strategy include the scope of services provided by hospitals and the expertise in given specialties, e.g., open-heart surgery. Demographics of the community are also important in selecting hospitals. The best example is Medicare, where hospitals located in areas with a high concentration of the elderly are used.

With a contracting strategy in place, preliminary

discussions with the selected hospital are then held, the purpose being to determine compatibility with Group Health's practice patterns, including patient management. The objective is to develop a long-term agreement with a hospital that results in a win-win affiliation.

Group Health currently contracts with seventeen of the twenty-seven local hospitals, after contracting with only one during its first fifteen years of existence. This expansion is a function of Group Health's growth, increased competition, and the marketing need to provide access to community hospitals. Until recently, the contracting process itself was relatively informal. There were no legal agreements binding the parties. However, a contract is now recognized as essential. The principal purpose of the contract is to define the method and extent of reimbursement for services provided by the hospital. This usually includes both in-patient and out-patient services. The three common methods of reimbursement are per diem rates, rate per admission, and a discount from billed charges.

A per diem rate structure is predominant because there is an incentive to the HMO physician to reduce the length of stay. In addition, it is a known, quantified number that can be budgeted, unlike fee-for-service reimbursement. There are variations on this method, including straight and staged per diem rates. Straight per diem rates provide for the same dollar amount each day, whereas staged per diem rates have a declining dollar amount for each additional day, in recognition of the higher intensity of services provided in the first few days. Rates per admission are used when the length and intensity of the hospital stay are predictable, as in the case of cardiovascular surgery and routine pediatric admissions. Discounts from billed charges are normally applied to out-patient services, other than surgery, and where in-patient HMO volume is low. Combinations of these methods of reimbursement are also used when appropriate.

In selecting the appropriate reimbursement method, three factors are taken into consideration. First is the placement of economic incentives. Ideally, the payment structure provides incentives for both the hospital and the HMO physician to control costs. However, an all-inclusive per diem rate gives the HMO an incentive to hold down the length of stay to appropriate levels, but offers no such incentive to the hospital. Therefore, a system providing for a combination of a per diem rate for fixed costs, including nursing, and a discount from billed charges for ancillary services is

designed to place the hospital and the HMO physicians, respectively, at risk. Second is the state of the art of the medical specialty. In the situation where certain types of admissions are less frequent but more severe than others, e.g., pediatrics, the reimbursement method should reflect that increased severity. Third is administrative ease. The payment structure should be as simple as possible.

Though the financial arrangement is the major element, there are other critical issues that need to be addressed in the contract. These include the scope of services to be covered, quality assurance and utilization review standards, and information reporting. It is important that these provisions be spelled out in the agreement to prevent misunderstanding.

The contract represents the formal affiliation between the hospital and the HMO. However, it does not address the gamut of operational matters that are important in a working relationship. There needs to be an on-going interaction between the parties for the greatest efficiency within the hospital, and to resolve operational problems. This can be accomplished through the involvement of the HMO physicians in the hospital's medical staff activities and through the structure of an HMO-hospital operational committee.

The joint operations committee monitors compliance with the contract and develops procedures to control costs. There is representation from both the administrative and the medical staffs. The committee also explores joint venture ideas in purchasing materials or providing services. It is a strong communication vehicle as well. An association between a hospital and an HMO cannot be carried out through a contract only. There must be an additional effort to make that relationship work.

In the Twin Cities, hospital contracting by the HMOs has made a significant impact on hospital costs and utilization. Nationally,[3] per capita hospital expenses increased by 14.7 percent in 1982. However, in the Twin Cities there was only a 4.1 percent increase in the same year. A recent study of the hospital costs released by the Minnesota Health Department showed that the two lowest-cost hospitals in the Twin Cities are the two hospitals with the highest volume of HMO business. One of those hospitals is one that Group Health has done business with for more than twenty-five years. It is interesting to note that the hospital is part of a multi-hospital system. The hospitals in the system where we do not

currently have contracts were ranked as higher-cost hospitals.

The impact made by HMOs is also seen in patient-day statistics. In 1982, the average rate of hospitalization was 1,604 patient days per thousand nationally; in the Twin Cities it was 1,237 days per thousand; and the Group Health average was 399 days per thousand.[4] That number has continued to decrease over the past few years.

Future Interrelationship

What has been described here is the traditional contracting relationship between an HMO and a hospital for the delivery of in-patient and out-patient services. In this relationship the HMO is clearly the purchaser of these services and the hospital is the seller. However, given the changing role of the hospital, with the growth of multi-hospital chains and their increased diversification, what will be the future relationship of HMOs and hospitals?

Unless hospitals evolve into a system of care, including the role of a third-party payer, they will no longer be significant providers of health services. They will become bed towers, buildings, with the patients managed by some other health system. However, HMOs will also move into other services and markets, including in-patient and out-patient services. Though HMOs and hospitals begin at different points of the evolutionary chain, it is inevitable that their paths will cross, as either competitors or cohorts.

What this will probably lead to in the Twin Cities health care market is the development of from four to six fully integrated, alternative provider systems. These systems will probably be a network of third-party payers, hospitals, physicians, and long-term-care agencies. This network could take many forms, varying in its level of organizational and legal structure. It is probable that in the beginning these systems will be loosely knit, with the use of joint venture and/or contractual agreements. The idea of merging organizations or establishing exclusivity of services provided is perhaps premature and risky. Ultimately, these systems can develop into this level of structure, once the supply of health care services balances with the demand. However, that is not likely to happen in the near future, given the projected glut in the physician market and continued excess hospital capacity.

These systems will, however, evolve over time. The early

stages will probably consist of joint purchasing of materials and the provision of support services such as transportation, laboratory and diagnostic imaging services, and home health care. Also, the initial network may involve the offer of alternative health plans to limited markets. These markets could include Medicare, Medicaid, and self-funded employers, where a broad system of providers, experienced in serving these populations, is needed.

Another force contributing to the formation of these alternative provider systems is the buyer of health plans and services, the employer. The employer is insisting on more flexibility and accountability when purchasing health coverage for its employees. There is a desire to understand better the operation of alternative health plans, including the participating providers. Employers are seeking clarity about the interplay of financing and delivering health care. The meshing of these functions will reduce this confusion and may permit the employer to manage health benefits more effectively.

Conclusion

It is evident that the HMO's relationship with the hospital community will continue to change. The evolution of this contractual relationship will mirror the changing health care industry itself. As hospitals and HMOs diversify into other markets, there will be a blending of their respective roles of providing in-patient care and third-party coverage. This will result in a better-managed, more effective system of providing health care to the degree that hospitals and HMOs recognize their mutual self-interest, and overcome their historically adversarial roles.

Notes

1. Minnesota Department of Health, 1983 HMO Statistical Report

2. Metropolitan Planning Board, St. Paul

3. American Hospital Association, Hospital Statistics

4. Minnesota Department of Health, 1982 HMO Statistical Report

SELECTIVE CONTRACTING: THE CALIFORNIA EXPERIENCE

REED MORTON. Our next speaker is Leona Butler, who is now with Blue Cross of California. It seems axiomatic that if you want to do well in a regulated industry you hire someone who is a regulator. Ms. Butler worked in hospital management, moved into the public sector and was a senior consultant to the state assembly regarding the development of MediCal before going to Blue Cross. So I think we look forward to hearing it from inside out and outside in.

LEONA BUTLER. Thank you. To understand what is happening in California today, it is helpful if one goes back in history. After Moses led his people through the desert he went up to the top of Mt. Sinai. Storm clouds gathered while he was up there. Finally he came down and gathered some of his leaders around. They conferred for a while, and he went back up to the top of the mountain. This time there was lightning and thunder. He came down again and conferred once more with his leaders before going up a third time. This time he was gone for quite a long while. There was a horrendous storm with violent winds and drenching rain. Finally, Moses came down from the top of Mt. Sinai with two tablets. This time he gathered all of his people around. He reported, "My people, he reduced the number to ten, but I must tell you, adultery is still in."

Negotiation, indeed, is what it's all about today in California. Two years ago, in May 1983, Blue Cross of California started to contract for its preferred provider plan in response to legislation that had been passed the previous year. I'd like to tell you about two communities and what's happened to them since. Not the big urban communities you're always hearing about--Los Angeles and San Francisco Bay area--but rather Fresno and Modesto: two typical San Joaquin Valley communities in the middle of the salad bowl of the world, where in an earlier time, the idea of an HMO was viewed as a Communist plot.

Blue Cross had been trying to get our HMO established in Fresno for two or three previous years, and had been totally unable to interest any physician in any kind of an IPA . I was there two weeks ago on a panel. That panel consisted of six representatives of different HMOs, PPOs, IPAs, and various other assorted kinds of "alternatives." It was a meeting before the medical society of the community; the physicians were asked how many belonged to two or more, and three-quarters of the members of the audience raised their hands.

That's in two years.

Exhibit two, Modesto. Modesto is the place where the Department of Justice once actually stopped the development of the Stanislaus PPO, being formed by the Medical Care Foundation. However, since 1980 Modesto has seen the startup of three HMOs, three PPOs, four urgent care centers, and two ambulatory surgery facilities. This is in a community of roughly 300,000 people. What happened?

In 1980, Blue Cross was paying hospitals an average per diem of $393 a day. By 1984, our payments had risen to $706 a day. Our payments per admission were $1,990 in 1980 and $3,332 in 1984.

The employers in California wanted to contain costs. They started forming coalitions. The state of California wanted to contain costs also. The Medical Program was at five billion dollars--the largest single item in the state budget.

The state decided that it was going to provide for selective contracting, that is, contracting that would allow MediCal recipients to go only to the contracting hospitals. The employers, Blue Cross, and the insurance companies decided that this was our grand opportunity. We were able to add to that piece of legislation a provision saying, "You can also contract selectively as insurance companies with providers." This piece of legislation was joined to the state budget, and the state budget could not have passed without this legislation passing. I think that tells you how very serious the employers had finally gotten.

In 1983, the Employers' Health Coalition in Los Angeles did a study of employers' costs. The coalition included 24 major employers in the Los Angeles area such as Atlantic Richfield Corporation, Chevron, Matel, various banks, and the electric and gas company. From '82 to '83 their increase in daily hospital costs had been 24 percent. There was a 25 percent increase in cost per case; an 83 percent increase in psychiatric cost per case; a 25 percent increase in physicians' fees per case (this is for hospitalized cases); a 12 percent decrease in hospital admission rates; a 2 percent increase in the average length of stay; and a 70 percent increase in the average stay for psychiatric care. Findings such as these by employers throughout the state led to the passage of the legislation.

When the legislation passed there was one PPO in the

state. Today in California we have somewhere around about 250 that have licenses. Seventy-five of these are actually operational and have patients. In a study reported in February 1985 in Modern Health Care, Amherst Associates surveyed 150 benefits managers of the major companies in the state. The findings: 66 percent of their respondents either have or plan to have a PPO in operation for their employees within two years; 54 percent of those not offering them right now said they will have them; 25 percent of them said they already had PPO choices for their employees.

Blue Cross of California's initial action was a major reason for PPO growth in California. We set the stage for what happened later. Today we have not only Blue Cross but Blue Shield, PruNet (which is Prudential), Aetna Choice, Transamerica Occidental, Pacific Mutual, and Metropolitan Life. NME now has a plan that it is selling directly; AMI is selling a plan directly; Humana is selling a plan directly. United Foundations for Medical Care have both a statewide and local PPOs. We have various providers who have formed PPOs; we have "other arrangements" in which third parties are negotiating directly PPO arrangements with employers; and we have MediCal.

If you are a hospital in California today, you have someone on your staff called a "contract manager" who does nothing but respond to requests for bids and monitor contracts. It is a nightmare, an absolute nightmare, for hospitals. They are scared. They are scared because they know that everyone on the shopping list that I just read to you cannot survive in the long run. But the hospitals don't know who's going to survive. They are afraid they will pick the losers. So there are many hospitals today in California with 50 or 60 separate contracts for HMOs, PPOs, and various other kinds of arrangements. Every one of those is negotiated separately. Every one of them has some different kind of utilization review attached to it. They are all priced differently; some are per day; some are per case; and some are discounts from charges. Obviously that kind of a situation cannot continue. I am very surprised the hospital industry as a whole in California has put up with it.

Given that background, it might be useful for you to know how we set out to do selective contracting. It's a pattern that, fortunately, many others are following. Blue Cross, being the largest carrier in the state, had to work fairly and in the public view. Every inch of the way we were looking for anti-trust prevention. We are not being sued for anti-trust

violations by any hospital, but by a couple of disgruntled doctors. The absence of suits is quite remarkable for this litigious state.

California has health facility planning areas (HFPA's). They are organic units, e.g., a city like San Francisco, with an identifiable population. HFPA's can give us population information because that's how the state collects its data. We started out by announcing that we would offer all hospitals in an HFPA the opportunity to make a proposal to us. In effect we put out an RFP. We gave a hospital roughly five weeks to make a proposal. There was a Blue Cross contract manager assigned to work with the hospitals in a particular HFPA. Each interested hospital could make a per diem offer to us. We made it clear that we wouldn't respond to the hospital unless we thought the offer was reasonable.

Meanwhile, we collected our own data. Using Blue Cross paid claims data, and data from the data collection agency of the state we put together a profile of every one of the 521 hospitals in the state, showing us the scope of services of the institution, its total revenue, and its debt service. The profile allowed us to examine the financial viability of the institution. We looked at: its increase in costs and charges over the last five years; its average length of stay over the last five years; significant changes in service that had occurred over that period of time; medical staff by specialty; and admission criteria.

We developed a computer model to help us determine the hospitals it would be advantageous to contract with. Included in the model were: total number of Blue Cross days in the previous year; percent of increase in charges over the past two previous years; the length of stay; the cost per day; the cost per case; "scope of services index," allowing us to look in a quantitative way at the range of a Medicare case mix index; and the number of physicians on the medical staff willing to participate in our plan. We also rather subjectively assigned some values to such things as location, access, and special services that might not be available in other institutions.

Using the computer model we were able to include factors in addition to a hospital's proposed price such as quality of care and the expected nature of our long term relationship with the hospital to decide which bids to accept. On the whole the other factors represented about one-third of our decision and price represented two-thirds.

Within an HFPA, all necessary services must be included in some contract. However, if in an urban area, you cerainly do not need to provide all of those services through one hospital. Thus, one problem in putting together a Blue Cross network in one area is to decide what provider should be responsible for what service. For example, in San Francisco we needed to provide for open-heart surgery. Still, we didn't want to contract with several hospitals doing open-heart surgery because we felt that would increase our cost. As we negotiated on open-heart surgery one high quality tertiary care university hospital reduced its bid price and received the contract. This eliminated another institution with very competitive prices. Also, because it made sense to package certain services together, another institution was eliminated as well. Thus some hospitals do not get contracts with us, not because their prices are not good, but because they do not fit into out larger plan. It's a tough world!

Once we knew whom we wanted to contract with, we then very often would go back and start negotiating down on the rate that had been offered. We talked about one per diem for all acute med-surg services. No matter where the place of service, whether in the ICU, CCU or CPU, we pay one flat per diem. However, we do have several per diems for the tertiary services. But payment is according to ICD-9 code rather than site of service. Thus, per diems differ for various open-heart surgical procedures, burn care, neonatal intensive care, et cetera. But we did not want a discount from charges, and we did not want anything that would force us into a utilization review that involved how many days in the ICU versus in less intensive care. We pay up to five different per diem amounts with a hospital.

We do not believe per diems are the best way to go. For the moment, they're easy and simple; you can understand them. We believe DRGs are the future. We are starting a pilot program right now to reimburse about forty hospitals on a DRG methodology. That's for our standard business as well as the preferred provider arrangement, the Prudent Buyer Plan.

Our research showed that for an employer to choose to purchase a preferred provider arrangement, there had to be no less than a 10 percent but preferably a 15 percent differential in premium. That is, for comparable benefits, you had to have at least 10-15 percent lower cost for the PPO. That research also showed that for urban areas, access is very important. People want less than 20 minutes' drive time in an

urban area. In a rural area, 30 minutes is considered acceptable. Our contracting aimed both to reach that price differential of 10-15 percent and to contract so that in the urban area, we had no more than 10 miles between hospitals. We therefore had to negotiate with hospitals with both access and price in mind. On the price side we expected at least a 20-25 percent reduction from what we had been paying. Remember, hospitals are roughly 50 percent of the health care premium dollar.

It's important to understand that the 20-25 percent reduction is not a discount. It might not be as difficult to get a 25 percent or even a 50 percent discount from a hospital that overcharges, as to get to a five percent discount from a hospital that is very lean and mean. So "discount" doesn't mean a thing. We look at our total cost per day for hospitalization in an HFPA area. We then attempt to reduce that price by 20-25 percent. This becomes a difficult problem when contracting with multiple hospitals, as we did in San Francisco. Contracts were signed with five out of the fourteen hospitals in the city.

How did we solve the problem? Again, we developed a computer model that we call a "channeling" model. That model contains relevant data from the previous year for the HFPA; the charges from and payments to hospitals; the number of Blue Cross days; and, scope of services. Before we finalize our contracts with a hospital we plug in the negotiated rates we were proposing to pay. The model predicts what happens if all of the patients in this plan go to the least expensive hospital you're going to contract with, what happens if they all go to the most expensive university hospital, or what happens (most likely case) if people distribute themselves very much as they do today with some going to the more expensive hospital and some going to the less expensive one. Unless we would achieve at least a 10 percent saving, we would not contract with that particular configuration. Our underwriters use that same model putting in the actual experience of a group, and examining what the results will be given per diem amounts that we're now paying to hospitals.

So our channeling model is a very useful tool. It helped us discover hospitals that gave us very low discounts because they already were so efficient, and others that offered us a 50 percent discount because they were inefficient. It also suggested which hospitals were poor long-term risks because they might look to maximize profits next year, to make up for the losses in the current year.

We believe the relationships with hospitals should be relatively long-term. Two or three years is not enough. The marketplace just is not viable if you don't begin with the idea of very serious long-term relationships. You can't say to a group of employees next year, "Sorry, last year Hospital X was the good guy; this year it's Hospital Y and you can't go to Hospital X any more." That is just not realistic. We looked for very long-term relationships when we started, and fortunately its lasted so far. We started contracting in 1983, two years ago exactly, and to date we have had one hospital that we have changed, and that was because of a change in ownership of the hospital to owners with a new philosophy.

Physicians are crucial. No PPO can operate without physicians. Physicians must be tied to the hospital. No physician can join our plan who is not on the staff of a participating hospital. It really drove the physicians nuts that we started with the hospitals, but we felt we had to because that was where the high cost was. Those physicians who have wanted to join the plan have certainly been able to get on the staff of some participating hospital, assuming the physician met the quality criteria that we established.

Today, two years later, we have 199 hospitals in the plan. We started with premium reductions that averaged about 12.5 percent. Our premium differential now is 24 percent with the Prudent Buyer Plan. I'm referring to our small-group market because that's a wide community-rated group. And the cost is 24 percent less with Prudent Buyer benefits than the same benefits under a standard plan. So, yes, it's working.

Utilization review, I believe, long-run, is one of the major things that is making it work. In 1983 Blue Cross had 452 days per thousand for our population of non-Medicare members. Kaiser's was 390. In 1984 it was 425 for Blue Cross, going down, and for the Prudent Buyer Plan, 325. It involves prior authorization for some forms of non-emergency admissions, and concurrent review. With that dramatic decrease in days per thousand, we have had only a 1.2 percent denial rate. Why the low denial rate? Because by contract, the hospital and physician both agree that should anything be denied in the UR process, the patient is held harmless and the hospital and physician eat the bill. It works without an adversarial relationship, without the denials, without the struggles, without the appeals. That is fascinating to me. It is not an adversarial relationship.

We're certainly not alone in what's occurring, but we're ahead in numbers of providers, employers, and patients involved. There are a lot of implications for you. For those of you who are students, I both envy you for the world that you're going to be in shortly and am kind of glad I'm not starting out, because it's a different world. At the moment the hospitals in California are panicked about getting contracts, and living with those contracts. Remember we are now paying many hospitals $640 a day whose average charges per day are $1,100 or $1,200!

Hospital-physician relations are becoming critical. The American Medical Association has recently formed a medical staff group. I think the American Hospital Association ought to form a physician group. Let me give you some examples. Merced, California has two hospitals. Both of them very much wanted a contract. You have to realize that today in California the hospital occupancy rate is 59.7 percent (that's first quarter 1985). One hospital is all that is needed in that area. The hospital that got a contract has not been able to bring its anesthesiologist in under contract to our plan. We're under the obligation to ensure that the patient gets a full range of services. And so we're having to pay an anesthesiologist at UCR rates because he will not sign. Anesthesiologists are the most recalcitrant group of all physicians, in terms of not wanting to contract. The other hospital happens to be a county hospital, well respected, and used by about half of the community. This hospital has come to me and said, "Our anesthesiologist is part of the per diem." Well, I've had no choice, given the competition there, but to put the hospital that has the contract on notice that either the anesthesiologist signs a contract with us in fifteen days or we must re-open the contract.

Now, think of the implications. I think we're just seeing the beginning of it. In California we have something called the "Corporate Practice of Medicine Act." Hospitals cannot employ physicians. I venture to say that within the next two years that act will be changed, and it will be changed by the hospitals. The hospitals have wanted it changed for a long time. They've been afraid to change it, but I can tell you that now they are going to have to change it.

Hospitals are getting into many new, expanded, out-patient services. For example, we have hospitals that are advertising the cost of how much it is to have a baby in their

institution, and also giving you the price of what it costs in another institution.

I do believe that we're going to get into joint ventures. With HCA, Humana, AMI, NME, all becoming, or joining forces with insurance companies, it'd be more than foolish for the hospital industry and the insurance industry not to see the advantage and, indeed, necessity of joint ventures. I think we're going to see more and more blurred distinctions between HMOs and PPOs and EPOs. We are developing a new one that we're calling "NFQ HMO," which means "non-federally qualified HMO." (We've got to find a better name than that.) We are going to see hospitals being capitated for some programs.

From the employer's point of view, the bloom in California is beginning to wear off the HMO. That is because the HMO in California, Kaiser particularly, is beginning to see an aging population. The costs are going up. At the same time, the older, sicker people are still in the funded insurance plan, with the experience rating of that causing the costs of it to go up. That's why I say joint ventures are going to be absolutely necessary. We will see more and more a company like Blue Cross covering all of the employees of a Rockwell or a GM or Coor's. For one price employees will be offered a choice: the HMO; the PPO; fee for service with reduced benefits or out-of-pocket expense. For the employer, it's all going to be one experience-rated bag. That's why Blue Cross of California is now developing a non-federally qualified HMO, because we believe experience rating for HMOs is going to become a very desirable thing.

We also believe that under this mishmash of the alphabet that we have today, "managed care programs" will develop. They consist of either the primary-care physician or another person specifically designed to help advise the patient where to go for what. We are going to see every aspect of that patient's care managed, that is, referral to specialists, hospitalization, discharge planning, hospice care, home health services, rehab services, et cetera. For years, we have all talked about the health care delivery system. I believe we haven't had a system. In effect we are beginning to develop a xystem.

We are also going to be seeing very special programs developed particularly for particular employers. We're doing one right now for a county that wants to cover its employees in a PPO. The trouble is, we are not contracting with the county hospital, and the county wants to use the county

hospital. So we're developing with that county a special program for its employees, the largest work force in that particular area. If the employee goes to the county hospital, 100 percent is paid; if the employee goes to a Prudent Buyer participating hospital, it's 90 percent that's paid; if the employee goes to a non-participating hospital, 80 percent is paid. That's a kind of simplification of the benefits, but we're going to see more and more of that kind of definite structuring for a particular employer.

It's a new world, especially in California, and health care always seems to move from west to east, rather than from east to west. So I wish you all luck as you go through what we've been going through these past couple of years. Thank you.

THE MICHAEL M. DAVIS LECTURE

SELECTIVE CONTRACTING AND THE COMMUNITY HOSPITAL

ODIN ANDERSON. It's been my pleasure for the last few years to help select and introduce the Michael M. Davis lecturer. But first I'll spend a couple of minutes to tell people who are too young, or who can't remember, who Michael M. Davis was.

Michael M. Davis was fifty-four years old in 1934, when he founded the program in Health Administration at the University of Chicago. Previously, he had a distinguished career in the health service delivery systems and finance. It may also interest you to know--it certainly interests me--that he obtained a Ph.D. in sociology from Columbia University in 1896. Following school, he went into social work, then switched to settlement work, and in 1910 he started working in the out-patient departments of hospitals and dispensaries. In the course of the years before 1934, he wrote a lot, and he was very conscious of the fact that the hospital institutions needed professionally trained administrators, who were not necessarily physicians. Eventually, he gained a position on the Rosenwald Foundation staff here in Chicago, and then persuaded the Rosenwald Foundation to contribute roughly $7,000 for three years to help pay stipends for would-be hospital administrators who enrolled in the Graduate School of Business. He preferred the medical school base, but the medical school wasn't interested. He later realized that the Graduate School of Business was a more logical choice because the school trained managers, and I think he will not turn over in his grave to realize that we are concerned with money through management.

The program was his legacy, and it was taken over by Dr. Bachmeyer, who was formerly superintendent of the hospital. As was Davis' custom throughout his career, once he got things started and moving, he moved on to something else. In 1962 when George and I came here with the Graduate School of Business, friends and admirers of Michael M. Davis collected enough funds to establish a lecture, the "Michael M. Davis Lecture," to be given once a year at the University of Chicago. The lecture was to feature a distinguished person speaking on some hot and pertinent topic. Strangely enough, Michael M. Davis was the first lecturer, at the age of eighty-three. I remember that occasion with a great deal of warmth. It was very touching; he was a sparkling man and he sparkled at eighty-three. He became the first Michael M. Davis

lecturer.

When he died a few years later I realized that he was mortal, and so every year, in honor of Michael Davis, we invite a lecturer to commemorate and continue the tradition of interest in the health services. So, we have with us today Robert Sigmond, who has done a lot of writing and research. Bob and I, it seems to me, sort of grew up together. I don't know who is the wiser, but that's another topic. I must have met him more than twenty-five, thirty years ago. When I met Bob, I had no idea that he would deserve an invitation to be the Michael M. Davis lecturer. Furthermore, I had no idea at all that I would be able to pay him through the M. M. Davis fund. I also know that the reason I wanted him to come was because of his concept of the community hospital. I look forward with great interest, and maybe even some trepidation, to his treatment of this topic in view of the previous speakers.

ROBERT SIGMOND. The subject of selective contract payment for hospital service is an important part of a much larger problem facing the people of the United States. Costs of personal health and medical services, particularly hospital services, have been rising for years at a faster rate than our gross national product, and the public correctly believes that this country can obtain more effective service for less money.

More selective contractual arrangements for hospital service offer real possibilities for new incentives to eliminate unnecessary costs, and therefore are bound to account for a larger share of hospital payments in the years immediately ahead. These new selective contract payment arrangements will necessarily have major impact on community hospitals, and on other hospitals competing with community hospitals for a share of the hospital marketplace. In this situation, new selective contract arrangements can either have the effect of undermining the financial base of the unique services that community hospitals can provide, or selective contracts can be designed to offer special financial incentives for hospitals to provide ever more cost effective community service. If community hospitals are able to respond appropriately to well-designed new selective contract arrangements, this nation will have taken a major step forward toward obtaining more effective health care at less money. Accordingly, I will address two related questions in this lecture:

1. How should selective contract arrangements be

designed to provide appropriate incentives for improved and less costly community service?

2. How should hospitals respond in this new selective contracting environment of fading notions of freedom of choice of unlimited and unfettered resources, so that communities will be better served despite ever more limited financial resources?

Contracting by or with Community Hospitals and Non-Community Hospitals

For purposes of selective contracting, a clear distinction should be made between (a) community hospitals and (b) those hospitals which are concentrating on providing patient care services, with little if any explicit attention to the over-all health status of the community. Similarly, it is important to distinguish between (a) those buyers or payer agencies which are simply acting as prudent buyers for specific groups of beneficiaries from (b) those which recognize some responsibility for simultaneously supporting a cost effective, accessible, quality healthcare system for the entire community as well as for their beneficiaries.

In general, community hospitals and buyers or payer agencies with common community commitments should attempt to negotiate selective contractual arrangements, reflecting their common interest in cost effective health service for the people in the hospital's designated community generally, and for the contract beneficiaries in particular.

By contrast, non-community hospitals and buyers can be expected to contract on the basis of competitive bids for specific units of care, managed by the contracting parties in accordance with standard contracts.

Both types of contract would be equally businesslike, but community hospital contracts would be negotiated and tailor-made to meet community as well as buyer needs. Non-community hospital contracts would be more standardized, reflecting a relatively mechanical process of purchasing and/or managing patient care services.

Community hospital contracts could eventually provide for a variety of payment arrangements for different kinds of service: some combination of (1) negotiated fees or prices for complex units of service, such as DRGs, for inpatient care, (2) capitation for primary services, and (3) program funding

or grants for expenditures and capital investments not necessarily related to direct service as such. Non-community hospital contracts, by contrast, would tend to be much simpler, covering specified or unspecified volumes of prospectively priced units of specific services. Under these conditions, almost inevitably the fees or prices of community hospitals for inpatient care would be lower than those of the non-community hospitals, because the latter would almost inevitably build full institutional financial requirements into their prices.

To the extent feasible, in terms of common commitment and cost effective results, preference should be given by buyers to community hospitals, selectively and collectively. The reasons for this preference become clearer as we discuss the differences between community hospitals and other hospitals. In any event, if there is sufficient preference for cost effective, socially responsible community hospitals, the costs of health services will decline in the community as a whole, and most (but not all) buyers will probably pay less for effective care for their beneficiaries than if they had contracted with non-community hospitals on the basis of competitively bid prices.

The Community Hospital

What are the essential characteristics of a community hospital, and how does it differ from non-community hospitals?

The key identifying characteristic of the community hospital in the words of the authoritative "Guide for Preparation of Constitution and Bylaws for General Hospitals" is that one of its objectives is community service, or more specifically in the words of the Guide "to promote the general health of the community." The community hospital's other three objectives can be the same as for any hospital: patient care, education and research. Non-community hospitals, by contrast, do not address the objective of promoting the general health of the community.

The concept of a hospital dedicated to community service--to promoting the general health of the community while conserving scarce resources--has a long and distinguished history and literature. But the concept is not well known or accepted by current leaders in formulating national health policy, or by today's academics. The concept has not been thought through recently, even by a large proportion of those responsible for governing, planning and

managing community hospitals.

The concept of the hospital as an institution concerned with achieving maximum market share, preoccupied with the bottom line and institutional survival, also has a long history. But this concept has not been held out as a desirable model until quite recently. Unfortunately, the bottom line/survival model is currently the accepted model in national health policy circles, and determines the nature of legislation affecting hospitals, as well as many decisions in corporate and union board rooms. Even more important, this model is beginning to dominate policy formulation in hospital board room as well.

The fact that fewer and fewer hospitals conform to the Guidelines on Ethical Conduct for Health Care Institutions, adopted by the American College of Healthcare Executives and the American Hospital Association, which mandate a community health focus, did not ever seem terribly important to most observers, even to those who were aware that ethical standards for institutions exist. The fact that the community hospital seems to be losing its credibility and legitimacy as a public service enterprise is a matter for much greater concern. Community hospitals are very special community resources. In their concern for improving and protecting the health of the community and conserving scarce resources, they can provide essential services that are not generally offered as effectively--if at all--by any other organization or institution in the community.

Bruce Vladeck has pointed out the need:

> ...to re-legitimate the hospital in the eyes of the public and of policy makers. It is critical to recognize the extent to which public perceptions of hospitals, which have historically been quite favorable, have changed in recent years, and the extent to which those changes in perceptions have colored public policy developments. I don't think we can do that solely by advertising. It's very difficult to convince the public of a proposition that fundamentally isn't true.
>
> The way to legitimate the hospital in the eyes of the public is to go back, in a sense, to the era in which hospitals were valued and were looked up to and were protected by public policy, because they were perceived as providing essential community service that no one else would--because they existed for the purpose of providing

community service, rather than because the vice-president for marketing and strategic planning told them that was a good thing to do. To the extent that hospitals are perceived as necessary community resources, they will be supported and maintained as necessary community resources. To the extent that they are not, then the kind of risk we are facing now only gets substantially worse.

The time has come to re-legitimate the community hospital by developing explicit standards that a hospital must meet in order to qualify as a community hospital, entitled to support as such, in selective contracting and otherwise.

The basis for developing explicit standards for the community hospital are found in a long series of documents: (1) the recommendations of the Commission on Hospital Care in the 40's; (2) the AHA's Statement on Optimum Health Services in the 60's; (3) the Guidelines developed in Detroit in the 70's by the predecessor organization of the Greater Detroit Area Health Council; (4) the Program for Institutional Effectiveness Review developed by the AHA in 1980; (5) the Guidelines on Ethical Conduct for Health Care Institutions, most recently updated in 1981 by the ACHE and AHA; and (6) the Policy on Imperatives of Hospital Leadership, adopted by the AHA House of Delegates in 1982, to mention just a few.

Just as Malcolm MacEachern developed national accreditation standards for hospitals over a half century ago by writing down what he knew about quality of care and safety almost literally overnight, one or more individuals familiar with the documents referred to above could quickly and easily develop a useful set of minimum community standards for any hospital to strive to meet, if it wished to be identified as a community hospital. This would permit society to distinguish community hospitals from other hospitals, and to encourage non-community hospitals to upgrade to community hospital status and to be able to selectively contract as such. Individual hospitals could carry out this process on their own, or by identifying themselves with over-arching health systems which would require them to play a constructive role in optimum health services in their own communities.

Such standards--like the standards of the Joint Commission on Accreditation of Hospitals--should apply to all classes of hospitals, including teaching hospitals, government hospitals, investor-owned hospitals, and specialty service hospitals. All of these could qualify if one of their goals is community service, i.e., to promote the general health of

the community. In any community hospital, this goal must be observable, but is necessarily balanced with a variety of other goals, particularly patient care, education and research. The key planning and management issue in community hospitals is how to effectively balance service to patients and service to the community (that is, potential patients). This issue is much more important and much more complex than balancing the interest of patients and the interest of bondholders, stockholders, or creditors.

Development of Minimum Standards for Community Hospitals

Minimum standards for community hospitals will necessarily incorporate all of the existing standards of the Joint Commission on Accreditation of Hospitals and other licensing and accrediting bodies, but much more. Today, a hospital can meet every legal and accreditation standard without giving any consideration to the community: without knowing the health indices of the community, even the leading causes of death of disease, or whether the infant mortality rate has bottomed out or is rising. No one within the hospital governing body, medical staff, or management is charged with responsibility for assembling and analyzing basic health indices, and in fact, in most all hospitals today, hardly anyone really knows the facts about illness, disease, and disability in the hospital's community. Accordingly, the typical hospital today does not know whether the services it provides are appropriate, necessary or even desirable from the community's perspective and whether the services, individually or collectively, are contributing to the health status of the community or to the affordability, accessibility and effectiveness of the community's health resources. Few hospitals are even able, with any precision, to identify their service community, and the population base that is required as the denominator for any measures of community effectiveness.

These are strong statements; unfortunately, they are true. Today, hospitals are as backward with respect to systematic approaches to their community health responsibilities as hospitals were with respect to systematic approaches to controlling quality in 1919 when the American College of Surgeons initiated the hospital standardization program.

In this situation, the basic elements of minimum standards for community hospitals are not difficult to define:

1. New standards must be developed requiring a community

hospital to define its service population on a geographic basis, to analyze that population's health problems and resources, and to identify the estimated impact of current and projected programs of the hospital on the health of that population.

2. New standards will include much more precise criteria for hospital mission statements, with special reference to improving the community's health status, avoiding unnecessary duplication of services, containing costs, and avoiding excessive emphasis on high technology and acute in-patient care. The standards will require evidence of commitment by individual members of the governing body and of the top management team to the hospital's community mission.

3. New standards will spell out criteria for determining the effectiveness of the linkages between the hospital and its community: including linkages with (a) organizations of key consumer groups such as labor unions, corporations, retired persons, neighborhood groups, (b) financing organizations such as Blue Cross/Blue Shield, HMOs, insurance organizations, (c) other health organizations, particularly other hospitals and group practices and institutions providing specialty services and services to special groups, such as the aged, (d) government, particularly at the local and state level, (e) professional societies, particularly medical and nursing and social work groups, (f) community organizations, particularly those concerned with families and family planning and with the underprivileged and handicapped, and (g) educational institutions, particularly those with interest in or commitment to education in health, health services, and health service management.

In particular, the standards will require evidence of provision for community input in the hospital's planning, decision making, and evaluation processes.

4. Evidence of cooperative arrangements with other institutions to reduce duplication of services, particularly in-patient services, and high tech services.

In addition, the standards will require evidence of assurance of comprehensiveness and continuity of care through formal networking with other health service organizations, including specific institutions beyond the community, specializing in care not available in the community.

The revitalization of the community hospital will depend

upon this institution becoming an integral element of a community health service system for all the people in the community. At this point in history, a completely autonomous, stand alone, community hospital is a contradiction in terms. A community hospital must be a key link between the community and other health and human service agencies serving its community.

Most communities are served by more than one hospital. In this situation, community hospitals are those which are committed to develop networking and cooperative arrangements with other hospitals committed to serve that community. A community hospital serving many communities that are, in turn, served by many hospitals must, therefore, necessarily have an extremely strong and highly developed commitment to and capacity for networking and cooperative arrangements.

Frequently, in these situations, corporate merger will be the preferable way to assure businesslike inter-institutional arrangements, so long as the linkage with the community interest is not weakened thereby. The unique challenge to the multi-hospital and multi-institutional health care corporation is the creation of an organizational and decision-making framework to maintain visible and viable commitments to specific communities.

No community hospital in the United States--no matter how large or complex--is able by itself to meet all of the health care requirements of its community on a cost-effective basis. Therefore, commitment to the community necessarily requires commitment to overall organization of comprehensive, coordinated, continuous, quality, cost effective service for all, in short, to an organized system.

In the years ahead, a community hospital will most easily be identified by the nature of its explicit commitments--by contracts--to a larger health service system which, among other things, shares its dedication to its defined community.

5. Evidence of outreach programs, involving provision of care beyond the hospital walls, particularly for primary care, home care, care for the chronically ill, hospice care, substance abuse programs, mental health programs and other health promotion and self-help programs, for self-supporting as well as dependent individuals and families.

6. Evidence of some form of rudimentary community-focused cost effectiveness analysis as the basis for

allocation of resources, inter-institutional linkages, introduction of new technology, and for shrinking the system.

7. Evidence of contractual linkage with one or more health care financing and marketing organizations with shared community goals, preferably a Blue Cross/Blue Shield Plan strongly committed to community service.

8. Evidence of specific programs and activities directed at those individuals and groups who are not in the marketplace, and for any number of reasons do not have ready access to quality, cost effective personal health services.

For the nation as a whole, the population (exclusive of Medicaid) which is uninsured is currently reported to be about one person in six. In many communities, the ratio is much higher. In addition, people slip in and out of this category from time to time, so that the proportion of the community's population who may be without adequate financial protection against health costs and who are necessarily the special responsibility of the community hospital is even larger. Community hospitals are required to design their programs in relation to the health service requirements of all the people in the community, but will necessarily develop special service and preferential financing programs to provide protection to those without financial protection. In doing so, community hospitals will enlist as much help from government and other community agencies as possible. For the foreseeable future, however, community hospitals are the institutions through which society demonstrates its capacity to care about this not inconsequential segment of the population.

Each of these eight points are developed in greater detail in various position papers and publications of the American Hospital Association and other organizations. In any given situation, these points can be explicated with ever more specificity by community and professional leadership on an incremental basis, depending on the dynamics of the situation, the degree of leadership, the resistance to change, and the scarcity or availability of resources.

As is customary in the health field, standards for community hospitals should initially emphasize commitments, process and structural standards, and in time place greater emphasis on outcome standards. Initial emphasis on outcome standards could be counterproductive.

Standards can be developed and administered at the

community, regional, state or national levels by official or voluntary organizations--or preferably by various combinations. The sooner individual hospitals have the opportunity to declare themselves as meeting accepted standards as ethical community hospitals or as non-ethical non-community hospitals, the sooner appropriate rewards and penalties can be put in place to encourage ever stronger community commitments, by as many hospitals as necessary.

We will undoubtedly always have both community and non-community hospitals. There is nothing wrong with that. The leadership of each hospital can make its own decision as to whether it prefers the tougher but more rewarding task of community service, or the simpler and possibly more lucrative task of marketing hospital service units. What is required is a method for distinguishing between the two, so that the two quite different kinds of institutions can be treated differently. I personally have little doubt about how most buyers will respond to the opportunity to choose. Buyers will choose in the community interest, if the issues are clearly spelled out by national and community health care leaders in terms of more effective health results, less money and fundamental ethical standards, and if the marketplace has the opportunity for informed choice among competitive systems at the community level. In many communities today a great deal of work will be required on an incremental basis to create an environment in which community standards will shape the hospital marketplace.

Initiators of Incremental Steps Leading to Revitalized Community Hospitals

Any of the following can take steps leading to development and acceptance of adherence to new standards for community hospitals, as outlined above.

1. Hospital trustees.

2. Practicing physicians, particularly those with hospital medical staff responsibilities.

3. Hospital managers.

4. Multi-hospital organizations.

5. Hospital associations, metropolitan, state, regional, and national, as well as those involving special types of hospitals.

6. Professional associations of hospital and health service executives, particularly the American College of Healthcare Executives.

7. Professional associations of physicians, nurses and other health groups, at the local, state and national level, particularly specialty societies such as the American College of Surgeons.

8. Community and business health-cost coalitions and their sponsors, particularly large corporations and unions.

9. Accrediting bodies, such as the JCHA, AAMC, the Residency Review Boards, and the NLN.

10. Blue Cross/Blue Shield Plans and other financing organizations, HMOs and PPOs.

11. Government agencies at the federal, state and local levels, including licensing bodies.

12. Philanthropic foundations, such as the Kellogg Foundation and The Robert Wood Johnson Foundation.

13. Academics, particularly those associated with graduate programs in health administration.

14. Other community, consumer, and professional leadership.

Each of these can begin to take incremental steps leading to an ever clearer distinction between community hospitals and non-community hospitals, and a preference for the former. As the nation develops a clearer perspective with respect to the trend in the ratio of these two fundamental classes of hospitals, it will be much easier to make and carry out effective health policy at all levels.

Most national health policy experts with which I have discussed the distinction between community hospitals and non-community hospitals believe that the proportion of community hospitals is so small as to be inconsequential. Further, they believe that any attempt to encourage hospitals to identify themselves to the marketplace as either community or non-community focused would not increase the proportion of community hospitals, probably the reverse. They may be right, but I don't think so. In this situation, it is imperative

that anyone in any of these 14 groups who believes in the value of community hospitals begin to take action, and quickly.

An attempt to set forth the incremental steps that leaders in each of these 14 groups can take to help to challenge community hospitals would transform this lecture into a book. Let me just suggest a few highlights with respect to one of the groups, the hospital trustees, probably the most important and most overlooked group.

Trustees of Community Hospitals

Hospital trustees are the most important group of all because they are responsible for hospital governance and for the relationship between their hospital and the community. Almost all are well-intentioned, and want to do the right thing. All want their hospitals to be business-like, but few are serving as hospital trustees in order to extend their business activities. They get enough primary emphasis on bottom lines, corporate restructuring and market-share in the other phases of their lives. Most originally joined a hospital board with the intention to serve their communities; many are clearly frustrated by the nature of hospital trusteeship today.

The fact is that most business and community leadership interested in health policy and cost containment simply do not trust hospital trustees, even those trustees who come from their own organizations. Hospital trustees are most commonly viewed as captives of entrepreneurially oriented hospitals, governing self-serving institutions, rather than engaged in public service, reflecting public or community concerns. Hospital trustees are viewed in much the same way as those Congressional members of appropriations committees who are known to be captives of the agencies supported by the appropriations. By contrast, highly respected Congressional appropriations committee members will always be fiercely independent, tough on the administrators of the government agencies affected, who will value their public point of view, interest, and support. These highly respected Congressional appropriations committee members will never become the pawn or lackey of the agency or the agency executive, but will always rise to defend the executives and the agency against unwarranted attack.

Because of the public and community responsibilities of hospital trusteeship, the Congressional governance model is

much more appropriate than the corporate governance model, so often advocated.

The current hospital serving model of hospital trusteeship is no longer valid for the community hospital. What is good for the hospital is not automatically good for the community (to paraphrase General Motor's Wilson). The time has come to shift to "what is good for the community is good for the hospital!" The current hospital trustee culture must begin to change in the community hospital. For the non-community hospital, the shift to a more classical business corporate model is appropriate. For the community hospital, the shift to a more public, legislatve model is preferable.

The cultural shock involved in changing the nature of community hospital boards can be very great. For example, in the typical hospital board today, a new trustee who speaks up aggressively for the community is typically assigned to the safety committee or the building and grounds committee for three or four years until they learn the ropes. Most are not prepared to wait that long; neither is society.

Those involved with developing and administering new standards for the behavior of trustees of community hospitals must approach the change in function incrementally, empathetically, and with patience. An important starting point is re-examination of how the Board of Trustees conducts its business: how the committees function, the kinds of issues that are considered, the nature of issue papers presented to them, the extent to which issues are focused in terms of community interest as contrasted with narrow institutional interests, whether alternatives are considered, the extent to which policy and management issues are separated, the process and the time allocated to different decisions, etc. Examination of most hospital board meeting agenda books demonstrates how backward and unbusinesslike many hospital boards are at what Michael Davis used to call "the business of the community." All of these matters make up the details of any effort to develop new standards for community hospital trustees.

Well-motivated hospital trustees--that is, most of them--will respond positively to new standards for their behavior, once they understand what is expected of them. Close to 100,000 strong, these men and women can be a powerful force for improvement of community health and conservation of scarce resources.

Clearly, such organizations as the Joint Commission on Accreditation of Hospitals, the American Hospital Association, hospital licensing boards, the Business Roundtable, philanthropic foundations--in fact, all of the groups mentioned above--can play a role in helping to redefine the hospital trustee role and culture. All can get started tomorrow.

The Role of Selective Contracting in the Revitalization of the Community Hospital

A. Some Historical Background

Selective contracting for hospital services has been an element on the hospital scene, and well documented for over 60 years. In the earliest days, specific hospitals contracted with one or more selected subscriber groups (Baylor, Texas). In other situations, a employee-employer benefit group has contracted with one or more selected hospitals (the UMW Welfare and Retirement Fund). In most communities, a non-profit community organization, authorized to use the Blue Cross symbol, contracted both with hospitals and with buyers, including employed groups, individuals, and governmental agencies. Under special enabling legislation in most states, Blue Cross/hospital contracts as well as subscriber contracts were subject to approval and regulation by the Insurance Commissioner, the Health Department, or both. Public hearings by Insurance Commissioners on changes in Blue Cross/hospital contracts date back to the 1950s.

From 1953 on, hospitals, Blue Cross Plans, and other contracting parties were guided in their negotiations by the "Principles of Payment for Hospital Care", which were developed at a series of conferences of hospital and payer agency leaders including government officials, conducted by the American Hospital Association. This document was revised most recently in 1965. These Principles set forth the obligations of both parties, including obligations for studies of costs and utilization that will have "value for the entire community as well as for the agencies involved." These AHA Principles, however, accepted the mistaken notion that although "individual hospitals face different financial problems...they must deal with contracting agencies as a group."

The Principles provided the basis for the original Medicare hospital contract. These Principles excluded reimbursement for charity, bad debts, education, research and

various capital costs, except under special circumstances, related to the communities served.

After the American Hospital Association adopted the misguided policy that prices should be set at a level to recover "full financial requirements" of individual hospitals, little attention was paid to the Principles of Payment. Subsequently, Medicare eventually developed a much different approach, based on so-called Diagnostic Related Groupings (DRG's), moving away from contract prices based on the costs of individual hospitals. Interestingly, however, an exceptional preferential approach was developed for over 300 sole community hospitals, defined in the most limited way on the basis of geography. An interesting beginning in special recognition of community hospitals. The sole community provider regulations do not yet recognize that it is much more difficult to finance a sole community hospital in a multi-hospital community than in an isolated geographic area with no competing hospitals.

B. Community Hospital Approaches to Selective Contracting.

In a period of selective contracting, it is clear that individual hospitals cannot and should not deal with contracting agencies as a group.

A community hospital can and should negotiate with contracting agencies in conjunction with other hospitals and health service agencies with which it has contractual relationships involving an integrated health system for its designated community. But it should not join with other hospitals that are not linked in such a system. A competitive approach to contribute most effectively to the community's health on a cost-effective basis is to be preferred.

Except under very special circumstances, community hospitals should not respond to offers to bid on serving sick people, if the bidding arrangements make no provision for supporting essential community services. The very idea is abhorrent to any responsible community organization attempting to be responsive to human needs. All contractual arrangements by community hospitals should be based on negotiations or bids that involve not only the nature of the service to be provided, but the characteristics of the population to be served, and the mutuality of goals of the contracting parties in relation to the community.

Ideally, a community hospital will identify a contracting organization that will conform to community standards, and that can represent the hospital in its negotiations and dealings with buyer organizations. Ideally, the contracting organization's community commitment would be so strong that it could also serve to represent the buyers, as well as the providers, a true intermediary role.

This was the traditional role of Blue Cross, which has more experience and expertise in hospital contracting than any other organization, serving hospitals not only for Blue Cross subscribers but also most Medicare beneficiaries as well. Blue Cross, through its intermediary contract arrangements, currently handles a majority of all hospital revenues in the nation.

If some Blue Cross plans have lost their community service identification so that they cannot serve the hospital's community objectives, hospital and other community leaders in these areas may have to re-invent it. As Rufus Rorem has said, there's nothing stupid about re-inventing the wheel if it has gotten lost. In any event, the time has come to re-examine and attempt to re-vitalize the community hospital/Blue Cross relationship to better serve communities in a period of selective contracting.

Risks and Opportunities of Selective Contracting

The risks and opportunities of selective contracting are staggering. The risks were well stated in a recent editorial by Emily Friedman:

> The question is really one of fiscal responsibility, in the true sense of that phrase. To encourage hospital efficiency by selectively contracting with cost-effective institutions is a popular concept that has been implemented by Medicaid programs, employers, and insurance organizations nationwide. Blue Cross, in fact, started out as a selective contractor that required certain standards of quality. But if selective contracts are let on a price-only basis, with no consideration for the costs of indigent and tertiary care, the hospitals that suffer most will be those that care for the poor, support graduate medical education and research, and are major Medicaid providers. Price-only PPO contracts could speed the deterioration of some of our most socially conscious hospitals.

The Blues have long been proud of their record of community service. Hospitals are, by and large, eager to participate in the competitive market. What is needed is dialog, accommodation, mutual understanding, and creative solutions. Otherwise, both sides will be wounded by a wave of lawsuits and bad feeling that will not address the central issue: how to combine the social responsibilities of hospitals and Blue Cross and Blue Shield with the need to control costs and promote hospital efficiency.

A more systematic analysis of the risks and opportunities of selective contracting to community health service is included in a paper prepared by Ted Raichel and Rich Maturi of the Blue Cross/Blue Shield Association for the National Advisory Committee of the Robert Wood Johnson Foundation's Community Programs for Affordable Health Care, chaired by John Dunlop, a leader in the community coalition movement.

Among the opportunities are: (1) more affordable health care for enrollees and others, (2) a more efficient and effective health care delivery system, and (3) stronger and fewer hospitals.

The risks of selective contracting are: (1) erosion of commitment by hospitals to serve those who cannot pay and who are not covered by government programs, (2) erosion of hospital commitment to essential medical standards of professional education and quality of medical care, (3) disappearance of high cost/low use essential services, (4) cost shifting from low risk, low cost populations to high risk, high cost populations, thereby increasing the proportion of the community's population that cannot afford to pay, and (5) undermining of the more responsible community hospitals by non-community hospitals as the system inevitably shrinks.

Communities associated with the Robert Wood Johnson Foundation's Community Programs for Affordable Health Care, which incidentally is co-sponsored by the American Hospital Association and the Blue Cross/Blue Shield Association, are addressing these opportunities and risks in a variety of ways to help assure that selective contracting is designed to contain community health care costs, without major adverse effects. There appear to be six approaches:

1. Agreement on minimum standards for acceptable contracting, relating to comprehensiveness of benefits, quality of care, commitment to serve those who cannot afford to pay, commitment to community rating, or avoidance of

discriminatory marketing and underwriting practices.

2. Agreement to exclude various elements of community hospital financial requirements from the contract price, and to finance these elements through grant programs or other acceptable methods. Such elements might include: capital requirements, free care, high cost/low use essential services, and medical education and research.

3. Agreement to include non-competitive standard factors in competitive contract prices for selected elements, such as noted above, with the revenue derived to be pooled and distributed in accordance with acceptable community agreements.

4. Commitment to cooperate with and support community-wide approaches to orderly shrinking of resources, and to avoid the adverse effects of bankruptcy on the community.

5. Commitment to development of subsidized contracts for low income and uninsured population.

6. Agreement to participate in a single community care network which provides for selective contracting under an umbrella organization that incorporates all or some of the above elements, including a variety of monitoring devices.

Communities in which leadership from business, labor, hospitals and payor organizations are exploring these approaches include such widely divergent places as Worchester, Massachusetts, the Twin Cities in Minnesota, and Phoenix, Arizona.

Standard Setting for Selective Contracting Agencies

All parties directly or indirectly related to selective contracting require standards to guide their behavior in relation to their community commitments.

Community hospitals require standards as to the characteristics of the payment agencies with which they might selectively contract, as well as the characteristics of the contracts that they might enter into with beneficiary groups directly or through payment agencies.

Payment agencies with the type of community commitments on which Blue Cross was originally founded require standards as to the kinds of contracts that they should enter into with

community hospitals and non-community hospitals, and with corporations, unions, and other beneficiary groups with varying commitments to their communities.

Beneficiary groups with community commitments also require standards with respect to community financing agencies with which they might contract.

The Blue Cross/Blue Shield Association in conjunction with the American Hospital Association and other organizations representing buyers and sellers might well take the lead in organizing a working conference to develop standards for selective contracting agencies to serve as intermediaries for community hospitals and for buyers concerned with community health services.

Consideration should be given to exploration of contracting involving not only payment for and management of specific health benefits, but also philanthropic contributions for elements of community hospital service that might be financed on the basis of program grants. Particularly with respect to corporate contributions through corporate foundations, such an approach would take real pressure off the benefit managers and greatly increase the influence and skills of corporate executives involved with community philanthropy.

A Time for Decision

Some hospital leaders believe that whatever happens to the healthcare system in the United States, there will always be community hospitals. If by community hospital, one means an institution with a responsible governing body, mission, medical and nursing staff, and capacity to plan and manage in relation to community health objectives, this is not necessarily true. There are no community hospitals in Great Britain; the only hospitals with any organizational and managerial identity are investor-owned institutions, related to the marketplace, not to the community. All of the former community hospitals in Great Britain are now simply elements of health district organizations with no organizational identity at all. The taxi drivers and the people know where the hospitals are, but they are not in the phone book and they have no management, governing body or organized medical staff that can bring out the best in them. The whole management team of each of the elements of each of these hospitals is at the district level, including even the Director of Nursing.

Eventually, if community hospitals in this country do not

assume responsibility as key organizational entities for optimum personal health services provided on a cost effective basis in the community, they too will lose their identity. New forms of community health service organization will emerge. In this eventuality, community health services will suffer during the long transition that will be required before new forms of community health service organization emerge and begin to work effectively.

In almost all communities in this country today, to paraphrase Winston Churchill, the community hospital is probably the worst possible organization for coordinating and promoting the health of the people--except for all other available alternatives.

Some may wonder--even assuming that my vision of the community hospital makes sense--whether many existing hospitals can get there from here--or if the transition effort is worth the bother that would be involved. For these, I urge you to visit some of our most outstanding community hospitals, as Paul Starr and I did the other day at the Park Ridge Hospital in Rochester New York, and study its transformation during the past decade. I remind you of earlier transformations of hospitals in earlier periods, and urge you to think about the frustration, pain, costs, and risks associated with alternative approaches to protecting and preserving the health of the people in communities in the United States during the remainder of the twentieth century.

The only alternatives currently under discussion--a free marketplace approach, massive government regulation or ownership, or corporatization of medicine--would all be much more painful and difficult, and fraught with many more uncertainties as to the outcome, in the absence of community hospitals.

Community HMOs theoretically could be conceived of as a preferable alternative, but this is an idea that has never been discussed by anyone, particularly those connected with HMOs today. Ultimately, re-awakened community hospitals might well evolve into key elements of community HMOs, or visa versa.

Those who believe that community hospitals can have a key role to play in provision of cost-effective personal health services have a unique opportunity and responsibility for leadership at this time. We must challenge those who might be selectively contracting for services of hospitals: Blue Cross

plans, HMOs, insuring organizations, corporations, unions and other buyers and government agencies. Those groups should develop selective preferential contracts with institutions which meet community hospital standards and they should hold out hope to other hospitals to aspire to this goal.

In particular, I challenge hospital trustees, medical staff leaders and managers of hospitals and multi-hospital systems. I urge their support for the development and adherence to explicit community hospital standards.

I challenge leaders in hospital accreditation and licensure, and of national state and local associations of hospitals, physicians, and other health related organizations. These groups can become advocates for a process of distinguishing between community hospitals and other hospitals in all contractual arrangements.

I urge leaders in health service education and in philanthropic foundations to support the development of standards for community hospitals and to support the concept of rewards for those associated with them.

In the original Michael M. Davis lecture, Dr. Davis himself challenged medicine to accept the primary responsibility of the public in deciding how the people will spend their money for health care to bring the full potential of this important service into the lives of everyone. I would also stress the key role of the medical profession, but expand that challenge to include everyone associated with contracting for services of hospitals at the community level. The time has come to abandon adversarial relationships among those providers and buyers who are dedicated to community health service objectives. The time has come to work together at the community level to strengthen the community fabric by common commitment to community hospitals dedicated to optimum cost-effective health service for all.

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SUMMARY PANEL DISCUSSION including David Dranove, Leonard Schaeffer, Leona Butler, and Robert Sigmond, with Odin Anderson presiding.

QUESTION. It appears that one of the things that has happened in many of the selective contracting areas is that it's been necessary to repeal legislation that forbids selective contracting. I'm curious about the motivation behind the original legislation.

LEONA BUTLER. As I understand it, those provisions originally were to ensure that a company like Blue Cross would not simply contract with a few friendly hospitals and then not contract with others, so that people would be denied payment for care if they went to one instead of to another. Now, it's very interesting, because it was the original PPO concept, if you will. I think the point is that today freedom of choice must remain available but that the individual get some responsibility back for the ramifications of the cost of that choice, so that in a well-designed kind of program, people can still go into a total freedom-of-choice kind of standard insurance plan but will have to pay something for it in the form of co-payments, deductibles, or higher premiums. But the principle was to give people access, total access, total freedom of choice, to any qualified provider of care.

QUESTION. [Re vertical organization of health care systems] I'm wondering if I can ask Mr. Schaeffer if he had any thoughts about which one would be better in terms of ensuring quality of care. Is it better to have something like a Kaiser model, or something like a Mayo Clinic model?

LEONARD SCHAEFFER. I think you're asking a question that's not so much about health care but about the optimum way to organize. What you see depends on where you sit. When I was in the federal government it was quite clear to me that one national policy with one person making all the decisions would solve all the problems. I have moved a bit from that. Still, I think if what you want to achieve is what Bob [Sigmond] was talking about, the hospital as a community resource, you have to be centralized to the maximum amount possible. I do think, though, that you have to create situations where economic incentives work on all the players; in other words, you can't have risk being assumed by an HMO and not by a hospital. You have to have a situation where everybody on the team wins or everybody loses, which is really what they have at the Mayo Clinic.

The other point I would make about the Mayo Clinic, which I think is an extraordinary institution, is that the first time I went there it reminded me of IBM in the 1950s. It's one of the most--"autocratic" isn't the right word, but it is so rigorously and procedurally run. I mean, all the doctors' offices are the same size; all the decor is mandated; it's a very unusual place. I've never seen the Mayo Clinic model replicated any place. It is utterly unique that physicians all buy into that, so I think it's extraordinary. But I think you have to balance the organizational need to be decentralized with the employer's need for ease of administration. Multi-site employers want one administrative mechanism to be used across as many sites as possible. That's why I think Blue Cross has been so successful: it provides administrative ease to the employer who foots the bill. So what you want is some administrative mechanism that makes it easy to do the financing but have the medical decisions and the operational decisions more closely linked to the needs of the people in the community.

I want to make one point about Bob's presentation, which I thought was excellent. It reminds you of the power of ideas, and a lot of stuff that we've lost over time. Every time I've made a jump in my career I've been odd man out. When I came into health care, the notion of financial management was just not a very attractive notion, and there just weren't many people who were really strong managers. Now when I deal with hospitals in our area, there are more pin-striped suits on their side than on mine. Everybody is clean-cut and they all have M.B.A.s, and the notion of community hospitals, I think, is dead and buried, nine times out of ten. The bottom-line--survival--is the ball game. So my point to Bob is that the problem with the hospital is the economic incentive. You've got all this brick and mortar, and to survive you have to have a whole lot of money coming in, which you should get filling up the hospital.

I would just, for the sake of discussion, mention the notion of a community HMO, which is what we think we are; we're the only not-for-profit, community-owned organization in the Twin Cities. We don't have to fill up the hospital. Our economic task isn't quite as burdensome and allows us to do certain things from a public-service point of view. I buy all the ideas that you mentioned and support them personally, except that I'm not so sure that the hospital is the right vehicle. The financial imperatives that surround all this brick and mortar cause you to become bottom-line-oriented,

because you need X amount of money every year just to keep the floors clean and to do other things. I would go for a community base, but I think you want an organization that's broader, and an organization that perhaps permits you to be a little more flexible. Still I thought the talk was excellent and it really cheered me up; I haven't heard that for a long time.

ROBERT SIGMOND. I personally would like to see the evolution of community HMOs. I don't care whether they evolve out of hospitals' getting tired of sweeping floors and putting mortar between bricks or HMOs taking on the hospitals: there are HMOs that own hospitals and it seems to work out quite well. The thing that I don't see, Len, and I'd be interested in your commenting on it, I don't see any HMO that has made a commitment to be concerned about and to direct its programs and its activities to the overall community. By its nature, as far as I can tell, the HMO serves its beneficiaries. The fact that it's non-profit isn't to me the key point. The question is, what is its mission; how does it carry out its mission; what proportion of its resources does it allocate to community services that are not related to its beneficiaries? And if some of the HMOs are doing that, they must be doing it quietly, because they don't want to disturb some of their accounts. But I think that's an exciting way to go, and I'd be interested if you sense that there is some movement along that line, that they're doing it but just don't want to come out of the closet and say so, because of marketing problems.

LEONARD SCHAEFFER. Well, I happen to know of one in the Twin Cities that's doing it, and I think it's safe to say that nobody cares, that that is not a viable way to attract anybody or to get much in the way of positive reinforcement. Also I think that we fail to do something that is very important in this community because operationally we don't think it's our job, and that is pure research. We are not in that business at all. We do some applied research, but we don't fund the kind of activity that I think is very important, at universities and other centers of excellence. That makes us unpopular with the people who might otherwise find us attractive. We also have a limited teaching role: we don't get involved in the classroom stuff, although we do provide teaching opportunities and learning opportunities for residents and sometimes for interns.

I think the fundamental issue is the point you made about the health of the community. And that used to be very popular and very important, until people realized how expensive it is,

and how long-term it is. Most employers buy the concept of wellness, but the problem is, wellness doesn't pay off unless the employee stays with you from day one until age eighty, because you really get the benefits over a person's life. We put a tremendous amount of money and a tremendous amount of effort in there, and it really doesn't turn on any employers at all. They're just not interested in it.

Another thing that we have tried to do is to get involved in what we think are the key life-style issues. Smoking is one. All of our facilities are now or soon will be smoke-free. That is your basic loser. I tried to persuade the hospitals in the Twin Cities to make their facilities smoke-free. No way; they just won't do it. If you look at most of the people in this room, statistically speaking, the greatest threat to your life if you're going to drive this year is an automobile accident. There are two issues: one is drunk driving; the other is seat belts. They are both major loser issues. We invested a tremendous amount of money in an anti-drunk-driving program. In Minnesota, and I would think here in Chicago, "real men" drink, and only sissies don't; and only sissies buckle up their seat belts. I think there's hope for the future, but it doesn't really sell.

So what you have to have, I think, is a commitment, as Bob was saying, but you have to have the economic flexibility to pursue those things without worrying about filling up the beds in your hospital. It's a very idealistic approach; I think idealism has left health care, or does not play the role it once did, and I think it ought to come back. People who are attracted to the caring professions want to help other people. That reservoir of idealism is being siphoned off into all this bottom-line stuff, market share, and all the things that everybody accuses me of.

I just don't think the hospital is the vehicle. Hospitals were invented to make things easier for doctors, and they are effective and efficient for physicians; they're physicians' workbenches. I don't think that they mirror the needs of the community. I believe that they lead to in-patient, test-intensive activities. They tend to make things expensive. They tend to make things complex, given where medical science has brought us today. I'm not being at all critical about the past, but today out-patient care, fewer days of care, less-intensive care, and fewer invasive tests are all desired. I think we need a vehicle that supports where medical science has brought us, but that also has the idealism of the community hospital, and a respect for the

health of the community. I don't know how you get that vehicle, but I think HMOs or pre-paid systems might be a good way to do it.

DAVID DRANOVE. I suggest that it's a good idea not to generalize about hospitals the way you would generalize about Italians or anybody else, but look at them one at a time, examine what they do, and don't make that kind of categorization that makes them all the same when they really aren't, any more than HMOs are all the same when they really aren't.

LEONARD SCHAEFFER. Now you've got a deal. I'll be careful about hospitals--no ethnic jokes about hospitals--if we can do the same for HMOs.

QUESTION. As a selective contractor one is always concerned about the teaching hospital. In a time when there weren't enough physicians certainly a teaching hospital would fit into Bob's category of the community hospital. In a time enow that there's a surplus, and it's going to be a growing surplus, I don't see how in that sense a teaching hospital can fit into your category of community hospitals. I'm curious how any of the panelists would address that problem, in light of the competitive market; whether that really is the answer to it.

LEONA BUTLER. I really want to respond to that, because I cut it out of my remarks when I saw time getting short. Our experience is very, very limited in terms of time-frame; I must put it in that context, honestly. However, we were able to achieve contracts that went through a selective bidding process but allowed actual points, if you will, for community activities, and so it was taken into account. We were able to contract with four of the six university teaching hospitals in the state. We did not find price to be a real issue with that contracting process. With one or two it was, but they were able to meet a price or come to a price with us that was better than some of the tertiary care, non-teaching institutions, and I'm speaking now about the actual university-based, not a related hospital that has some teaching programs.

Now, long-range, I don't think the answer's so simple at all, but that as a matter of fact, contractors, as Bob suggested, must take into account the need for maintenance of the teaching programs, and that has to be a consideration in the contracting. However, I think we will see many

institutions that have residency programs having to drop those programs. Given the oversupply of physicians, particularly in the specialties, that exists today, I don't know that that's such a terrible thing to happen, but it must be watched.

DAVID DRANOVE. I'd like to add to that. The full cost of educating a medical school student may be $100,000 or more. Tuition runs, perhaps, $10,000-$15,000 per year. This suggests that every single person who buys into Blue Cross or any other health insurance plan is subsidizing every medical school to the tune of approximately $340,000 for that person's career. I believe one of the thrusts of selective contracting is, for better or for worse, employers who are buying health care are saying, "We're not going to subsidize anybody but ourselves." That's going to mean teaching hospitals are going to be hurt; community hospitals that offer services that are not appealing to the employers that are signing the contracts are going to be hurt as well. As I said earlier, I think it's good that we're going to put our cards on the table and decide once and for all what we are going to support and what we're not. I'm afraid teaching, when we look at how much it's been subsidized, may be a loser.

COMMENT. Another one may be care to those who are indigent--those not covered by the MediCals and the Blue Crosses of the world.

LEONA BUTLER. I really have to take issue with what David just said, because I do believe that the insurance company that purchases services from an institution has a responsibility to ensure that indigent care, teaching and other programs that are needed continue. I believe that the informed purchaser can work out a means whereby that can occur. It may mean a diminished number of slots in medical schools. Indigent care is a lot tougher issue, I think, than teaching.

DAVID DRANOVE. Fortunately or unfortunately, depending on your point of view, the ultimate payers owe their prime responsibility to their shareholders; and like it or not, individual shareholders are going to be subject to the free-rider problem: "Let somebody else pay for it; I invested in this company for profit." And if that's the way we are organizing the eventual decision-making power, we are going to have to face the problem sooner or later of paying the subsidies.

QUESTION. I'd like an answer from Bob Sigmond concerning

the community hospital. It does appear that to fulfill the functions of the community hospital, there are significant costs involved that aren't necessarily going to be recouped. Have you thought about this reward structure that would allow the community hospital to do what you would like it to do?

ROBERT SIGMOND. Well, I made some very brief references to it. I think that the most important point is to get away from this idea of full payment for the service. I don't know of any health system anywhere in the country--in the world--that works on that idea. The payment for services of hospitals and health service organizations is usually some combination of payment on the basis of price for specific services, some kind of capitation payment, and some kind of block grant payment. I think the most exciting idea on the horizon right now is the idea of having preferred provider arrangements by corporations who will pay on a price basis for things like DRGs. Then they will go back to paying for a lot of other services the way they used to, but on a much more sophisticated basis, through grants to their corporate foundations. Now, I think there are a number of advantages to that, of which the least important but maybe most dramatic is that you automatically achieve the objective of every corporate manager: you increase the profit margin, because to the extent that you put all those costs in the benefit payment, that's an expense. To the extent that it isn't, it's in the profit margin, goes to the corporate foundation, and is given out. Nobody cares that much what the manager does with the profit margin, just so it's there.

There are some other advantages. If we get back to the basic idea, and then develop a modern adaptation of it, of paying for capital costs, for example, on the basis of paying them only to those institutions that you have preferred arrangements with, so you have lower prices because there aren't any capital costs in the price, then the corporation can influence the health care system. And it can get some credit. It can even get its name back on new additions. There are all kinds of opportunities.

Further, you avoid giving capital costs to institutions that you know you want to close. I don't know what is more irrational than passing out a bottle of whiskey to everybody and then trying to get them not to drink it! There is no reason why capital costs, costs of education, or research should be in the price. There are a whole series of things that should be financed by community financing mechanisms. The more that you get out of the price, first of all, the more

affordable health care is to those who have to pay for it and the greater the opportunity for distinguishing community hospitals from non-community hospitals: the non-community hospitals just won't get anything except what they get in the price. That's what they want.

QUESTION. I'd like to return to the question of indigent care, uncompensated care. I think you're absolutely right in your characterization of what most bargainers would like to do by way of the prices they bargain for. I also think that we set a precedent twenty years ago of not covering costs of either bad debts or uncompensated care that don't apply to our subscribers, in Medicare and Medicaid. That was based on an even older tradition of Blue Cross not doing it. Now, I think it's a very serious problem, and the question I have is how, given that tradition and given this kind of motivation, do you get people who are looking for these kinds of arrangement to pick up that rather significant cost?

LEONA BUTLER. Bob made a very important point: how can you possibly include that in a price? It is a community issue, not the price for one employer, one insurer. There are some interesting models being looked at right now. Florida is trying one approach, a room tax sort of approach; there are other proposals out there. This is an issue that goes way beyond selective contracting today.

QUESTION. Bob, would you agree that providing care to the indigent is not part of a community hospital's role as you described it?

ROBERT SIGMOND. Oh, it's definitely part of a community's role.

QUESTION. But it shouldn't be picked up in the prices charged by the hospital.

ROBERT SIGMOND. Well, these are quite different things. Who else is going to assume society's responsibility to the poor while we have Reagans for president, other than the community hospital? It is their responsibility; it's society's reflection of that responsibility. Now the question is, how do they get that money? The policy in our field all along has been, you get it from wherever you can get it on a community basis, and you get it out of price as a last resort.

ODIN ANDERSON. I gather we are continuing the debate in the country generally between the community and the market in

some way or other. I think we might end on this exciting, or dismal, note. In any case, it is an important note. Thank you very much.

EVALUATION OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM: THE FIRST 18 MONTHS*

NELDA McCALL. AHCCCS, the Arizona health care cost containment system, is an innovative system for providing acute medical care services to the indigent population of Arizona, the only state without a traditional Medicaid program. Arizona's experience will provide insights for the debate now under way concerning the effectiveness of pro-competitive cost-containment strategies in both the public and the private sectors. Arizona receives federal funding for AHCCCS as a demonstration project of the Health Care Financing Administration.

AHCCCS is testing a number of cost-containment features simultaneously. It selects its providers through a competitive bidding process; these providers are reimbursed under a prepaid capitation system. The state itself is also reimbursed on a prepaid capitation basis by the federal government. Under the program, beneficiaries are assigned to a particular "gatekeeper" who manages their medical care, and they are required to make small co-payments for services they receive. The original legislation required that most of the program's administrative functions be contracted to a private administrator. The state has now taken over this function, although it has retained the option to contract out specific functions. In addition, the original legislation called for the program to include private, state, and county employees in addition to the indigent. To date, these groups have not been included. The counties determine the eligibility of medically indigent (MI) or medically needy (MN) individuals, and continue to provide long-term care and other services they had previously provided that are not covered under AHCCCS.

Those eligible for AHCCCS include all categorically eligible groups under Medicaid--Aid for Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) recipients--and those determined to be medically indigent and medically needy by Arizona's counties. The state receives federal matching funds for the categorically eligible but not for the MI and MN. As of May 1984, of the approximately 190,000 beneficiaries eligible for AHCCCS, over two-fifths were AFDC recipients, about one-fifth were SSI

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beneficiaries, and nearly two-fifths were in the MI or MN category. Benefits covered include most acute-care services: hospital, physician, laboratory, x-ray, medical supply, pharmacy, and emergency. Care at skilled-nursing facilities and home health services are not included in the AHCCCS program's benefits.

The evaluation of this demonstration is being conducted under contract to HCFA by SRI International of Menlo Park, California. The evaluation team also includes the Actuarial Research Corporation of Annandale, Virginia, and the Research Triangle Institute of Research Triangle Park, North Carolina. The evaluation includes assessment of program implementation, operation, and outcomes.

Problem of Rising Health Costs and Arizona's Response

In the past two decades, health care costs have increased dramatically, both in dollars and as a proportion of the GNP. Rising public expenditures have increased the access of low-income Americans to medical care. However, cost increases--especially in government-financed programs--have forced policymakers to seek ways to bring costs under control.

During the 1970s, many cost-containment efforts focused on regulation, by controlling the supply of health care resources to control overall expenditures. A number of recent proposals, called "pro-competition" approaches, suggest changing the incentives of health care providers as a means of controlling health care costs. Arizona's AHCCCS demonstration contains a number of these pro-competitive strategies. Their implementation and operation, as well as program outcomes, must be documented and assessed so that what is learned can be transmitted to other policymakers and program managers.

Evaluation Issues

The analysis of the evaluation issues is divided into two parts, an analysis of the implementation and operation of the program and an evaluation of program outcomes. These analyses, however, are closely tied, since analysis of outcome data cannot be done in isolation from knowledge of program operation issues.

The implementation and operation issues of this project are being studied by doing case studies. The implementation and operation issues include both the six major innovations in

the program and the seven other administrative and operational issues. The six innovations being tested in the AHCCCS demonstration are these.

1. Competitive bidding: having health plan organizations submit competitive bids for serving those eligible for AHCCCS in each of Arizona's fifteen counties

2. Prepaid capitated financing: paying these plans on a set fee for each enrolled participant rather than paying for every service rendered

3. Capitated payment by HCFA to Arizona: putting the state of Arizona at risk with a fixed capitation payment from the Health Care Financing Administration

4. Primary care gatekeepers: having primary-care physicians serve as "gatekeepers" to the entire health care delivery system

5. Restriction of freedom of choice: requiring participants to receive all program services for one year from the one plan that they choose or to which they are assigned

6. Co-payment: requiring participants to make nominal co-payments for service, to curtail unnecessary utilization

The other implementation and operation issues relate to the administration of AHCCCS and its function. There are seven.

1. Administration of the program. The original legislation required that the program's administration be contracted to a private administrator; now these activities are functions of the state.

2. An examination of the claim and encounter data system. The system by which capitated programs pay claims and collect encounter data is of importance in the current health care marketplace.

3. Eligibility determination, marketing, and enrollment activities. Eligibility determination for MN and MI eligibles is the responsibility of the counties; eligibility determination for SSI and AFDC eligibles, marketing audit, and enrollment were functions of the private administrator and are now functions of the state.

4. Analysis of whether high-risk beneficiaries tend to concentrate in certain provider plans. The presence or absence of selection bias can have a substantial impact on capitation payments to the plans and on the financial viability of the plans.

5. Relations between AHCCCS and county-provided long-term-care services. The AHCCCS program provides only acute care services, except for physicians' services to AHCCCS eligibles who are residents of long-term-care facilities.

6. Participation of public and private employee groups in the program. The program was originally designed to include public employees and private employee groups, although this has not occurred.

7. The impact of AHCCCS on the health care delivery system in Arizona. An innovative program of this type will have effects on the health care delivery system in general, and specifically on county health care systems, the availability of prepaid plans, special population groups, and community awareness of the necessity for cost-effective delivery of medical care.

The outcome issues to be studied include cost, utilization, quality and appropriateness of services, access to care, and satisfaction with care received. Does the AHCCCS program cost less than a traditional Medicaid program? How does the use of services in AHCCCS compare with that in a traditional Medicaid program? Is the quality of care provided in AHCCCS the same as in a traditional Medicaid program? Do patients have good access to care, and are they as satisfied as they would be in a traditional Medicaid program?

Data to be Collected

Both primary and secondary data collection activities will be conducted. Primary data collection activities include a household survey of beneficiaries, a mailed survey of providers, and an audit of the quality of care. Household surveys scheduled to begin in June 1985 will be conducted with approximately 1,050 AHCCCS beneficiaries in Arizona and with a control site sample of 650 Medicaid beneficiaries in New Mexico. The mailed survey is scheduled for July 1985 with 975 AHCCCS providers. A quality-of-care audit scheduled to begin in January 1986 will also be conducted. In this audit, approximately 2,400 ambulatory and 3,000 hospital records of AHCCCS beneficiaries and New Mexican Medicaid beneficiaries

will be reviewed.

Secondary data to be collected include cost reports submitted to the AHCCCS program by the plans, the claim and encounter data collected by AHCCCS from the plans, Medicaid claim data from New Mexico, and all documents, correspondence, and reports relating to the project's implementation and operation analysis.

Reference

Some results of the evaluation of the Arizona Health Care Cost Containment System can be found in Howard E. Freeman and Bradford L. Kirkman-Liff, "Health Care Under AHCCCS: An Examination of Arizona's Alternative to Medicaid," Health Services Research 20:3 (August 1985); "The Arizona Experiment: Competitive Bidding for Indigent Medical Care," Jon B. Christianson, Diane G. Hillman, and Kenneth R. Smith, Health Affairs, 2:3 (Fall 1983); and "Refusal of Care: Evidence from Arizona," Bradford L. Kirkman-Liff, Health Affairs, 4:4 (Winter 1985).

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