cc: C. R. Richards
M. Cascone
W.E.F. 7/6/84

FLORIDA HOSPITAL ASSOCIATION, INC/BOX 6905, 307 PARK LAKE CIR, ORLANDO FL 32853 305/841-6230
CAPITAL OFFICE

July 3, 1984

William E. Flaherty, President
Blue Cross/Blue Shield of Florida, Inc.
Post Office Box 60729
Jacksonville, Florida 32236-2729

Dear Bill:

Thank you for your letter of June 25, 1984. We are pleased that you will be able to meet with the Board of Trustees of the FHA on September 28, 1984. In addition to hearing from you about the changes taking place in the board structure of Blue Cross of Florida, the FHA Board would also be interested in:

1. Blue Cross/Blue Shield of Florida's involvement in the development of HMOs and PPOs.
2. Developments at the national level (BCA) of guidelines for tightening coverage of imaging.
3. The trend in other states for Blue Cross plans to participate in various new forms of reimbursement (DRG-based and all-payor systems) and what we may expect in Florida.
4. Your views on what we can expect in Florida under the new Health Care Consumer Protection & Awareness Act, and other forms of regulatory pressure (specifically the role of the HCCB).
5. Future relationships between Blue Cross and the hospitals of Florida.
6. Effects of reduced utilization of hospitals.

The hospitals appreciate the long-standing ties with Blue Cross/Blue Shield of Florida, and we look forward to exploring with you the new relationships that are developing in this time of rapid change.

Thank you for the invitation to the July informational meeting. I look forward to seeing you there.

Sincerely,

John M. McBryde, CAE
President

JMMcB:ss

cc: Jack T. Stephens, Jr., Chairman

W.E.F. JUL 5 1984

I. INTRODUCTION

A. Pleased to have this invitation to meet with you and exchange views on issues of mutual concern.

B. We are both operating in a rapidly changing heath care market. Each of us is being impacted by legislative action, growing competition in the marketplace and environmental circumstances. Open communication with one another becomes more important than ever. So I'm especially pleased that you've created this opportunity for us to come together.

C. As President of BCBSF, I value the support and counsel which you, as leaders in the hospital industry have continually provided to the company.

D. Since the founding of BCBSF, you have made many contributions to our growth, development and success.

E. Market changes, are requiring a change in our longstanding roles and relationships with one another.

1. Our recent board restructure is an example of how we are changing so that each of us can adapt and continue playing a key role in health care in the eighties and beyond.
2. Although our board will be smaller in size and the number of members directly involved in the delivery of care will be reduced, hope to foster a continued dialogue with the hospital community.
   a) Creating Institutional Services Advisory committee. Both current hospital board members and additional representatives from the provider community will be invited to serve.

F. So, although our traditional roles and relationships are changing. I believe there are many opportunitites for us to work cooperatively . . . and continue the dialogue we have always enjoyed.

G. In a recent letter from John (McBryde), he requested that I address several specific points, and I want to be responsive. So in the next 20 minutes, I'll be sharing my perspective on such topics as:

1. BCBSF HMO's & PPO's
2. Trends in reimbursement
3. Relationship between BCBSF and hospitals
4. Implications of the new HCCAA
5. BCA guidelines on imaging, and
6. Effects of reduced utilization on hospitals

SLIDE #1
EMERGENCE OF HMO'S AND PPO'S . . . A RESPONSE TO MARKET DEMAND

II. EMERGENCE OF HMO'S AND PPO'S . . . A RESPONSE TO MARKET DEMAND

A. These options represent an essential element in the changes we believe are needed to make our health care system more responsive to Floridians' financial concerns. With multiple choice in the marketplace, people can seek out the care that gives them the most value for their health care dollar.

SLIDE # 2
Cost/value Diagram (see attachment)

SLIDE # 3
SFGH

SLIDE # 4
CHP

1. Progress of our two operational HMO's
   a) SFGH membership gain of over 33%
   b) CHP enrolled an additional 14,000 people, paid off an outstanding loan and had a financial gain in 1983.

SLIDE # 5
Four-Year HMO strategy
o Ten HMOs statewide
o Accessible to 60% of Florida's residents
o 25% of the HMO Market

2. Long-term HMO strategy
   a) A new site for development in 1984 (Jacksonville); two planned for early 1985 (Orlando & Tampa/St. Pete)
   b) By 1988, plan to have a minimum of ten throughout Florida
   c) Accessible to 60% of the population
   d) Target 25% of the market by 1988 (approx. 400,000 Floridians)

SLIDE # 6
Initiation of PPO Network
o Marketing in Duval and Dade counties
o 17 service areas throughout Florida by mid 1985
o Projected enrollment of 60,000 within first year

3. PPO Activity
   a) Acceptance of HMO's is serving as a catalyst for evaluating the potential of another alternative delivery system: the Preferred Provider Organization (PPO).

b) Expect several Preferred Provider arrangements to be offered to employer groups soon in communities around the state.

1. We have started marketing in Duval and Dade counties
2. These two locations are part of a total of 17 service areas we hope to develop by mid 1985
3. Some of the criteria considered in the selection of these areas include: population
   number of hospital
   scope of services
   community perceptions
   cost effectiveness, etc.
4. Projected enrollment of 60,000 by 1988

4. PPOs and HMOs are an integral element in our strategic plans for future growth and development

a. They represent our recognition that in order to meet buyer demand, we must provide options in financing and delivery

b. While these new initiatives are a major part of our strategic plans, they do not supplant our commitment to our traditional business lines.

1. These lines account for 99 percent of our business and we expect to maintain and expand these as well.

III. FUTURE RELATIONSHIPS BETWEEN BCBSF AND THE HOSPITALS OF FLORIDA

A. As each of us adapts to new market conditions we are both becoming more and more involved in the financing and delivery aspects of health care.

1. This may well lead us into competition with one another in some areas.

2. Anti-trust implications preclude us from business as usual, in which a representative group of hospitals negotiated a contract with us.

SLIDE # 7

BCBSF/HOSPITAL CONTRACT AGREEMENTS

A shared commitment to:

- o cost consciousness
- o quality consciousness
- o enhance community perceptions, and
- o provide wide scope of service

3. Increasingly, we will be negotiating contracts individually with one another based on a shared commitment to: cost consciousness
quality consciousness
community perceptions, and
level of service

4. While the competitive nature of our business is growing, a strong need remains for us to work together closely in offering consumers these integrated financing and delivery systems.

SLIDE # 8

REIMBURSEMENT TRENDS

IV. REIMBURSEMENT TRENDS

SLIDE # 9

REIMBURSEMENT TRENDS

- o Transitional Stage
- o PCPP Status
- o Need for Hospital Input
- o Experimentation with payment plans

A. The basic reimbursement method that we created eight years ago, and which has existed between us since then is the Prospective Charge Payment Program (PCPP).

1. Its validity and viability are in question as a result of enactment of the Health Care Consumer Protection and Awareness Act and changing market conditions.
2. These circumstances necessitate that we design and negotiate a new contractual reimbursement program.
   a. We will be seeking input from the hospital community as to alternative reimbursement forms which may be appropriate.
3. Together, hope we can develop other forms of reimbursement . . . those which are reflective of the resources committed to the care of the patient, such as:
   a. enhancements of DRG
   b. capitation payment methods (as in N.D., Mass., Rochester, NY, etc.)
   c. norms based on peer groupings
4. Whatever reimbursement form(s) we choose, it is likely to be modified as our industry continues to change at an accelerating pace.
5. Our challenge will be to adjust and initiate financing and delivery programs which reflect and respond to the changing health care needs of the residents of Florida.

B. Trends among other BCBS Plans.

1. If we examine BCBS Plans nationwide, because of the deversity of approaches doubt that we could identify the one or the best hospital payment program that lies ahead.

a) Several innovative programs are taking shape and may serve as models for the future.

b) Historically, Plans in NE and Midwest, with large market share, have negotiated significant discount arrangements with providers. Plans in the South and Southwest, with less market penetration, tend to have paid on the basis of charges.

c) Increasing competition among insurors is requiring Plans to assess their reimbursement relationships with providers and seek to negotiate the best arrangement they can for their customers

SLIDE # 10

REIMBURSEMENT TRENDS

- o Prospective Payment
- o Increased Predictability of cost
- o DRG-based payment of cost

2. In surveying the various payment plans being developed, the majority are prospective types of payment which should allow buyers to better predict their costs for health care services.

3. There is currently impetus toward DRG based reimbursement programs -- particularly so in Florida, where so much of a hospital's care is Medicare related.

SLIDE # 11

BCA TASK FORCE CONCLUSIONS

Outmoded Payment Practices

- o Uncontrolled billed charges
- o No process for limiting costs
- o No differentiation of Plan rates from hospital charges

4. Also indicative of possible payment trends are the conclusions of a special BCA reimbursement task force created in '82. The task force identified 3 Plan payment practices no longer considered acceptable:
   a) uncontrolled billed charges,
   b) no process for limiting costs being paid, and
   c) no differentiation of Plan rates from hospital charges

SLIDE # 12

STATE REGULATION AND ALL-PAYOR SYSTEMS

V. STATE RATE REGULATION AND ALL-PAYOR SYSTEMS

A. Regulatory approaches likely will continue to be promoted, chiefly by those unable or unwilling to develop competitive payment options and those advocating a "quick fix" approach to cost containment.

1. It's significant to note that those state's which have an all-payor system are in jeopardy of losing their Medicare waiver (e.g. N.J., Mass., Maryland).
   a. The rate of increase in hospital admissions is dropping more dramatically in non-waiver states.

B. Through my participation on the Governor's Task Force and my role on the HCCB, you probably know that I advocate the competitive model over regulation.

1. Under rate regulation, even where applied as a safety net, you tend to find that what is intended as a ceiling essentially becomes the floor.
2. When you set a maximum allowable rate of increase, you have an incentive to go right to it. That's because it may be denied in future years unless you budget for it in the planning year.

C. The recent enactment of the Health Care Consumer Protection and Awareness Act, in the main, represents a political response to the public's growing outrage with current health care costs.

1. It will be incumbent upon us, as advocates of free market competition, to effectively manage health care costs if we are to stave off further regulation.

2. Any doubts that the battle is over, in my view, are premature.

SLIDE #13
WHAT LIES AHEAD

VI. EFFECTS OF REDUCED UTILIZATION ON HOSPITALS

A. Our diverse and changing environment, of course, makes it difficult to forecast with accuracy what lies ahead for us.

1. Despite this unpredictability, it is not a question as to whether we are going to change. The question is when, how much and in what way?

2. Just as market conditions require us to change our structure and initiate alternative financing and delivery systems, hospitals also are changing. Competitive pressures, Medicare payment constraints, reduced utilization, etc., bringing this about.

   a) Most recently, we are identifying a move by big business and organized labor toward uniform health care benefits, uniform delivery of that benefit nationwide and predictability and containment of cost.

   b) Recent BCA Diagnostic imaging guidelines represent another example of the impetus for adaption and change.

      1. BCA research indicates that diagnostic radiology services now account for 3 - 5% of total hospital charges.
      2. intent of the guidelines is to encourage appropriate selection and use of imaging procedures.
      3. guidelines developed with and supported by many representatives from the provider community.
      4. our own medical staff will be working with you and physicians to evaluate the impact of these guidelines and the appropriateness of developing medical policy prior to implementing or integrating any of them into our own utilization management programs.

3. For all of us to succeed we'll need to respond to these environmental changes. At the same time, we won't want to jeopardize or downgrade quality.

SLIDE # 14
FACTORS FOR SUCCESS
- Flexibility to change
- Risk-taking
- Respond to market needs

4. As we position ourselves to continue playing a key role in health care in the eighties and beyond, flexibility, a willingness to take risks and responsiveness to market demand should enable us to successfully deliver quality products and service at reasonable cost.

SLIDE # 15
COST/VALUE SLIDE

Thank you. I'd be happy to answer any questions.