

The Evolution of an HMO Hands-On Experience for North Carolina Physicians

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AS THE EDITORS OF THIS journal planned this issue on managed care, I was asked to offer an article from my perspective regarding managed care and its evolution in North Carolina. I begin with my experience with Carolina Physicians Health Plan, later Healthsource North Carolina. One approach to this challenge would have been to describe the roles of an extensive list of physicians who played vital parts in the developments I will describe. Their hours of deliberating, strategizing, organizing, problem-solving, managing, and directing are far beyond measure, however. I will focus instead, therefore, on concepts and events. For the record I will describe highlights of one particular HMO that was initiated by physicians and grew into the largest HMO in the state. Subsequent developments in the Triangle region will be mentioned, along with some reflections on lessons possibly gained from these scenarios.

The Early Years

The movement for a physician-owned HMO in Wake County began in 1984. Kaiser Permanente had established its staff model HMO, and Blue Cross/Blue Shield was rolling out its Personal Care Plan. Health America, based in California, was initiating a capitated HMO in our area. The latter two companies were recruiting groups of physicians, and applying considerable pressure to join. Health America was pressing physicians to sign capitated contracts. The physicians of Raleigh, for the most part, realized that they were in no position effectively to assume such actuarial risk. Nonetheless, physicians were feeling coerced to participate in this growing HMO movement.

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A few physicians met with an ad hoc committee of the Raleigh Chamber of Commerce and heard a clear message from the business community of frustration with the rising costs of healthcare. Business leaders challenged the medical profession to devise a more effective way to deliver quality care that was also cost-effective. Such a committee today could use the same script as was articulated in 1984.

In this context, a small group of Raleigh physicians began to meet weekly, dedicating their Tuesday evenings to achieving a better understanding of the implications of the HMO activity in our community. Beginning in February 1985, five or six doctors diligently joined this effort. As they learned more about the HMO activity, it became apparent that HMOs varied considerably on their policies and mode of operation. Within several weeks this group of practicing physicians perceived that an effective response to growing pressures was to form a *physician-owned and -directed HMO*. Several consultants were invited to visit, and they readily pointed out that for such a venture to succeed, it should be at least Triangle-wide and not restricted to Wake County. Fortunately, several physicians in Durham and Chapel Hill were receptive to this idea.

Coordinated Medical Services, a physician-led company from Ohio, was employed to help establish such an HMO beginning in central North Carolina. A feasibility study was done. Licensure was initiated from the Department of Insurance. Four hundred and thirty Triangle physicians posted \$3,000 each to fund the feasibility study and to buy stock in the holding company, Coordinated Medical Services of North Carolina operating as Central Carolina Physicians Health Plan (CPHP). By early 1986 the company was functional, and on July 1 the City of Durham with its employees became its first client.

The HMO started with capital of only \$860,000. In retrospect it is obvious that this capital was not adequate to support this venture. The economic disadvantage was com-

pounded by the initial accounting firm's failure to allow for incurred but not reported expenses. Reports from the accountants were favorable at the end of 1986, but when the delays in reporting expenses became realized, it was quite apparent that this positive information was not accurate. Major grievances followed with the accountants. Eventually they did partially compensate for their mistake, but by this time a significant financial hole had been dug and the compensation was too little and too late. Another critical factor in the HMO's financial woes was the increased level of reserve required by the North Carolina Department of Insurance.

In the context of this financial difficulty the board of directors reluctantly voted to shift from an open access to a gatekeeper plan. There were other steps taken at the time to improve the economics of the plan, but this change seemed to bring about a significant improvement in the balance of payments versus premiums.

In 1987-88, 350 physicians in Wilson, Rocky Mount, and Greenville bought into the company. Its name was changed to Carolina Physicians Health Plan, and licensure was extended over 25 counties. The board of directors was expanded to add physicians from these communities. Enrollment continued to grow both in the Triangle area and the East. By the end of 1988 there were 36,500 members in CPHP.

Sequential Effects of Insufficient Capital

Even so, there were major pressures to increase capital reserves or lose licensure. The board of directors wrestled with alternative solutions:

- (a) sell more stock;
- (b) temporarily increase the withhold;
- (c) sell the full company;
- (d) sell a portion of the company.

The first two alternatives were deemed unacceptable to our physician members. Intense negotiations ensued for choices (c) and (d), with attractive proposals presented for each. By secret ballot, with a 12 to 7 count, the board's decision was to sell 29% of the company to Healthsource rather than sell the company entirely.

Healthsource was a remarkably compatible partner. It was originated by physicians in New Hampshire in the early 80s. It had many similarities to Carolina Physicians Health Plan, but had taken the additional step of raising capital through a public offering. With its capital reserves it was acquiring companies in New England, along the East Coast, and reaching into the Midwest. It had an all-physician board of directors, and the CEO was a former family physician.

In 1997 Healthsource made a persuasive offer to acquire the full company, with Carolina Physicians Health Plan becoming Healthsource North Carolina, a fully owned sub-

siary of Healthsource, Inc. One board seat on the parent company was filled by a physician from the North Carolina board. At that time, Healthsource, Inc., had physician-directed HMOs operational in 10 states; soon another two states were added. In 1998 Healthsource, Inc. progressed from over-the-counter trading to be listed on the New York Stock Exchange.

As Healthsource, Inc. was growing, most notably in North Carolina with 250,000 enrollees, it became a target for acquisition. Several suitors emerged. There were two in particular, and in 1997 a proposal for acquisition by CIGNA was accepted by the board of directors and subsequently approved by the shareholders.

Interestingly, there were significant reservations and dissent among the physicians on the Healthsource board for this step, but attorneys and business people at the board meetings reminded the directors of their fiduciary responsibility to seek value for the shareholders. Economic and legal pressures drove the board to accept the offer despite the philosophical differences.

Reflections on Experience

The sale of Carolina Physicians Health Plan first to Healthsource and then to CIGNA was economically quite advantageous for the original stockholders, but at a cost of forfeiting the mission initiated by physicians in 1985-86. After the acquisition a few doctors were invited by CIGNA to serve on local committees, but effective authority was lost. Not only were the decision making and policy setting lost, but also access to data.

In the early days of the Central Carolina Physicians Health Plan Board of Directors an interesting scenario occurred, which was reflective of the difference in mindsets of physicians and the insurance industry. In reporting results to the board, accountants described the "medical *loss* ratio." Naively, the physicians initially did not grasp the terminology habitually used by the health insurance industry to refer to monies paid out for healthcare. They found the attitude reflected in this terminology to be contrary to the mission of the company. The board, feeling that the company was established for the purpose of effectively paying for healthcare, directed the accountants to use the term "medical *cost* ratio" as being more compatible with that mission.

From such lessons about the industry came a mission statement, adopted in the spring of 1991. It included phrases such as:

- "founded on the principles of preserving traditional physician-patient relationships";
- "provide cost-effective health services that meet the needs of the marketplace and simultaneously provide quality healthcare";
- "maintain physician involvement to assure quality

in the design and provision of managed care”;
“promote high ethical standards”;
“achieve profits and growth commensurate with
sound business practices.”

Through the experience of physicians on the board of directors of a publicly traded HMO there were several other lessons learned. First, the most significant factor in assessing how an HMO establishes its profitability is the profile of the enrollees. “The book of business” (i.e., the population insured) is generally the most critical factor in the economic potential of the HMO. The business minds of the company would lobby for efforts to minimize enrolling patients with diabetes or HIV. Also notable was the high cost of employees of hospitals. Various considerations were offered for shaping the enrollment.

Second, costs were influenced more by utilization than by the physician fee schedule. The utilization of hospitals was critical and the hospital fee schedule was an important factor. More vital than the physician fee schedule were the orders that the physician wrote to generate costs for studies and therapies. Despite the relative importance of these factors, it seems that the large insurance companies find physician fee schedules to be the most vulnerable target for enhancing their profits. Fortune 500 companies negotiating with cottage industries makes the playing field uneven.

On the contrary, pharmaceutical costs were a major challenge then as they remain today. From the late 1980s throughout the years with Carolina Physicians Health Plan and Healthsource, data showed that each year the most rapidly increasing component of the healthcare costs was for medications. The company developed tiers of copays to try to influence patients, and sometimes physicians, to seek more economical alternatives with their prescriptions. Efforts were made to encourage use of generics. Still, pharmaceutical costs continued to rise almost uncontrollably.

At board meetings, the physicians would receive reports of catastrophic cases on a regular basis. Rather consistently, critical neonates were among the most expensive patients. In this non-Medicare population the lesson with sick neonates was striking. Efforts were made to improve prenatal care, but there was very little progress evident in terms of decreasing costs for neonatal intensive care.

For an interval of time in the 1990s, HMOs did have significant effects on costs of healthcare. Some inefficiencies in the system were eliminated. The HMOs did accomplish savings, but the potential to continue finding new savings has proven to be elusive.

The tools implemented by managed care to curb extra costs have themselves quickly become a source of added costs, not only within the insurance industry but also with major impact on physician overhead. It appears that for several of these tools more dollars are spent than saved. Precertification programs can add considerable expense for

both the managed care companies and physician practices—not to mention the hassles provoked—and yet deter very little in costs for procedures or hospitalizations.

The adversarial relationships that have developed between health insurance companies and patients, physicians, and hospitals have become progressively more prominent. Efforts have often become counterproductive as mistreated providers find ways to retaliate.

Combining these factors with (1) the remarkable growth in the technology of medical care, (2) the associated increase in public expectations for management of medical problems, and (3) the powerful influence of our litigious environment, results in a hugely complex conundrum for our society and its healthcare system.

Ongoing Challenges for Local Physician Organizations

What have physicians done about organizing healthcare delivery in the Triangle since that decisive turn of events in 1997? In Durham and surrounding counties PrimaHealth has been established, bringing together community-based and Duke University physicians.

In Wake County, Key Physicians was developed as an IPA for primary care doctors. Key Physicians has been effective in building a network of 150 primary care physicians. Further growth is currently limited based on legal advice relative to antitrust issues. Even so, it has been effective in negotiating agreements with some HMOs involving bonuses for favorable scores on health quality parameters and curbing of pharmaceutical costs.

Patient’s Choice, Inc., also was begun in Wake County. This company was an outgrowth from Key Physicians with the purpose of direct contracting with local employers. For direct contracting, a network of physicians to cover all specialties was necessary. Such a panel was recruited in Wake County then expanded through alliances with UNC physicians as well as PrimaHealth. Contracts have been forged with each of the hospitals in the Triangle area.

Lessons from the earlier experience were applied in the formulation of Patient’s Choice, which was created as a not-for-profit entity. Its success cannot lead to loss of control and an acquisition that eliminates the original purpose of a locally owned and physician-directed company. With direct contracting that utilizes effective stop-loss insurance, underwriting risk is not assumed and no capital reserves are necessary to satisfy Department of Insurance requirements. Overhead is held to a minimum, and there are no dividends to be paid. The medical director and physician committees are local. Patient’s Choice is positioned to be flexible in benefit design and can adapt well to a defined contribution approach for health insurance if an employer so desires.

Fundamental Conclusions

Ownership is vitally important. Basic economics teaches that a downside consideration for incorporating is to lose control. For a company to seek investor capital from business interests is to take a big step on a very slippery slope.

When physicians and other providers are economically controlled by such corporations, a commodification of healthcare occurs which undermines professionalism. Such

professionalism is critical to preserving trust in the doctor-patient relationship.

While the quest continues for a more effective system, every day we physicians set aside these issues as we face one-on-one our individual patients in the exam room, the operating room, or the emergency department. Even in the face of these economic and logistical pressures, we must strive to sustain our professionalism by keeping the needs of our patients as top priority.