1976 AMA CONFERENCE, JANUARY 22 - 25, 1976, CHICAGO

PROFESSIONAL LIABILITY

Mr. Walter P. Bailey delivered a report for Mr. Lester R. Rawls, Director of the National Association of Insurance Commissioners (NAIC's). The Chief Insurance Regulatory Authority of the fifty-four states and territories have long wanted data on malpractice problems. A uniform reporting system for the 30-odd insurance companies that together write virtually all the nations medical malpractice insurance policies, has been operational since July 1.

The NAIC is keeping track of PL legislation in various states and forty-two states have enacted legislation in 1975. Thirty-three states are attempting to reform the legal system, twenty-two states the Health Care Delivery System and thirty-two states have authorized further study of the malpractice problem. The controversy has centered on insurance and costs.

Medical, legal and inflation problems have supplied complexities which are beyond normal insurance company solutions and, therefore, the NAIC is receiving statistics from each carrier so that they may evaluate existing legislation, see what is needed and develop programs to aid the medical injuries problem. They are concerned with insurance data on who, how much, and profit and loss, as well as general trends and cost trends. The first summary of data collected shows complexities and no easy solutions. Some findings are: 1) more suits were filed against doctors who do no surgery than against any group of specialists who operate or assist, 2) Board-certified specialists were sued much more frequently than uncertified doctors, and 3) FMG's were sued less often, proportionately, than their American-trained counterparts.

REPORT 4 (Cont) PL

A shortening of the Statute of Limitations would speed up processing and allow insurers to proceed with more certainty. There is a long delay between incident and statement and the average is about three years. Many carriers got burned and some will not know that they were burned for four or five years. Then they too may get out of the business.

It is interesting to note that when physicians own the carriers, they do not choose to write all doctors in the area. Will the remainder be economically barred from practice?

86% of PL concerns hospital incidents. In Virginia, they are attempting to make hospitals responsible for all PL happenings within the walls of the institution. This may eventually give hospitals control of who practices there and how they will practice. It will give the hospital a financial incentive to run its own effective review system. (NOTE: The speaker listed the high volume specialties and did not list Neuro-Surgery, which is a specific problem in New Jersey.) It seems there are twice as many claims against self-employed physicians as against group practices. Board Certified physicians draw 1½ times as many claims, probably due to more high risk procedures.

Of the claims closed in 1975, most occurred three years earlier, the average settlement was $6,672.00 and the average paid claim was $17,723.00. Two-thirds were misadventures in procedure (including unnecessary procedures) and one-third were misadventures in diagnosis (including both delay in diagnosis or misdiagnosis.)

PROFESSIONAL LIABILITY SEMINAR

Some states are attempting court reform legislation (Florida, Pennsylvania) to set limits on an individual physician's liability, with a pool to handle the excess. This makes a "Captive Company" more viable because it would only have to insure up to the first 100,000. If a pool is established, it ought to be mandatory for all physicians to pay into the pool, or some physicians might prefer independent insurance and the program would not have sufficient numbers to become successful.

Mr. Richard P. Bergen, J.D., Director, AMA Department of Legal Research, stated that many of the recently enacted bills were being tested by the courts and would probably go to the Supreme Court. A trial court in Florida held unconstitutional that all claims must go to mediation. In Idaho, a top limit was held unconstitutional. In Illinois, the remedial panel "must go to review" and the top limit are challenged by the courts. In Tennessee, there is a question concerning their requirement for review by panel prior to suit.

He stated that the New York Court of Appeals in November 1975 made a highly important decision. In the Montgomery case which appeared in the New York Law Journal of November 26, 1975, the suit upheld the auto no-fault law, but in doing so it supported the concept of remedial legislation and said that: 1) the US court does not bar State Legislation from changing common law, and 2) that access to the court is not a constitutional right.

Mr. Jay Hedgepath, L.L.B., General Counsel, American Hospital Association, in Chicago, stated that the volume of State Legislation during the past year has reduced pressure for a "Federal solution" to the malpractice problem.

is tremondous cooperation between the AMA and the HSA in assisting with legislation and joint legislation proposals as well as both getting together with the insurance industry and meeting with other trade associations to draft legislation. Most legislation is so new that results have not been too dramatic and the insurance industry is looking for quick results. The legislative items of real promise will be contested in the courts and the biggest advance is that we are now getting hard data to work out a methodology for getting realistic premiums.

He stated that if the institution takes complete responsibility for PL within its doors, some physicians feel that the hospital will take an inordinate interest in how and who practices in their hospital. He feels that we will shortly learn from litigation how to better prepare legislation on the Statute of Limitations, limitations on pain and suffering and Res Ipsa Loquitur. The "Captive Company" Jack Sargeant, Executive Director of the Medical and Chirurgical Faculty of Maryland, stated that they have developed "mutual liability insurance society" which is owned by its members and created by general statutes. Five of the eleven board members are physicians, five have an insurance company background and one is a medical society executive.

A "Captive Company" provides availability of coverage where none exists. William K. Scheuber, Executive Secretary, of the Alameda-Contra Costa Medical Association, Oakland, California, states they took the "Captive Company" route because there was no coverage available in the summer of 1975.

Another type of coverage could be available under the Joint Underwriting Association(JUA) however, the insurance company in this type of

situation has no physician input and works out a cost plus arrangement with no insurance company risk. The CMA got the JUA to agree to take areas where other coverage was not available.

The question about the "Captive Company" is how could amateur doctors succeed where professional insurance people failed. Insurance companies are used to rigid old techniques and treat physicians as if they were a fleet of taxi cabs to be insured. In general, they do not seem to be open to new solutions or varying their insurance formats. The advantages of a "Captive Company" are: 1) the use of insureds as underwriters, They state what kind of doctors they are underwriting and what kind of behavior they will tolerate, 2) the use of insureds as claims consultants. They have a thorough collaborative approach to defense, 3) they save sales costs, 4) they can perhaps save some management costs and are looking into this, and 5) they use investment income to operate a loss pool, and this is all monies but operations monies, and 6) they use excess funds for things that such funds were never used before, a) research, b) litigation, c) legislation, d) publicity and e) to see that doctors pay attention to some things that they have overlooked in the past such as using safeguards that were never used before and providing good rates for parttime coverage.

Mr. Tom Tucker, Vice President, of Marsh & McLennan, Illinois, stated the total capacity of the insurance industry was reduced through losses in underwriting and investment and the industry outlook on PL is highly speculative. They don't know what the future holds for "tail" coverage. They don't know the future atmosphere, social financial and in the courts on physician coverage. He stated that small physician owned companies moving in may change the ideas and generate a responsive operation. They are alarmed because consumerism is causing a trend in

more claims and more costly claims. The trend is going up 25% a year and this trend must slow down before the insurance industry outlook becomes better. He suggested that "Captive Company" won't know whether or not they have a success until they are in operation five years.

Jack Sargeant says that physicians in Maryland enjoy the confidence of the state assembly because they stepped in and assumed responsibility. On the other hand he stated that insurance companies have low creditability with the Maryland legislature because they are pulling out of the state. In effect, the doctors told the legislators that they will assume this responsibility if the legislature will assume the responsibility of limiting tort law.

ARBITRATION

Irving Ladimer, S.J.D., Program Director, of the American Arbitration Association, discussed PL arbitration. Non-binding is the submission to a neutral panel for arbitration for handling outside of the courts. Binding means that the decision of the neutral arbitration panel shall be as binding as a court judgment.

There should be a written formal agreement between the doctor and patient on a voluntary basis. Versatile, flexible arrangements not only suitable to physicians, but to the advancement of medical care for all should be sought.

The New York Medical Society and the New York Hospital Association are working out arbitration agreements and the American Arbitration Association is the mediator. Such agreements are possible in thirty-six states which have arbitration laws.

Medical Foundations have worked out mandatory systems. The Kaiser Plan has one mandate for joining the Plan and receiving their benefits package --the acceptance of a mandatory form for arbitration. The courts upheld that this is fair, constitutional and protects the rights of all. Although this was upheld in California law, we don't know whether this will be upheld for the private physician. The Ross-Loos Closed Panel Medical Group in Los Angeles has a mandatory clause and has had a substantial number of early, fair case settlements. An arbitration plan must have essential fairness and be legal. Much of this depends on the kind of arbitrators selected. The American Arbitration Association supplies a three panel system comprised of an M.D., an attorney and a member of the public.

The Kaiser Plan uses two attorneys and one retired judge.

Sam Horowitz, M.D., Member of the Council on Arbitration, California Medical Association, reported on a project encompassing nine hospitals. They are attempting through arbitration: 1) speed claims, 2) provide an efficient convenient procedure, 3) less publicity, 4) limit awards, 5) minimize appeals, and 6) assure small claimant hearings. He states the negative part, or what is lost in his system, is the loss of jury sympathy and the time it takes to explain the entire process.

Dr. Horowitz stated that patients reacted favorably. only three-tenths of one percent refused, on admission, to sign the arbitration agreement. Thus far, few cases have been arbitrated and more education in the legal community may be necessary, but it is now getting good results because settlement costs are substantially lower.

They have made the arbitration clause the first article in their service contract. The patient must be given thirty days to rescind the agreement in writing. It outlines, in large contract type, that they will be giving up their court right and spells out how the public will be in on the arbitration through alI cases being submitted through panels of the American Arbitration Association. He stated that it was not a substitute for insurance coverage and that physicians should also carry adequate insurance.

CROSSROADS HEALTH PLAN-ESSEX COUNTY MEDICAL SOCIETY

HMO Initial Development Grant Application

HEW Site Visit

A G E N D A

Wednesday, December 29, 1976 -- Seton Hall University, South Orange, Stillman School of Business, Exxon Conference Room, 2nd floor.

	Topics	Discussion Leaders
9:30-12:00 Noon	Introduction	Dr. Lapeyrolerie Dr. Bythewood
	Project Overview	Mr. Detore
	Legal, Organizational Structure and Providers	Mr. Detore Dr. Benz Dr. Richlan Mr. Silver Mr. Muglia Mr. Allen
12:00-1:15 p.m.	Luncheon	
1:15-2:45 p.m.	Marketing	Mr. Detore Mr. Moore Mr. Monfiletto
2:45-5:00 p.m.	Financial	Mr. Detore Mr. Muglia
	Budget and Work Plan	Mr. Detore Mr. Muglia Mrs. Garvin

TOPICAL OUTLINE

9:30 a.m. - 12:00 Noon

1. Topic: Introductory Remarks
   Frank Lapeyrolerie, D.D.S.
   Alton E. Bythewood, M.D.

   Welcome, introduction of participants, support of ECMS.

2. Topic: Project Overview
   Robert Detore

   Historical development, community and provider support, goals of ID grant application.

3. Topic: Legal, Organizational Structure and Providers

   Legal feasibility analysis -- Harris Silver

   CHP By-laws, ECHO By-laws, provider contracts -- R. Detore, Dr. Benz, Dr. Richlan

   Organizational Relationships -- CHP-ECHO, ECHO-other providers-- R. Detore, Dr. Benz, Dr. Richlan

   Physician Recruitment and Education (ECHO) -- Dr. Richlan, Dr. Benz, R. Detore

   Peer Review and Utilization Controls -- Dr. Benz, Dr. Bernstein, Dr. Richlan, Marc Allen.

   Hospital Contracts -- R. Detore; Hospital Administrators (F. Brower, D. Bruschi, etc.)

   Fee Schedules -- Dr. Richlan, Dr. Benz, R. Detore

   Management Information System -- R. Detore, M. Allen

   Co-Medical Directors -- Dr. Lapeyrolerie, Dr. Benz

   Delivery System (referrals, ER services, health education, social services, etc.) -- Dr. Richlan, Dr. Benz, R. Detore

1:15 p.m. - 5:00 p.m.

4. Topic: Marketing

   Enrollment projections, marketing plans, health benefit package, Newark residents.

5. Topic: Financial

   Premium structure, financial plan, loan program, break even point.

6. Topic: Budget and Work Plan

   I.D. grant budget, project timetable, activities and tasks.

CROSSROADS HEALTH PLAN

NEWS LETTER

Crossroads Health Plan
185 Central Avenue
East Orange, N.J. 07018

December, 1976
Volume I Number 3
Ernest Monfiletto, Editor

Topics: I.D. Grant Application Submitted to HEW; Medical Society Organizes IPA; Dr. Richlan Appointed Co-Medical Director; President Signs HMO Amendments; Consumer Advisory Council Formed; HMO Subscribers Projected at 20,938 by 1980; Membership Department Promotes Crossroads to the Public; Interest Among FORTUNE 500 Companies in HMO's Increases; Qualified HMO's Now at 21; News Briefs.

I.D. GRANT APPLICATION SUBMITTED TO HEW

On November 1, 1976, the Board of Directors of Crossroads Health Plan submitted an Initial Development Grant Application to HEW Region II. HEW approval of this grant application will enable Crossroads Health Plan to prepare for operational status as a federally qualified Individual Practice Association model HMO serving the residents of Essex County by the first quarter of 1978.

The initial development phase will extend from February 1977-January 1978 and will provide continued funding under the HMO Act of 1973 for the completion of legal, marketing, financial and provider activities in preparation for operational status.

MEDICAL SOCIETY ORGANIZES IPA

The Essex County Medical Society has taken the leadership in organizing an Individual Practice Association (IPA). The Essex County Health Organization (ECHO) is an Individual Practice Association sponsored by the Essex County Medical Society. Individual Physicians (M.D.'s and D.O.'s) who join ECHO will be able to care for patients enrolled in the Crossroads Health Plan and other HMO's that may develop in the Essex County area with reimbursement on a fee-for-service basis for each patient service rendered. Fee schedules will be approved on an annual basis by ECHO member physicians.

The Essex County Medical Society is working closely with Crossroads Health Plan in the planning and development of an IPA model HMO in Essex County. A majority of the Board of Directors of Crossroads Health Plan are local physicians who are members of the Essex County Medical Society. George Benz, M.D., a member of the Board of Directors of Crossroads Health Plan and a Trustee of the Essex County Health Organization stated: "The Individual Practice Association model HMO jointly sponsored by the Essex County Medical Society and Crossroads

children's ear exams conducted to determine the need for hearing correction.

-- Extends period for use of loan funds (time to reach breakeven) from 3 to 5 years, although maximum loan remains at $2,500,000.

-- Amends Title XVIII of the Social Security Act to provide that SSA can contract only with HMO's qualified by PHS under the HMO Act.

-- Amends Title XIX of the Social Security Act to provide federal participation in Medicaid payments under prepaid risk contracts only if the contracts are with qualified HMO's.

-- Extends authorization under the HMO Act for two years: FY 1976 - $40 million FY 1977 - $45 million; FY 1978 - $45 million; FY 1979 - $50 million.

SUBSCRIBER ADVISORY COUNCIL

A Subscriber Advisory Council to the Crossroads Health Plan Board of Directors has been formed to provide structured input to the Board from representatives of community groups, social agencies, health professions, organized labor, employer groups and government. The Council will advise the Board of Directors during the pre-operational stages of development. Once the HMO is operational, the Council will be composed of Plan subscribers who will have responsibility for nominating members to the HMO Board of Directors as well as regular input in the development and implementation of HMO services and programs. Ernest Monfiletto,Membership Services Coordinator of Crossroads Health Plan, commented that"the Subscriber Advisory Council is a major step toward greater community involvement in health care issues in general and specifically the development and operation of a Health Maintenance Organization."

Members of the Consumer Advisory Council include: Arlene Henry, Philip Cocco, Sr., Monroe M. Kramer, Eva Lewis, Sanford Kaplan, Joseph Stellato, Max Wolfe, Marilyn R. Udis, Tony Tolles, Dr. Carmine Loffredo, David Gross, Anna Princiotta, Councilwoman Gail Rosen, Anthony Della Salla, Andrea Contaldi Maenza, Armstead Burke, and Vivian Braxton.

HMO SUBSCRIBERS PROJECTED AT 20,938 BY 1980.

The Membership Department under the direction of Brian Moore, Membership Director, has undertaken extensive marketing surveys of employers in the Essex County area. These surveys conducted by phone and/or personal visits to 300 major employer groups have resulted in data that has been utilized by the Membership Department and experienced HMO marketing consultants in the development of an enrollment plan for Crossroads Health Plan. Based on extensive survey data and the experience of other HMO's, it is estimated that first year (1978) enrollment will be 5,688; second year (1979) enrollment will be 10,290; and third year (1980) enrollment will be 20,938 members.

MEMBERSHIP DEPARTMENT PROMOTES CROSSROADS TO THE PUBLIC

During the past six months, the Membership Department has conducted a public information program to expose the general public to the HMO concept and Crossroads Health Plan. This public information program has resulted in newspaper articles and radio interviews. Articles on Crossroads Health Plan and the HMO concept have appeared in the Newark Star Ledger, New York Daily News, Passaic Herald Newsand the weekly Worrall Publications in

Personnel Research Associates recently announced the publication of their newsletter "The New Jersey Emoloyer". This newsletter is an excellent resource for employers and other interested groups in HMO activities in New Jersey. For more information, contact Marilyn Udis at 49 Oak Ridge Road, Verona, New Jersey.

HMO's received praise in the third Forward Plan for Health FY 1978-82 developed by the U.S. Public Health Service. The report stated, "One purpose of the HMO concept is to stimulate reforms in health care financing consistent with the broad support for realistic, quality programs to de-emphasize inpatient care. Studies of utilization rates of Federal employees has produced a solid base of evidence that HMO patients have a markedly lower rate of hospital admissions and a shorter length of stay than those covered by conventional plans. HMO plans continue to expand, having doubled their enrollment in the past three years. Amendments to the HMO Act should contribute to the continued growth of this delivery model."

Prudential Insurance Company continues to show more than passing interest in the HMO field. Prudential recently opened a new $2.7 million health center in Houston organized as an HMO. The Ambulatory Care Center occupies 30,000 square feet in a three-story building and is staffed by 28 physicians. The organization will seek Federal qualification. Recently Prudential has shown an interest in assuming responsibility for the South Shore Health Plan, a IPA model HMO in Atlantic City that was recently denied federal qualification.

General Motors spent more last year with Blue Cross-Blue Shield than it did with U.S. Steel, the major supplier of metal for its cars according to an article by Stuart Auerbach in the Washington Post on March 16, 1976. The $825 million spent on health benefits for GM's employees added $175 to the cost of every car and truck built. The Nation spent $118 billion for health care last year, an increase of almost 14% over 1974, about double the rate of the national cost of living increase. Commercial insurance carriers and third party payers have increased their rates recently by 35% while prepaid, HMO-like groups showed an increase of 14% according to the Federal Employers Health Benefits Program Study report.

If you have any suggestions for topics to be included in this newsletter or if you would like to write an article on a topic of interest, please contact the Editor, Ernest Monfiletto, at 676-1117.

Confidentiality in In-House and Out-Patient review:

We understand CHP looked into five data systems and desires to contract with Wassau to supply a system which will handle review and physician reimbursement.

What kind of confidentiality will be built into the system?

Why can't Ken Phelps, who is handling all PSRO's in State do this better and cheaper since his equipment will be here?

The physician reimbursement should ideally come from and through their IPA, not the HMO. What arrangements are anticipated?

Essex County Medical Society

144 SOUTH HARRISON STREET
EAST ORANGE, NEW JERSEY 07018
Area Code 201 672-1816

December 28, 1976

Mr. Robert Detore
Crossroads Health Plan
185 Central Avenue
East Orange, New Jersey

Dear Bob:

I just received your two page Scope and Responsibilities of ECHO Permanent Committees.

1-I feel that instead of Judicial Committee, the Committee should be the Appeals Committee or Grievance Committee. The Judicial Committee has a distinct meaning to all physicians in Essex County and will create confusion if there are two of them in our County.

2-The "Staff" part of what you suggest is what absolutely horrifies me. This hits at the nub of the matter. The staff of IPA Committees must be employees paid directly by the IPA and under no circumstances anyone who receives a check from any organization that the IPA will contract with. I heartily dislike your proposal.

Sincerely yours,

Arthur R. Ellenberger
Executive Secretary

ARE/lc

An Individual Practice Association
Sponsored by The Essex County Medical Society

ESSEX COUNTY HEALTH ORGANIZATION

EXECUTIVE AND EDITORIAL OFFICES: 144 SO. HARRISON STREET, EAST ORANGE, NEW JERSEY 07018

Report to First Meeting of the Trustees of ECHO held on Tuesday evening, December 21, 1976 at the office of the Essex County Medical Society.

From: Arthur Ellenberger

Early this Fall the late William Braun, Sr., Esq. submitted Incorporation Papers for ECHO to the Secretary of State. In October he determined that we needed a C-4 and filed for this non-profit status with the IRS. I have written to the Law Firm to see that this is followed through and formal approval is received on both matters.

The Annual Meeting of our Orgazization must be held in May or June. However, he provided that our Board of Trustees could elect temporary interim officers who officially carry on business for the Corporation until the Annual Meeting:

President: Calluori

President-elect: Robins

Vice-President: Zaccardi

Secretary: Bythewood

Treasurer: BERNSTEIN

The Board of Trustees shall establish and appoint the following permanent committee and chairman from the membership of the corporation:

a) Peer review committee on professional fees and relative value index.

Bythewood

b) Peer review committee in standards of care and utilization.

Maureen H. Wallen, M.D.

c) Administrative committee.

Blythewood

d) Data Committee.

e) Appeals Committee: to adjuducate complaints of patients or members.

f) Nominating Committee: shall consist of five members whose duty shall be to compile a list of all vacancies in the Board of Trustees which shall occur at the time of the Annual Meeting and submit a panel of candidates to the secretary of the corporation at least ninety days prior to the Annual Meeting.

1. Thompson Chr
2. Shereshore
3. Blythewood
4. Beasley
5. Bernstein

The Executive committee shall consist of the President, President-Elect, Vice-President, Secretary, Treasurer and one physician who is a member of the Board of Trustees and appointed by the Board of Trustees. One member of the executive committee shall be an osteopathic physician.

Crossroads (HMO) Board

Our Council (ECMS) and Crossroads have agreed to the Proposed Board Composition on the right:

Present Board Composition	Proposed Board Composition As Recommended by the Board of Directors
8 ECMS appointed physicians	11 physicians appointed by ECMS of which 2 will be appointed by ECMS from the CPA membership.
4 CPA appointed physicians	2 CPA appointed members
7 consumers	7 consumers
2 community leaders	1 community leader
TOTAL — 21 members	TOTAL — 21 members
38% ECMS appointees	52% ECMS appointees

Dr. Bythewood, President of ECMS, will therefore have to appoint a few more physicians to the HMO Board. Do any of our IPA Trustees desire to serve on the HMO Board also.

QUESTION: Will the Trustees make the decision as to how the fees will be handled? Should we hold a membership meeting on this? Membership questionnaire?

I.D. GRANT APPLICATION

Partial Costs Breakdown

PHS Funds		$ 40,825
1.	Consultant fees/trainee costs (ECMS)	
	Legal	$ 1,600
	Financial/Actuarial	4,200
	Peer Review	17,500
	Provider Education Seminars	3,000
	TOTAL	$ 26,300
2.	Consultant fees (CHP)	
	Legal	$ 4,000
	Marketing	4,725
	TOTAL	$ 8,725
3.	PHS Consultant Fees for Pre-Qualifications	$ 5,000
4.	Co-Medical Director (CHP)	$ 5,000
	Co-Medical Director (ECHO)	20,000
	TOTAL	$ 25,000
ECMS DESIGNATED FUNDS		$ 46,300

1600
4200
3000
8,800 could be used from consultants

HAROLD B. FEIN, M.D., P.A.
123 DUNHAMS CORNER RD.
EAST BRUNSWICK, N. J. 08816

AREA CODE 201
TELEPHONE 254-3300

November 23, 1976

Harold Kallman, M. D.
President, New Jersey Academy
of Family Practice
c/o Edison Medical Group
Edison, New Jersey 08817

Dear Harold:

Recently two articles appeared in the local Sentinel newspaper which I believe were thinly disguised advertisements for the Rutgers Health Maintenance Organization. In your capacity as chairman of the State Academy of Family Practice, the public should be made aware of the potential drawbacks of this type of delivery of health care. The following should be made evident:

(1) Participants in the plan can pick only those doctors who are members and do not have a free choice of physicians or consultants.

(2) The family physician is personally available more hours per week than the physician assigned to them by the HMO and both provide coverage around the clock.

(3) Because of prepayment one can postulate that HMO patients would be under treated in order to keep costs down. The Frame Study has proved that health maintenance does not prevent need for crisis intervention and hospitalization.

(4) The success of the HMO is predicated on a large enrollment which by its nature is bound to give a more impersonal and clinic atmosphere.

As members of the Academy I feel that we should give our support only to those insurance plans which give our patients total freedom in selection of their family physician and consultants who neither advertise or solicit patients.

Sincerely,

Harold

Harold B. Fein, M. D.

HBF:z

P.S. I have discussed this with Dr. Victor Boogdanian who agrees with its content and we plan to bring this before the next joint meeting of the Departments of Family Practice at Middlesex Hospital and St. Peter's Hospital.

An Individual Practice Association
Sponsored by The Essex County Medical Society

ESSEX COUNTY HEALTH ORGANIZATION

EXECUTIVE AND EDITORIAL OFFICES: 144 SO. HARRISON STREET, EAST ORANGE, NEW JERSEY 07018

Dear Doctor:

The Essex County Health Organization has been incorporated under the auspices of the Essex County Medical Society. At present, 100 physicians are members of ECHO, and we are encouraging you to do likewise.

The Essex County Health Organization is:

1. An Independent Practice Association open to all licensed physicians in Essex County.
2. A Medical Society sponsored Organization composed of physicians and controlled by physicians.

We encourage your membership in ECHO for the following reasons:

1. As a member of ECHO, we can continue to provide medical services to our patients who join HMO's now and in the future.
2. ECHO members will ratify the fee schedules for HMO physician services.
3. ECHO membership is renewable on a yearly basis. If you are dissatisfied with the fee schedule or the HMO, you can resign your membership.
4. As an organized group of physicians, we will be able to influence the direction of HMO's developing in our area and marketing to our patients--something we cannot do as individual physicians.

We are asking that you join ECHO NOW because:

1. Our existence as an effective group depends on physician support and membership.
2. Continued funding for our development is based upon physician support and membership now.
3. ECHO membership gives you a voice in developing the fee schedule and the contractual relationships between the HMO and ECHO. If you are not satisfied with the outcome of these developments, you can decide not to participate. Joining now will not bind you later.
4. The ability of our colleagues who have already agreed to ECHO membership can only be strengthened in their dealings with HMO's by your demonstration of support.

Please read the enclosed brochure and membership card carefully. We look forward to your joining ECHO. If you have any questions, please feel free to call us or any member of the Board of Trustees.

Sincerely,

INCORPORATORS---ESSEX COUNTY HEALTH ORGANIZATION

George L. Benz, M.D.

Arthur Bernstein, M.D.

Alton E. Bythewood, M.D.

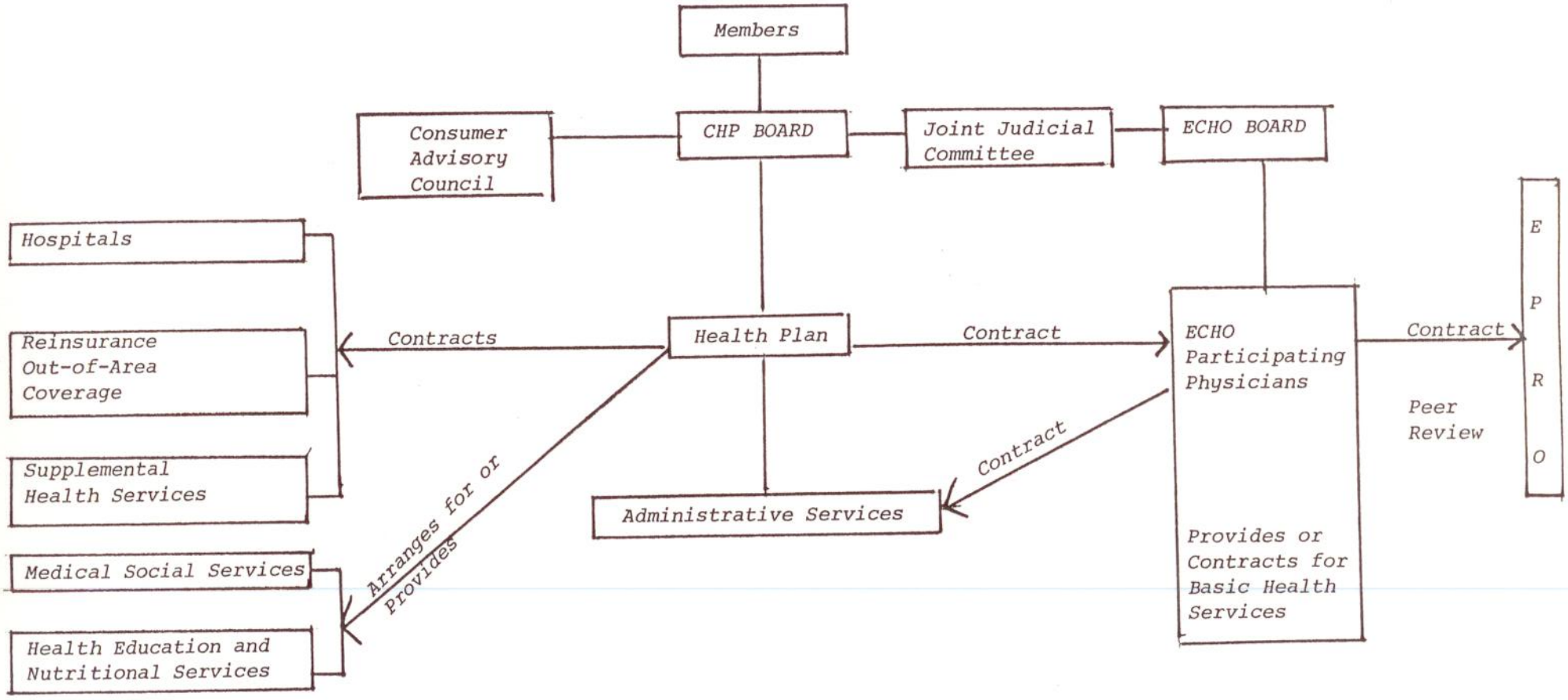
Enio J. Calluori, M.D.

Charles I. Nadel, M.D.

John J. Thompson, M.D.

CROSSROADS HEALTH PLAN

Chart of Organization



CHP HEALTH DELIVERY SYSTEM

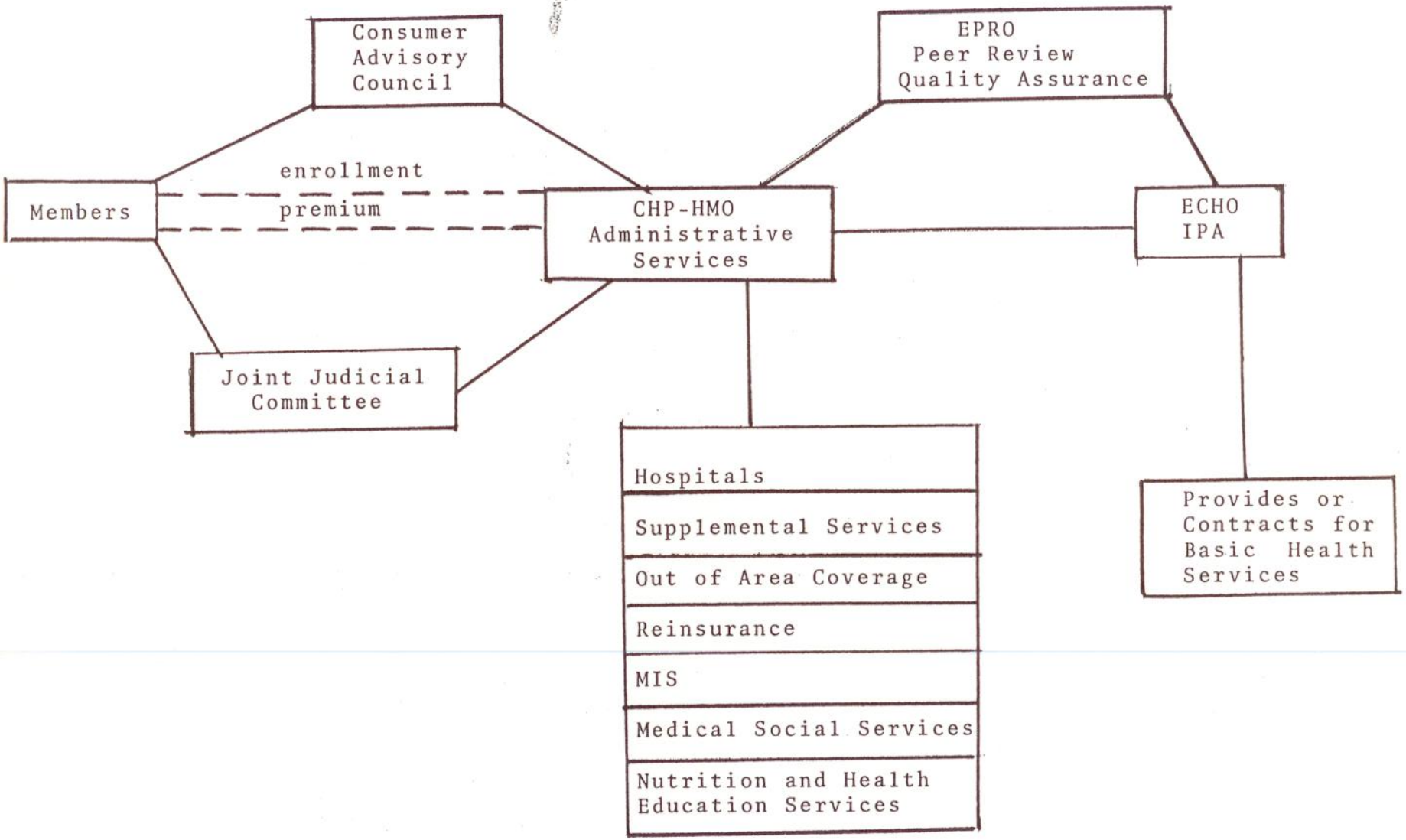
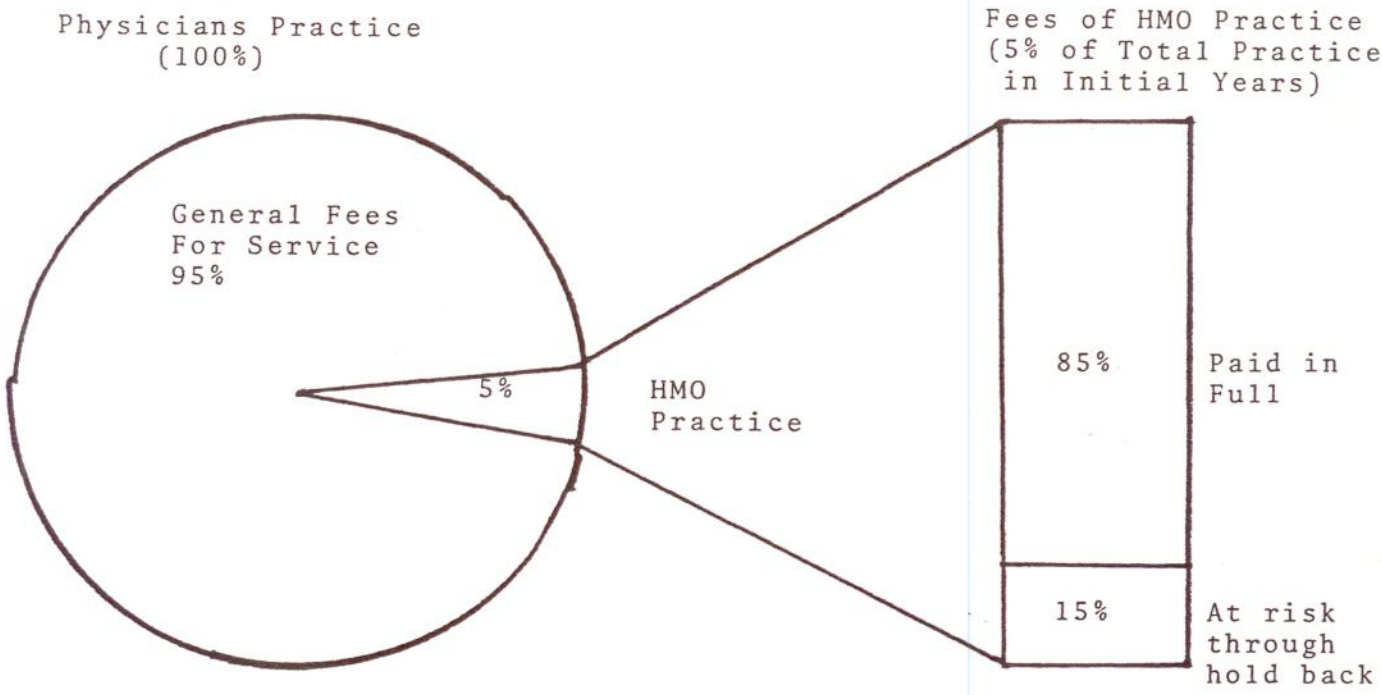


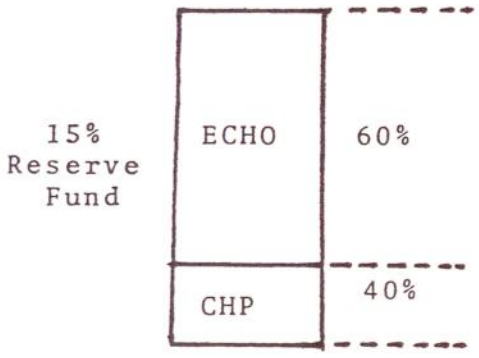
EXHIBIT 70

CHP-ECHO
RISK SHARING MODEL



Therefore, 15% of physicians' fees for only 5% of his practice are at risk. 15% x 5% = .75% Actual Risk

Physicians' Risk Portion of Fees: necessary to insure against excessive utilization of inpatient, surgical and outpatient services.



If CHP experiences expected utilization on all or part of 15% reserve is not needed to cover operating deficit surplus will be allocated "60-40" - 60% to go to physician members; 40% to CHP dedicated to member benefits for the purpose of reducing the premium or creating an additional health benefit.

CROSSROADS HEALTH PLAN-ESSEX COUNTY MEDICAL SOCIETY

HMO Initial Development Grant Application

HEW Site Visit

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	Legal, Organizational Structure and Providers	Mr. Detore Dr. Benz Dr. Richlan Mr. Silver Mr. Muglia Mr. Allen
12:00-1:15 p.m.	Luncheon	
1:15-2:45 p.m.	Marketing	Mr. Detore Mr. Moore Mr. Monfiletto
2:45-5:00 p.m.	Financial	Mr. Detore Mr. Muglia
	Budget and Work Plan	Mr. Detore Mr. Muglia Mrs. Garvin

TOPICAL OUTLINE

9:30 a.m. - 12:00 Noon

1. Topic: Introductory Remarks
   Frank Lapeyrolerie, D.D.S.
   Alton E. Bythewood, M.D.

   Welcome, introduction of participants, support of ECMS.

2. Topic: Project Overview
   Robert Detore

   Historical development, community and provider support, goals of ID grant application.

3. Topic: Legal, Organizational Structure and Providers

   Legal feasibility analysis -- Harris Silver

   CHP By-laws, ECHO By-laws, provider contracts -- R. Detore, Dr. Benz, Dr. Richlan

   Organizational Relationships -- CHP-ECHO, ECHO-other providers-- R. Detore, Dr. Benz, Dr. Richlan

   Physician Recruitment and Education (ECHO) -- Dr. Richlan, Dr. Benz, R. Detore

   Peer Review and Utilization Controls -- Dr. Benz, Dr. Bernstein, Dr. Richlan, Marc Allen.

   Hospital Contracts -- R. Detore; Hospital Administrators (F. Brower, D. Bruschi, etc.)

   Fee Schedules -- Dr. Richlan, Dr. Benz, R. Detore

   Management Information System -- R. Detore, M. Allen

   Co-Medical Directors -- Dr. Lapeyrolerie, Dr. Benz

   Delivery System (referrals, ER services, health education, social services, etc.) -- Dr. Richlan, Dr. Benz, R. Detore

1:15 p.m. - 5:00 p.m.

4. Topic: Marketing

   Enrollment projections, marketing plans, health benefit package, Newark residents.

5. Topic: Financial

   Premium structure, financial plan, loan program, break even point.

6. Topic: Budget and Work Plan

   I.D. grant budget, project timetable, activities and tasks.

CROSSROADS HEALTH PLAN

NEWS LETTER

Crossroads Health Plan
185 Central Avenue
East Orange, N.J. 07018

December, 1976
Volume I Number 3
Ernest Monfiletto, Editor

Topics: I.D. Grant Application Submitted to HEW Medical Society Organizes IPA Dr. Richlan Appointed Co-Medical Director; President Signs HMO Amendments; Consumer Advisory Council Formed; HMO Subscribers Projected at 20,938 by 1980; Membership Department Promotes Crossroads to the Public; Interest Among FORTUNE 500 Companies in HMO's Increases; Qualified HMO's Now at 21; News Briefs.

I.D. GRANT APPLICATION SUBMITTED TO HEW

On November 1, 1976, the Board of Directors of Crossroads Health Plan submitted an Initial Development Grant Application to HEW Region II. HEW approval of this grant application will enable Crossroads Health Plan to prepare for operational status as a federally qualified Individual Practice Association model HMO serving the residents of Essex County by the first quarter of 1978.

The initial development phase will extend from February 1977-January 1978 and will provide continued funding under the HMO Act of 1973 for the completion of legal, marketing, financial and provider activities in preparation for operational status.

MEDICAL SOCIETY ORGANIZES IPA

The Essex County Medical Society has taken the leadership in organizing an Individual Practice Association (IPA). The Essex County Health Organization (ECHO) is an Individual Practice Association sponsored by the Essex County Medical Society. Individual Physicians (M.D.'s and D.O.'s) who join ECHO will be able to care for patients enrolled in the Crossroads Health Plan and other HMO's that may develop in the Essex County area with reimbursement on a fee-for-service basis for each patient service rendered. Fee schedules will be approved on an annual basis by ECHO member physicians.

The Essex County Medical Society is working closely with Crossroads Health Plan in the planning and development of an IPA model HMO in Essex County. A majority of the Board of Directors of Crossroads Health Plan are local physicians who are members of the Essex County Medical Society. George Benz, M.D., a member of the Board of Directors of Crossroads Health Plan and a Trustee of the Essex County Health Organization stated: "The Individual Practice Association model HMO jointly sponsored by the Essex County Medical Society and Crossroads

children's ear exams conducted to determine the need for hearing correction.

-- Extends period for use of loan funds (time to reach breakeven) from 3 to 5 years, although maximum loan remains at $2,500,000.

-- Amends Title XVIII of the Social Security Act to provide that SSA can contract only with HMO's qualified by PHS under the HMO Act.

-- Amends Title XIX of the Social Security Act to provide federal participation in Medicaid payments under prepaid risk contracts only if the contracts are with qualified HMO's.

-- Extends authorization under the HMO Act for two years: FY 1976 - $40 millio
FY 1977 - $45 million; FY 1978 - $45 million; FY 1979 - $50 million.

SUBSCRIBER ADVISORY COUNCIL

A Subscriber Advisory Council to the Crossroads Health Plan Board of Directors has been formed to provide structured input to the Board from representatives of community groups, social agencies, health professions, organized labor, employer groups and government. The Council will advise the Board of Directors during the pre-operational stages of development. Once the HMO is operational, the Council will be composed of Plan subscribers who will have responsibility for nominating members to the HMO Board of Directors as well as regular input in the development and implementation of HMO services and programs. Ernest Monfiletto,Membership Services Coordinator of Crossroads Health Plan, commented that"the Subscriber Advisory Council is a major step toward greater community involvement in health care issues in general and specifically the development and operation of a Health Maintenance Organization."

Members of the Consumer Advisory Council include: Arlene Henry, Philip Cocco, Sr., Monroe M. Kramer, Eva Lewis, Sanford Kaplan, Joseph Stellato, Max Wolfe, Marilyn R. Udis, Tony Tolles, Dr. Carmine Loffredo, David Gross, Anna Princiotta, Councilwoman Gail Rosen, Anthony Della Salla, Andrea Contaldi Maenza, Armstead Burke, and Vivian Braxton.

HMO SUBSCRIBERS PROJECTED AT 20,938 BY 1980.

The Membership Department under the direction of Brian Moore, Membership Director, has undertaken extensive marketing surveys of employers in the Essex County area. These surveys conducted by phone and/or personal visits to 300 major employer groups have resulted in data that has been utilized by the Membership Department and experienced HMO marketing consultants in the development of an enrollment plan for Crossroads Health Plan. Based on extensive survey data and the experience of other HMO's, it is estimated that first year (1978) enrollment will be 5,688; second year (1979) enrollment will be 10,290; and third year (1980) enrollment will be 20,938 members.

MEMBERSHIP DEPARTMENT PROMOTES CROSSROADS TO THE PUBLIC

During the past six months, the Membership Department has conducted a public information program to expose the general public to the HMO concept and Crossroads Health Plan. This public information program has resulted in newspaper articles and radio interviews. Articles on Crossroads Health Plan and the HMO concept have appeared in the Newark Star Ledger, New York Daily News, Passaic Herald News and the weekly Worrall Publications in

Personnel Research Associates recently announced the publication of their newsletter "The New Jersey Emoloyer". This newsletter is an excellent resource for employers and other interested groups in HMO activities in New Jersey. For more information, contact Marilyn Udis at 49 Oak Ridge Road, Verona, New Jersey.

HMO's received praise in the third Forward Plan for Health FY 1978-82 developed by the U.S. Public Health Service. The report stated, "One purpose of the HMO concept is to stimulate reforms in health care financing consistent with the broad support for realistic, quality programs to de-emphasize inpatient care. Studies of utilization rates of Federal employees has produced a solid base of evidence that HMO patients have a markedly lower rate of hospital admissions and a shorter length of stay than those covered by conventional plans. HMO plans continue to expand, having doubled their enrollment in the past three years. Amendments to the HMO Act should contribute to the continued growth of this delivery model."

Prudential Insurance Company continues to show more than passing interest in the HMO field. Prudential recently opened a new $2.7 million health center in Houston organized as an HMO. The Ambulatory Care Center occupies 30,000 square feet in a three-story building and is staffed by 28 physicians. The organization will seek Federal qualification. Recently Prudential has shown an interest in assuming responsibility for the South Shore Health Plan, a IPA model HMO in Atlantic City that was recently denied federal qualification.

General Motors spent more last year with Blue Cross-Blue Shield than it did with U.S. Steel, the major supplier of metal for its cars according to an article by Stuart Auerbach in the Washington Post on March 16, 1976. The $825 million spent on health benefits for GM's employees added $175 to the cost of every car and truck built. The Nation spent $118 billion for health care last year, an increase of almost 14% over 1974, about double the rate of the national cost of living increase. Commercial insurance carriers and third party payers have increased their rates recently by 35% while prepaid, HMO-like groups showed an increase of 14% according to the Federal Employers Health Benefits Program Study report.

If you have any suggestions for topics to be included in this newsletter or if you would like to write an article on a topic of interest, please contact the Editor, Ernest Monfiletto, at 676-1117.