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MANAGED CARE -- WHAT IS WORKING?

Moderator: WILLIAM F. BLUHM
Panelists: RALPH D. ALEXANDER*
GEORGE C. HALVORSON**
CARL F. MYERS***
Recorder: WILLIAM F. BLUHM

- Experts from the HMO industry will discuss various aspects of what is (and what isn't) working in managed care. Subjects will include:
  - -- Utilization review
  - -- Strategies
  - -- Benefit designs
  - -- Regulation

MR. WILLIAM F. BLUHM: Ralph Alexander is a former CEO of the Met Life subsidiary that was responsible for the national HMO practice. He had ten years with Blue Cross/Blue Shield and ten years with insurance companies, and has been long working in managed care, utilization review (UR), and related areas.

George Halvorson is President and CEO of Group Health Incorporated of Minneapolis, a staff model HMO in Minnesota. They are one of the few remaining and successful HMOs in Minnesota and that's saying quite a bit. George has 22 years of experience in the health care field and is the author of a book entitled, *How to Cut Your Company's Health Care Costs*, published by Prentice-Hall.

Carl Myers is the Vice President of Medical Affairs and a medical director for the Wisconsin Health Organization in Wisconsin. He's a retired oncologist and has been working in managed care for a number of years.

MR. RALPH D. ALEXANDER: Knowing that I was going to speak on the subject, I was attracted to an article in *The Wall Street Journal* on October 19, 1989. It said "employers have not cut health care costs by using peer review programs." It went on to say that during the past five years the number of companies using preadmission certification and the utilization review has grown from about 5% to somewhere between 50% and 75%, but "utilization management does not appear to have altered the long-term rate of increase in health care costs." This was a two-year study done by the Institute of Medicine, a part of the National Academy of Sciences. It continued to say that employers who saw a short-term modification of benefit expenses are now seeing a return to previous trends. They noted that utilization management frequently reduces hospital costs, but savings are offset by increases in physicians' services and higher administrative costs for Utilization Review (UR) programs. They noted current UR programs are too narrow and focus on the need for hospital services rather than the need for the medical or surgical procedure itself. They concluded by saying that we need ways to reduce the complexity, paperwork, and cost of utilization review processes. Well, those are most of my remarks.

* Mr. Alexander, not a member of the Society, is a Senior Consultant for Milliman & Robertson, Inc. in St. Louis, Missouri.

** Mr. Halvorson, not a member of the Society, is President of Group Health, Inc. in Minneapolis, Minnesota.

*** Dr. Myers, not a member of the Society, is Vice President, Medical Affairs of Wisconsin Health Organization in Milwaukee, Wisconsin.

I really think that the pressing issue is "does it work?" If so, what works and what doesn't work? Mr. Myers said, when I had mentioned this to him earlier, that what bothers him is that articles of this type seem to lump all medical management, cost containment, and UR processes into one very simple category, as though a 1-800 number for a long distance line UR process was the same as a local medical care organization which is at risk for UR results. I think that's very true. Going back to the 1970s, the term *peer review* was used a lot and peer review could mean anything from something meaningful to absolutely nothing but the name on the door. So my first caution is: managed care is a very broad term and you have to be very specific about what you mean when you use that term. There are a variety of programs which are being lumped under that broad title. In my experience, anytime the basic provisions of managed care, with emphasis on "managed," have been applied, they generally have worked; but I've seen lots of situations where the name has been used like a panacea and nothing much has resulted from it; in fact, the net result would be higher costs.

I'd like to talk about some of the various forms of managed care. I will talk about some of the things that have worked, and talk about some of the newer things that are being tried with some success.

First of all, with regard to inpatient hospital utilization, I think everyone knows that there has been a general decline in hospitalization utilization during the last five years. The particular reasons for that decline, I think, are mixed. They include, undoubtedly, a certain amount of utilization review activity. They also, I think, build on the fact that there was a fair amount of fat in the hospital utilization picture and a general awareness on the part of everyone that hospital costs were expensive, hospital days were expensive, and generally we should try to limit hospital utilization to that which is truly needed. Now, that's the good news. The bad news is that matching that decline in hospital utilization (and you'll notice I'm stressing hospital utilization, not necessarily hospital costs), the cost per day has tended to go rather sharply up.

Matching that decline in hospital utilization has been a general increase in physician services. One of my clients, an HMO in the South, reduced their hospital days per thousand in about six months time from 450 days per thousand to 330. This is a fairly short adjustment on the part of the medical community, and yet their cost on a per-member/per-month basis stayed around $90, which was totally uncompetitive.

On the outpatient hospital side, providers are now seeing it as a revenue enhance. The cost and the pricing are out of proportion to the true overhead. In some cases it's been necessary for HMOs and managed care organizations to reverse the protocol, which had been moving surgery out of the hospital to the outpatient unit, and admitting patients to the hospital for particular procedures, because the cost of performing the procedure on an outpatient basis might well equal 1½ or 2 days of hospital care.

Mental health and substance abuse expenses had started getting out of hand in the early 1980s; at least that's when I noticed them as a management problem. Capitation risk arrangements, which were pioneered by the HMOs, have indeed proven quite successful. The typical capitation arrangement would include inpatient/outpatient mental health and substance abuse all in one budgeted package. Perhaps 5-6% of the total premium dollar would be allocated to the capitation arrangement and there's been quite a bit of success living within that budget and producing quality medical care. Lately we've seen some real positive moves with regard to utilization review of mental health services on a nonrisk basis. A few years ago I wouldn't have recommended anyone consider utilization review of mental health services that did not have some kind of provider risk for the individual performing the service, but I think the reason why we're now seeing some results in this area is that standards are beginning to emerge. There's a consensus building in terms of when patients need a particular intensity or quantity of mental health services and when they don't, and that was totally lacking a few years ago. We're a long way from getting to the point that inpatient hospital care is today, but there is some progress in that area. I still would urge some kind of risk arrangement whenever possible. I think anytime someone is performing a service, whether it's a third-party administrator or a UR firm, and that service involves a certain amount of confrontation or a certain amount of conflict, in the absence of a financial incentive, the tendency is to slide off of the point of conflict, only to get inferior results.

MANAGED CARE -- WHAT IS WORKING?

Lately I've been reading, with interest, that some consultants have talked about the need for inpatient hospital care for substance abuse. In fact, another article in *The Wall Street Journal* referred to a hospital survey which showed that individuals who stayed in the hospital longer for substance abuse treatment seemed to have better results than those who were discharged earlier. And so we're seeing some questions raised about quality in connection with noninpatient-oriented substance abuse and shortened stays. My opinion on that, other than having seen the survey, is that there's still no evidence that outpatient substance abuse treatment is not just as effective as inpatient. We do have to keep in mind that both of them are not terribly effective; substance abuse is a problem not easily addressed by medical treatment.

The subject of provider discounts reminds me of checking in and renting a car, where you're asked if you have a corporate discount. A hugh manual that lists every corporation the world's ever seen, both here and abroad, is checked to find out what your corporate discount is. I think provider discounts are rapidly approaching the mechanics of the car rental corporate discount, as everybody has one, and just to get that discount puts you on a level playing field. Now, the problem with this is that there are still a lot of players who believe that getting a hospital discount is the centerpiece of the managed care strategy and that's the main thing they should be trying to do with their managed care program. I think this is a case of a simple, easy-to-understand objective -- getting a provider discount -- crowding out the more difficult, much more needed objective of accomplishing managed care. So you've got to have provider discounts in order to have a level playing field, but it's important to understand that there's no particular marketing advantage in getting that discount. We now see situations where providers are gaming the system and have gotten wise to the whole game of provider discounts. They will increase their fees perhaps 20% to turn around and grant a 15% discount. So you see phantom fee schedules, which are primarily used as a starting point in calculating the discount, which are given to the various provider contractors seeking discounts. We're rapidly approaching the situation where the unit price for a provider is at a commodity status. The growing availability of comparative data makes an obsession with provider discounts a very short-term and misplaced priority.

Looking at the issue of physician services, we start by remembering that as hospital utilization has declined, physician services and their expenses have shot up and so we have to deal with the whole benefit plan. We can't just focus on one aspect. Otherwise, like a water bed, you push it down here and it pops up there. Physician services have long been sort of a black box where it was hard to figure out what was medically necessary in the physician's office. That is beginning to change in that we're seeing standards begin to emerge for the appropriate treatment of certain disease modalities, but it's in the very early embryonic stages. Retrospective audits of procedure coding patterns is being done now by a number of UR firms, and some of the management information systems (MIS) software vendors are leading the way. This typically is a retrospective analysis of a particular physician's coding patterns to see whether or not his or her utilization of upscale or upgraded procedure codes exceeds the norm. It's a kind of pattern analysis, and we're looking for fee fragmentation, and procedure code creep. It's really kind of an overall pattern that you have to examine, because you can't argue successfully, without going in and examining medical records, whether or not a doctor is upcoding on a particular patient. The patterns are very effective in pinpointing that.

Pretreatment authorization is a take-off on preadmission hospital certification, and it's primarily being done by HMO firms at the moment. This involves criteria for medical appropriateness of certain selected, high-ticket, very elective procedures, and the situation is the same as pre-admission hospital certification. If the patient does not get preadmission certification for these procedures, then the benefit payable might be 50% of what it otherwise would be. When there's a network, there's a requirement that the physician get the service preauthorized, or he may not get paid at all. Or he may be fined and then eventually that physician may be departicipated from the network. The latter arrangement certainly works a great deal better than the former, but the physician is the one responsible for satisfying the UR protocols.

Now with regard to physician services automated patterns of care, the Herrington protocols are in use by a number of players, and this is primarily valuable because it is automated. It is not that the utilization values themselves are golden, but it is that it starts with an automated approach that each individual plan or health care manager can then customize to suit the particular objectives of that plan.

Last, but certainly not least with regard to physician services, is the whole concept of selective contracting for networks. This, I'm convinced, is the future for managed health care. You need utilization review and monitoring when you have physicians who have a tendency to render poor quality or high-cost procedures. If, in fact, you narrow the network to physicians who have been preferred, who have been selected based on qualitative measures, you have less need for ongoing and continuous monitoring of your utilization review. Now remember, the UR process itself is somewhat costly. In terms of what's working, some of the newer emerging UR protocols are inpatient hospital standards of efficiency. These are distinguishable from the typical utilization review screening criteria by virtue of their having been started from scratch, or from an efficiency standpoint, rather than historical patterns of past utilization. The problem with the past patterns of utilization is that they, first of all, included both complicated and uncomplicated cases. That made, for example, the professional activity study (PAS) 50th percentile Western too low for complicated cases as a screening criterion, but too high for uncomplicated cases. So a lot of the cases would scoot right through and fall well below that criterion, but when a complicated case came along, it would tend to bump against the criterion. There would be an additional UR process and then that case would be approved because it was, in fact, more complicated. So the standards of efficiency that are emerging do not depend on historical averages of hospital utilization from bygone days when more medical care was better care, but rather they reflect contemporary standards of consensus among better physicians as to what is the efficient, proper way to treat a patient. They are expressed in terms of daily treatment plans, not as an overall macro number such as seven days for a gallbladder. On day 1: this is what needs to be done for the typical gallbladder situation; day 2: this is what needs to be done; day 3, day 4, and so forth. This presents a much more constructive basis for UR nurses having dialogue with physicians offices.

Cookbook medicine is a pejorative that has frequently been used to talk about UR criteria, but in fact, if you put another label on it, it's health care protocols, which is the way physicians learn how to practice medicine in the first place. The concept of cookbook medicine says "I'll treat everybody the same without regard to their medical condition." That's bad. But to recognize that perhaps 70% or 80% of all medical care is a routine presentation of a particular diagnosis does offer the opportunity to have standards which can be used for the uncomplicated case. Now, an uncomplicated case can be a serious illness. You could have a triple bypass, but the point is that this is a typical, triple bypass patient for which fairly standard protocols will, in fact, apply, especially in the inpatient hospital setting. This is a major breakthrough in terms of utilization review processes and medical management because it allows a management-by-exception-type UR process. One of the things noted by the Academy of Sciences report is that there's too much paperwork, too much complexity, and too much cost. As I go around the country and evaluate UR firms and work with clients, I see that there's a lot of process, a lot of motion, and a lot of expense associated with reviewing hospital cases where there's no difference in the result. In other words, we would have approved the same number of hospital days for the same cost if we had not had this cumbersome review process.

What this allows is a management-by-exception approach so that you can approve, by standards of efficiency, perhaps 70% of the hospital cases just upon approving the admission in the first place -- a specific diagnosis, the treatment plan falls within the criteria, no further review is needed. Perhaps you might have a clerk salaried at $14,000 a year, calling the medical records department to make sure this patient was, in fact, discharged. It doesn't require an RN and it doesn't require a medical director to do that. In fact, what it does is free up the UR department to focus UR resources on those cases where there is a potential difference resulting from UR -- the high-cost cases, the catastrophic cases. Those complicated cases, when a patient moves from the routine presentation of a triple bypass to complications or secondary diagnosis, that's when the physician should be asked to submit his revised treatment plan, and when you need UR nurses and medical directors to interact and approve that particular plan. The result is that the UR process is intensive on a relatively small number of cases, is much less intrusive to the physician and, more importantly, to the customer, the patient.

For actuaries, this is a very key question, How shall I go about rejecting or pricing all the wonderful things that are being done by the medical management UR department? And it's one that frequently comes up. What kind of value do I put on this? All too often the value or the discounts or the concessions made in normal pricing, that are geared to the utilization review of medical management results, are seat-of-the-pants guesstimates, or are in response to whatever the marketing imperative seems to be. I would submit that is an inappropriate and somewhat

dangerous route to take, as you can see by lots of HMO and PPO plans that have lost a fair amount of money from underwriting losses based on those kinds of pricings.

A better approach would be to conduct a medical audit that would evaluate what has happened historically in either a medical delivery system, if it's an HMO or a PPO, or with regard to a large case group account, (a large employer for example) or with regard to a pool of business where a paid claims data base has been accumulated by the carrier. And this medical audit would be done on two levels. One is an MIS comparison of patterns of utilization. All you're looking for there are line item details such as diagnosis, hospital, physician, and total charges, and comparing that print-out with the efficiency standards that would define what is optimal treatment protocol or what are optimal cost utilization levels for those diagnoses. And then the second level would be to take a subsample of those cases and do a medical audit that involves hospital charts and office audits. This allows you to measure the deviation from the standard and make regional adjustments, which are quite important. Because, after all, the whole business of being in business is a relative matter, as there could be a length of stay that's perhaps five days long in one part of the country routinely, but in another part you've got to have three just to be competitive. You can still temper how aggressive you need to be based on your competition and what is relatively important for your business reasons. So you'd measure the deviation from the standards and then you identify what kinds of problems you have there. If you've got OB stays that are four days long, it's easier to move from four days to two days than it is to cut $2 off the laboratory expenses in the physician's office, for example. Some things are easier to change in a short period of time than other things. So we need to make a judgment of those things that are not standard: how difficult it will it be to change it and then come up with a method and a strategy which is quite specific. Don't say, "we're going to do better" or "we're going to try to limit the number of physicians," decide what exactly will be done to change the situation and in what period of time, and develop a work plan and a strategy for accomplishing it. Now, all this is geared to the actuary who is suddenly being asked to put a pricing discount or a value on the results of cost containment or managed care. So I'm putting you in sort of a corporate environment, an insurance company or HMO/PPO environment.

Then last, but not least, is what is a reasonable time frame to accomplish those changes? We're talking about, for example, pruning the physician network to eliminate 10% of the high-costing physicians. How long would that really take? Will it take six months? Two months? Two years? And very importantly, I think the actuary needs to be monitoring the timing of real events. So that if we assume a sequence where in the first six months we'll be able to reduce the physician fund pricing 5%, let's look and see whether those things that were supposed to happen have, in fact, taken place during that first six months. If not, you need to call the whole thing off and get back to real pricing based on actual costs. This is a situation that a lot of actuaries get caught in -- not being marketing-sensitive and being accused of being cynics. I suggest a hard-nosed, real planning approach to it based on a medical audit. Those are the things I wanted to mention in terms of what's working.

MR. GEORGE C. HALVORSON: In order to put what I'm going to say in context, I am going to talk about the cost containment achievable in a staff model HMO. The HMO of which I'm the CEO is a 270,000-member staff model. We own our own clinics. We own our own pharmacies, labs, and x-ray equipment. We are fairly well vertically integrated in terms of a care system, and right now we're the 12th largest multispecialty group practice in the country. So our structure is different than many other HMOs, and the things we've been able to achieve fit our model and the Kaiser model, in many respects, better than they fit other HMO models.

It isn't news to anyone here that health care costs are skyrocketing. The point I'd like to make is that managed care, well done, can slow the cost of increase, but definitely cannot stop the cost of rate increase and, in my opinion, there is little or no chance that we are going to see any kind of a plateauing, and no chance that we're going to see a rollback in the cost of health care. The first reason for that is inflation. We face the same inflation in health care everyone else faces, but inflation alone would not do as much damage as the health care cost increases you're seeing now would seem to indicate. We could easily have single digit inflation in the cost of our coverage every year and run somewhere around 5% and 6% without any problem, based just on the cost of buying equipment, paying salaries, and putting together the health plan.

The factors that are causing the costs to go up much more rapidly are utilization shifts and technology. Our population in this country as a whole is aging. People are becoming much more demanding. They're getting used to getting information about care from *USA Today* and demanding that care be delivered to them. The expectations relative to the ability of care to cure are going up readily rather than going down, and technology is hitting us in two ways. The one way you're probably very aware of, and see with some regularity, is what I call explosion technology -- the major breakthrough type of thing -- the situation where we now save a one-pound baby. It may cost us a million dollars to get that baby home from the hospital and it may cost us another $200,000 a year to take care of that baby once he's home from the hospital. Those are big expenses, but we are now, in many cases, able to keep one-pound babies alive in the health care system.

Those costs are huge and they're dramatic, but they are not actually as dramatic as the infiltration costs, the technology creep, and that is what's really driving up health care costs today, in my opinion. We're seeing heart cases that were taken care of four and five years ago by general internists now all going to cardiologists. The cardiologists all do procedures. A general internist is no longer considered to be the appropriate person for a heart case and five years ago he was the specialist who the general practitioner made the referral to. Those costs run up the cost of care.

There are new drugs coming out and they're not always dramatic. There are new prescription drugs for allergies that don't make people drowsy. There's a high demand for that drug. It costs four times as much as the old allergy drugs that made people drowsy. There's a constant development of new procedures and new drugs that are coming out that are running the cost of care up and it's insidious. It doesn't stand out in any particular direction, but if you take a look at the way we deliver care, the standards of care are changing and medicine is keeping pace with those standards. A full-term baby before being born is now looked at with ultrasound equipment. That wasn't done a couple of years ago. That adds $120-150 to the cost of every maternity case; they check to see if the placenta is still in place. There are all kinds of little technologic developments that are coming along, and I don't think we're likely to turn that around.

A well-run HMO can manage inflation to some degree. We can have a definite impact on utilization, and we can have a significant impact on technology shifts, but we cannot turn the situation around and bring care back to a stable level. HMO rate increases have been running significantly below fee-for-service rate increases and that includes PPO rate increases. A couple of years ago PPOs were presented as being the major salvation of the health care world relative to cost and, in fact, employers surveyed two years ago believed that PPOs were the right answer. We're now seeing what happens when the incurred but not reported (IBNR) gets run out and the front-end cash flow advantages disappear. PPO rate increases are now significantly higher than HMO rate increases, and I think we're beginning to discover that much of the promise of the PPOs was based on hope and not on the actual delivery of care.

Before I get into what we actually do to contain the cost of care, I'd like to talk about what some people claim is the major reason that HMOs have been able to be much more moderate in their rate increases, and that is what I like to call the "S" word. Fee-for-service plans have been claiming that risk skimming is the reason for HMO rate moderation. Studies that have been done of the prior use of health care benefits by people who were with fee-for-service plans have indicated that, in many groups, the people who joined the HMOs tended to have been lower cost users of care in the year before they joined the HMOs. That point of view is becoming fairly widespread and, in fact, some otherwise reputable people are stating it now as a fact of life. The prior use study methodology is severely flawed in that it assumes sort of a random selection of people moving into the HMO and, in fact, people have joined the HMOs for specific reasons. So we took a look to see what the subsequent use was.

If the people had lower utilization prior to joining an HMO, what happened after they joined the HMO? What we found is that people tend to join, our HMO at least, with the intent of using care. They joined to get the better benefits. This is particularly evident in areas like maternity, mental health, chemical dependency and elective surgery. In a group where we have over 10,000 members and active enrollment growth, the new members joining us tend to utilize at about 550% for the two years after they join us. That study covers 200,000 people over three years. This is not one group. This is our entire block of business during that three-year time span comparing the new people with the old people. Prior use data doesn't do a very good job of predicting pregnancies.

Our studies also show that people who leave our HMO, the people who move from us to fee-for-service tend to be lower-than-average users of care. And as we do our studies of the people who leave us, we have identified that the people who have seen our doctors 20 or more times in the prior year are almost completely unlikely to ever leave us. They bond. The same thing happens in fee-for-service. People who are sick tend not to move from fee-for-service to an HMO. People in an HMO who are sick tend not to leave the HMO and go to fee-for-service, because people who are undergoing a course of treatment typically, for all kinds of reasons that are understandable to all of us, don't like to change doctors. The migration from plan to plan tends to be people who are currently nonusers, and those people tend to stick wherever they are when they become users.

One of the things that we do in our plan is total replacements. We go out to the market and we go to the buyer and say, "If you get rid of your fee-for-service plan and give us the entire group, we'll give your group a choice plan where there's a deductible and co-payment for going out of network and we'll take the entire group." On that basis, out of 850 groups, about 450 of them right now are total replacements -- there is no other carrier in the group. We experience rate many of those groups because they're large enough to experience rate. Our experience has been, on those groups where we experience rate, that the savings for the buyer over a two-year period of time tends to be about $600 per family contract. Now that's a lot of savings. Those are groups where the fee-for-service plans' rates were often $100 or more over ours to begin with, and the contention was that the reason the fee-for-service rates were so high was because we had all the healthy people. So our response is, give us your sick and your tired and put them in our health plan, and we'll take them. The result has been that either those sick people decide that the employer who offers us is so stupid they don't want to work there anymore and they all quit and go someplace else, or we're doing a much better job with containing costs than that risk-skimming argument would seem to imply. But the result has been extremely positive for the employers that have done that with us.

Our studies also show an interesting piece of data. (By the way, the *HMO Journal* and the *Group Health Association of America (GHAA) Journal* have published some of these studies.) On an apples-to-apples comparison of health-screened, age-rated, full-benefit, nongroup policies in the same market, our rates were far below those of our major fee-for-service competitor by about the same percentages that they typically attribute to risk selection in the group setting. Now, we sell a nongroup policy, and they sell a nongroup policy. We have a full-benefit policy. They have a policy that has slightly lower benefits. We health screen. We don't take anyone with cancer and they don't take anyone with cancer. We use the same kinds of underwriting guidelines and, in fact, they're underwriting guidelines that we got from indemnity actuaries, and so we end up with a risk which ought to look an awful lot alike. Our benefit is a little richer.

TABLE 1

INDIVIDUAL HEALTH SCREENED ENROLLMENT RATES
Males

Age	Group Health	Largest Indemnity Carrier	HMO Price Advantage
Under 30	$ 54.00	$ 69.00	-28%
30-34	59.00	75.71	-27
35-39	69.00	88.25	-27
40-44	80.00	107.34	-33
45-49	104.50	135.80	-29
50-54	127.50	170.47	-33
55-59	147.50	206.68	-40
60-64	164.00	276.89	-68

For males, under age 30, we're at $54 and they're at $69. That's a 28% advantage for us. If you get down to age 60-64, we're at $164 and they're at $276. There's a 68% difference for us. These are the kinds of numbers that typically show up in group settings and in that setting they are blamed on selection. For females it's even more extreme. When you get down to the 60-year-olds, we have a 200% difference in the rate. Their rate is 200% over ours. My suspicion on that particular one is they're trying very hard not to enroll any 60-year-olds, and that rate isn't a function of utilization. But on the rest of this I think it probably is, and those are fairly dramatic differences. We don't actually find this plan to be their competitive plan. They don't sell a lot of

it. What they sell is a $500 deductible and a $1,000 deductible, but they do rate this as a separate pool, and these are the rate differences that you see. I think they're fairly significant.

TABLE 2

INDIVIDUAL HEALTH SCREENED ENROLLMENT RATES
Females

Age	Group Health	Largest Indemnity Carrier	HMO Price Advantage
Under 30	$ 81.00	$107.02	-32%
30-34	88.50	116.09	-31
35-39	97.00	138.39	-42
40-44	102.50	151.56	-48
45-49	128.50	178.87	-39
50-54	137.50	212.82	-54
55-59	147.50	250.24	-70
60-64	164.00	328.91	-200

Given that, what would I argue is the real reason for our success? If it's not selection, what else do we do? I would argue that we actually manage care. What makes managed care work? The first thing is appropriate incentives. We have salaried physicians. Our physicians have no incentive whatsoever to overtreat and they have no incentive to undertreat. They're not penalized if they overtreat and they're not penalized if they undertreat. They're on salaries and their entire role is to deliver appropriate care. Other HMO models achieve something comparable to capitation. Again, they're paid X amount of money per patient per month. There's no incentive to overtreat whatsoever. There are significantly negative consequences because the patients can get very sick if the doctors are undertreating, so right off the bat the individual who's making the key health care cost decisions has a financial incentive not to waste money.

I had a conversation with a family practitioner in Minnesota who's president of a large clinic, and he was talking about how much he hated fee-for-service. He basically said that he wished he were a salaried physician, because it's impossible to make a living just dealing with the things you need to deal with. He said, "I always have to find some warts to take off in order to make ends meet for our clinic." There's a whole different set of incentives, and this isn't a new situation. George Bernard Shaw, in the preface to his play *The Doctor's Dilemma*, said that being diagnosed by a fee-for-service doctor is very similar to being tried in the court where the judge will only be paid if he finds you guilty. It's not the ideal situation.

What do we do, given our approach? First of all, we do protocol-driven medicine. That was alluded to earlier. We take a look at how care ought to be delivered, and we look at both the quality of care and the efficiency of care. We find that they tend to coincide quite a lot, and we focus on appropriate care. The biggest buzz word you're going to hear in the next couple of years in this industry is going to be "appropriate care." People are beginning to get religion on that issue, and beginning to realize that *appropriateness* is a term that can be applied to care, and that appropriateness can mean immense efficiency.

We have a very active and aggressive preterm birth program. We identify high-risk mothers. We are running 47% below the state of Minnesota average for preterm birth. We improved our own numbers since starting that program by about 25%, but it's made a significant difference in reducing low-birthweight babies for us. That saves us a lot of money. It saves an immense amount of tragedy on the families involved, and it's protocol-driven medicine. If we were in a fee-for-service setting, the things that we do to accomplish the preterm program would not be reimbursed. The fee-for-service setting leans the reimbursement toward dealing with the high-cost cases, but not in preventing them in any way.

Ear tubes is another example. It's about the most common procedure done to young children -- putting ear tubes in to let the ears breathe. It's a highly abused procedure. Before ear tubes are inserted, our pediatricians go through a protocol. They go through drug number one. Then they go through drug number two. Then they go through a consult. Then they go through drug number three. Then they take a look at whether or not the ear tubes are needed. And in most cases they're not. We do the ear tubes, but we don't do them with anywhere near the incidence that

they're done in the fee-for-service setting, and when we do them, we do them in a much lower-cost setting.

Hysterectomies are another example. Our percentage of hysterectomies is much lower than the fee-for-service procedure numbers.

Vaginal births after C-sections (V-BACs) are interesting procedures. Medical science has now proven that, in most cases, mothers can give birth safely in the normal birth approach rather than have a second C-section. It used to be a fact in medical science that if a mother had one C-section, every birth after that had to be a C-section again. That's incredibly expensive. It puts a terrible burden on the mothers, relative to the quality of their lives. If you already have one child at home, and I can speak to this because we just went through it, and the mother has a C-section with the second one, for two or three weeks she can't even lift the first baby. The burden on the family is immense. We have a very active V-BAC program. We counsel the mothers on how it can be done. We go through various kinds of testing to make sure the scar is in the right place and we check it out. Our rate of V-BACs right now is three times the state average in Minnesota, and it's going up significantly because we have an aggressive program. The types of things we do to make that program work wouldn't be reimbursed in the fee-for-service setting. The doctors would have no incentives to do them and, in fact, every incentive in the world to do additional C-sections, because that's where the money is.

Our C-section rate, again, is protocol-driven. We don't quite hit the standards that the *New England Journal* says are the right standards, but we are running significantly below the averages of C-sections in Minnesota. We're doing C-sections at a far more appropriate level than fee-for-service medicine. Again, it's a quality of life issue for the people involved. We're saving all kinds of grief in family settings. We are helping people avoid major surgery, and we're saving a lot of money. In a fee-for-service setting, it would be a stupid thing for us to do because the money is in C-sections. The money is not in normal births.

We have a lipid clinic. When Alvistaton came out, instead of just prescribing it to everyone who might possibly be an appropriate person to receive it, at about $1,200 a year, we've done a much better job of going through a clinic process of counseling these people and teaching them about weight issues and other types of things, and then using the drug as a last resort.

The last one I'll mention is one that I think particularly illustrates the whole point, and that's dental sealants. We have a prepaid dental plan. We have staff dentists, and one of the things that we have been doing for over ten years is sealing teeth. When the children come in to us, particularly the new groups, we seal their teeth, and the result of that is we reduce about 90% of the cavities over the time period when the children are growing up. In fee-for-service dentistry, most benefit plans don't even cover sealants. If they do cover it, they cover it at a level that is much lower than the amount of time the dentist has to spend on it, or they provide partial coverage. So the dentist has to collect the difference, and the dentist isn't going to see those children anymore. From our perspective as a managed care system, we're very happy not seeing those children anymore. In a fee-for-service setting, the dentist doesn't see those children. They're going to spend a lot of time in the waiting room reading the magazines, and ultimately they won't be able to afford the waiting room. So the incentives in something like this really work for managed care, and I think illustrate the difference between managed care and unmanaged care.

The things I have mentioned are protocol types of things. In addition to that, there are some major structural efficiencies that occur in our kind of system. For example, we own our pharmacies and we have pharmacies in almost every clinic. We are unable to put pharmacies in a couple of our clinics because the buildings had a pharmacy prior to that and there are some rules about how many pharmacies can be in those buildings. We know that we save about a quarter of a million dollars per clinic by the efficiencies of having our own pharmacies. They're staffed completely by pharmacists. We're not getting by with cheaper people, but it's saving us an immense amount of money relative to the mass purchasing of drugs. We eliminate the need for the pharmacy profit and overhead if we do it ourselves.

We own our own laboratories. We have American College of Pathology-approved laboratories. Every lab technician is certified. The receptionist is not drawing blood and the nurse is not doing the lab tests. Everything is as appropriate as we can make it medically. If you want to look at the numbers, our average cost per test is running about $3.41. In the fee-for-service world, and this is

the most recent Congressional number, it's $8.68 per test, and if the physician owns the lab, it's $9.93 per test. The lab cost per visit is about $1.88 for us and about $5.26 for the physician-owned labs. If you compare the incidence, and this isn't a rationing issue, we do .55 tests per patient visit. They do .53. So we're cutting the cost by two-thirds, doing slightly more tests, and doing that because our structure is set up to be much more efficient. We do the same thing with x-rays, but I'm not going to go through all the numbers.

We look at a lot of procedures that are done in the hospital now -- the hospital overhead charge. We move those procedures, whenever possible, into our clinics. We have very high-tech clinics, and we eliminate a lot of costs in the hospital. We go through the same thing on "make or buy" decisions on technology. Doppler ultrasound equipment came out a couple of years ago. It is used for identifying whether or not the blood flows in the right direction in the valves in the heart. We took a look at the cost of that equipment. We tried to identify how many cases we thought we would need to use it on in the following couple of years, and we did a quick "make or buy" decision. We decided that it made a lot more sense for us to spend a quarter million dollars and put the Doppler ultrasound equipment in one of our specialty clinics. We paid for the machine in about a year and a half, relative to the cost that we would have paid to use it in a hospital -- paying the hospital use fees and the hospital overhead for that equipment. That's a standard procedure when new technologies come out. We go through that kind of a process in the managed care system. There would be totally different incentives if we were in a fee-for-service system.

We own our home health program. It's tied to discharge planning. We manage each case very carefully from the time the patient leaves the hospital. We identify what needs to be done in the home. We not only own a Medicare-certified home health company, but we also do things like IV therapy in the home. We do back therapy. We do a lot of things that ordinarily are done in the hospital setting on a custodial basis, and we bring the cost down. We have an after-hours care team. We have doctors and nurses around the clock answering the telephone. We've reduced the emergency room visits by about 43% at night. Patients are able to call in and identify their problems. They are asked if they can wait until morning, or they are prescribed home treatment.

We have OB/midwife teams. We have the largest OB group in Minnesota. We also have the largest midwife group, and we just delivered our 10,000th baby through midwives. That program is very cost efficient. It's very high quality. The patients enjoy it, and we have a board-certified OB in the delivery room at all times. It's the type of thing we can do in a managed care setting. It would not bill as well in the fee-for-service setting.

We pick hospital centers of excellence. As a managed care system, if a new procedure comes out that needs to be done in a hospital, we check all the hospitals in town and identify the one that's the best for the procedure and then contract based on volume with that hospital. We end up not having to do things twice because we do them right the first time.

You've probably all seen the numbers that demonstrate the difference in outcomes between the worst hospital in town and the best hospital in town for things like heart surgery and eye surgery. We tend to use the best and, because of our volume, we also get a good price on the best. Some models like us. We don't own hospitals ourselves. We have long-term relationships with a couple of hospital systems. Kaiser, Group Health of Puget Sound, and some other plans own their own hospitals, and they've done something very intelligent there. They take a hospital from being a revenue center, where they have all of the administrative cost burden associated with going after revenue, and transform it into a cost center, which is much more efficient to run. There is a lot less overhead, and it works more efficiently relative to the actual needs of the plan. It's another aspect, I think, of the future of managed care.

We have technology assessment teams. We have common medical records, so there's a single record on everyone's care that goes from doctor to doctor. There are not 15 different charts for a person that's seen by 15 different doctors. The elimination of the claims processing intermediary is important relative to managed care, and it's one of the reasons the Canadian system has done so well. We and Kaiser and other models replicate it. We eliminate the entire claims processing industry, in effect, relative to our people. When our doctor fills in the chart, that drives the information that goes into our computer. It doesn't then have to come out as a bill, go in the mail to somebody else who then has to punch it into a computer and have it become a claim and go through claims processing. Once it goes into our computer from the doctor, it also goes into our computer as a piece of utilization information and the claim is adjudicated at the same time by

the computer. So for about 1.5 million encounters per year, we've eliminated the cost of claims processing with our model.

We also do in-house peer review and we do in-house review of the care process. We do in-house referral review, and we do in-house training and pruning. I'll mention just two of those briefly.

On referral review, when our referral doctors get a referral from one of our doctors, part of their obligation is to identify whether or not the care was delivered appropriately before the referral was made. If it wasn't delivered appropriately, then part of their obligation is to retrain the primary care doctor who made the referral. There's a constant improvement process going on that also saves us a good bit of money. Simultaneously, if the referral is made for something that the primary care doctor should have been able to take care of himself or herself, he or she goes through a retraining process. Say a doctor is making too many dermatological referrals. He's referring them a step too early. What he could have done was prescribe a medicine, and if that didn't work, make the referral. One of the things we do is move the care back from the referral doctor more to the primary care doctor on a physician-by-physician basis in consultation with the referral subspecialist. There's nothing like that, even remotely like that, in fee-for- service. The fee-for-service referral doctor wants as many referrals as possible and isn't going to give any negative feedback to the referring doctor. If he gives negative feedback, the next patient is going to go to somebody else. So it's a very different model that exists in this situation.
I will also mention retraining and pruning. If we don't like the way a physician is performing in our model, it's fairly easy to deal with. Once we've tried to retrain and once we've gone through the other necessary steps, we can ask him to leave and go back to fee-for-service medicine.

In California, the rate of people moving from the Kaiser-type plans to fee-for-service is running at about seven people per one thousand, which I think is a pretty low number. Seven people out of a thousand probably fill in the forms wrong. There's a very high satisfaction level with the value of what's being received. There's a consistently lower rate increase need for the staff model HMOs than for anything else in the industry, and there's a very high level of member satisfaction. And this is a number from our market.

Obviously rationing isn't what's driving our care delivery. In our setting, in the state of Minnesota, we asked the question, through an outside survey company, "How likely are you to change health plans in the next two years?" For HMOs overall, the individual practice association (IPA) models, the number was 11%. With our plan, the number was 4%. And actually, the number of people leaving us at open enrollment in groups is running at about 4.5%, so 4% was a pretty good predictor. For fee-for-service, it was 35%. People are unhappy with the care and the cost of care that they're receiving. This is something you heard earlier.

Managed care works. The term isn't magic. Care actually has to be managed. There are an awful lot of systems of one kind or another, right down to 800 numbers, that are called managed care. They are not managed care. The care actually has to be managed and not just discounted. Discounts are very good. They save money but they're very fragile. Any doctor who's smart enough to make it through medical school is smart enough to be at a discount within a year or two. That's one of the reasons those numbers go down and then shoot up again. The practice of care changes a little bit. There are seminars for medical groups on how to maximize your billing, and those seminars are well attended. I wouldn't lump all managed care together into one package. What Kaiser has been able to do is very different than what the neighborhood hospital-based PPO has been able to do.

One last point that I think may be of significance, particularly to actuaries, is a hard point to explain. Let me preface it by saying that we made a decision as a health plan, the health plan that I work for, to create a data base that can provide every imaginable utilization report that any insurance company can give for utilization of patients. If you want to know how many appendectomies we did and what the cost was and whatever else, we can give all of that. We met with our consultants and identified what they thought the best reports were. We set up a data base that can give all of those reports -- on a group-specific basis. And so, I'm not making my next comment because we can't do that, but because some of that is actually, I think, irrelevant and not very useful. Group-specific data units are too small in evaluating the efficiency of a health plan. What needs to be looked at are things like the overall rate that the health plan charges the group, the unit price for particular types of procedures -- if we do C-sections, what is our unit price -- protocols, plan performance relative to major diagnoses and procedures. That's where it makes

sense. If our plan is doing C-sections at half the community rate and your particular group, the group you're advising, is with us and does C-sections at twice the rate and that group is a group of 100 people, obviously what you need to do is think about not whether or not we did something wrong, whether or not we need to do all kinds of examinations of each of those C-sections, but look at the big picture and say, "Yes, this plan does a good job on C-sections. In fact, it does a much better job than the community at large on C-sections, and therefore the C-sections we had were appropriate. Not only were they appropriate, but they were probably managed at significantly less cost than that same C-section would have been managed in the fee-for-service setting." One of the common mistakes is a kind of myopia going on. There's a desire to micromanage health plans based on a small subset of data. As a health plan we need to look at the entire practice of a given physician over a time period in order to clearly identify the patterns of care. I've met with groups who are talking about pulling enough information from us on their group so that they can call us to find out whether or not a particular pediatrician is doing too many ear tubes. You can't do that on a subset of people that exists in a group data set; it has to be looked at overall. I think the more sophisticated buyer ought to be looking at the major types of procedures and diagnoses and what protocols are in place and how those things are handled on a planwide basis in comparison with the community. If that works, then look at the rate and identify whether or not the rate is a palatable rate, but do not look at group-specific data with a false level of precision.

DR. CARL F. MYERS: It's very unusual for me to agree with two speakers, but I have to admit I agree with the great majority of the comments that George and Ralph discussed. What I have to say is purely opinion, and it shouldn't be confused with facts. My particular background is that I was an oncologist for six years and got involved with managed care on the contracting side with physician groups. A lot of my bias, a lot of my reasons to get into the managed care side was that I felt that administrations needed to have more medical input. Unlike a lot of my administrator/physician colleagues, I'm a great fan of physicians. I think they're the good guys, not the bad guys. I think that they are ill prepared, however, in many cases, to move from the cottage industry that they were in the 1970s, into the very medical/industrial complex-type industry that we're seeing now and we'll see even more so in the future.

My comment, and Ralph mentioned it before, is that managed care isn't managed care. I primarily have been working with a network model, which means that I have both independent physicians in our HMO as well as clinics, but clinics that primarily do fee-for-service or about 50% fee-for-service. I have some constraints in what I'm going to say. I'm not sure how applicable something that happens in Milwaukee would be to New York City, or would be to even someplace else in the Midwest. My other bias is that I come from a start-up company, basically. We've only been around for four years. It's a provider-owned model. It's owned by five different Catholic orders, which in itself is a treat. We were the 14th HMO to move into a very saturated, small marketplace in Milwaukee. It's now down to nine, and we're second largest. I wouldn't know what to do if we had any money. We started with $3.2 million of capital. We've never had an infusion of capital since that. We've been making money, but Ralph probably in Met Life on a bad day lost more money than we've made in three years.

Although we do have 100,000 members, we're a very small part geographically in Wisconsin. Care Network is the Catholic holding company.

We operated for four months in 1985 and by 1987, annually, we made $300,000. The estimate for 1989 actually was made in March, and we'll be slightly over the $1.5 million mark, and our estimate for next year is over $3 million.

There are a couple of different errors I can make in this talk. One would be to be too specific, and the other would be too general. I decided to go with the too general error.

I will go through as if I were giving a ten-week course. What would be the germs of truth that I would try to leave you with? I would basically call this talk "Managed Care 101." Week 1 is the introduction, and I think the first two speakers have covered a lot of what I would cover here. Weeks 2 through 8 are the functional areas of competence that are necessary for a managed care company. The first two speakers talked about the nuts and bolts of utilization, and what can be done in the medical management area. I'm talking more on what makes a managed care company successful. I think the medical piece has been pretty well taken care of. It would be important during week 9 to see how the functional areas all interlock. And then during week 10, a little bit

of my own biases would show what effective management is, and what styles of management work in managed care and why.

Week 1. Why managed care? Obviously, in the 1970s, HMOs started because preventive medicine was going to save a lot of money. They really went nowhere in the 1970s -- I'll give you a clue as to what preventive care is. The great majority of preventive care means that it's a personal decision. You don't smoke. That's a big one. You don't drink and in particular, you don't drink and drive, or you don't drink to excess. You wear seat belts. You stay out of the wrong side of town at night. You're the right weight. The only medical one that really hits the top seven or eight is you get your blood pressure checked, and if your blood pressure is high, then you go through the steps to lower your blood pressure. So preventive medicine is a personal decision. It's not something that, by being in a waiting room for half an hour, and seeing a physician for three minutes, usually does much. What managed care is, I think, has been covered. Is it the future? I can answer yes.

For weeks 2 and 3 of the course, this is what I usually ask, how do you deal with physicians? I could talk for hours on the peculiarities of working with physicians, both in contracting and getting them to do what you want them to do. George has a slight advantage, his physicians are salaried, which means that they're interested when George, the administrator, says something. In my case, they're not salaried. They join us independently, and they can leave us independently. You have to work on what's good for them and convince them what's good for them.

Some of my biases here in working with physicians and understanding physicians have to do, not with a staff model, but more with independent physicians. Physicians are harried, to put it nicely. They're very busy. They feel that the 1970s were the years in which to practice. To put it more realistically than nicely, they're whiners. Whenever they get a chance to tell anyone how bad it is, they'll spend a lot of time going into the gory details. What's also interesting is that they'll complain about their salaries to people who don't make one quarter of what they make. Then they're amazed that they don't get a positive response on this. That's very peculiar. It's somewhat egotistical, somewhat self-centered. Again, I'm a real fan of physicians. I think they work very hard, and I think they are well trained. But some of the skills aren't there. I've noted that physicians are extremely loyal. They evaluate someone's performance, not so much on the level of performance, but how hard they work at it. This is interesting. I will go into physicians' offices and look at their business claim setups, and find that they are in a royal mess. The physicians may be losing 10-20% of the efficiency in the office, minimally because they're not dealing with computerization. They have poor office assistance. When you talk to the physicians, they know that, but the assistant has been in their office for 15-20 years. They work from 8:00 a.m. until 8:00 p.m. sometimes, and they really value the loyalty of the employee, much more than they value the effectiveness. I've seen this time and time again.

I've also seen some very poor consultants, especially in the managed care area, working with a group of physicians, giving bad information. The physicians will stick with them, right through the bankruptcy court, and actually pay them after that, out of their own pocket, outside of the bankruptcy proceedings allotment. Incredible.

Physicians are also extremely skeptical when it comes to business decisions. The best business people I've seen evaluate on both sides. Is this a win/win situation, this contracting business? And don't beat it to death. Physicians don't seem to have that; they don't seem to have the confidence to be able to say that this is a good deal. The way they negotiate, very often, is they will eat you up and shout at you and tell you your mother wears army boots. They keep at it for weeks on end, until both sides are so exhausted, that they both will come back and they will sign. They will sign exactly what you gave them eight weeks ago, because they figure it has to be a fairly good deal because you never gave in. If you give in, they figure that you're dishonest because you didn't come to them with a good deal to begin with.

These are clues. When working with physicians, don't take it personally. That's an important one. Don't get caught up with the fact that they're going to have a holier-than-thou attitude, even though physicians may be making much more than whoever else is on the other negotiating team. The person on the other negotiating team is only working for money. The physician considers, I truly believe, that his major purpose is not to make money, but it's to care for people. But he won't give anybody else the opportunity to take some credit for the service to an organization that somebody else may give. You cannot delegate physician relations. I have seen this destroy

excellent relations in the past. If it's not the CEO, it has to be somebody who is at the upper executive level, who has the autonomy or authority to make a decision and have the company stick with it. Once it gets delegated down to the physician, where somebody doesn't have that autonomy, you're going to lose the ballgame.

Something to remember when working with physicians is that you should look for areas in which you can lose a battle, that's the quickest way to win the war. I would say the war that you want to win is a strategic structure. The first two speakers have covered that well enough.

Another key piece to physician relations is that physicians are like most people you know; they believe first impressions are pretty good. And then over time you find out they have their warts also, and it comes down to a realistic level. I see this time and time again. When I bring a new nurse into a physician group, they don't like the person. I tell my nurses when they're with a new physician group, "be prepared, they'll beat you up." What the nurses must do is keep a professional demeanor, not challenge the physicians on medical issues, and just stick with it. Four to six months later, the same physicians that beat up this nurse will actually wonder where she is, and miss her when she's gone on vacation. That's a clue on starting physician relationships. If you expect to cut a deal, don't send somebody out of Los Angeles, to negotiate a deal in another city; it isn't going to work. You need local people, you need the time in order to have the physician or the physician groups feel comfortable with whomever they're working.

I think utilization management, quality assurance has been touched on well enough, but I will say a couple of things. Ralph mentioned the fact that a lot of managed care companies, by rote, do the same thing over and over again. I think what we call the sentinel effect, meaning high visibility for a short period of time, the same kind of thing you see in advertising, is a lot more cost effective. The physicians don't know when you put emphasis on a particular area, and they tend to act as if that high level of utilization was there for a period of time. So we'll have little blips. We'll focus on one area intensively for a short period of time, and then let that drop for a while and put the resources elsewhere. I think that physicians are sometimes given a bad rap on the fact that they seem unable to be educated, or they don't know how to practice in a cost effective manner.

Under fee-for-service, as George was saying, physicians never get a feedback loop. They never get evaluated by anyone. And how can you improve without that feedback loop? What I've seen is that through peer interaction, and peer sanctions when it's necessary, if there is good valid data, physicians want to practice cost effectively. Sometimes they'll run into problems, and as was mentioned before, once you practice cost effectively in a fee-for-service system, how do you make a living?

Week six and seven is labeled the "External Customer Interface." I'll focus on marketing. In saturated marketplaces, with HMOs, the marketing department is trapped into overpromising. They are either talking to a union group or to a human resource person, and they are asked, "Well, can you do this? Can you do this? Can you do this? Can you do this?" And the answer is, usually, because the marketing person is in a marketing mode rather than operations mode, "Yes, we can do this, this and this."

What I have found to be very effective, rather than this overpromising, is what I call operations interface marketing. I put nurses out to talk to the human resources people. I talk to the human resources people, and we have our MIS people talk to the human resources people. We talk about what we can do and what we can't do. And I have found that the quickest way to close a sale is to talk about what we can't do. The market is so tired of overpromising that once we start talking about reality, they'll sign. It's incredible.

Once we've done the marketing piece, once we've gotten in the door, what we have seen to increase our penetration rates is not the airwaves, not the advertising, but basic service. The first year we may only average 5-7% of a company that has multiple options, and in Milwaukee, you sometimes have six or seven options. By the third year, we're up to 30% on average. We advertise very little, but I think it's the emphasis we put on services. The MIS area, and here I actually should say services rather than systems, although it's all right as systems is the basic infrastructure for the whole company. I'm a key believer in the need for data for decision making rather than data for data. The best study that I know of is an elegant study of Board of Directors behavior. It was done at the University of Chicago in decision making research. They had several boards

make decisions at a board retreat. In some cases they would give three pieces of information and in some cases they would give ten pieces of information. All of the ten pieces of information were relevant and what three they would get was randomly elected. They did several different exercises, and so it was cross-referenced among many boards. What they found was that when there were three pieces of information, the boards were very uncertain about their decision making (whether or not it was good). However, they made better decisions. With ten pieces of information, and this I find fascinating, they were very certain that they were right, but they were more often wrong. Although I'm a great believer that data is necessary for many purposes, I think it can be overdone for its own sake, and you have to sometimes move with the data that you have. The importance of data from my point of view is that I need data in order to reveal competence to my physicians. I need data in order to reveal competence to companies. Often all I have to do is present data, present it in a competent fashion and be able to answer some simple questions. They may ask me, "Can you do this, can you do that?" I try to defer that. Do they really want it, or do they just want more data? Often I find that they really don't want what they asked for. Because the next month they forget about it anyway. So it could have taken a lot of MIS time, but the competence on our part was revealed.

You also need data in order to seek fairness as far as compensation. One of the things I find in our own company, and I think we see it in a lot of places, is that a lot of time is spent on the data, and very little time is spent packaging the data. Data are a very valuable marketing resource. It's a very valuable decision tool, but data need to be presented in a package that takes credit for that. I think most companies have loads of data and nothing is done with it. That's just a wasted resource.

On to week 9 -- cross-functional processes. It's necessary, but not sufficient, to have competence in all of the functional areas: marketing, member services, utilization management, finance, MIS. But that alone won't make a managed care company work.

I'll mention one example, the OB-GYN specialty. This is one of many different examples that I could use as far as the cross-functional nature of managed care. If you think of the functional area as the up and down slats of the fence, the processes that go through a company would be the two by fours that keep the slats together.

In this OB-GYN specialty example, we found in one of our physician groups that the referral costs when an obstetrician was the primary care physician was not only double what obstetric referral costs usually were, it was about three times what the referral cost usually were. To a great extent it was manpower. The obstetricians were so busy that they would not want to see a patient with a sore throat, even if they knew how to take care of the sore throat. So there were more referrals, and higher costs. This was something that the utilization management team discovered. When it was presented internally to the marketing department, their response was, "That will kill us. If the woman can't have the obstetrician as her primary care physician, especially since some of our competitors use that as a big marketing point, we'll die. We can't handle it." Member services said it was a basic nightmare. Systems complained about the fact that they would have to have new numbers, all the physicians would be paid differently. The referral system would be different. The people who take care of the directory said the timing was terrible. "It's not time for the right directory." Enrollment complained because they had gotten their set-up correct already, and they did not want someone to say, "This group couldn't be a primary care physician, there would be more mistakes made." So the process started in the utilization department, which basically said, "We have to do something about utilization here. This is costing us efficiency." Everybody in the organization threw up their arms and said they didn't want that to happen. They didn't care that much about utilization, but they did care about their functional part, and their functional part was harder once this was done.

This was a good exercise. We got all the managers from all these departments together and had them think about how they were going to monitor the problems. People who were into referrals would say, "This is the referral error or problem. It'll go up this much. Customer complaints will go up this much, etc." And what we did then was say, "Okay, how are you going to do it so that you don't have increased customer complaints?" We were basically thinking in a process-oriented mode rather than a functional-oriented mode. We had the brainstorming session, and we came up with several good ways to operationalize this one piece, and that started in utilization management. The point is, whenever any one thing happens in one department, it is going to affect every department. And operationally, if it's going to work, you have to have the people talking to each

other. Rather than think in a functional mode, which I think managers normally do, they have to think in a synergistic mode.

Taking ownership of problems is something that we stressed to our middle management, because it isn't natural. What happens is a problem will be discovered at customer service and the quickest thing to do is pitch it over to provider relations or utilization management. Everybody has a piece of the problem. And they clean their desk by shipping it off, rather than taking the ownership of the problem and going to all the other people who have a piece and putting it together. We are back to the picket fence example, as far as management. We have the managers think about managing their function, managing those slats that go up and down, but the manager's job is to do the process; this means managers have to take on the problem. They have to go to the different departments in order to get the job done, and they have to take ownership of problems that are cross-functional. If they do, it works, and if they don't, it fails. It takes a lot of creativity. On the upper management piece, I think you could talk about many different things that upper management needs to do. Cultivating human resources, to a large extent, with a highly professional group of people, is having to instill a higher purpose. In our company it's basically to have a major impact in the quality of care. Top management also has to pay attention to the personnel details. This cannot be delegated too much, and I think sometimes it's overlooked.

How many people are familiar with the Deming Information, the statistical basis of management? There is a revolution out there from Ed Deming. Dr. Deming was given a lot of the credit in Japan. He's an American who went to Japan in the 1950s and basically taught the Japanese how to work with statistical management techniques, in both the industrial quality improvement or quality assurance process, as well as in the healthcare field right now. I think it's somewhat overdone. It doesn't have to be as formalized as it is for quality improvement, but I think it's as good a method as any.

I think that a lot of different leadership styles work. However, in a managed care company, because of the complexity of the interaction of the functional areas, I have a success bias towards participatory management versus directive management; bottom up versus top down and very much a flat organization. I think that the execution has an emphasis over strategy, and that over time, if it's a very participatory organization, strategy defines itself.

MR. RICHARD J. NELSON: Mr. Halvorson, you said you're doing some experience rating on cases with your group-model-type HMO. How do you attribute claims costs when you're paying salaries to your doctors? How do you attribute a claims cost to your groups for an appendectomy, for example?

MR. HALVORSON: I mentioned that we have created a data system so that we can get fee-for-service equivalent data. What we've done is surveyed the community and identified what the prevailing fees are, and when we do an experience rating, we base it on community equivalent fees, rather than our cost. We know when we have a bill from a hospital. If a procedure is done at our clinics, and the procedure is a throat culture, we know what the fee-for-service or prevailing charge in the community is, and we charge that. Sometimes that causes us to overstate our revenue, and sometimes understate our revenue, depending on how many things we've done. In many groups we do quite a few things that don't show up as a fee-for-service allowable billable. But basically it nets out to about the same for us. We tend to discount the fee schedule a little. As the point was made earlier, fee schedules in that case are somewhat irrelevant, and a discounted fee schedule is more of a security blanket for the buyer than it is anything real. When we discount the fee schedule, we discount down to our cost. No one gets a below cost deal.

MR. BLUHM: For those of you who haven't faced the question before, that was a very relevant question, because most group model HMOs that are trying to experience rate and attribute the cost to each employer typically don't have the sort of data that George is talking about. They have a lot of trouble attributing cost, and they may not even keep track of encounter data, of people coming in the door to talk to the primary care physician.