Interview with James I. Rodriguez, FACHE, President and Chief Executive Officer of TexHealth Central Texas

James I. Rodriguez, FACHE, is president and CEO of TexHealth Central Texas in Austin. Prior to this role, Mr. Rodriguez held various leadership positions, including executive director of the University of Texas Medical Branch Galveston’s three-share health benefits program and physician-hospital organization (PHO) administrator with Cincinnati Children’s Hospital. In addition, he has held leadership positions with provider-owned HMOs, PPOs, and a Medicare Advantage plan.

Mr. Rodriguez holds a bachelor’s degree in marketing from Wright State University and is a Fellow of ACHE. He is a founding member of the National Multi-Share Coalition, a contributing member of the TexHealth Coalition, and a governing board member of the National Forum for Latino Healthcare Executives.

Dr. O’Connor: You have had a long and successful career. What events in your career have been pivotal to your success?

Mr. Rodriguez: I graduated from college in the mid-1970s and started a local carpet-cleaning business. That experience imbued me with an entrepreneurial spirit that has served me well. I have always been on the cutting edge of things. When I got married, my wife said, “Jim, dress rehearsal is over, you have to get a real job!” Because there were not many opportunities available in 1977, I took a job as an administrative assistant in a community mental health clinic, working in accounting doing billing and collections and keeping books, which was not my area of training; my business degree was in marketing. But it exposed me to the financial side of the business. Eventually, I started doing some consulting with other community mental health centers and preparing them for their audits with public accounting firms. In due course, I got my license as a public accountant. (In Ohio, you can be licensed without being a CPA; that is, you can be a public accountant.) That experience was good as it was a counterbalance to my marketing training. In 1985, I was on the cutting edge helping to start a Medicaid HMO in Ohio. I always wanted to be in healthcare, so it was a good transition because it took me to the payer side, which was important for my career development. Over the years, I was either managing health centers, in leadership positions with payer organizations, or consulting.

Later, I was in a small boutique consulting group that was on the edge of the PHO movement in the 1990s when hospitals were buying physician practices. That was when I knew that healthcare was for me, as it exposed me to the things necessary for private practice operations as we were buying physician practices. We built big PHO entities. Those are a few of the key work experiences that allowed me to become a better-rounded leader. Today, folks tend to go unidirectional. That is to say, if they...
are in accounting, they stay in accounting; they usually don’t get experience in the marketing area, and so on. To be a well-rounded individual in a leadership position, one needs to broaden one’s experiences by working on both sides of the fence.

**Dr. O’Connor:** What are multi-share health plans? How do they work? What are the benefits and challenges associated with such plans?

**Mr. Rodriguez:** A multi-share plan is like a health benefits program. The Texas Legislature paved the way for such plans to become legal entities. While we are not an actual insurance company, we function very much like a PPO insurer. Basically, we offer limited health benefits programs to small businesses. For example, caps on the number of annual physician visits an enrollee can make are fairly common in today’s market, but back in 2007, when we first started these plans, such limits were less common. These plans bring down the cost because of the limits. Essentially, a multi-share plan collects the premium from three different channels. One channel is the employer. The second channel is the employee, who must make a contribution. The third is an outside organization. This third channel could provide grant funding from state or local government or other outside sources. Even health systems and hospitals have contributed the third share in some of these programs. The point is that multi-share plans reduce premiums so that healthcare coverage is affordable for low-wage workers and small businesses. We are trying to target those segments in Texas that historically have been unable to afford a health benefits program, and we do it in a way that leverages employee, employer, and community contributions. With this model, everyone has “skin in the game.” I also think there are significant opportunities for a three-share plan to support the mission of an ACO. I’m still exploring what that model may look like. For example, some of the populations in the ACO are those who sometimes find low-paying jobs and consequently float in and out of the ACO. But what if the ACO can enroll those small businesses into the ACO system through a three-share plan? There would be not only continuity of care for those members but also the leveraging of employer and employee contributions to the care system.

The multi-share plan is not an entitlement program but a “boot strap” program that allows people to access the health insurance world that they have been shut out of previously. Once they have access to healthcare and start using services, they feel better, they become healthier, and their quality of life improves. They soon recognize the value of having a healthcare program and the access it provides. For example, we received a grant allowing us to reduce the employees’ contribution to the plan all the way down to $9.50 per month. We saw substantial growth in enrollment as a result. Then the grant went away. It was supposed to be a five-year grant, but it became a one-year grant due to budget cuts. The good part was that the grant allowed people who had enrolled to remain on the program for one full year. When the year ended, those folks had to go from paying $9.50 per month to paying $84.50 per month—which was a huge increase. However, about 75 percent of the people who were no longer on the grant continued with the program because they saw the value of being enrolled...
in a health benefits plan. That is really what a multi-share plan is all about. It’s a way to get people into the health insurance world and give them the opportunity to be as healthy as they can be if they take advantage of it. We offer one free physical per year, which is a benefit included in the Affordable Care Act (ACA), but we included it early on. We have people who actually leave our program and move into the commercial health insurance market. We think that is great. As business improves for the employers and they start making more money, they are in a position to purchase a regular commercial health insurance program, and that’s one of our ultimate aims.

**Dr. O’Connor:** Do you see the multi-share health plan as a universal and viable solution to the problems facing small businesses in providing health insurance coverage for employees?

**Mr. Rodriguez:** Yes, I believe both sides of the political spectrum see the value of a multi-share plan. For example, if you look at Congressman Paul Ryan’s proposal for Medicare, he is talking about premium support. We call it premium assistance. Basically, it is a subsidy—a word that people shy away from because it sounds like an entitlement. But Republicans are talking about using it for Medicare, and Democrats have proposed it for other healthcare programs. It is a viable method and can be a partial answer—not necessarily the full answer, but at least a partial answer to the issues that we face with healthcare access. The key, I think, is that you get as many people into these programs as possible so they can experience what it means to have healthcare coverage. We have encountered so many people who have not had healthcare coverage for 5, 10, even 20 years, and who have not seen a doctor for eight or more years. It is mind-boggling to see what people do when they are without healthcare coverage. Yes, I see the multi-share plans as a viable solution, especially for small businesses. It is like a first step. If you own a small business and you’ve got employees who are low-wage, you know that a doctor visit is going to cost them at least $100. In addition, many of these small businesses cannot afford to pay people for sick leave. If an employee takes off from work to see a physician, he or she will probably not be paid for that time. So there is a real disincentive to see a physician. But if you have a program where the copay for a physician visit is $20 or $30, it is still a lot less than paying $100 or more. Even though the time off from work is unpaid, at least they will be able to get themselves well. Most uninsured employees wait until they can’t stand their health problem anymore. Then they run to the emergency department because they know they have to be treated there.

**Dr. O’Connor:** Can you offer some examples of how multi-share health plans address health disparities in a population?

**Mr. Rodriguez:** Because multi-share health plans offer a lower-wage employee the opportunity to have coverage, and thus access to healthcare that he or she may never have had before, the ultimate outcome is improved for minority populations. We have people who have had chronic diabetes for most of their adult life. Their blood sugars bounce up and down and they often cannot understand how to get it under control.
But when you have a nurse giving you a call once a week to help guide you in keeping your diabetes under control, it helps. There is that personal accountability. They know that the nurse is going to call, so they do things they’re supposed to do; they begin to understand more and feel better, and it has an impact. So yes, I see multi-share plans as an important way of addressing disparities in a lot of minority populations.

**Dr. O’Connor:** You have experience turning around underperforming PHO provider networks. What are the keys to strengthening relationships in physician network partnerships?

**Mr. Rodriguez:** When I was working with an HMO that contracted with PHOs for the delivery of services, what I found was a lack of communication. I believe that the key to strong relationships between two entities such as these is communication. When I visited a PHO and sat down with the CEO, I said, “Look, we are no different than you are. We are trying to establish a good product. Tell me what your problems are and how we can help.” Most of the time I got responses like, “I can’t believe you’re saying this. We never had anyone from your organization ask us what we need and how you can help us.” Taking the tack of viewing the PHO as the customer of the insurance company, and not the other way around, is important. The PHO is there to help you provide a service to your end customers. If you take the attitude that the PHO, too, is a customer, it makes a positive difference.

I also established what I called a purposeful partnership. I would bring in speakers and have events that just the PHOs were invited to. We would alternate facilities and locations so each PHO could host the event and take credit for it. It led to good relationships all the way around. The key is being able to look at the PHO as a customer and ask what we can do to help.

**Dr. O’Connor:** Shortages of primary care physicians are expected to become more acute as baby boomers age and as accountable care organizations (ACOs) become commonplace. Such shortages can be a barrier to the creation and functioning of ACOs. What can ACOs do to best position themselves to recruit primary care physicians?

**Mr. Rodriguez:** It is a tough issue, especially when we know there is a shortage of primary care physicians. It really boils down to a build-or-buy decision: You either build the primary care function yourself or go out and buy it. The attitude among physicians is changing. It used to be that most physicians were rugged individualists, but younger physicians don’t want that kind of life anymore. They want quality of life and more time with their families and kids. What kind of quality of life can an ACO offer to its physicians? It is not just pay; it is also quality of life. The mistake we made in the 1990s was that we were offering higher salaries. We were saying to physicians who were making $80,000 a year, “Come work with us, sell us your practice, and we will pay you $160,000 a year.” Well, that was unsustainable. There was not enough business to pay the physician that much. What we found was that hospital systems don’t really know how to operate physician practices; physicians do. You have to give some freedom to the physicians who are in the ACO to be able to run...
the practice themselves. Obviously, you have to hold it accountable, and you can do that through pay and other methods, but the point is the doctors have to feel like they are still in control. So those are the two key areas to consider: physicians’ quality of life and their ability to run the practice the way they think it is best run.

Dr. O’Connor: Any thoughts about the ACA and its financial incentives for motivating people to obtain health insurance?

Mr. Rodriguez: I have been looking at the 2014 penalties in healthcare reform, and the structure has been bothering me. The individual mandate of the ACA requires people to pay a penalty if they choose not to obtain health insurance. My communication coordinator and I have been looking at this and are determining the level of penalty an individual would have to pay in 2014, 2015, and 2016. We are finding, for example, that a person who makes $30,000 a year would be required to pay a $200 penalty in 2014. This penalty would be paid through his or her federal taxes. If I’m 28 years old, just starting my career and making $30,000 a year, how do I deal with this mandated health insurance issue? Should I try to get a high-deductible, high-copay insurance policy that costs $150 a month? Or should I just wait until the end of the year when I file my income taxes, check off that I don’t have health insurance, and pay the $200 penalty out of my refund? Let’s say my tax refund is $600, but the $200 penalty is deducted, reducing my refund to $400. On an annual basis, the choice is between paying $1,800 ($150 × 12) or $200 out of my refund. I don’t think the incentive is strong enough to get younger people to buy health insurance. The ACA is intended to promote universal coverage and spread the financial risk of health reform. I don’t think we will see the young people jumping on board and purchasing their own insurance coverage to avoid the penalty.

The penalty does not impose enough financial pain. Moreover, we have many people who don’t want to participate due to cost, even though their health status is not good and they could truly benefit from the coverage. We need them to participate and spread the risk. How do we motivate them to come into the system? The only way to solve this is to make the penalty more severe. If you’re going to pay a $200 penalty at the end of the year instead of $150 per month for health insurance coverage, maybe those numbers should be made closer to each other. I am not seeing anyone address this issue.

Dr. O’Connor: What topics and issues would you like to see addressed by authors in the Journal of Healthcare Management?

Mr. Rodriguez: I would like to see authors address more on the insurance side of healthcare. We are on the advent of ACOs, and I still don’t see very much that addresses being totally responsible for a population’s health. When you start getting capitation to manage the healthcare for a specific population you are in essence an insurer. I would like to see authors address ACOs and how those entities will take responsibility (risk) for their population’s healthcare needs. How do they do that within a set, capitated fee, which in essence makes them an insurer?