

NIHCM Reception

1 Nov 1994  
5:30 PM

OCT 28 1994



Arkansas  
BlueCross BlueShield

Robert D. Cabe  
Senior Vice President,  
External Services  
520 W. Capitol, Suite 1100  
P.O. Box 1489  
Little Rock, Arkansas 72203-1489  
(501) 378-2436  
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October 27, 1994

Ms. Carol Rasco  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, D.C. 20500

Dear Carol:

We are delighted that you will be able to join us for a portion of the evening's festivities in connection with the annual board meeting of the National Institute for Health Care Management.

I am enclosing for your information a package of materials which were prepared and distributed in connection with an NIHCM national teleconference in which we participated. It will provide some information about the NIHCM and about that particular event.

We are also looking forward to meeting with you at 5:00 p.m. on Tuesday, immediately before the NIHCM reception.

With best regards, I am

Cordially yours,

A handwritten signature in black ink, appearing to read "RDC".

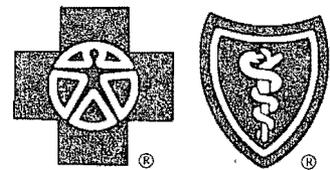
Robert D. Cabe

RDC:baj  
Enclosure

cc: Mr. Robert Shoptaw  
Mrs. Sharon Allen

**Talk To People Who Listen.**

Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company



**Arkansas**  
**BlueCross BlueShield**  
Talk To People Who Listen.

**RATING  
&  
ANALYSIS**  
1994



**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association



*The Insurance Information Source*

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**ARKANSAS BLUE CROSS and BLUE SHIELD**  
**FINANCIAL HIGHLIGHTS**

**1993**

**CONSOLIDATED FINANCIAL INFORMATION\***

	<b>BALANCE SHEET</b>	
	1993 (SEE NOTE 1)	1992 (SEE NOTE 2)
<b>WE HAVE:</b>		
Cash and Cash Equivalents	\$ 77,110,000	\$ 92,998,000
Investments	159,510,000	130,675,000
Accounts Receivable	36,957,000	31,537,000
Property and Equipment	24,093,000	19,556,000
Prepays and Other Assets	35,066,000	23,009,000
<b>Total Assets:</b>	<b>\$ 332,736,000</b>	<b>\$ 297,775,000</b>
<b>WE OWE:</b>		
Claims Payable	\$ 86,466,000	\$ 83,643,000
Unearned Premiums	25,639,000	18,115,000
Accounts Payable and Other Liabilities	41,875,000	48,901,000
<b>Total Liabilities:</b>	<b>\$ 153,980,000</b>	<b>\$ 150,659,000</b>
<b>WE HAVE SET ASIDE:</b>		
Unallocated Reserves	178,756,000	147,116,000
<b>Total Liabilities and Equity:</b>	<b>\$ 332,736,000</b>	<b>\$ 297,775,000</b>

**SUMMARY OF OPERATIONS**

Premium Income	\$ 456,075,000	\$ 430,212,000
Investment Income	8,391,000	10,550,000
Other Income	13,560,000	10,157,000
<b>Total Income</b>	<b>\$ 478,026,000</b>	<b>\$ 450,919,000</b>
Claims Incurred	360,983,000	363,928,000
Operating Expenses	74,433,000	60,971,000
<b>Total Expenses</b>	<b>\$ 435,416,000</b>	<b>\$ 424,899,000</b>
Net Gain Before Tax	42,610,000	26,020,000
Federal Income Tax	12,957,000	8,054,000
<b>Net Gain After Tax</b>	<b>\$ 29,653,000</b>	<b>\$ 17,966,000</b>

\* As derived from the audited financial statements of Arkansas Blue Cross and Blue Shield. For a complete copy of Blue Cross' audited financial statements that were prepared in accordance with generally accepted accounting principles, please call the public relations department at 378-2132.

**THE YEAR IN REVIEW**

**PRIVATE BUSINESS**

Claims processed	4,196,431
Claims, processed benefits	\$ 346,481,734
*Average claims processing times	
*Provider payable	3.9 days
*Policy holder payable	11.3 days
*Investigated claims	29.6 days
<b>Total customer inquiries - 1993</b>	<b>359,150</b>
Answered on initial contact	85%
Remainder of inquiries answered in an average of 6.6 calendar days	

**MEDICARE BUSINESS**

Claims processed (Part A & B)	15,519,783
Benefits paid (Part A & B)	\$ 1,653,127,232

\*Includes Individual and Group Services claims

Arkansas Blue Cross and Blue Shield is a member of the Blue Cross and Blue Shield Association. This means Arkansas Blue Cross and Blue Shield has licenses from the Blue Cross and Blue Shield Association to offer health insurance benefits and related services under the Blue Cross and Blue Shield names and service marks in the State of Arkansas.

The Blue Cross and Blue Shield Association is not a single company. Rather, it is a coordinated group of 69 individual and autonomous Blue Cross and Blue Shield Plans located throughout the United States and Puerto Rico. Each plan is an independent, non-profit corporation committed to providing affordable health care financing. One of the unique aspects of the Blue Cross and Blue Shield Association is that each member plan is managed and controlled by its own community-based Board of Directors which must contain a majority of "public members." Public members are people from the community who are not employed in the health care industry. Consequently, the Blue Cross and Blue Shield Plans have a strong commitment to their local communities and customers, which is not necessarily shared by commercial insurance companies.

Neither the Blue Cross and Blue Shield Association nor the other member plans of the Blue Cross and Blue Shield Association act as guarantors of the financial obligations of Arkansas Blue Cross and Blue Shield. However, Arkansas Blue Cross and Blue Shield and the other member plans in the Blue Cross and Blue Shield Association are subject to uniform financial standards established by the Blue Cross and Blue Shield Association which are intended to foster a system in which each member plan maintains adequate financial resources to meet its obligations to its customers.

NOTE: (1) In 1993, the company adopted FAS 115, Accounting for Certain Investments in Debt and Equity Securities. The cumulative effect, net of income taxes, is an increase to December 31, 1993 unallocated reserves of \$2,731,000.

NOTE: (2) The company has adopted FAS 109, Accounting for Income Taxes, retroactive to 1991. As a result, assets and ending unallocated reserves as of December 31, 1992 have been increased by a net amount of \$10,130,000.

**BRADLEY D. JESSON**  
 HARDIN, JESSON, DAWSON & TERRY  
 FORT SMITH

**JACK JUSTUS**  
 EXECUTIVE VICE PRESIDENT,  
 ARKANSAS FARM BUREAU  
 FEDERATION, LITTLE ROCK

**MAHLON O. MARIS, M.D.**  
 HARRISON

**J. THOMAS MAY**  
 PRESIDENT, SIMMONS FIRST NATIONAL  
 BANK, PINE BLUFF

**HAYES C. McCLERKIN**  
 SMITH, STROUD, McCLERKIN, DUNN &  
 NUTTER, TEXARKANA

**TOMMY E. McFALLS**  
 DIRECTOR OF ORGANIZING, UNITED  
 PAPERWORKERS INTERNATIONAL UNION,  
 AFL-CIO, NASHVILLE, TN

**GEORGE K. MITCHELL, M.D.**  
 VICE CHAIRMAN OF THE BOARD,  
 NORTH LITTLE ROCK

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 PRESIDENT, MUNRO & Co. Inc.,  
 HOT SPRINGS

**W. PAT PHILLIPS, M.D.**  
 FORT SMITH

**LOUIS L. RAMSAY, JR.**  
 CHAIRMAN OF THE BOARD,  
 SENIOR PARTNER, RAMSAY BRIDGFORTH  
 HARRELSON AND STARLING,  
 PINE BLUFF

**ROBERT L. SHOPTAW**  
 PRESIDENT AND CHIEF EXECUTIVE  
 OFFICER, ARKANSAS BLUE CROSS AND  
 BLUE SHIELD, LITTLE ROCK

**TOM SLOAN**  
 MANAGER, L.C. SLOAN ESTATE,  
 WALNUT RIDGE

**LUCILLE WILSON**  
 EXECUTIVE VICE PRESIDENT,  
 ROB WILSON MOTORS, INC., MALVERN

## MESSAGE FROM THE CHIEF EXECUTIVE OFFICER



These are exciting times! 1993 was another superb year for Arkansas Blue Cross and Blue Shield in terms of membership growth, customer service accomplishments and additions to contingency reserves. However, 1993 was even more significant because it marked the emergence of an unmistakable trend toward the restructuring of health care delivery — a restructuring characterized by managed care delivered through integrated networks. The momentum of these changes is being principally driven by two forces: marketplace competition and repositioning by providers and third parties in anticipation of national health care reform.

On the surface, this level of unprecedented change appears to be about the relentless issues of soaring costs and lack of access to health care by a growing population of uninsured Americans. These are certainly key symptoms of the underlying problems and effectively serve as the focal point for the growing political debate regarding the merits of the various health reform proposals. More subtle, and potentially more important in the long term, is the change in the way health-related organizations view their core mission — how they view their customers, their employees and the communities they serve.

Terms such as "total quality management" and "continuous quality improvement" are no

longer abstract ideas, but the centerpieces around which progressive new organizational cultures are being built. The end consumer of health care is being recognized as the ultimate judge of both the quality and the value being delivered.

Blue Cross has been successful in moving from an essentially single-product line, hospital-medical service corporation to a well-positioned, managed indemnity mutual insurance company. The next milestone in our organizational progression is to become a fully integrated managed care enterprise. The realization of this goal includes the integration of health care delivery, finance, and administration through long-term partnerships with providers of care and vendors of leading-edge technologies.

The transition to a fully integrated managed care enterprise will be neither easy nor inexpensive. Competition from specialized managed care companies and traditional commercial insurers will be intense. Informed industry observers are projecting start-up costs for a viable integrated managed care entity to range from \$60-\$150 million, depending on the size of the state and the characteristics of the delivery system already in place. The stakes are high, but so are the potential advantages to consumers of health care who are ultimately our customers and the reason we exist.

Blue Cross is committed to being a strong advocate for the positive changes necessary to make health care coverage both universal and affordable. We are further committed to being a strong and proactive participant in the brave new future characterized by this fundamental restructuring of the way health care is delivered, financed and consumed throughout Arkansas.

Respectfully,

Robert L. Shoptaw

## MEMBERSHIP

CLASSIFICATION	TOTAL MEMBERS	INCURRED BENEFITS
Non Group	3,374	\$ 4,887,164
Direct Pay	509	2,877,937
Student	851	580,961
Farm Bureau	13,790	11,440,360
Groups Other Than Experience Rated	62,262	51,620,071
Experience Rated	170,213	193,470,837
Medi-Pak	107,537	72,625,146
UniqueCare	8,132	1,619,214
Minimum Basic Benefit	72	14,273
Extended Benefits		7,345,771
Administrative		
Services Only	126,763	136,390,587
HMO Arkansas	19,386	20,458,464
<b>Total</b>	<b>512,889</b>	<b>\$503,330,785</b>

## OFFICES

<b>EL DORADO</b>	1920 North College • 71730
<b>FAYETTEVILLE</b>	2011 Green Acres Road • 72703
<b>FORT SMITH</b>	Superior Federal Tower Suite 408 • 5000 Rogers • 72903
<b>HARRISON</b>	Security Plaza P.O. Box 2446 • 72601
<b>HOT SPRINGS</b>	Rix Professional Center 1401 Malvern • Suite 110 • 71901
<b>JONESBORO</b>	2512 South Culberhouse Suite C • 72403
<b>PINE BLUFF</b>	2007 West 28th • Suite 2 Plaza Shopping Center • 71613
<b>RUSSELLVILLE</b>	1110 West B; Suite H • 72801

Arkansas Blue Cross and Blue Shield  
A Mutual Insurance Company  
6th and Gaines • P.O. Box 2181  
Little Rock, AR 72203-2181  
(501) 378-2000

An Equal Opportunity Employer



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## FINANCIAL HIGHLIGHTS

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Arkansas  
**BlueCrossBlueShield**  
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# COST CONTAINMENT

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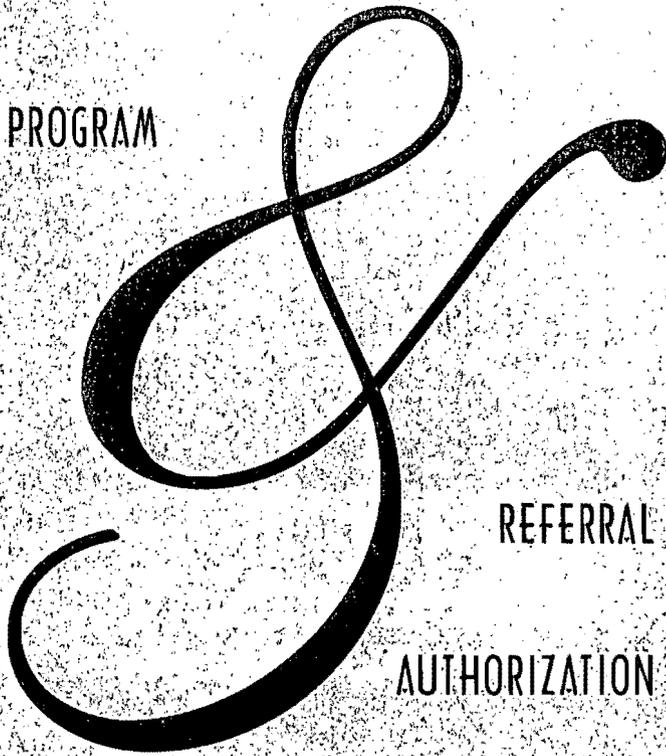
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# PRIMARY CARE NETWORK

HOSPITAL

PRE-NOTIFICATION

PROGRAM



REFERRAL

AUTHORIZATION

PROCESS

**US<sup>AB</sup>le Administrators**

A Division of First Pyramid Life Insurance Company

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**Arkansas  
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

## Fact Sheet

**Formal Name:** Arkansas Blue Cross and Blue Shield,  
A Mutual Insurance Company

**Address:** 601 Gaines Street  
Little Rock, AR 72201

**Telephone Number:** 501-378-2000

**President and CEO:** Robert L. Shoptaw

**Spokesperson:** Robert D. Cabe, Senior Vice President, External Affairs

**Office Phone:** 501-378-2436

**Home Phone:** 501-661-9516

Founded in 1948, Arkansas Blue Cross and Blue Shield became a mutual insurance company in 1987. Today, Blue Cross is the largest health care insurer in Arkansas, employing more than 1,600 Arkansans. Although the company's main office is located in Little Rock, Blue Cross also has eight district offices.

**Main Office:** 601 Gaines, P.O. Box 2181, Little Rock 72203-2181

**District Offices:** El Dorado - 1920 North College, 71730  
Fayetteville - 2011 Green Acres Road, 72703  
Fort Smith - Superior Federal Tower, Suite 408, 5000 Rogers, 72903  
Hot Springs - Rix Professional Center, 1401 Malvern, Suite 110, 71901  
Jonesboro - 2512 South Culberhouse, Suite C, 72403  
Pine Bluff - 2007 West 28th, Suite 2, 71613  
Russellville - 1110 West B, Suite H, 72801  
Harrison - Security Plaza, P. O. Box 2446, 72601

Arkansas Blue Cross and Blue Shield operates under the direction of a 15 member board of directors.

USable Corporation, a wholly owned subsidiary of Arkansas Blue Cross and Blue Shield, has three operating companies: USable Life, The First Pyramid Life Insurance Company of America, and USable Systems, Inc.

USable Corporation also owns 50 percent of HMO Partners, Inc. (Health Advantage).



**Arkansas  
BlueCross BlueShield**

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## **Fact Sheet**

- ABCBS is the largest health care insurer in Arkansas. The Company and its USABLE family of companies have more than 1,600 employees statewide.
- ABCBS is Arkansas-based and operates exclusively within the state.
- ABCBS has a membership of more than 512,000, covering 23 percent of Arkansas' under-age-65 population and 30 percent of the state's over-65 population.
- ABCBS is managed by an in-state board of directors.
- ABCBS is regulated by the Arkansas Insurance Department.
- ABCBS participates in the Arkansas Life and Disability Insurance Guaranty Association, which protects policyholders from insolvency.
- ABCBS holds an "A+" rating from Standard & Poor's Corp.
- ABCBS holds an "A-" rating from A.M. Best Company.
- ABCBS' administrative costs (including salaries and overhead) are the lowest, as a percentage of earned premium income, of any Arkansas health insurer.
- Over the past several years, ABCBS has ranked in the top ten Blue Cross Plans nationwide in terms of financial reserves.
- ABCBS' current "months in reserve" is 5.3 months.

## Arkansas Blue Cross &amp; Blue Shield

## RATING A+ (GOOD)

Insurers rated 'A' offer good financial security, but capacity to meet policyholder obligations is somewhat susceptible to adverse economic and underwriting conditions.

## RELATED RATINGS

None

## HOLDING COMPANY

None

## DOMICILE

Arkansas

## LICENSED

Arkansas

## RATIONALE

The 'A+' claims-paying ability rating of Arkansas Blue Cross & Blue Shield (ABCBS) is affirmed. The rating is based on improved operating results, excellent capitalization, and significant local competitive advantages. Offsetting these strengths is the uncertainty of the healthcare environment.

ABCBS operates as a mutual insurance company, which has enabled it to compete with other commercial insurance companies. The company has been able to improve earnings over the past five years, primarily through improved underwriting practices and cost controls resulting from the implementation of managed care programs or based on price negotiations with providers. An emphasis on preventive measures and utilization review have also contributed. Also, the company's claims-processing system is more efficient and has enhanced the company's ability to detect invalid claims earlier in the process. As a result of these programs, net income increased to \$28 million in 1993 from \$18 million in 1992. In 1994, income is expected to slightly decrease due to continued systems expansion and the stabilization of rate increases in the Medicare supplement business.

ABCBS benefits from an excellent capital position relative to the company's business mix and asset quality. Operating leverage (premiums/surplus) improved to 2.7 times (x) in 1993 from 4.8x in 1989. Capitalization has been improving due to better earnings at ABCBS as well as improved subsidiary earnings.

S&P believes that the health insurance industry faces significant risks in adapting to healthcare reform. However, despite the uncertainty, ABCBS is well-positioned in Arkansas due to good relationships with regulators and healthcare providers.

## ARKANSAS BLUE CROSS &amp; BLUE SHIELD/SELECTED STATISTICS

(MIL. \$)	—Year ended Dec. 31—				
	1993	1992	1991	1990	1989
Total revenue	453.0	424.3	338.4	386.1	360.8
Net operating income	28.1	17.7	11.9	16.2	(1.2)
Net income	28.1	18.0	12.0	16.5	(1.3)
Return on assets (%)	10.98	7.84	5.80	8.84	(0.78)
Total general account assets	275.0	238.3	212.5	198.4	168.6
Total assets	275.0	238.3	212.5	198.4	168.6
Statutory capital (incl. AVR)	170.1	137.8	109.1	95.8	73.5
Operating leverage (prem./surp.) (x)	2.7	3.0	3.4	3.9	4.8

## S&amp;P CONTACTS

Cindy I. Trosterman (212) 208-1341

Timothy W. Clark (212) 208-1593

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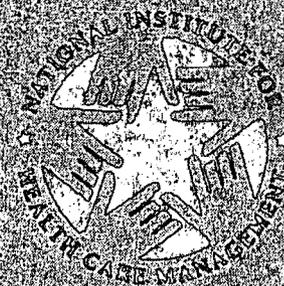
**Arkansas  
BlueCross BlueShield**

Patrick O'Sullivan  
Manager  
Advertising and Communications

USable Corporate Center  
320 W. Capitol — Suite 900

P.O. Box 2181  
Little Rock, AR 72203-2181  
(501) 378-2221  
FAX (501) 378-2969

MEETING  
RURAL  
HEALTH CARE  
NEEDS  
THROUGH  
INTEGRATED  
DELIVERY  
SYSTEMS



NIHCM

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**MEETING RURAL HEALTH CARE NEEDS  
THROUGH INTEGRATED DELIVERY SYSTEMS**

A Live, Interactive Video Conference  
Moderated by Sander Vanocur

Friday, July 15, 1994

KARK-TV Channel 4  
201 W. Third Street  
Little Rock, Arkansas

**Program**

8:00-8:30 a.m. -- Breakfast Refreshments  
8:30-10:30 a.m. -- Live Broadcast  
10:30 a.m. -- Local Follow-up Discussion

**National Broadcast Sites**

Des Moines, Iowa  
Little Rock, Arkansas  
Washington, D.C.

**Arkansas Panelists**

Stan Grise, VP of Finance, Munro & Company, Inc.  
Michael Mackey, M.D., Director, Area Health Education Clinic, UAMS  
Charles McGrew, Director, Health Facility Services, AR Dept. of Health  
Randy Spicer, Pres. & CEO, First Pyramid Life Insurance Company

**Sponsored by**

National Institute for Health Care Management

**Hosted by**

Arkansas Blue Cross and Blue Shield

**RSVP Information**

Seating is limited for our KARK studio audience. Please respond with your attendance plans to Peggy Houser at Blue Cross, 378-2223.

For complimentary parking, please park in the USABLE Parking Deck, 4th and Spring Street, and bring your ticket with you for stamping. We will have greeters at the door of KARK to escort you to the studio. Coming and going during the two-hour broadcast is possible, but we recommend you arrive prior to the 8:30 a.m. start time and enjoy the breakfast refreshments.

## RURAL HEALTH TELECONFERENCE PARTICIPANTS

### **Thomas H. Boyer, Jr.**

*Legislative Assistant*

*Office of Representative Blanche Lambert (D-AR)*

As Legislative Assistant, Mr. Boyer is responsible for Rep. Lambert's activities on the Committee on Energy and Commerce in the primary issue areas of health care, energy, trade, labor, finance, telecommunications and education. Mr. Boyer has previous experience analyzing Medicare, Medicaid, social security and veterans' issues for The Honorable Don Riegle (D-MI). Mr. Boyer serves on the American Diabetes Association, DC Board of Directors and holds a BA in Political Science from Hope College.

### **Dr. Andrew Coburn**

*Associate Director for Research*

*Maine Rural Health Research Center*

Dr. Coburn's extensive research has addressed the problems of health insurance coverage, rural health, health care access and utilization, physician payment and long-term care financing. In addition to holding the position of Principal Investigator at the Maine Rural Health Research Center, Dr. Coburn also is a member of the RUPRI Rural Health Reform Expert Panel which has been analyzing the impact of federal health care reform legislation on rural health systems. Dr. Coburn is an active member of the National Academy for State Health Policy. He received his Ph.D. in Health Policy from the Heller School at Brandeis University.

### **The Honorable Dennis A. Dellwo**

*Washington State House of Representatives*

Mr. Dellwo is an 11-year member of the Washington State House of Representatives. He serves as Chair of the Health Care Committee and was actively involved in the recent major Washington State health reform effort. He is also a member of the House Appropriations, Financial Institutions and Insurance Committees and a partner in the law firm of Winston & Cashatt in Spokane, Washington. Mr. Dellwo has a Law Degree from Arizona State University.

### **Edmund Gray, M.D.**

*Director (Retired) of Northeast Washington Medical Group*

*Chairman, Washington Basic Health Plan Advisory Board*

Dr. Gray has been a physician and surgeon in Washington State for 40 years and during that time has received numerous awards and recognition for his work. His professional affiliations include, among others, Member of the Board and Chair of the Medicaid Committee for the Washington State Medical Association; Member and former Chief of Staff of Mt. Carmel Hospital; Founding Member and former President of NorthEast Washington Medical Group; Medical Director of ALCOA; and Chairman of Washington Basic Health Plan Advisory Committee. His publications include "The Un- and Under-Insured Patient & Basic Health Care — The Washington State Experience." Dr. Gray earned his M.D. from the University of Washington in Seattle.

**Stan Grise**  
*Vice President of Finance*  
*Munro & Company, Inc.*

As Vice President of Finance for Munro & Company, Mr. Grise is responsible for the firm's accounting, finance and information systems. He also manages benefit plans, including health care and group insurance, for Munro's 2,500 employees and is a trustee for the company's pension plans. Among his affiliations, Mr. Grise is Secretary/Treasurer on the Board of the local YMCA and Second Vice President of the United Way of Garland County.

**Duane Heintz**  
*President*  
*McNerney Heintz, Inc.*

Mr. Heintz formed McNerney Heintz, Inc., a consulting and management firm providing services to purchasers and providers of health care services, specializing in the evaluation, development and operation of managed health care delivery systems. Prior to forming McNerney Heintz, he managed the health care services for Deere & Company, responsible for designing, implementing and coordinating non-occupation health care delivery system alternative programs focused on cost containment. He has held positions with the Iowa Hospital Association, Lutheran Hospital Society of Southern California, California Hospital Medical Center, American Public Health Association and the Walter Reed Army Medical Center. Among his affiliations are Founder and Chairman of the Board of the Midwest Business Group on Health, Iowa Governor's Commission on Health Care Costs, Iowa Foundation for Medical Care and National Committee on Quality Assurance. Mr. Heintz received his BS from Iowa State University and MA from the University of Minnesota.

**Michael Mackey, M.D.**  
*Director, Area Health Education Clinic, N.E.*  
*University of Arkansas Medical Sciences*

Dr. Mackey has been in private practice in Jonesboro, AR since 1978, specializing in Internal Medicine/Nephrology. Since 1981 he has served as Assistant Professor in the Department of Medicine, University of Arkansas Medical Sciences (UAMS). He is Director of the Area Health Education Center-NE which is a regional campus in Jonesboro, providing off-campus rotations for medical, nursing, pharmacy and other allied health students of the University. Dr. Mackey graduated from and completed his Internship and Internal Medicine Residency as well as a Fellowship in Nephrology at the University of Arkansas Medical Sciences.

**Charles McGrew**  
*Director, Section of Health Facility Services and Systems*  
*Arkansas Department of Health*

Mr. McGrew has 25 years of experience in all areas of public health and health systems development, ranging from directing the Bureau of Public Health Programs in Arkansas to serving as the Director of the City-County Health Department in Missoula, Montana. He has been heavily involved with health care reform at the national, state and community levels and has developed conferences in Arkansas and Iowa addressing rural health issues. Mr. McGrew is a full-time consultant for the Governor's Task Force on Health Care Reform and provides support for the Arkansas Health Resources Commission and the Legislature's Rural Health Subcommittee. He holds a BS from Arkansas Tech University and a Masters in Public Health from the University of North Carolina.

**Dr. Ira Moscovice**  
*Professor and Associate Director*  
*Division of Health Services Research Policy, University of Minnesota*

Dr. Moscovice has nearly 20 years' experience in the health services field, having held positions with the University of Washington, University of Minnesota and the Hadassah Hebrew University Medical Center. Among his affiliations are the Medicare Beneficiary Access to Care Panel, National Review Committee for Health Care Financing and Organization Initiative, National Rural Technical Advisory Panel and the National Advisory Committee for Demonstration and Research on Health Care Costs. Dr. Moscovice has written numerous articles and papers addressing rural health care issues. He was honored as a Distinguished Researcher by the National Rural Health Association in 1992. Dr. Moscovice holds a BSEE from City College of New York, an MS from Columbia University and a Ph.D. from Yale University.

**Paul Pietzsch**  
*President*  
*Health Policy Corporation of Iowa*

Mr. Pietzsch leads the Health Policy Corporation of Iowa (HPCI) which is a private, non-profit organization formed to develop and support initiatives which relate to cost containment, quality and access of health services in Iowa. HPCI has been recognized nationally as an effective coalition, developing health care purchasing initiatives; conducting meaningful research, data collection, analysis and education; and providing leadership in setting community health goals. Mr. Pietzsch received his Bachelors Degree in Business Administration from the University of Iowa and a Masters Degree in Public Health from the University of Minnesota.

**Robert D. Ray**  
*President and CEO*  
*IASD Health Services Corp.*

Formerly Governor of Iowa from 1969-1983, Governor Ray now serves as President and CEO of IASD Health Services Corp. which provides coverage for more than 1 million citizens. He is Co-Chairman of the National Leadership Coalition on Health Care Reform and Chairman of the National Advisory Committee on Rural Health Care. While Governor, he established the Governor's Commission on Health Care Costs which served as the blueprint for many of the cost containment programs of the 1980s. Among other affiliations, Governor Ray is a member of the Iowa Business Council; serves on the Board of Governors of Drake University; and is a trustee for the Herbert Hoover Presidential Library Association. Governor Ray earned degrees in Business Administration and Law from Drake University and holds honorary degrees from 13 colleges and universities.

**Mary C. Selecky**  
*Administrator*  
*Northeast Tri-County Health District*

As Administrator of the Northeast Tri-County Health District in Washington State, Ms. Selecky supervises the activities of the three county public health district. She is a member of the Washington Rural Health Commission, Chairman of DSHS Medicaid Advisory Committee, member of the Board of Directors of Northeast Washington Rural Resources and Past President and Current Legislative Chair of the Washington Association of Local Public Health Officials. Prior to joining Tri-County, Ms. Selecky was Acting Director of the Stevens County Counseling Center; an Administrator of Trico Economic Development District and Assistant Dean of Students, University of Pennsylvania. Ms. Selecky holds a degree in History and Political Science from the University of Pennsylvania.

**Randy Spicer**  
*President and CEO*  
*First Pyramid Life Insurance Company of America*

Prior to being named President and CEO of First Pyramid Life Insurance Company of America (a subsidiary of Arkansas Blue Cross and Blue Shield), Mr. Spicer was with the Prudential Insurance Company of America for 21 years. At Prudential, he held various positions including National Director of Cost Containment, Vice President of Group Marketing, Vice President of Managed Care Operations and Vice President of Enterprise Planning. Mr. Spicer earned a Bachelor of Science in Business Administration and Masters Degree in Business Administration from the University of Arkansas.

**Mary Swetnam**  
*Legislative Director*  
*Office of Congressman Rick Boucher (D-VA)*

As Legislative Director for Rep. Boucher who serves on the House Energy and Commerce Committee, Ms. Swetnam is responsible for health care reform, senior citizen's, environment and appropriations issues. Prior to joining Congressman Boucher's staff in 1989, she worked for Senator Bill Bradley (D-NJ). Ms. Swetnam holds a Bachelor's Degree from the College of William and Mary.

**Ted Totman**  
*Legislative Assistant*  
*Office of Senator Charles Grassley (R-IA)*

As a member of Sen. Grassley's staff, Mr. Totman has been responsible for Finance Committee health issues, private pensions, social security and veterans affairs. He served as Staff Director of the Subcommittee on Aging during the 99th Congress and as a professional staff member of the Subcommittee, Mr. Totman worked on the Public Health Service Act, pension issues and older Americans issues. He holds a BA from Union College and an MA from the University of Chicago.

**Robert Van Hook**  
*Special Assistant, Office of the Assistant Secretary for Planning and Evaluation*  
*Department of Health and Human Services*

Currently serving the Clinton Administration, Mr. Van Hook has over twenty years' experience in health policy and management, working at the local, state and national levels, including a key health position in the administration of former Governor Jay Rockefeller. Following his work in West Virginia, Mr. Van Hook served as executive director of the National Rural Health Association where he championed the cause of rural health at the national level and helped build the NRHA into a national force in health policy. Mr. Van Hook is a graduate of the University of South Florida and holds a Masters Degree in public health from the University of North Carolina in Chapel Hill.

**David Vellinga**  
*President*  
*North Iowa Mercy Health Center*

Prior to becoming President and CEO of North Iowa Mercy Health Center, Mr. Vellinga was President and CEO of St. Joseph Mercy Hospital in Mason City, Iowa. He is a member of the Healthcare Forum, the American College of Healthcare Administrators and the Board of Directors of the Iowa Hospital Association. Among his affiliations, Mr. Vellinga is a member of St. Joseph Community Hospital Board, Mason City Chamber of Commerce Board of Directors and Chair of the Mercy International Health Programs Board of Directors. He holds a BA degree from Northwestern College and a Masters Degree in Hospital and Health Care Administration from the University of Iowa.

**Dan Winegarden**  
*First Deputy Insurance Commissioner*  
*Iowa Health Care Reform Council*

Mr. Winegarden was appointed by Governor Branstad to lead Iowa's comprehensive health care reform initiative which is expected to deliver a legislative proposal to fairly remedy cost, access and quality issues, with bipartisan involvement and support from major interest groups, especially the average health care consumer. Concurrently, he serves as First Deputy to Iowa's Insurance Commissioner with responsibility for the Division's Special Projects and Initiatives. Mr. Winegarden holds a degree in Economics and Political Science from Iowa State University and a Law degree from the University of Iowa College of Law.



NIHCM

MEETING RURAL HEALTH CARE  
NEEDS THROUGH INTEGRATED  
DELIVERY SYSTEMS

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**EXECUTIVE SUMMARY**

**Issue/Background**

Many health reform bills propose delivering care through competing private health plans that are accountable for access, quality, and cost management. However, some policy makers question whether rural needs can be met through private initiatives to integrate health care financing and delivery.

The National Institute for Health Care Management (NIHCM) Video Conference and Roundtable Discussion is intended to provide information from the field (sites in Arkansas, Iowa, and Washington) and from national experts about models for integrated health care delivery and insights into federal policies that would allow creative initiatives to meet rural health needs.

In preparing for the conference, NIHCM commissioned two papers from prominent national experts in rural health care. Ira Moscovice, Ph.D. prepared a report reviewing integrated delivery and financing approaches in rural areas (Moscovice, 1994) and Andrew F. Coburn, Ph.D. and Keith J. Mueller, Ph.D. prepared a report on integrated service networks and the impact of health reform proposals (Coburn and Mueller, 1994).

These papers, along with other relevant papers and a NIHCM fact sheet on rural health care (NIHCM, 1994) are available at the conference. This executive summary provides an overview of the experts' review of the current situation, paradigms for integrated networks and managed care, and policy issues and approaches.

**Current Situation and Paradigms of  
Integrated Service Networks and Managed Care**

**Current situation and potential for networks and managed care**

About one-fourth of Americans live in rural areas — areas that comprise about three-fourths of the nation's counties. (NIHCM)

- o The rural population tends to be older, and slightly more likely to be uninsured, than their urban counterparts.

- o Rural areas tend to have fewer health professionals serving the population:
  - more than 20 million Americans live in a "Health Professions Shortage Area" — an area with a primary care physician to patient ratio of 1 to 3,500 or more;
  - providers in rural areas tend to be older, and confront a greater workload and lower remuneration than urban physicians.
- o While there are a large number of rural hospitals (45 percent of the nation's hospitals and 22 percent of the nation's hospital beds), the hospitals are struggling to attract and retain insured patients, and physicians, who often bypass them to go to more modern urban hospitals.

Moscovice suggests that the current climate is receptive to network formation in rural areas, and Coburn, Mueller cite a widespread view that:

"the development of integrated service networks (ISNs) offers substantial potential for helping rural communities overcome longstanding problems in the availability and accessibility of essential health services."

#### Rural health networks

Moscovice provides alternative definitions of integrated rural health networks, and reviews the current status of their development.

- o Rural networks "that provide the full range of acute inpatient and outpatient services to rural communities are relatively rare" and are confined to a small number of rural health maintenance organizations (HMOs).
- o Existing networks "tend to be groups of similar primary care, and sometimes secondary care, providers that form to address common problems or to respond to reimbursement opportunities..."

#### Rural managed care

Moscovice also reviews rural managed care arrangements, noting that the development of such organizations is likely to pose special challenges in rural areas. He summarizes current information about rural managed care.

- o Current penetration of managed care in rural areas is low, but is likely to increase.
- o Limited capital and technical expertise are deterrents to development of managed care.
- o Physicians are of mixed views: those without managed care experience generally have negative views; those with experience are more positive "or at least neutral." Rural physicians in the future may be willing to trade autonomy for a more secure patient base.
- o Rural hospitals see managed care as a potential opportunity to maintain their patient base (and fill beds), but utilization increases "are likely to be fleeting."

- o Non-physician providers may be used extensively by managed care plans because of the primary care provider shortages.

Moscovice goes on to review managed care models in rural areas, which until recently were usually HMOs. He cites three models of HMO development in rural areas:

- o Urban-based independent practice association (IPA) HMOs expanding into rural markets (the market in Minnesota is an example of this model);
- o Rural-based group/staff model HMOs (Geisinger Health Plan in Pennsylvania is an example);
- o Rural-based IPAs sponsored by consumers or providers in the rural area (HMO Wisconsin is an example).

### Policy Issues and Approaches

Coburn and Mueller review three essential preconditions for the development of integrated services networks that could pose "significant challenges" for rural communities and "lend themselves to policy intervention:" an appropriate market/service area; a stable financial base; and the need for capacity building.

#### Appropriate market/service area

Market area definitions are important to the success of networks in rural areas in two ways: the population base included, and the degree of overlap with "natural markets" that cross state lines. Five policy issues embodied in current legislative proposals are discussed:

- o appropriate definitions of boundaries for group purchasing areas;
- o participation in plans purchased through regional purchasing groups;
- o inclusion of Medicare and Medicaid beneficiaries in purchasing groups;
- o requirements that health plans serve underserved, rural areas; and
- o risk adjustments to premiums for underserved rural areas and populations.

#### Stable financial base

A stable financial base is critical to the viability of rural integrated services networks. Two policy issues are discussed:

- o adequate insurance coverage and benefits; and
- o adequate provider reimbursement.

#### Capacity building

Underserved rural communities face numerous barriers to the development of networks. Policy issues and approaches for capacity building are discussed by Coburn and Mueller, and by Moscovice.

- o Financial support, including assistance in capital investments for network formation, is discussed by both papers. Moscovice also suggests provisions to limit the financial risk of individual rural health practitioners under managed care arrangements.
- o Technical assistance and support in planning, developing and operating new systems, is discussed by both papers.
- o Regulatory flexibility, balancing antitrust enforcement with network establishment, is suggested by both papers. Moscovice also suggests flexibility in the form of modified solvency standards for rural-based health plans.
- o Expansion of provider supply is suggested by both papers, especially primary care professionals likely to participate in rural networks, along with the protection of existing programs such as community health centers and rural clinics.

Coburn and Mueller review the status of federal legislation in addressing these policy issues and approaches. A review of some of the key Congressional Committee health reform bills as they pertain to rural issues is also available at the conference.

### Endnotes

Ira Moscovice, Ph.D., "Integrated Health Service Delivery and Financing Approaches in Rural Environments," June, 1994.

Andrew F. Coburn, Ph.D., and Keith J. Mueller, Ph.D., "Rural Integrated Service Networks: the Impact of Current Health Reform Proposals," July 15, 1994.

National Institute for Health Care Management, "Facts About Rural Health Care," July, 1994.



NIHCM

## FACTS ABOUT RURAL HEALTH CARE

### Rural Demographics

#### Population

- Rural America is quite diverse, ranging from remote "frontier towns" to bedroom communities of large cities. Rural is defined as: (1) frontier areas with six or fewer people per square mile; (2) remote rural areas with greater than 30 minutes of travel time to a population center of 10,000 or more people; and (3) less remote rural areas with 30 minutes or less of travel time to a population center of 10,000 or more (Berman, 1994).
- About one-fourth of Americans live in rural areas; more than three-fourths of the nation's counties are rural (Bureau of the Census, 1993).

#### Insurance Coverage

- In 1993, 18.6% of the nonelderly rural population was uninsured versus 17.1% of the nonelderly urban population (EBRI, 1994).
- In 1990, 14.5% of rural residents were enrolled in Medicare compared to 13.5% percent of urban resident (Health Care Financing Administration, 1992).
- In 1993, 12.2% of rural residents and 11.4% of urban residents were covered under Medicaid. However, only 45% of rural residents with incomes below 100% of poverty were covered under Medicaid, compared to 51% of their urban counterparts (EBRI, 1994).
- Employer-sponsored health insurance covered 59% of rural residents in 1992 compared to 63% of urban residents. Rural Americans rely more heavily on non-group sources of health insurance. In 1993, about 9% of insured rural residents were covered by these private policies compared to 7% of urban residents (EBRI, 1994).

#### Age

- In 1992, 13.5% of the population in rural states was 65 or older compared to 12.6% in urban states (Bureau of the Census, 1993).

#### Poverty

- States with predominately urban populations had an average poverty rate of 11.5% in 1990, while those with mainly rural populations had an average poverty rate of 15.4% (Bureau of the Census, 1993).

#### Employment

- Rural employment grew by only 6.9% between 1979 and 1986, compared with a national rate of 10.8% (Korczyk, 1994).
- One's chances of dying from accidents in a rural area are 40% higher than in urban areas. Rural residents are more likely to be self-employed, work in seasonal or temporary jobs, and be employed in farming, underground mining, or other hazardous industries (Fuchs, 1994).

## Health Services Capacity

### Physician Shortage

- As of December 1992, more than 20 million rural Americans were living in federally designated Health Professions Shortage Areas: areas that have a primary care physician-to-patient ratio of 1 to 3,500 or worse. In rural areas, 35% of the population lived in communities with a primary care physician shortage compared to 10% in urban areas (Federal Office of Rural Health Policy, 1993).
- Over 400,000 Americans live in counties where there is not a single physician, and 34 million live in places where there are too few physicians (Pushkin, 1994).

### Physician Issues

- Many special issues face rural physicians: (1) provider workload is 20 - 30% greater in rural than urban areas; (2) remuneration is 10 - 20% less; (3) over 50% of rural physicians are on call every other night while urban physicians participate in call groups; and (4) 13% of physicians are over 65 years of age versus 9% in urban areas (Berman, 1994).

### Hospitals

- Forty-five percent of all community hospitals in the U.S. are in rural areas, but these hospitals contain only 22% of all hospital beds. In 1992, urban hospitals reported occupancy rates of 68.6%, compared to 57.4% in rural hospitals (AHA, 1993).
- Hospitals are struggling because insured patients often bypass them to go to more modern urban hospitals. Similarly, rural hospitals have difficulty recruiting primary care physicians due to inadequate facilities. Escalating technological advancements encourage the concentration of advanced medical services in large urban complexes (Pushkin, 1994).

## Growth in Rural Integrated Health Care Systems

### Trends

- Rural America participates in "managed care" in the sense that the primary care physician is typically the gatekeeper to the entire system. While there are a few long-term examples of rural integrated health systems, rural areas have recently seen increases in integrated financial and delivery systems (Pushkin, 1994).

### HMO Penetration

- In 1990, 301 HMOs served both urban and rural counties and 15 more served rural counties only (GHAA, 1994).
- Thirty-six percent of rural counties had at least one HMO providing services to their residents in 1992 (Wellever, 1994). Bedroom communities were twice as likely as other rural areas to have an HMO (Pushkin, 1994).

*(Reference Sheet Attached.)*

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## INITIATIVES IN RURAL HEALTH

### IN THREE STATES

### WASHINGTON, ARKANSAS, AND IOWA

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### COLVILLE, WASHINGTON

The town of Colville, Washington, serves as the hub for a very rural area in northeast Washington State, extending from the Canadian border south to Chewelah, Washington, and from the Idaho border west to Republic, Washington. This region covers parts of three counties, and has a population of about 30,000 spread across more than 1000 square miles. Like many rural areas, this region suffers from higher than average unemployment and per capita income levels that are significantly lower than state and national averages. In 1988, the state created the Washington Basic Health Plan (WBHP)—designed to serve the working poor by providing subsidized health coverage through private, capitated integrated delivery systems. Residents under age 65 whose families earn less than 200 percent of the federal poverty level are eligible to enroll in the program. Some local employers also contract with WBHP to provide coverage to their employees.

The area surrounding Colville was approved as one of 17 pilot sites for the Washington Basic Health Plan in 1988, and the physicians of the NorthEast Washington Medical Center in Colville developed an integrated delivery system—in partnership with the local hospital, Mt. Carmel—to serve the local population eligible to enroll in the Washington Basic Health Plan in 1991. Local enrollment in the WBHP program stands steady at approximately 1,000 enrollees—the maximum allowed by the state at this point. The Washington State Health Services Act of 1993 will extend the WBHP program to an additional 195,000 enrollees.

The program places a strong emphasis on enrollee education and prevention programs. Each enrollee is screened as they enter the program and meets with their primary care provider or a member of an intake team. During this initial meeting, enrollees are educated about the benefits and limitations of WBHP and how to access and use the integrated delivery system. They are also educated about nutrition, lifestyle

factors and care of any chronic illnesses the patient might have. The primary care physician then evaluates the patients medical needs and acts as case manager, arranging any necessary diagnostic testing, referrals, or hospital care. The hospital and health department each sponsor an ongoing series of educational programs on health related topics that are open to the community in addition to the activities of the clinic.

The physician-hospital partnership has since expanded to serve the Healthy Options program for AFDC recipients in Washington State. Like WBHP, Healthy Options is a capitated program. The system's experience with these programs has been a valuable practice ground for dealing with capitation. The system intends to move toward a more formalized structure and begin offering their services to local employers and other private-sector purchasers. At this point, about 20% of the physicians' reimbursement is capitated. They expect this percentage to grow to 50% by July 1995 and 95% by 1999. Blue Cross of Washington and Alaska (through its subsidiary, NCAS) is the carrier that assumes risk for WBHP. Medical Service Corporation of Eastern Washington (a Blue Shield plan) assumes risk for the Healthy Options program. Both of these risk contracts are renewed on an annual basis.

This initiative is not only an example of a successful effort to serve a previously underserved population, but may also be representative of the community-specific relationships that often develop in rural areas. The current integrated delivery system builds upon community-centered cooperation among health care providers which began in response to health planning activities in the 1970's. For fifteen years, the physicians offices have been located on the campus of Mt. Carmel Hospital—a Dominican hospital since WWII. The NorthEast Washington Medical Center was formed in 1979 with seven physicians (all but one of the physicians in the area). There are now 26 providers belonging to the Center: 10 Family Practice physicians, 3 Internal Medicine subspecialist physicians, 2 general surgeons, 2 orthopedists, 1 urologist, 1 radiologist and 5 physician assistants. The program also houses two full-time Family Practice residents. Local physicians claim that such integrated systems may work better in rural areas than urban areas, because local primary care and specialist physicians interact much more frequently and cooperatively on an ongoing basis than is typical in many urban practices.

All of the local health care providers—the hospital, the physicians and the public health department—cite a strong sense of partnership and focus on community needs as a critical contributor to the success of the plan. The relationship between the hospital and physicians to serve Basic Health Plan enrollees is executed largely by handshake and exhibits a degree of fluidity which makes it responsive to changing reimbursement streams and public policy. Both the hospital and the medical group also enjoy a solid

working relationship with the local public health department, which is viewed as a "connector" filling in with specialized clinical services (e.g., well-child immunizations and treatment of STDs) and referring patients into the community medical system as appropriate.

The State of Washington's overall health system reforms build on the State's experience with its Basic Health Plan. The Basic Health Plan successfully required that only capitated health plans participate and qualify for the program's subsidies. In Colville and other areas, providers and health plans successfully developed new integrated plans to serve these enrollees. The Washington State Health Services Act of 1993 requires that by July 1, 1995 all health coverage in the state be provided through certified health plans (CHPs) which will be integrated, capitated systems offering a uniform set of benefits.

## **ARKANSAS**

With only about half (54 percent) of the population living in urban areas of 2,500 people or more and 71 of 75 counties designated as medically underserved, Arkansas is a state that faces difficult challenges in providing access to health care for people in rural areas. Several notable efforts to meet this challenge are being made by the University of Arkansas and Blue Cross and Blue Shield of Arkansas.

### **University of Arkansas**

As part of a long-standing effort to improve access in rural areas, the University of Arkansas' Area Health Education Centers (AHEC) program is taking steps to help provide physician services for rural communities and community health centers in very rural areas. These areas are sufficiently remote that they may never be able to attract a physician to live permanently in the community, yet physician services are needed in the area. To meet this need, the AHEC program has begun to associate with (and in at least one instance, purchase) thriving physician practices in nearby small towns, with the hope of expanding these practices so that their physicians can commute on a parttime basis to the more rural health centers.

The approach seems promising as a way to recruit additional physicians to serve rural areas because they would be joining a stable practice and would be assured of having colleagues and backup coverage, rather than having to serve alone. The attraction for physicians in the existing practice is that they will become members of the medical school faculty, being paid on a salary plus incentive basis. Their practice will also be a site for residency training for medical school graduates, with the hope that some will

choose to stay on and join the practices. (The first practice to enter into this arrangement with the AHEC is a three-physician primary-care practice group; all of these physicians served as residents in the area before deciding to establish their practice there.)

These primary care physicians will also serve as care managers in the University's evolving integrated managed care company, QualChoice of Arkansas, which will provide a point-of-service managed care plan across the state, including rural areas. The plan is contracting with panels of 5 to 20 primary care physicians who will serve as the first point of access for patients entering the medical system. Each panel's physician payments are partially based on the cost of services provided to patients who use the group for primary care.

### **Arkansas Blue Cross and Blue Shield Primary Care Network**

The Primary Care Network (PCN) program, administered by FPL/USABLE Administrators, a subsidiary of Blue Cross and Blue Shield of Arkansas, is a managed care program to serve rural areas. This program, which now includes 44 rural sites, was initially started in rural areas where a self-insured employer of at least 100 employees (typically 500 to 600 employees) showed interest in establishing a managed care system that promised to give the employer some control over costs. (These employers are often national employers that have a plant in a rural Arkansas site—for example, Kodak and Emerson Electric.) FPL/USABLE Administrators aids in forming a cooperative arrangement between the employer and primary care physicians in the community to start the PCN; they also serve as the third-party administrator and provide managed care expertise as well as data and other information to help the employer and participating physicians monitor cost and utilization patterns.

The employers select the physicians who will participate initially in the plan. A board made up of equal numbers of physician and employer representatives oversees the activities of the PCN. Each year, the physicians and employers negotiate a budget for the full gamut of medical services covered under each employer's health plan. The board meets regularly to monitor use and cost patterns and discuss how unacceptable performance can be changed. Participating physicians are at partial risk for the cost of all covered medical services: 20 percent of the physician fee (based on the Blue's standard fee schedule) is withheld, and if expenditures come in under target, physicians receive the withhold and, in some cases, an additional bonus that represents a portion of the employer's savings.

The participating primary care physicians serve as gatekeepers for other medical services: patients selecting the PCN option are required to go through the primary care

physicians as a condition for having the cost of the service paid by the medical plan. One reason that local physicians are willing to participate is that they see the PCN as a mechanism for ensuring that people seek medical services within the community rather than going to nearby larger communities. They also recognize that a medical system which delivers good medical care at a predictable cost aids in keeping the larger local employer in the area.

Once a PCN has been established, other self-insured employers in the community can participate. In addition, a plan is being considered that would permit small rural *insured* employers who have coverage with Blue Cross and Blue Shield to participate as well. The Blues, representing these insured employers, would serve on the PCN board that oversees the network operations, and they would have responsibility for negotiating a budget for these insured employers. This stage of the program might be available later this year.

Some small community hospitals have expressed interest in being participants in the PCN and have suggested that they might be willing to accept a form of capitation payment. In some cases, the PCNs have established referral patterns to physicians and facilities that are part of the Blue Cross and Blue Shield statewide PPO, an arrangement which allows the PCN to get these services at discounted rates.

## IOWA

There are a variety of initiatives underway to develop integrated health delivery systems that serve rural areas throughout Iowa. These include efforts by providers, health plans, and employers, both as individual and collective purchasers. Employers in particular have been a driving force in the development of an efficient health care infrastructure to support their employees in rural areas.

At the same time, state government in Iowa has been working cooperatively with purchasers to design policy supporting the development of cost-effective private plans within a model encouraging the use of price-sensitive consumer choice to drive the market. For example, Iowa has recently created the designation of "Organized Delivery System" (ODS) as an alternative to licensure as either an insurer or an HMO. Dan Winegarden, First Deputy Insurance Commissioner in Iowa, says this new designation is appropriate because both of the existing designations "are limited to a specific corporate organizational structure that is far less flexible than is possible within a PHO. Both have deficiencies from the viewpoint of buyers (primarily employers) trying to encourage health care providers to share incentives to deliver high value care—to do it better for less, while living within a budget defined by the buyer." In another example, state

policymakers have demonstrated that they are also sensitive to local health referral patterns by pursuing innovative service area definitions which facilitate flexible alternatives to serve rural health needs.

## **Employer Initiatives**

In one employer-sponsored initiative, Health Policy Corporation of Iowa (HPCI), a voluntary employer coalition on health, has several purchasing initiatives underway. In a model similar to the Business Health Care Action Group in Minneapolis, their larger employers have banded together to purchase collectively and encourage the development of one or more "benchmark" plans. These benchmark plans will involve integrated health delivery systems, initially serving urban as well as rural areas in central Iowa and expanding to other areas over time. It is intended that these benchmark plans will also form the core offerings of a voluntary health insurance purchasing cooperative for small employers sponsored by HPCI. Health plans and providers are responding to these employer initiatives by developing new integrated financing and delivery systems. For example, the Unity Choice Health Plan described below is one of the new systems applying to serve as a benchmark plan through HPCI's purchasing initiatives.

In a small town initiative, local employers in Pella, Iowa, have recently encouraged local physicians and the local hospital to form an integrated delivery system where the providers also bear financial risk for health care delivery. This rural integrated system then chooses the tertiary care centers with which they wish to affiliate. The employers will hire a single third-party administrator and pool their health care data, thus using their combined market strength to create incentives for greater accountability on the part of the health plan.

In another employer-sponsored initiative, John Deere built Heritage HMO in a move to secure cost-effective health care for Deere employees. Deere has also created a series of family health centers which provide comprehensive primary care, laboratory services, and pharmacy for Deere employees. This effort is part of a strategic alliance with the Mayo Clinic, which helped them design the centers and their clinical guidelines and guarantees center patients access to Mayo specialists for problems that cannot be treated locally. Deere and Mayo are now pursuing a strategy to develop and operate clinics in other areas for non-Deere employees.

## **Unity Choice Health Plan**

Unity Choice Health Plan is a new statewide integrated health plan. Unity Choice is a partnership among physicians, hospitals and Blue Cross and Blue Shield of Iowa. Rural physicians that are part of the plan may belong to one of three physician-hospital

organizations (PHOs) distributed throughout the state or contract directly with the plan. The PHOs are each owned 50% by the hospital and 50% by the physicians. Each PHO contracts with 8 to 20 physician practices. Since physicians, hospitals and the insurer share in the ownership, they also share financial responsibility for health care delivery and risk management. The intent is to align the financial incentives of all of the partners toward efficient use of medical resources.

Unity Choice is organized around a primary care case management model—meaning primary care providers are responsible for oversight of all of a patient's medical care, including assuring appropriate referrals to specialists and monitoring the care received from specialists. If a rural primary care provider refers to a specialist in an urban area, an urban primary care provider acts as interim case manager. This provides for more "hands-on" management of specialty care than would a long distance relationship between the primary care physician and the specialist.

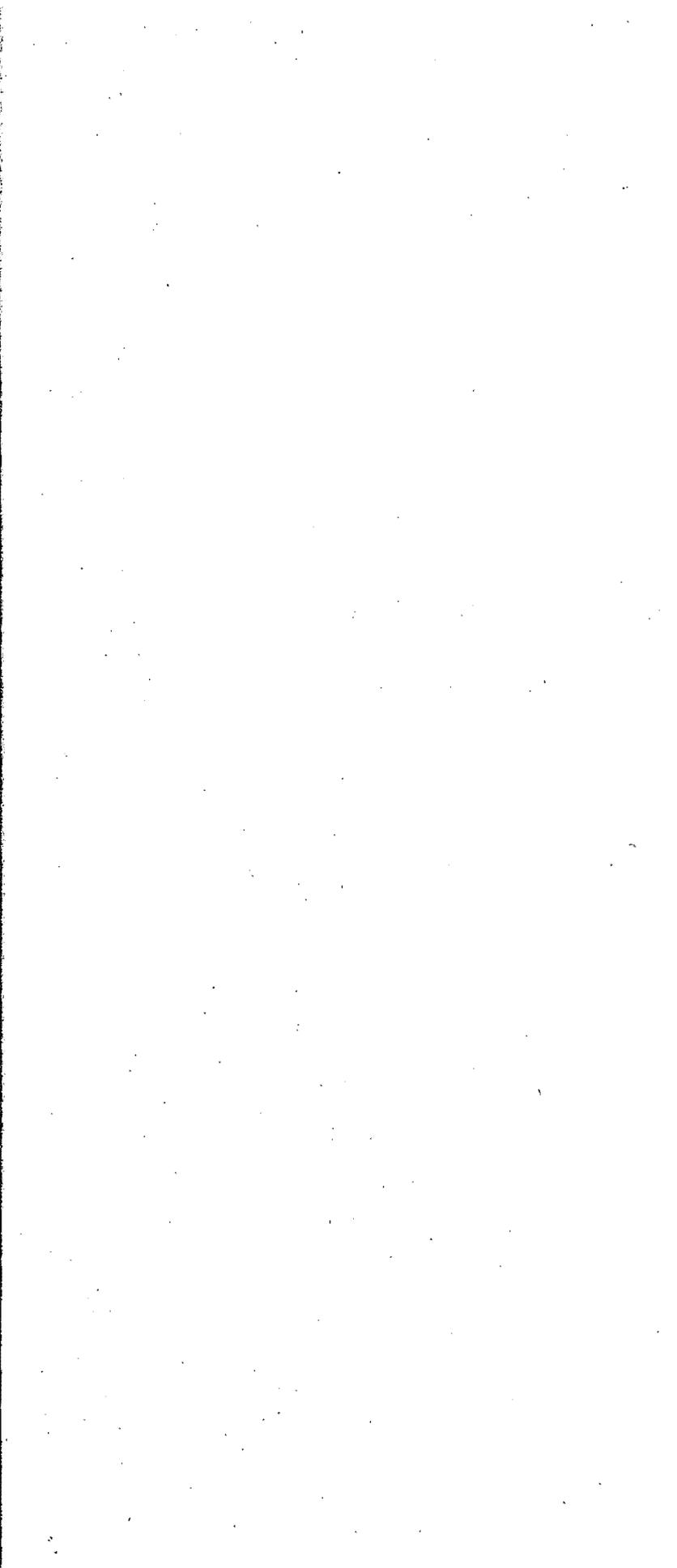
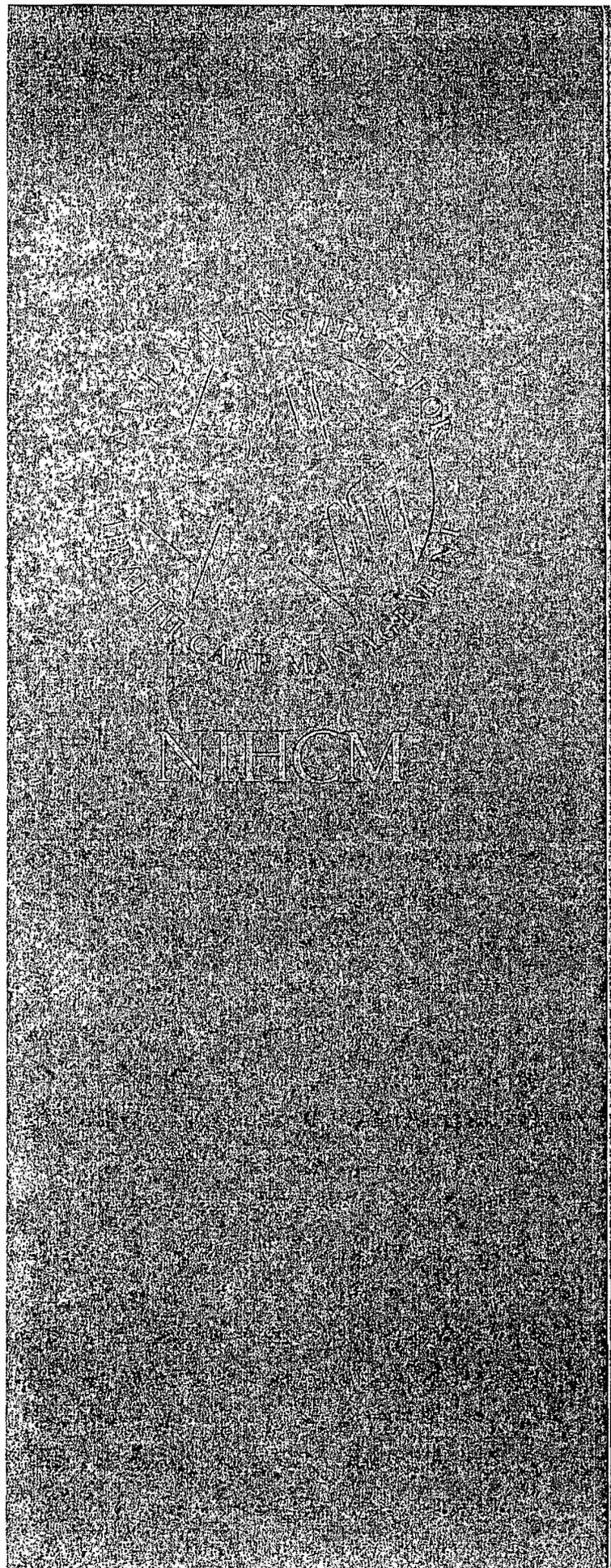
The plan uses several strategies that should serve to bolster primary care capacity in rural areas. First, they are supporting physicians financially. In rural areas where volume may not be great initially, physicians in the network are guaranteed a minimum level of income from the plan. Second, the benefit plan design is structured so that patients pay a lower coinsurance if they receive primary care from a local provider, rather than traveling to more urban areas for primary care. (This variation on benefit plan design was inspired by the Iowa Farm Bureau, which wanted to encourage members to receive routine primary care in local areas, thereby helping to ensure on-going availability of health services in rural areas.) Third, they are placing the technology for automated medical records and automated office management in rural physicians' practices to reduce their administrative costs and improve their interface with the health plan overall. It is anticipated that these efforts will improve the ability of rural areas to recruit and retain primary care providers.

The use of computerized systems is also important for medical management and continuous quality improvement within the plan. Information collected as a by-product of these systems is used to profile provider practice patterns and support a decentralized, peer-review oriented medical management and continuous quality improvement system. Most quality management is conducted face-to-face within the PHOs, not retrospectively or by telephone. Utilization review nurses are on-site, rather than located in a central urban area.

All of these initiatives are examples of the ways in which employers, health plans and state policy in Iowa are coalescing to support a model of "value purchasing." Such a model establishes a structure in which price-sensitive consumers are provided a choice of

competing health plans, and can choose based on the plans' prices and ability to best meet the consumers' individual needs and circumstances.

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April 1994

Reprint

## ORGANIZATION BRIEF: The National Institute for Health Care Management

### Background

There is a growing need for better answers and solutions to health care delivery and financing. The National Institute for Health Care Management (NIHCM) was established in 1993 to find workable solutions to these problems. NIHCM fulfills its mission by • sponsoring high quality, nonpartisan, objective research; • acting as a clearinghouse for research on health care management and state managed care data; and • providing members with a forum to continue to build managed care expertise.

### Mission

The mission of the institute is to:

- Support research and analysis of health care issues, particularly those that involve management, financing and delivery of health care.
- Develop a research program to assist consumers, health care professionals, government, its member companies and health care industry in an overall effort to deliver high quality, cost effective care to all residents of the United States.
- Promote innovation to continuously improve the health care system. It is the purpose of the institute to identify, analyze and disseminate best practices to its members, others in the industry, the government and the public.

### Organization

NIHCM is a non-profit organization founded by 11 of the nation's leading health care companies from across the country, each of which has made an initial three-year funding commitment to NIHCM. NIHCM member experience provides a solid foundation for identifying and implementing practical solutions to problems in the health care system. The institute's members include:

- Arkansas Blue Cross and Blue Shield
- The Associated Group
- Blue Cross of California
- Blue Cross and Blue Shield of Georgia
- Blue Cross and Blue Shield of Iowa
- Community Mutual Insurance Company
- Blue Cross and Blue Shield of Texas
- Veritus, Inc.
- Blue Cross and Blue Shield of Virginia

- Blue Cross of Washington and Alaska
- Blue Cross and Blue Shield United of Wisconsin

NIHCM receives counsel from an outstanding advisory board including:

**John Cogan, Ph.D.** - Senior Fellow, The Hoover Institution, Stanford University; Former Deputy Director, Office of Management and Budget (Reagan Administration); Former Member, Pepper Commission

**John Iglehart** - Founder and Editor, *Health Affairs*; National Correspondent for *The New England Journal of Medicine*; Former Editor, *The National Journal*

**James J. Mongan, M.D.** - Executive Director of Truman Medical Center; Dean, University of Missouri at Kansas City School of Medicine; Former Assistant Surgeon General and Associate Director for Health & Human Resources (Carter Administration)

**Uwe Reinhardt, Ph.D.** - James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University; well-known author, lecturer and expert on national and international health economics issues

**Mark Warner** - Managing Partner, Columbia Cellular Corporation/Capital Cellular Corporation; Chairman, Virginia Health Care Foundation; Chairman, Council for Democracy

**Gail Wilensky, Ph.D.** - Senior Fellow, Project HOPE; Former Administrator, Health Care Financing Administration in the Department of Health and Human Services; Former Deputy Assistant to the President for Policy Development (Bush Administration)

### NIHCM Initiatives

#### Current Research Projects

NIHCM will fund research that focuses on two research themes: (1) building health care reform implementation expertise -- defining workable solutions to health care management in a reformed environment, and (2) identifying the characteristics of successful managed care delivery -- which practices distinguish outstanding managed care plans. Findings of sponsored re-



Nancy Chockley  
Executive Director  
NIHCM

search will be shared with the public and used to improve health care financing and delivery.

NIHCM is currently sponsoring a project that offers a unique and integrated examination of the implementation of health care reform at the state and local levels. The work product will provide both an analytic framework for understanding reform, as well as a blueprint for policymakers to help in decisionmaking.

NIHCM has also funded a study that examines the new generation of managed care as it is being developed in local markets. This study highlights examples of creative managed care approaches to health care delivery, including health plan efforts to measure and market quality, employer initiatives for more effective purchasing decisions, data collection efforts, new relationships between health plans and providers, and the regulatory environment within which managed care must function.

NIHCM will fund only research that fulfills specific criteria. Research must be:

- high quality, objective and nonpartisan;
- of national importance given health care reform;
- relevant to managed care;
- useful to policymakers, consumers and the managed care industry;
- timely given the progression of the health reform debate;
- achievable within a reasonable time frame; and
- able to contribute to improving managed care delivery in general and member plan practices in particular.

Beyond research, the institute will be sponsoring other projects and awards. These include:

- **White Papers** - NIHCM will publish two white papers in 1994 on important issues related to health reform and managed care. The first is on health plan solvency under health care reform and will be published in the spring. NIHCM is accepting proposals for the second white paper to be published this fall on topics related to its research themes. These are intended to be thoughtful analyses and essays that will inform the policy community and policymakers in the health care field.

- **Surveys** - At its initiation, NIHCM sponsored a Louis Harris Survey, which indicated that policymakers want and need much more data in order to make informed decisions about health care reform. NIHCM will continue to sponsor periodic surveys.

- **Awards for Excellence** - NIHCM will be sponsoring three awards for excellence in reporting and research on health care

reform implementation and best practices in managed care issues. The awards will offer \$5,000 for best published, academic orientation article and best newspaper article or series (large circulation and small circulation publications). Awards will be presented at a reception during NIHCM's meetings in November 1994 and July 1995. Authors are encouraged to contact NIHCM for further information.

- **Public Forums on Managed Care and Implementing Reform** - NIHCM will sponsor public forums to examine real world experience with solving problems in health care delivery. These one-day events will focus on implementing reform, e.g., how states and the private sector can advance rural network development.

- **Clearinghouse** - NIHCM acts as a clearinghouse to distribute relevant research on managed care issues and reform related topics. The clearinghouse primarily serves policymakers and the media. NIHCM has also developed a comprehensive state-level database that combines a variety of resources that will be published in a book in the fall of 1994.

- **Member Workshops on Best Practices** - NIHCM sponsors member workshops on strategic planning issues, in which members share expertise as well as learn from experts in the field.

#### **NIHCM Board and Staff**

The chief executive officers of member plans serve on the board and direct activities of the institute. NIHCM's board chairman is Leonard D. Schaeffer, chairman and CEO of Blue Cross of California and former president, Group Health, Inc. of the Twin Cities, as well as former administrator of the Health Care Financing Administration during the Carter Administration.

NIHCM's day-to-day operations are headed by executive director Nancy Chockley. Ms. Chockley, formerly with Mercer Management Consulting, has considerable experience in business consulting and strategic planning for health organizations. This experience brings a practical perspective to making market and governmental reforms work. Other key staff include Kathy Eyre, senior research director, and Andy Bressler, director of policy. Ms. Eyre is a former Pew Career Development Fellow and federal health care antitrust prosecutor. Mr. Bressler was formerly with Mercer Management Consulting.

#### **Information**

Questions regarding the National Institute for Health Care Management and its research agenda, awards and other activities can be addressed to: Nancy Chockley, Executive Director, NIHCM, 1818 N Street, NW, Suite 300, Washington, DC 20036; TEL 202/296-4426; FAX 202/296-4319.

Bob Cobe / Nov. 1 / Barbara

Robert Cobe 6/25/42

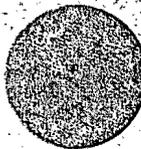
Sharon Allen 6/19/44

Robert Shoptaw 11/16/46

THE WHITE HOUSE  
OFFICE OF DOMESTIC POLICY

OCT 20 1994

CAROL H. RASCO  
Assistant to the President for Domestic Policy



To: \_\_\_\_\_  
\_\_\_\_\_

Draft response for POTUS  
and forward to CHR by: \_\_\_\_\_

Draft response for CHR by: \_\_\_\_\_

Please reply directly to the writer  
(copy to CHR) by: \_\_\_\_\_

Please advise by: \_\_\_\_\_

Let's discuss: \_\_\_\_\_

For your information: \_\_\_\_\_

Reply using form code: \_\_\_\_\_

File: \_\_\_\_\_

Send copy to (original to CHR): \_\_\_\_\_

Schedule ? :  Accept  Pending  Regret

Designee to attend: \_\_\_\_\_

Remarks: *Open* *Carol & Chris will*  
*met CHR @ 100*  
*@ 5300am*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ROBERT D. CABE

October 19, 1994

Dear Carol,

I'm enclosing an invitation to the November 1 dinner of the National Institute for Health Care Management.

Annuncas Blue Cross is a charter member of the Institute, and Bob Shapiro, Sharon Allen and I will be attending. The invites include the Board, Advisory Board, and several people active in Congress, the media, academia, etc. on health care matters.

The 10/21 RSVP date is not a problem. If your schedule permits and you would like to attend some or all the evening's events, we would be delighted to have you. Just let me know any time before 11/1 —

P6(b)(6)

Best regards,  
Bob

*The National Institute for Health Care Management  
cordially invites you and your spouse to attend*

*The NIHCM 1994 Annual Board Dinner and  
Research Award Reception*

*Tuesday, November 1, 1994*

*The Decatur House  
748 Jackson Place, NW  
Washington, DC*

*5:30-6:30 - Cocktails*

*6:30-7:00 - Remarks by Sheila Burke*

*7:00-7:30 - Remarks by Bruce Vladeck*

*7:30-9:00 - Award Ceremony & Dinner*

*9:00-10:00 - Performance by the "Capitol Steps"*

*R.S.V.P. (202) 296-4426  
by October 21, 1994*

*Business Attire*

1818 N Street, NW  
Suite 300  
Washington, DC 20036



NIHCM

EXECUTIVE OFFICE OF THE PRESIDENT

24-Oct-1994 03:37pm

TO: MILLER\_RA

FROM: Geraldine E. Covington  
USSS Waves Center

SUBJECT: Read Receipt for Appt. request - Cabe, Robert and others

Geraldine E. Covington read your message titled  
Appt. request - Cabe, Robert and others on 24-Oct-1994.

EXECUTIVE OFFICE OF THE PRESIDENT

24-Oct-1994 03:36pm

TO: Geraldine E. Covington  
FROM: Rosalyn A. Miller  
Economic and Domestic Policy  
SUBJECT: Appt. request - Cabe, Robert and others

Date 01-Nov-1994 Appointment with RASCO, CAROL H

Room No. Bldg. 2FL/WW WH Requested by Rosalyn A. Miller Phone # 456-2249

Comments:

TIME	VISITOR'S LAST, FIRST NAME	BIRTHDATE	SOC. SEC. #
05:00pm	Cabe	Robert	- -
05:00pm	Allen	Sharon	- -
05:00pm	Shoptaw	Robert	- -