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THE ABCs OF HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND PHYSICIAN HOSPITAL ORGANIZATIONS (PHOs)

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This session will teach the ABCs of HMOs and PHOs. Many actuaries are not knowledgeable about the basics of HMOs and similarities to PHOs.

MS. LYNETTE L. TRYGSTAD: As everyone knows, there has been a very high level of interest in managed care over the last few years and certainly in the current political environment we think that is going to increase. There are two areas that we think are going to be increasing: the formation of new HMOs (in which we predict there will be a high level of activity) and from the provider perspective, the development of PHOs. Jeff Smith is going to give you some introductory information on HMOs. Jeff is a vice president of Actuarial Services at United Health Care. His background includes 20 years at the Blue Cross Plan at Columbus, Ohio. During the last five years, he was the chief financial officer. He then went to PHP of Ohio to form a managed care insurance company, and when he had done the job correctly, United Health Care came in and acquired him. He now works for most of the United Health Care Plans by providing medical cost analyses, trend projections, and some compliance work; he also supports their underwriting department.

After he has finished his presentation on HMOs, I am going to present a section on PHOs. I am a consultant with the firm Reden & Anders in Minneapolis. We specialize in health care consulting primarily in the managed care market. When we started four years ago, that was not the case, but it has grown steadily over the last few years. The other aspect that has grown steadily is what we do for providers. I started out as a life insurance consultant, and after I finished exams and had two kids, I said, well, now what is there to do, so I switched to health insurance consulting, which I have been doing for seven years.

John Stiglich is also from my office. He is an ASA in the Society and I found out he has never had the pleasure of being a recorder. I could not deny him that experience. Also, I want to just warn you that this is geared as an entry-level presentation and we are going to start out at that level. If we use some terminology that is not familiar to you, please call us on it. Also, if there is more you want to know in addition the basics please bring it up at the end of the session. We would be happy to talk about those kinds of issues.

MR. JEFFREY L. SMITH: As Lynette said, we are going to at least start out with some of the basics and some introductory, preliminary information, but we will leave plenty of time for questions if you want to elevate the discussion.

How many of you work for an HMO? (One.) I knew that the number would be small, but I anticipated more than that. Back in the early and mid-1970s, when I was involved in starting up an HMO from scratch, there really were not such things as managed care actuaries. Kaiser had economists, marketing people and financial people, but as far as I knew, it did not have actuarial talent and staff, and there were

few HMO actuaries involved in the other start-up operations. They did not have the money because they were not large enough, and, there was not a body of knowledge that could be classified as HMO actuarial expertise. Although, as we will hear, that is rapidly changing and there are quite a few staff actuaries as well as consulting actuaries who are primarily, if not exclusively, in managed care work. That is how things have changed over the 20 or more years in which HMOs have been growing. Even though Kaiser has been around for probably 40 or 50 years, the real emphasis on HMO formation really started in the early-to-mid-1970s.

So let us talk about the four major characteristics that describe an HMO. One of the things that you think about in concert with an HMO is a provider network. Provider networks can be very narrow or very broad depending upon the model and the nature of the HMO. Related to that is the provider contracting mechanism. The second major characteristic is, as the name implies, promoting health maintenance and prevention rather than reimbursement for claims, losses due to illness and disease. The third major characteristic is utilization controls and the fourth one is the actual organizational structure itself.

In the early 1970s, when the HMO Act was passed, it created the concept of an HMO at the federal level and states created their own levels of enabling legislation giving both privileges as well as responsibilities and regulation for formation of HMOs. HMOs were formed primarily as non-profits, and especially in those early years were sponsored/owned by either hospitals, physicians, Blue Cross/Blue Shield plans, or freestanding entities that were sponsored by coalitions or joint ventures, etc.

What I would like to devote my comments to is how HMOs have changed from the 1970s to the 1990s and especially what those changes mean for actuaries. First, let us look at provider networks. Originally, and I use the word originally meaning back about 20 years ago, the provider network was identified with the delivering model of the HMO. In other words, a staff model and group model HMO generally had a different provider network characteristic than an individual practice association (IPA) model. Group and staff models, as the names imply, are either a group of physicians that the HMO contracted with, or on a staff basis, they were, by definition, employees of the HMO. In an independent practice association the HMO contracts individually with hundreds or thousands of physicians.

There has been a great blurring of definition of managed care organizations. Managed care organizations and HMOs were interchangeable terms 20 years ago. Now they are certainly not interchangeable terms. I use the word health plans to include HMOs, PPOs, Exclusive Provider Organizations (EPOs), and PHOs. I don't know what other acronyms we can define, but the point is that the characteristic of the provider network has changed quite a bit and it is probably most indicated by the open networks or the point-of-service products. The HMO, as it originated, was one of several alternatives offered to employees of larger corporations. That is how the marketing mechanism started and because of the limited nature of some of the HMO networks, they could not be a replacement for the commercial insurance product that the employer offered to all the employees. There were many actuarial implications such as risk-pool splitting, the inability to really predict the enrollment levels and risk characteristics that created many of the problems for HMOs. We got into shadow pricing and other things.

With the impetus of carrier replacement strategies (that is, the managed care organization enrolling all of the employees rather than just a specific subset) some mechanism had to be provided so care could be rendered to those people who went outside a limited network. So the provider networks that are associated with the managed care organizations have certainly changed. Lynette will talk about PHOs so I will not spend any time there.

Integrated service networks are also relatively new. I am most familiar with Medica, the half million member HMO, and Health Span, which is a consortium of a number of hospitals that are going through a corporate merger. They will be both a vertically and horizontally integrated system of health care delivering and financing and administration; everything will be rolled up into one corporation. It is called an integrated service network, and it will be interesting to see how that figures over time.

Let's discuss provider contracting. Twenty years ago, in the original contracting mechanism, facility contracts were negotiated as discounts off of billed charges. The physician component of group and staff models generally were capitated. IPAs were saddled with fee schedules and those fee schedules also generally had withholds of as much as 20% or 30% in order to provide some residual capital to the HMO if the utilization exceeded the expectations in the premium developments. We are moving more and more away from those limited types of reimbursement. I will use the word risk arrangements for something that is quite a bit more diverse. This is something we can follow up on in the question and answer portion because there are so many different types of reimbursement and risk-sharing mechanisms.

One of the reasons why HMOs stayed with discounts from billed charges rather than going with diagnostic related groups (DRGs) when they were introduced, is that DRG reimbursement rates were usually calculated based on average levels of length of stay. Because of utilization controls and case management, HMOs' lengths of stay typically were significantly lower. So it cost HMOs, which just reimbursed at a commercial amount or some discount off the Medicare DRG payment, more money because they were paying more out in DRGs than they would on a discount off of billed charges basis. Movement is going now toward a per-case or per-stay type of reimbursement. In some cases reimbursements are a combination of medical, surgical, obstetrics and even neonates under one per-diem or per-stay rate with some provision for outlier utilization. In many cases, the contracts are also on a multiyear basis instead of one-year contracts. There are three-, five-, seven-, and nine-year contracts either with fixed escalators in terms of percentages or fixed escalators in terms of the index that is used to moderate reimbursement from year to year.

Fee schedules are still there in IPA model programs. There has been more constraint and the fee schedules were modified with the resource-based relative value scale which has provided more incentives for primary care, (i.e., higher reimbursement for primary care physicians). In the 1970s, in a group or staff model, there was one capitation that was for all of the noninstitutional care that was rendered. Now we are seeing capitations being divided up into many different components. In IPA model plans, primary care is still reimbursed on fee for service, but specialty care is capitated with a different and narrower configuration network.

We also have introduced the gatekeeper concept where the primary care physician has some responsibility for the care delivered by the specialist. Because of the resource-based relative value scale (RBRVS) and the sensitivity of the specialist who has a primary care physician who is not knowledgeable of that particular specialty directing the care of that member, we now have what is called a care manager. Either the primary care physician or the HMO contracts with one specialist to coordinate the care and direct the patients to all the specialists within that specialty category. That is just another area of refinement in terms of both reimbursement and risk sharing and network configuration.

Let us talk about utilization controls. In addition to provider contracting, the other thing that enabled HMOs to succeed and other managed care organizations now continue to succeed is control of utilization. Initially, utilization controls were (and still are in some cases) considered a big hassle. Precertification of admissions was probably the first effort to control utilization. With the claims adjudication there was also a retrospective nature of utilization review where comparisons with the discharge diagnosis and the admitting diagnosis were compared. If there were any disagreements and there was no management plan in place and the diagnosis changed there were retrospective penalties. Providers do not look kindly on retrospective penalty. As a result, those things are going by the wayside. There was fairly limited concurrent utilization review. The big hammer on utilization for those benefits where utilization review was a little bit more difficult or controversial is just to put benefit limitations on particular parts of the benefit program. As we move now from utilization review into care management, we are trying to do more provider profiling and look at the outcomes of care that are rendered both from a cost and a quality standpoint. Instead of being a policing entity up front, we look at the financial and health quality effectiveness of the provider at the tail end and not get in their way at the front end. Let them do their business but hold them accountable for the results of their delivery of the health care services. That is what we are going to see as the centerpiece of utilization/financial controls in managed care organizations.

Structure and accountability. I said that initially the formation of HMOs were primarily nonprofit or through some sponsor organization. We have seen, certainly in the last five years, a significant amount of market consolidation where the smaller HMOs have been acquired by larger HMOs. There's certainly a number of very large, publicly held HMOs or management holding companies that own or manage HMOs. I happen to be the employee of one of those. I do not want to indicate that there are no more nonprofits because there certainly are quite a few, but the nature of that landscape and capital needs are changing. Capital needs were initially required to gain market share. Capital needs now are more often required for data. The information processing systems that are necessary to support the needs of solvency regulation and our needs as actuaries cost money. Only the larger organizations that are fairly well capitalized can afford to develop those data systems independently. Others have to rely on either affiliations or purchasing or leasing commercially developed software.

What are the implications for us as actuaries? As we have moved from fairly defined networks and fairly defined reimbursement and risk structures, the data needs become critical. As we look to capitate specialty care or capitate beyond what the traditional group or staff model HMOs have done, we must realize that one of the real bug-a-boos of providers is the paperwork. As providers want to get more and more

at risk as they do under PHOs, one of the things they are requesting to do is not submit paperwork. Some of the larger groups want to do their own claims processing and reimbursement to the specialist and not go through the managed care organization. While that seems efficient from their perspective, from our perspective, unless they are required as part of the agreement to continue to send encounter and claim information, we wonder what happens to our data. It disappears at times when we are really saddled with the planning, solvency, asset/liability issues, pricing, and providing increasingly complicated financial reporting mechanisms to employers. Those of you who at some time down the road may consult either on behalf of providers or on behalf of insurance companies or managed care organizations themselves should realize that the data-needs requirements are going to get tremendously more complicated and essential. As far as outcomes research, we cannot really identify and quantify the financial aspects of the different methods of care delivery if we have no data to support the outcome.

Carrier replacement strategies are becoming more and more threatened under a Clinton-type arrangement where there are two or three, or four accountable health plans that are mandatory to be offered through Health Insurance Purchasing Cooperation (HIPCs). It appears that we are going back now to those attributes of risk pool splitting that were effective 20 years ago in a dual-choice or multiple-choice environment. This is another reason why data needs are extremely important.

MS. TRYGSTAD: I am going to be presenting physician hospital organizations and giving you a little bit of background rather quickly on some aspects to consider when you think of a PHO. I will then get into some elements of a typical development process and some of the issues to consider once you are into an implementation phase. We will also review some key issues to watch out for when these organizations are starting up in terms of their ability to be successful. Finally, we will end up with some issues on how actuaries fit into the process.

A key question many people ask is why are these organizations starting up? Why are they becoming so popular? I can tell you from my experience that there is no end to the possibilities of these organizations. I also think it is primarily driven by the political environment. Everyone wants to know what this means to them, "Managed care is coming and I have to be ready." There was an article in *Hospital Management Review* in April that had 60 case studies. It reported that integrated delivery systems produced the following advantages: They improved hospital performance, not only in terms of market share but also in overall profitability. They produced cost-effective care. They gave at least the same level or higher level of dollars to primary care physicians. They improved patients' quality of life. Finally, it allowed the organization to be well situated to adapt to a changing environment. This is a rather rosy picture of the environment for PHOs. You will see at least as many articles saying that these things are doomed to failure because they are starting for all the wrong reasons (that is, they're defensive).

Physician hospital organizations provide integrated health care. It is a structure by which the physicians and the hospitals work together in delivery of care. This may sound like a very simple thing but it is not. These two parties are not used to working together. They maybe do not even like the idea of being in an arrangement with each other. It provides them the means of doing collective contracting as a

single organization either directly to a health plan or directly to employers. To many of them their ideal is to eliminate the insurance company middleman.

Another reason for their popularity is defensive posturing. The providers see these organizations as a means of preserving or maintaining their ability to regain control of their profession and to have autonomy. Some of the things that Jeff discussed make it a little less difficult for doctors to work with an insurance company if insurance companies try to be less dictatorial towards them and how they practice medicine, as well as control or having a say in what their financial incentives and compensation will be. Ideally, they are going to provide managed care. But the problem with saying that is what does managed care mean? To a lot of people, it means that you have precertification. Almost all contracts today have precertification, but this is a very rudimentary level of managed care and maybe does not get you very far in terms of both efficient and cost-effective care.

As you move up the continuum you move towards discounted fees. Again, it is an early level of HMO development in which you at least cut back on the cost of the care whether you are providing the appropriate care or not. Then you get into authorized referral which is a euphemism for a gatekeeper where you, hopefully, will eliminate some of the inappropriate care for the specialist. As you move up into capitation a certain level of care must be managed for a certain fixed dollar regardless of whether the patients are seen in a certain time period. Generally when you operate under a capitation it means that your utilization has to be more efficient in order to get you back to the same level of compensation that you had prior to capitation. One way to do that is to eliminate inappropriate visits, but another equally important way is to look at how you can be more efficient. Maybe this means that you hire physician assistants or nurse practitioners.

Managed care, as it is used today, generally means that we are pushing more and more of the risk onto the providers in an effort to align the incentives to get efficient health care services. At the one end (where the environment has been traditionally) is fee for service. The only risk here for the provider is that the reimbursement he gets from the health plan is not equal to his charge level. If he balance bills the patient for the difference, there is not much risk. The middle level is an organization that is just getting into capitation. There is much uncertainty and skepticism on the part of the providers so maybe there is a willingness to set-up capitation with a fee-for-service guarantee underlying it. And as you move towards full capitation at a higher level of risk, there is no fee-for-service guarantee. You must control efficient care within the types of services you may be risk sharing with the referral or hospital pool.

At one end you have the employer/employee going through the health plan. The health plan contracts with the PHO. The health plan must also provide for nonparticipating providers because no organization can provide all levels of care. They might not have a chiropractor. They might not have an oncologist.

This structure might not be there. The organization instead might be that the PHO pays for the nonparticipating providers where the health plan is essentially maybe capitating the PHO for all services as a percentage of premium or something and the PHO has to arrange for the delivery of the care outside their network.

There are different parties within the PHO. There is the board itself and then the Management Service Organization. That is an organization that may or may not be separate. If it exists, it is providing practice and administration support to the providers or maybe just to the physicians and not the hospital. Then there is utilization review. Whether the providers do it all or not they will want to have a say in what is done. Maybe it is actually done through the health plan, but the providers must feel an ownership of the process.

In another case we can eliminate the health plan and say that the employer is directly contracting with the PHO. The only other difference in this case, because the health plan is gone, the PHO needs to provide all those types of services that the health plan normally does like claims processing, billing, and marketing. While insurance companies are used to thinking in these terms, this is a totally new field for the providers.

We are going to discuss the development process. Funding of a feasibility study is usually done by the hospital. It is easier for them to raise the money. They are also used to thinking as an institution and thinking of business plans whereas physicians are out there to practice medicine. Once you get into the implementation phase, however, you must have all parties contributing to the funding, hospitals and physicians, and at least in the startup you would probably need some type of a loan arrangement.

Who develops it? Obviously, if the hospital's funding it, you must get the hospital and its board involved. Sometimes it is the physicians, but whether they are the instigator or not, if you do not have physicians in the development process, I do not think it is going to be a successful organization. They typically bring in a team of consultants to help with strategy or management, marketing, actuarial, and, of course, legal issues.

I allot a minimum of three months for development, and I feel that is extremely optimistic. I have a question mark on the maximum development period because I think it could go on forever. It will depend on the motivation of the group and how well they get along. If there has been a threat of a Kaiser plan moving in your backyard, you are pretty motivated and you are going to do it quickly. If the only reason they do it is to establish a forum to get together monthly, or weekly, and talk about what is coming then the process is going to take forever. If you stay on target it is probably going to take nine to twelve months to develop the organization just in terms of getting the right things done and making everyone comfortable with the idea. As part of the feasibility stage you are going to do a market assessment in terms of the population you are dealing with and the competition in your market.

Another important phase is employer interviews. Usually you are going to target large employers. They often want to eliminate the insurance company and they can directly contract with the self-funded and large employer. When you deal with large employers that have multiple locations you must ascertain whether the person in your particular region has the decision-making power to buy health care. Oftentimes a *Field of Dreams* kind of discussion takes place where you must decide, if you build it, will they come?

Then, of course, you have the physician interviews. You want to find out why they are there. What is their view towards managed care? What are their concerns on reimbursement strategies? Are they interested in going towards capitation? Are they interested in using only fee for service? Are they there only because they wanted to know what is being done and maybe thwart any activity so that the organization is not started? Hospitals and physicians are not natural parties to form this alliance, and they need to work out what they would be comfortable with.

Then we get into provider reimbursement issues. The organization should be making basic high-level decisions. What type of reimbursement is it interested in? Is it a maximum fee schedule or is it capitation? What level is it going to be at? Is the group you are working with perceived as a higher cost group that the community is willing to pay for? Do they need to reduce their charge levels to get down to what somebody in a different marketplace is willing to pay? This discussion should clarify their market position. Ultimately, it needs to determine the impact on a provider-by-provider basis. In my opinion, the detail is evaluated all too often at too early a stage when it probably should be delayed until later in the process, after the higher level decisions have been made.

You also need to look at business plan performance and express your strategy in a written format. At this point there is probably a decision whether to go ahead or not go ahead and what form the PHO is going to take. We also get into some of the implementation issues. One of the biggest is the structure and governance of the group. Because of a natural distrust between the parties, there is equal board representation for both the hospital and the physicians. Sometimes they will be separate so that you have a physician organization set-up which then forms into the PHO.

The PHO, the hospital, a physician group practice, or an individual physician can be the owners of the PHO. The PHO is the one that does the contracting either directly with the health plan or with the employers.

Another organizational approach has the physicians organized into an IPA or a PPO first before joining the PHO.

The last example of a PHO structure is called the foundation model. This model is gaining a great deal of interest. The foundation model in legal terms is a 501(c)(3) trust which means it is nonprofit and tax exempt. The hospital and the group practice would be corporate members of the foundation. The foundation owns all the assets of the members and agrees to provide care through the foundation.

They also need to make staffing decisions to set-up the infrastructure of the organization. The most important one is the executive director who ideally would have been an acting person during the development stage. They should have an insurance background or maybe a hospital or contracting background, and the ability to work with people and get them to work together as an organization. They need to find the medical director. They might need other staff members in such areas as utilization review or billing. They need to look at all the typical insurance services or systems.

They can either make their own medical guidelines or obtain them. There are organizations that sell guidelines or they can get them from their particular college specialty of practice. You get greater buy-in if you develop your own or modify some that you get. It might not be practical from a time standpoint to develop your own. Above all, whatever they come up with, you have to decide ahead of time what your ability to monitor them is. If you set up a guideline and never evaluate whether you have achieved it, you are getting nowhere.

Then you get into the provider payments. This is very much like what Jeff went through in terms of discounting fee schedules or capitations. A key feature for the providers is understanding when they are big enough for risk acceptance and what they are getting exposed to in accepting risk. There is a balancing act between getting into capitation when the size is too small to be predictable with a high degree of confidence, and minimizing the exposure through a small membership so the dollar amount lost is not as large.

There are different ways of paying providers with either an incentive or a penalty approach. A penalty approach might be the withhold type of approach. An incentive might be a bonus approach tied to patient satisfaction surveys. There is also the whole idea of risk pools and risk-sharing between different kinds of providers.

Some PHOs decide this is the way medicine should be practiced. In that case they might decide to file for an HMO license to get the certificate of authority in which case they need to do such things as develop underwriting guidelines and rating methodologies.

One of the issues you need to watch out for when developing a PHO is distrust between the parties. Disruption in the process can occur between not just hospital and physician (because ideally you are going to be reducing hospital stays) but also between the primary care physician and the specialist because you may be disrupting traditional community referral patterns. The worst case scenario is if you are in a relatively small community and there are not enough PCPs or there are not enough doctors in general. Initially, it is highly unlikely you are going to end up in a gatekeeper model in that kind of environment. You need strong leadership during the development process and it needs to come from both sides—physician and hospital.

You need to determine what the market wants from the consumer standpoint. Maybe they are totally uninterested in a network that does not allow them to go to outside providers. You need to educate the providers in what it means to accept a risk. The physician commitment is required throughout the process. If you set-up a structure where it only cost the doctor $200 to join this organization, he would be a fool not to join. So he joins but it is unlikely that he is really subscribing to the philosophy of the group. And as Jeff mentioned, setting up a network is very expensive and you need many systems to do things right. They should be aware that this is probably going to cost them a great deal of money in terms of claims management systems, utilization review, referral tracking, utilization protocols and outcomes analysis.

Jeff mentioned that it is important for physician hospital organizations who want to do their own claims processing to keep their data. From the provider standpoint it is

equally important that they have an ownership of the data, particularly if the health plan is going to capitate them in some manner. The health plan no longer carries the risk and maybe there is a certain fear of them not caring enough to do what needs to be done. As a result, the providers need to have that same data. In many ways, when you form a correct, fully managed care physician hospital system, you have all the aspects of a health plan whether you actually have the health license or not.

I wanted to close with some of the actuarial things that we can do. The most important one is that we need to educate the providers. One of the speakers at another session said that providers are becoming aware that there are actuaries and they need actuarial input. However, oftentimes they do not know what we do. They do not know what it means when we give them information and they do not know exactly what it is they need from us. We need to educate them in terms of their risk and in terms of the terminology. Some do not understand what a capitation is. Others do not fully understand what conversion factors are. Many of them do, but you always have to start at a very basic level until you find out what the group you are working with understands.

There is also a big issue related to relying on the actuary. Many providers think we own some kind of crystal ball. We do our detailed statistical analyses, but there is no way of knowing how it is going to turn out at the end of the year. They need to have an understanding of how much results can vary.

Contract evaluation is not just an up-front analysis. You need to help providers research through proposals and translate them into charges. There is also ongoing evaluation. The fee schedules are going to change from year to year. If there are incentive pools to be paid out, how should they be allocated between the different providers? There is also a very big market for provider reinsurance.

We would like to open the discussion up to questions.

MR. STEVEN P. ZOLDOS: Under the PHO model where the health plan is eliminated, would they be able to market to a small employer base in a large city, and if so, how would the state insurance department fit into that picture?

MS. TRYGSTAD: I think that might vary by state. I would recommend against it. I think there is too much volatility for them to deal with if they are not anticipating that in their capitalization structure. Many want to do that especially in the smaller areas. It is a big potential market for them but it is a very risky market and they need to understand that.

FROM THE FLOOR: Could you talk about HEDIS and what it is and also what the acronym stands for?

MR. SMITH: It is the Health Employer Data Information Set (HEDIS). It is a joint venture of a number of organizations to provide some uniformity on what the data elements are that are going to be collected in order to do the outcomes assessment. It encompasses a wide variety of things including employer/employee satisfaction with the benefit plans. It includes claim and diagnosis information so they can track people and look at survival rates of transplantation, for example. It is a fairly broadly defined

vehicle for data collection, and it is my understanding that they are in either the second or the third evolution of what that data's going to look like. It is essentially going to provide both employers and employees an information set that they can use to evaluate which health plan they want to join in a multiple choice environment as well as perhaps whether they want to go to a particular hospital where their surgeon is going to admit them for a particular procedure. So it is an informational tool for the patient as well. Does that get to your question?

FROM THE FLOOR: Is it providing primarily customer satisfaction or provider efficiency data?

MR. SMITH: It was mainly put together for provider outcomes data. Member satisfaction is an important thing to consider, but one of the primary motivations was to be able to perform outcomes research and get outcomes information on the medical and financial efficacy of medical care delivery.

FROM THE FLOOR: I am wondering at what size providers start looking at an HMO or a PHO type of arrangement. Would it be a small group? When do we start?

MS. TRYGSTAD: What size do they look at it for?

FROM THE FLOOR: Would you look at dollars or how many people are in an area when you start considering an HMO or a PHO?

MS. TRYGSTAD: I will talk from the providers' perspective first. There is a wide range of thoughts on how big you should be to be fully capitated. You can obviously be a PHO at any size if you are going to be paid fee for service. If you are going to accept risk and have some predictability on the cost, I have seen a great deal of commentary that at the primary care level you should have between 150 and 500 members. It is a wide range so it tells you that people do not necessarily agree. As you move into specialty categories, you are going to see a need for more members before you can accept full capitation and that will depend on the specialty. If you are an obstetrician/gynecologist, you need fewer members than if you are an oncologist. It is probably between 1,000 and 3,000 members, and I would give the same kind of range for a hospital capitation.

MR. SMITH: I think much of that depends also on the level and degree of risk that the plan has the capacity to accept. For example, for an HMO or a health plan to be stable (I use stable in the context of being able to maintain an adequate level of surplus), the numbers are in the 20,000–30,000 member range. Obviously, for a PHO, if they have adequate reinsurance for transplant cases and the AIDS cases and all those other things that as a health plan you need surplus for, then certainly the numbers are going to get down into the range that Lynette mentioned.