

**RECORD OF SOCIETY OF ACTUARIES
1994 VOL. 20 NO. 3A**

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

Moderator: JANET M. CARSTENS
Panelist: NANCY NELSON
Recorder: SCOTT E. GUILLEMETTE

This session will explain various physician reimbursement arrangements and degrees of risk sharing, including reimbursement of individual physicians as well as provider groups.

MS. JANET M. CARSTENS: With me is Nancy Nelson from the Tillinghast office in Minneapolis. I have recently transferred to the Tillinghast Milan, Italy office from the Minneapolis office. We will talk about various physician reimbursement arrangements and related degrees of risk sharing. Our discussion focuses on arrangements that might be offered by managed care companies, such as health maintenance organizations (HMOs). We will present an overview of key definitions, concepts, and incentive compensation arrangements. Nancy is going to present an HMO case history. At the end of the session we plan to take questions.

First, it is important to make a distinction between primary care and specialty physicians. Reimbursement arrangements for the two categories of physicians have developed somewhat differently, although they are now becoming more similar. Primary care physicians generally include those physicians who perform routine services, such as office visits, inpatient visits, routine laboratory and preventive services. Primary care physicians often refer patients to specialists. Primary care physicians generally include family and general practitioners, general internists, and pediatricians. Sometimes managed care companies include OB/GYNs and internists with subspecialties.

Specialty care physicians, on the other hand, are those physicians who practice in specific areas of medicine or surgery; for example, cardiologists, orthopedists, neurologists, urologists, radiologists, and anesthesiologists. Typically primary care physicians have the most frequent contact with the patient. They direct much of a patient's care to the most appropriate setting by acting as gatekeepers.

Various payment methods have emerged for primary care physicians with the onset of managed care. The concept of provider risk sharing has changed from a fee-for-service basis to a discounted fee, then to a negotiated fee, and finally to a capitation basis. Until recently, capitation was used for primary care services and some specialty services, such as mental health and lab services. Most specialist services were reimbursed on a fee-for-service, discounted fee, or a negotiated fee basis. Lately, we have seen capitation development requests for orthopedic, OB/GYN, ear/nose/throat (ENT), and emergency room services.

Under a fee-for-service basis, the physician is reimbursed based on charges submitted for each service provided. Payment may be adjusted by applying a usual and customary (U&C) fee maximum, but with U&C maximums the physician has the opportunity to balance bill the patient. Fee-for-service reimbursement, therefore, does not contain costs and does not transfer any financial risk to the physician.

Under a discounted fee arrangement, the physician is reimbursed based on charges submitted less a specific discount. For example, reimbursement may be at 80% of charges. The physician's total income is at risk, based on the percentage of the population that is subject to the discounted fees, but the physician does not share in any utilization risk. There is also no control over future cost increases under a discounted fee arrangement.

Under a negotiated fee arrangement, the physician is reimbursed at the level that is specified in a negotiated fee schedule for each service provided. Usually, if the physician's normal fee is less than that listed in the fee schedule, the actual fee will be paid. Once again, the physician's total income is at risk, depending on the percentage of the patient population that is subject to the negotiated fee. Future cost increases are controlled to the extent that physician fees are at or above the scheduled amount, but are less controlled for physicians with fees below the scheduled amount.

Under a capitation arrangement, the physician is paid a fixed amount each month. In return, the physician agrees to provide a specific set of services for a defined population. The payment typically varies by age and sex of the members in the covered population. Capitation arrangements represent a true transfer of financial risk to the physician. The physician accepts risks for both the utilization and intensity of services, as well as the expected fee-for-service equivalent reimbursement. Under the first three methods of reimbursement, the physician may perform additional services to increase the level of total compensation. However, with a capitation arrangement, this is not possible for those services included in the scope of the capitation agreement.

Another form of physician reimbursement that may be paid to primary care physicians acting in the capacity of a gatekeeper is a case management fee. The physician is paid a specified amount each month for each member of a defined population in recognition of the case management services the physician provides. Amounts are typically small and generally range from fifty cents to one dollar. The amounts are not adjusted for the member's age and sex.

Other useful words and abbreviations include panel size, per member per month (PMPM), withhold, referral or risk pool, individual practice association (IPA), and group practice. For the purpose of this discussion, panel size refers to the number of members that have signed up with a physician or a group of physicians. We have included panel size in our list because, typically, under a capitation arrangement, a physician or group of physicians would accept the capitation only if the panel size exceeds a minimum threshold amount.

PMPM represents the amount of monthly reimbursement under a capitation arrangement for a member assigned to the physician. This is usually developed as the expected cost per person for the services that are included in the capitation definition. Adjustments are made to the PMPM for benefit plan design and differences in age/sex mix.

A withhold is an amount that is withheld from the physician's initial reimbursement and placed at risk. Amounts withheld generally range from 10–20% of the fees or

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

capitation. Return of the withhold depends on the financial results of the contracting managed care company.

A referral or risk pool comprises expected costs resulting from referral services provided to the primary care physician's patient panel by specialty physicians. The primary care physician may be placed at risk for referral costs that exceed expected levels.

An IPA is a group of independent practitioners who have agreed to become part of a physician network. A group practice is a group of physicians that practice together, sharing financial results. The effects of any kind of contractual reimbursement arrangements are often more fully realized through a group practice than through an IPA because of the closer financial and professional relationships typically associated with a group practice.

Physician compensation is often divided into two components—a minimum or a core payment for services rendered and an incentive payment, which represents income that is not guaranteed. The incentive component can be structured as a penalty, such as a withhold arrangement, or it can be structured as a reward where there is a potential to earn additional income as a bonus. Incentive payments can also be a combination of withhold and bonus arrangements where, generally, the return of withhold would be determined first, followed by the calculation of any bonus payment.

The primary objective of any incentive compensation arrangement from the viewpoint of the insurer is to provide a financial incentive to encourage a desired behavior pattern. A secondary objective may be devising an arrangement that is consistent with overall plan results while recognizing real differences in physician performance. The key to the arrangement is that it has the largest effect on physicians most important to the plan, but avoids random payments or penalties. Factors that drive the design of the arrangement include performance measurement standards, identification of payment recipients, as well as the frequency and amount of payments. Methods used to measure performance can include inpatient utilization review targets, overall utilization targets, or referral cost targets. Performance measurement methods are usually adjusted for high-cost claims, or possibly an age/sex adjustment, to reduce the variability of results. Other methods used to measure performance can include conducting member satisfaction surveys, meeting overall plan goals, performing on a consistent basis, and making a retroactive comparison to peers.

Identifying who receives payment should include a review of the incentive payment relative to the physician's capitation payment and/or total income. The incentive payment should be large enough to be noticed by the recipient, or there will not be any incentive to manage care. Therefore, it may be appropriate to include only those physicians whose patient panel exceeds some minimum level. A formula could also be developed to reward a targeted percentage of physicians, physicians associated with some targeted percentage of membership, or those physicians with the best performance relative to preestablished targets of utilization and/or costs. Identifying the physicians who will receive an incentive payment should also take into consideration the length of the evaluation period to avoid random fluctuation.

RECORD, VOLUME 20

The desired frequency of payment will have an important effect on the design of the incentive compensation arrangement. Many of the arrangements in use make payments on either an annual or a quarterly basis. The advantages of annual payments are simplified accounting, because settlement is only done one time per year and there is less fluctuation of payments from year to year than from quarter to quarter. Under an annual payment frequency, the results of the managed care company will be known. As a result, the possibility of paying incentive compensation can be reduced or eliminated when the insurer is in a loss position. Quarterly payments are usually done on an interim basis with an annual settlement. Quarterly arrangements must be relatively simple to be administratively feasible.

The total amount to be paid as incentive compensation may be limited to the return of all withholds, a flat bonus guarantee, a minimum guarantee with adjustments for overall profitability or for exceptional performance levels, or as a function of risk pool results. If incentives exist for other providers, such as hospitals, the order of priority for returning withholds and/or paying bonuses must be determined in advance. The amount of incentive compensation to be paid per physician must consider whether equal payments will be made to all or only key physicians. The amounts may reflect only a return of withhold or there may be a minimum established, with additional amounts based on performance. Alternatively, the results can be solely performance based with no minimum or maximum, except as is limited by overall plan results.

In practice, several different approaches are used for incentive compensation arrangements. In general, they are based on whether settlements are calculated and paid at an individual, group, or physician panel level. The groupings of physicians may be based on a willingness to be grouped. Also, groupings can be based on specialty type, such as pediatricians versus internists, or they may be based on hospital affiliation or geographic proximity. A settlement is paid based on group or panel results. Subsequently, the group or panel makes its own internal decisions regarding distributions to the individual physicians. The arrangement may be either risk or reward based. Risk could be a withhold, or a reward could be through a bonus payment. The bonus payment is often based on the ratio of actual to expected costs for services that are not capitated. These may include referral costs, hospital costs, or a combination of both.

We have also seen incentive compensation arrangements that incorporate quality measures and accountability for services. For example, each physician may be given a weighted score based on quality assurance, which can be measured through patient satisfaction surveys or other quantifiable variables. Alternatively, the weighting can be based on referral pool adequacies. Capitation payments are then graded based on the physician's score, with perhaps a 100% capitation for a high score down to a 60% capitation level for low score. Bonus payments can also be graded, and for physicians who receive high scores, bonus payments may be made more frequently, such as monthly.

MS. NANCY F. NELSON: Jan has given us a general overview of approaches to physician compensation with an HMO slant. This presentation is intended to be a basic introduction to managed care arrangements. I know we have some different perspectives in the audience, including someone from Canada, a casualty actuary working in the reinsurance area, as well as representatives from HMOs, Blue Cross

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

and Blue Shield plans, and commercial insurers. I would be tremendously interested in comments on current issues from these different perspectives.

I am going to give you some history on an HMO, indicating how the plan's physician compensation arrangements have evolved over the last eight years. This plan has added a new feature every year. I do not want to characterize anything presented here as necessarily the best way, because there is not a best way in any physician compensation situation. One method might be better than another for the contracting parties, depending on the situation. Similarly, the local environment alone may dictate what physicians are willing to accept. I have masked a few of the details, but essentially this is a real company's history. I will present a year-by-year history and then discuss what it is currently doing. It is an IPA-model HMO, which means that the primary contracting basis is with individual physicians. It has about 40,000 members in two primary service areas. The product mix includes both traditional HMO products and point-of-service products. I can characterize the plan by saying it has an evolving approach to physician compensation.

I chose 1987 as my starting point because that is when I began working with this HMO. I can safely say that 1987 is representative of where it was at the point the HMO began its operation, which was about 1983. The HMO had a contract with a network of individual primary care physicians (PCPs) with a capitation contract, featuring reimbursement on an age/sex-adjusted basis with variations by benefit plan. The ability to track claims for services provided was limited under the capitated arrangement. There was potential for an incentive payment based on referral services, and there were minimal restrictions against the primary care physicians to self-refer services, such as X-rays and minor surgery services.

The primary care physician had essentially no disincentives from providing these services to the patients. A pooling arrangement permitted an incentive payment. The first \$5,000 per patient of referral and hospital expenses was tracked, and the PCP received an incentive payment of 50% of any amount left in the individual referral pool on an annual basis. This potentially increased the cost of the plan with no risk to the providers. You are rewarding them and not necessarily giving them a disincentive from any particular behavior. You also face the possibility of the plan needing to pay an incentive payment in a loss situation.

The capitated primary care services include: office visits to PCP, home visits, in-office laboratory tests, preventive exams, preventive immunizations, medical social services, health education/information, family planning/services for infertility, and eye/hearing screening for children to age 19. The last two benefits are required for a federally qualified HMO. The scope of service definition is important because it is changed later.

On the specialty side, the plan contracts with a very broad network of specialists. I think this was largely the result of the inclusion of essentially all the major hospitals in both primary service areas. When there is a large hospital network, there is almost always a large physician network. Specialists were paid at the lesser of charges or a maximum fee schedule amount. In 1987, there wasn't a good evaluation of the fee schedule's level of effectiveness. Many physicians were still being paid at the charge level, meaning that the fee schedule was probably generous. I think, over time, the

RECORD, VOLUME 20

plan addressed that by increasing the fee schedule very slowly. Today, physicians are effectively being paid at the negotiated fee schedule, so they are being cut back from their submitted charges, but this is seven years later.

In 1988, the plan tried to capitate additional services. Laboratory capitations were introduced. This was primarily a capitation of services other than those that could be provided very quickly in an office with very quick results. By doing this, the HMO was able to decrease, and basically control, the trends on laboratory services. The HMO also capitated mental health services. The plan contracted with a specialty mental health provider capable of providing inpatient and outpatient services and professional services. The mental health expense was cut by approximately 50%, and utilization was cut by about 40%. This resulted from the introduction of the capitation and the control that the capitated provider was able to place on the services.

In 1989, the plan modified its primary care contracts. Capitation payments were increased in response to demands from the physicians for additional compensation, and a case management fee for administrative services was added. The same results might have been achieved by increasing the payment rates by age and sex. The plan also increased the amount in the incentive referral fund from \$5,000 to \$10,000 and changed the definition of services included in the referral pool. The services removed were maternity, newborn hospital care, and transplants. The rationale for excluding these services from the pool was that the primary care doctor has very little control over these services, which are also very costly. The idea of immediately being at risk for a newborn with a catastrophic condition was perceived as being unfair to the physicians.

Rather than limiting or setting the payments strictly on the individual physician's referral funds and paying back 50% of the funds, the plan changed the reimbursement to include a guaranteed minimum and maximum payment. A total dollar amount was established, and then the referral fund balances were used to decide how to take the money and carve it back to the individual physicians. The way the fund capitation rates were set, I believe, was the greater of either a fixed dollar amount per member per month or a certain percentage of plan profits.

There were other changes in 1989. At the same time that the changed definition of referral pool services was implemented, the age and sex factors used to fund that pool were realigned. The plan required referrals to newly capitated specialists. It added a choice of a high versus low primary care physician capitation. Essentially, the high capitation adds the option of being capitated for services such as X-rays, electrocardiograms (EKGs), and minor office surgeries. Again, these are things the physicians were self-referring instead of taking risk in the form of a capitation. The need to have two levels of capitation stems from the ability of some physicians to provide the expected definition of services while others can not.

The plan introduced specialty capitations in 1989. In this program, for certain physician specialties, the plan contracted with a single specialty physician or practice to provide all services required for members in that specialty area. The capitations did not match between the two service areas. Services capitated, in at least one service area, include allergy services, ENT, gastroenterology, dermatology, and urology. We

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

have seen an increasing interest in this kind of a capitation arrangement of specialty services. Our experience is that the arrangements that work best include those services that tend not to be tremendously intensive, such as a dermatologist who is going to have numerous office visits and minor surgeries. Compare this to trying to capitate neurologists, who have very expensive cases, but far fewer of them.

In addition to the primary care contract, the plan also introduced a full, medical expense capitation contract in 1990. This was negotiated with two, large multi-specialty groups, one in each of the two service areas. Under these contracts, the plan capitated all physician expenses. The medical group provided essentially all physician services to the members who selected that group as a primary care provider. Rather than having a hospital/physician referral pool, the plan now has a risk pool just for hospital services.

A full physician capitation program raises a number of new issues. What do you do with services that are traditionally hospital based? These are services where the physicians are often not part of the medical group; rather they are salaried at the hospital or they have a separate practice that is based at the hospital. I believe those services are included in the capitation.

Out-of-area services are a related issue. What do you do with the physician services that were received in an emergency situation? Does the plan keep risk in that situation, or does the capitated provider take risk for them and have those count against their referral expense, or do they simply pay for those services out of their capitated dollars? Durable medical equipment and ambulance services cannot be provided directly, so they have to be bought. Should the physicians pay for these from their capitation or should the risk for these services be absorbed by the plan?

How do you pay the capitation? There are a number of plans that have paid a percentage of premium to a medical group. This can work well when the medical group owns the HMO. For this particular HMO, the plan chose to pay a capitation on an age/sex and benefit-plan-adjusted basis. Another issue concerns services that have to be referred because the physician group does not have the capacity or expertise to provide them. In that case, should the plan keep risk for these services? Or if the risk is transferred to the physicians, who will make sure that the physicians have an adequate reserve level to pay for those services when the bill comes in?

The plan is now starting to look like a hybrid between a group plan and an IPA-model HMO. If you recall, we have a member who has a choice of picking a PCP that is either in the medical group or an independent primary care physician. For the physician in the medical group, all compensation is capitated. All the primary care and specialty services that the member receives are through the medical group, with the rare exception of outside referrals. On the other hand, if the physician is an independent PCP, he is getting a capitation, but the specialty physicians are primarily being paid on a fee-for-service basis, with the exception of the few that have specialty capitations. Primary care services are performed through the independent PCP. Referral services are performed either through one of the capitated specialists or through one of the other network specialists.

Changes made in 1991 were primarily the result of changes in benefit plans. The plan introduced a point-of-service plan, which has many ramifications for physician contracting. Physicians are generally adverse to being at risk for things they do not control. For this particular plan, the capitation rates on the primary care side were reduced by the amount that was expected to go out of network. The adjustment made was about 10%. The physicians accepted that, but I don't think they are always willing to take a cut when a point-of-service arrangement is introduced. However, the referral fund deposits were not changed. Any charges on the referral side were made against the incentive funds with the same \$10,000 limits. They were willing to accept that arrangement because the plan placed limits and exclusions on very catastrophic cases.

Another change made in 1991 was in response to changing practices in medicine. Specifically, the plan increased the capitation at very young ages to recognize changes in the cost of immunizations. In 1991, the cost of one of the common childhood vaccines became very high, almost overnight. Since then, there has been another change related to immunizations as a result of a change to the recommended schedule for HIB immunizations. I mention this because these changes are appropriate if you are working as a team with your physician, and there is some change in the way medicine is expected to be delivered. If you do not recognize these changes in their payment, then you do not have a fair partnership with your physicians.

There were no contract changes in 1992, but the HMO performed some interesting data analysis. I had mentioned earlier that the plan was not tracking what was going on underneath the capitation. In 1992, the plan made a special effort to do a study of the primary care claims. All data that had been submitted for primary care services were included; the physician was required to submit claims in a "dummy" form, as part of the capitation contract. Nothing was paid in response to submission of the claim; the study was simply trying to capture the information. The study took the dummy claims and valued them using a fee schedule. The plan concluded that the services these physicians provided under the capitation were worth less than what the plan actually paid them. There are a few things you might conclude from that. One is that the plan is paying the physicians too much. The second is that possibly all the services being provided were not being submitted. Perhaps, because the physicians do not get more money, reporting claims is an administrative bother, and an underreporting problem exists. The third situation is that you are paying them the right amount and they are doing exactly what they said they did. Maybe a small profit to them under that capitation means they are managing care, which is exactly what you want them to do. So it is interesting, yet difficult, to draw a final conclusion from this information.

Another interesting finding from that same study was the existence of distinct differences in utilization patterns between the two service areas. One area had materially lower levels of office visits, EKGs, and X-rays. In particular, the EKGs and X-rays are things the physicians directly control by prescribing or ordering them, and consequently, they control the expense to a large degree.

In 1993, the plan had no major contracting changes, but was actively considering ways to expand the network, enter rural markets, and add more group practices.

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

The HMO also developed a model of a total physician-hospital capitation. We did some additional data analysis in 1993 by sorting claim costs on a per-member-per-month basis, by type of PCPs for group practices versus independent physician practices, and compared them. These are summarized in Table 1. These ratios included both fee-for-service expenses and capitated expenses plus bonuses. There was a material difference for those patients in the (in-network) medical group. In total, there is a 15% difference in cost. The group practice PCPs are 15% lower than those who are in the independent physician primary care plan. There was less of a difference in physician costs, but very material differences in hospital costs.

TABLE 1
EVALUATION OF COSTS BY TYPE OF PCP

Type of Expenses	Ratio of Medical Group Costs to Independent PCP Costs
Physician	0.93
Inpatient hospital	0.77
Outpatient hospital	0.75
Total	0.85

In 1994, the results of the plan's efforts to expand during 1993 paid off. The plan has added four new medical group contracts and one full capitation contract. In the full capitation contract, both physician and hospital services are capitated to a fully integrated physician hospital organization (PHO). As a result, the plan has developed what it is calling a limited network or exclusive network product, featuring six medical groups plus a capitated PHO. There is a small network inside of the larger HMO network, which continues to include the independent physicians.

A few other things still under consideration in 1994 relate to the independent primary care physicians, including a new formula for delivering incentive payments. The formula that is being envisioned would consider referral expense levels, which, up until now, have been the only element in the formula. In addition, prescription drug use and member complaint rates would be part of the formula. A fourth component would be a measure of the number of cases within the plan that were referred to a medical review board and had a negative outcome. If there is a positive result, the factor would not be in the formula; but if there is a negative result, an offset on the physician's incentive evaluation would be made. This brings us to the plan's current status.

We have a few ideas that might be good for questions or discussion items. Are there better ways to deal with primary care? What about specialty care? What are really appropriate incentives? Are there better ways to encourage efficiency? What do we do about patient satisfaction?

MR. KURT J.F. GIESA: How do you calculate a specialist capitation or, for that matter, even a primary care capitation, given a list of services?

MS. CARSTENS: Generally, we look at utilization by the common procedural terminology (CPT) code and multiply the anticipated utilization levels by the expected

RECORD, VOLUME 20

average cost or targeted reimbursement by CPT code. We then calculate a per-member-per-month estimate based on these products. The same process is followed for both specialists and primary care physicians.

MS. NELSON: One problem with specialty services is trying to make sure you include in the analysis all the services that you are going to capitate. For example, if you have an ENT capitation, you may want them to be doing all your tonsillectomies or adenoidectomies, but currently you have some general surgeons performing some of these services. You have to make sure that you include the utilization for those services that are not being provided by that subspecialty into your calculation. Alternatively, you might say, I only want this specialized surgeon to do the more specialized procedures. I want the general surgeon to do the basic procedures. In that case, you have to carve them out of the capitation, so the specialty capitations are trickier.

MR. ROBERT J. TROCKI: When you were talking about the 1992 data analysis, you said it was difficult to tell whether there was underreporting or overpayment. How do you deal with that problem when you are trying to set the following time period's capitation rates, particularly if you believe there was underreporting?

MS. NELSON: If you believe there is underreporting and you believe the level of expense you have is satisfactory, maybe you can go ahead and give them a trend increase, if the physicians are willing to take it. On the other hand, if you do not believe it is underreporting, I would say to my physicians, "Everything we have says we are already paying you enough, and we are not going to pay you any more." I would see how far that approach went as a negotiating strategy.

FROM THE FLOOR: If you think it is underreporting, then are you trending both for the cost and the utilization increases that you expect?

MS. NELSON: Your question is, would you trend both cost and utilization?

FROM THE FLOOR: Right. If you have underreporting, then you may have some actual trend that you want to apply to the utilization piece of it. There is also an implied piece, if they are underreporting, to make up for that underreporting.

MS. NELSON: There are two things. First, are you going to take your current capitation and increase it by a trend? Second, do you take your experience, where you think there is underreporting, and put a trend on top of that to build your new capitation? It depends on what you are using as your starting point for the increase.

MR. ALAN N. FERGUSON: What about risk pools or risk maximums? For example, one plan that we have has a capitation limit in place of \$60,000 per patient. What we do is figure out how much we are paying on a fee-for-service basis, or an equivalent fee-for-service basis. If that amount should exceed \$60,000, then we start paying on a fee-for-service basis beyond that. Is that what you were talking about? Would that apply to either the physician, who is currently capitated, or to the hospital?

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

MS. NELSON: The types of limits I was talking about are on internal risk settlement. Those referral and hospital claims measured against the \$5,000 or \$10,000 target were all being paid fee-for-service to the specialist for the limit set in place. If you have a full capitation and a threshold on it, the calculation you are describing is a calculation of what has been provided on a fee-for-service basis. This is exactly what you would have to do. You would have to prospectively agree on the basis to be used to evaluate the services.

FROM THE FLOOR: What about administrative services only (ASO) arrangements? One of the problems that I found in developing a plan that is acceptable to employers is the idea of setting a target. If the plan does better than the target for that particular employer, generally you could recommend that there be an additional payment by the employer. In other words, the employer is being billed for the charges as they are being incurred. Then the problem arises that, if the plan does well, you are asking for more money from the employer. An easier way is to have a withhold and share the withhold by paying some of it back to the employers when experience is not so good, or vice versa. Do you have any comments on that?

MS. NELSON: I think what is most typical in an ASO arrangement is that, if there is a primary care capitation, the employer is usually willing to accept that as an expense charged directly back. The rest of the services are usually paid on a fee-for-service basis. There is not usually a three-legged settlement between the plan, the providers, and the employer. The employer's argument typically is, "Don't tell me that it is the physician who did a good job of managing my employees. The truth is that my employees are healthier, and that should have been their expected cost." The way it usually works is that services are on some sort of a negotiated or a discounted fee.

MR. TIMOTHY J. ALFORD: On your 1993 data analysis, what was the split of the 40,000 members between the ones that were independent versus the medical group? Was there any adjustment or any stop-loss level placed, especially on the hospital side, for the numbers you gave? A group of 40,000 members is relatively small to be credible.

MS. NELSON: I agree it is small. Inside of the medical groups, there were probably somewhere in the neighborhood of 8,000-10,000 members. The hospital claims were not adjusted for catastrophic expenses.

MR. ALFORD: Did you have any catastrophic claims that would have an impact on your ratios to make the results less meaningful?

MS. NELSON: We do get large claim data from them because we also work with them on their claim liabilities. In the last several years, I know they have had one very, very large claim. However, I do not believe it was in this particular experience period. I can't say for sure that it was not a factor in any of those numbers.

MR. KENNY W. KAN: You mentioned the use of CPT codes. Although it may not be applicable to your present HMO client, how would you adjust capitation rates for workers' compensation, Medicaid, Medicare, and state laws, especially with regard to minimum loss ratios and other risk classification categories, such as area factors and age/sex differences?

MS. NELSON: I don't think the loss ratio is an issue. We are paying a capitation that is a subset of the total premium. It is a piece of expense that is going to count toward your premium, and that is a separate question. With regard to the other populations, you would try to project utilization for that particular population. Certainly more data exists for a commercial population; less exists on Medicare. If you are in the situation where you would need a capitation for Medicare, as an HMO doing a Medicare risk contract, there are very specific ways the cost projection can be done that tie the commercial and Medicare rates together. Medicaid would be approached in a similar way.

MR. KAN: How do you balance the delicate act of juggling considerations in developing your capitation rates with respect to actuarial soundness, reserving methodology, and marketplace competitiveness? For example, if you have a conservative reserving methodology, obviously your capitation rates would be very high and may not be very competitive in the market. As an actuary, one needs to ensure that the rates are viable. How do you strike the right balance?

MS. NELSON: If we have a capitation, we are going to fix that piece of the expense. Essentially, you are transferring that piece of risk to the physicians. As an insurer, you no longer have that risk, so you are not going to be reserving for that piece of expense. You might want to be concerned about reserves being maintained by the provider. They are directly responsible to pay for services for which they are at risk, but which they cannot provide in-house.

MS. CARSTENS: The whole issue of whether or not there should be a reserve held for capitated services is a big issue right now, but it does not become the insurer's risk anymore, or the insurer's liability; it becomes the provider's.

MR. MARK F. HOWLAND: We ask our female subscribers to choose both a primary care physician and an OB/GYN; we have capitations for each. However, we find that a lot of the OB/GYNs perform services in addition to OB/GYN services, and some PCPs perform some OB/GYN services. There is some overlap that varies by provider. Without customizing capitations to each particular provider's habits, we are finding that providers do not want to provide services if it is not in their capitation. We are finding that setting the capitations is changing the practices of providers. Any suggestions for avoiding that conflict?

MS. NELSON: I do not have any good ones. You could say that, if you are a family physician and you want to provide this service, then do so. However, I think you have a problem with your patient who says, "I do want this physician for a family physician, but I also want an OB." You are in a situation where the capitation that the physician gets paid is a function of what the patient wants. One situation you could use for female patients in a certain age range is not to pick two primary care physicians; let them pick the OB as a primary care physician, and assume that the OB is going to make appropriate referrals. I am not sure the dual primary care situation creates a real benefit.

MR. GEORGE CALAT: I have a basic question on your 1993 analysis. You showed the 15% lower cost for the patients affiliated with the group practice. What are some of the basic reasons for that? I assume everything else is standard between

PAYING THE DOCTORS BILLS—HOW IT CAN BE DONE

the two sets of patients, as far as the capitation levels. What is your conclusion on why this 15% difference occurs?

MS. NELSON: I think the difference is that, inside the medical group, there is a physician managing referrals and hospital admissions. That physician is very, very particular about deciding when people should go in the hospital, so hospital admission rates are significantly lower. I did not show it, but we had two years of data on one of the medical groups. In one year, they were both significantly lower than the primary care or the independent primary care physician groups. However, the second year there was a bump for one of the groups. I spoke with the plan's medical director about that. His response was that during the first year, where the numbers are dramatically lower, there was a physician in place. The second year, there was not a physician in place the entire year. Part of the time, the utilization review (UR) program at that clinic was run by a nurse practitioner, and the utilization went up. The plan believed very strongly that it was a result of the lack of strong physician control.

MR. CALAT: Does the HMO help in any way to facilitate that control? Does it provide medical protocols of any kind? Is it per practice? Does the HMO do all that on its own?

MS. NELSON: The HMO has utilization review requirements for its independent physicians, but I believe the plan allows the medical groups to do all the referring and utilization management themselves. My understanding is that the HMO has not been involved in setting protocols for either its IPAs or medical groups.

