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"SHIFTING RISKS"—WHAT'S NEW IN MANAGED CARE

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The panel will provide an update on current developments in the financial transfer of risk under alternative managed care arrangements. The panel will also discuss the emerging issues with respect to capitation arrangements.

MR. DENNIS J. HULET: I'm a consultant with Milliman & Robertson and I manage a practice that I characterize as a healthcare management practice. It includes about a 50/50 mix of actuaries and clinicians, both doctors and nurses. With me is John Price, an actuary for Intermountain Healthcare, also known as IHC Health Plans, in Salt Lake City. He's been in that role for quite some time. He's in the trenches and is trying to prove that HMOs that include an actuary in senior management are better than HMOs that relegate the actuary to the role of ratemaker. Next is Nancy Nelson, who works as a consultant with Towers Perrin. Like me, she has no operational assignment, but tries to use her broad experience in the managed care industry to advise clients so they can make good decisions in their operation of healthcare plans.

According to an October 17, 1995 issue of *USA Today,* 20% of the U.S. population is covered by an HMO plan, and 63% of employees covered by health plans are enrolled in HMOs or other managed care. It also states there's been an increase from 2.7 million Medicaid members covered in managed care plans to 7.8 million. The article says there's an average cost per worker covered of $34.85 for HMOs and $38.50 for traditional indemnity plans, about a 10% difference on the average between the costs. It also indicates that there are 56 million total members in HMOs right now compared with 9 million in 1980. So there's been tremendous growth in managed care, and I think that growth has changed the traditional role of health insurance actuarial work.

There's also a comment in this article that I think pertains to some of what we will discuss here. It says New York pediatric neurosurgeon Fred Epstein is concerned about how he sees many HMOs operating. He says, "Their priorities are backwards. Their priorities are cost containment. Their CEOs are making millions of dollars a year. They are simply looking at how to make money on healthcare." He continues, "HMOs can be a deal if you have a common problem," but, he says, "they're often incapable of meeting specialized needs." Then luckily the article redeems HMOs by adding this comment. "But for all the attacks on HMOs, the recent analysis in *The Journal of the American College of Cardiology* shows quality of care may be on par with traditional plans. The study of 8,000 heart attack patients found those treated in HMOs and traditional medical plans fare almost equally well in the short term even though HMO patients were half as likely to undergo costly angioplasty." That last comment I think is what brings us here to talk about shifting risk. If we can shift the risk and make better use of health resources, then we can provide high-quality care at a lower cost.

We'll start off with John Price's comments on the operational aspect of HMOs, then we'll hear from Nancy, and I'll follow up with my comments, some of which may be offensive to actuaries since I think we're part of the problem.

MR. JOHN A. PRICE: I'd like to talk about two specific examples of what our company is working on in the area of shifting risk. But first, I will talk briefly about the objectives and what's needed in this process. As I look at it, the major objective of these managed care arrangements is to create sustainable improvement in cost and quality. The solutions to meet that objective are, obviously, not easy. On a broad basis each participant in the financing and delivery process should be "at risk" for the part that he or she can control most. Second, each participant could realize financial gain for desired outcomes. So physicians, who may even complain about managed care intervening in their medical practice, may also be complaining that they don't have enough to gain out of the arrangement and that they may have been left out of the decision loop.

Two resources needed to achieve the objective are to have comprehensive information available on a timely basis and in a useful way to each participant. That's a resource not always available, certainly not traditionally. Managed care tries to focus on this area. Also, providing appropriate incentives for each participant to act on the information available is a critical element in the process.

Let's take a quick look at who the major participants are in the process. They are the employees and covered dependents, employers, insurers, plan administrators, hospitals and other specific resource vendors, and physicians. What can each of these participants control most? Employees and dependents can control when and where they access medical care the most. Employers' decisions and ability to control healthcare mostly fall in the area of plan design, network selection of insurer or plan administrator, and determining that portion of plan costs that will be the employer's versus the employee's. The insurers and administrators control most of the infrastructure to provide service to the enrolled participants and execute the plan design of the employer and, also, to incorporate in varying degrees and varying ways, the managed care concepts that have evolved. Hospitals control most of the resources they render and the accessibility of those resources—where they're located, what hours they're available, how many different types of resources there may be and, of course, the actual cost to deliver the service. Physicians enjoy an unusual position in that they are the experts of the process. They determine the process of care from the point of evaluating symptoms, diagnosing disease, determining interventions, and then monitoring those results to see that appropriate outcomes occur.

I'd like to cover the first and last of these participant areas as examples of where we are currently focused. For employees who can determine when and where to access care, we are providing a service that we refer to as demand management services. As to the physicians, we are developing mechanisms to both report on and motivate physicians based on episodes of care. In the first category, demand management services, the focus is primarily on the employee and spouse. I'd like to describe to you the features of a demand management service. They are to triage the employee's and dependent's access to healthcare services, that is the emergency room, urgent care, primary care and, also, provide the office appointment scheduling service in that triage process. It can also educate employees and dependents regarding prevention of disease, wellness programs, what to expect in the management of a disease and, also, answer questions about the plan design and the eligibility rules of the plan in which they participate. This latter point, obviously, requires a high degree of integration between the plan administrator and the demand management service, particularly, through computer systems.

The demand management service might also include what's called *outbound calling* which can be used to promote the education of the members in healthcare topics, prevention of disease, wellness, and clinical compliance as a followup to a process either initiated through the demand management service or from the physician's office. This service is commonly known as a 24-hour telephonic access service to a healthcare professional such as a registered nurse. The healthcare professional on the phone will provide advice based on clinically developed algorithms or protocols in response to the symptoms indicated by the caller. This resulting advice is based on algorithms that have been developed with the physicians who are managing the process of care.

The telephone encounter itself is documented electronically for purposes of maintaining a record and managing liability. The process is close to the practice of medicine but does not involve clinical diagnosis. Rather, it advises a person to better respond to the symptoms he or she has. The documentation can be used to update individual physician records. Once the encounter is closed, the information is passed back to that person's physician indicating the nature of the symptoms and the advice given. The next time that physician sees the enrollee, he or she has information in their medical records about that encounter and can assimilate it with the patient's other clinical information. Telephone encounter information is also communicated to the plan administrator whom some benefit impact or plan administrative impact may need to be recorded. I'll talk about that later.

The outcomes of the encounter process are monitored. There may also be outbound calls to determine customer satisfaction or what action a person may have actually taken once having been given advice about when and where to seek care. These outcomes are then reviewed with physician groups so that the process can be updated and improved. The one area that we're pursuing that has been less frequently pursued at this point is to involve the member in the cost of care based on using the demand management service. What I mean by that is co-payments or coinsurance are variable based on whether a person seeks advice and follows that advice. If I were to call in and say, "I have chest pain," one of two extremes could be happening. I could show all the symptoms of a potential heart attack in which case the demand management service would advise me to go directly to an emergency room or even dial 911 for me. Or, at the other extreme, once having collected all the information, the service may have said, "You ate that for dinner? No wonder you have pain. Just take two aspirin and call your doctor in the morning."

In the latter case I didn't really need to go to an emergency room. If I did go, my co-payment would be higher and my health plan would be advised of the encounter and that no authorization for advice was given to seek emergency care. If in the former example I needed emergency room care, my copayment would be less, so I would have the incentive to make the call. The same would be true for urgent care and primary care physician encounters. One of the tricks in the process is to get people to think about how they access healthcare and to use this demand management service as an adviser before they determine whether to seek care at that point in time and where to go to receive care.

In doing the analysis to implement this program, we've found that a couple of things are particularly critical. One is, as I mentioned earlier, computer systems and their integration. The demand management service operates on a computer system separate from the health plan, but the information on both benefits and eligibility need to be shared, as well as encounter information and advice that's been provided to the callers needs to be connected with the plan files. In addition to that, in preparation for introduction of the

service, relationships among employers, employees, plan sponsors, and physicians need to be developed further and proper expectations created. A great deal of work is needed in that area to make this service a successful one; one that will cause people to want to seek the advice of the service.

The potential savings, as we've determined from our data, are that if there is a high level of acceptance of the concept among enrollees, claims costs can be reduced from 4% to 6% and a net plan savings of 2.5–5% can result. The overhead of running a service, depending on the volume of business, runs on the magnitude of 1–1.5%. In the end, if the process is managed effectively we think it can also improve employee satisfaction with the health plan and medical care through correct expectations and prompt, useful advice.

The other area I'd like to talk about is the episode-of-care reporting and compensation. The whole process of medical care is provided on what I'll call an episodic basis. That is there's a clinical, logical process that's occurring as a physician evaluates a disease and determines what to do about it. For purposes of this discussion I'll define episode of care to include chronologically all services and resources directed at managing disease. That is, it involves all the different vendors: a hospital, a primary or secondary care physician, a pharmacy, a home health vendor, or durable medical equipment vendor. There are many types, but they're all part of a chronologic process under the management and direction of the physician. Currently, no single healthcare provider holds all this data relating to an episode of care. In fact, few in our profession have seen what all that data looks like assembled together. Some staff model HMOs have done work in this area and have achieved some degree of data collection and reporting.

When such data are assembled, three observations immediately follow. One is that it is extremely difficult to assemble credible data. For example, are you aware that in your database doctor A who practices on the north side of town and has one set of tax I.D. and Drug Enforcement Agency (DEA) numbers is the same doctor practicing out of another office on the south side of town with another set of tax I.D. and DEA numbers? Second, to evaluate that doctor's practice and how he or she practices medicine, it's necessary to assemble all that diverse data and collect it under the identity of one physician. Merging prescription drug data with hospital and physician encounter records is also critical. Having a computer system that can correctly identify all these services and assign them to one member with the right date of service and the right diagnosis is particularly challenging.

Once the data are assembled and analyzed, they describe a process that has high variation. That immediately leads to the third observation. Processes which are considered to have such difficulty in measurement and high variation are considered unstable and inefficient by manufacturing standards. What I'm talking about are the concepts developed by W. Edwards Demming which are at the cutting edge of many improvements in the manufacturing industry. The most visible to us from day-to-day are computers and automobiles, which have become far more reliable.

Health insurers and administrators often view data either as subsets or aggregates of an episode of care, but not an episode of care specifically. They may view a particular type of service and the cost of that service, or a particular provider or class, a particular diagnosis aggregated together, or even an insured with the aggregation of all the different episodes of care that may be involved in treating that person. Historically, we haven't

always assembled data in a way that's conducive to monitoring episode of care. The same is true in risk-transferring arrangements which have been historically used with providers even in many managed care endeavors.

Fee-for-service arrangements have focused on a given service, and even though the payment for that service may relate to an overall budget, it is, again, separated from episode of care. Global payments tend to focus on one component such as a facility, for example, in an episode of care. This approach still follows some fee-for-service mentality. Primary or specialty care capitation focuses on a portion of the professional services, but, again, not specifically on episodes of care. Even broad-based capitation of hospital, physician, or pharmacy services only focuses on one particular resource. Comprehensive capitation that involves all of the above is merely a process to transfer the responsibility and risk of managing this process to people who generally don't have the entire breadth of data to manage the medical care process themselves directly. So, capitation without comprehensive data can be problematic for the provider. Capitation often is not adjusted for morbidity of the population covered. There are commonly age/gender adjusters that are used, but they tend to explain only about 5–10% of the variation in the cost outcomes of an episode of care. Capitation itself has a limitation if it's used on smaller populations of enrollees. It's fraught with randomness, and good and bad outcomes can result without regard to how efficiently the practitioners manage or render care.

The big focus and work that we're involved in is developing episode of care payments and one advantage is that it reduces substantially the morbidity risk for the providers. It focuses on the process of care the way clinicians think. It also needs to involve all the healthcare service vendors involved in the episode of care. Needed are creation and maintenance by physicians of care process models or best practice for many of the frequent or high-cost episodes of care. Severity of illness adjusters for some diseases, which are prone to wide ranges of severity and resource consumption, are needed as well as reporting systems that provide both specific and comparative data by episode of care for physicians, so they can see how their results compare to their peers, and how their actual results compare to expected results, are the other vital components.

The whole process also needs the involvement of the physicians both in the management of care and the review of outcomes. And, of course, incentive payments are needed to reward physicians both for individual performance and overall system performance. There are many advantages to be gained from the concept. Not that the other forms of payment don't achieve a purpose, they do, but only to a degree. The advantages of the process of episodic care payment include a greater ability to relate the process to outcomes. By *outcomes* I mean clinical outcomes as perceived by physicians, and customer service or satisfaction in the eyes of the members, such as perceptions of service quality and clinical quality, and financial outcomes from the perspective of each of the participants.

This reporting and incentive system provides the ability to identify and eliminate the causes of variation in the healthcare process and to maximize outcomes. Eliminating outliers from the distribution can improve both the mean result and the variance a little bit. Improving the whole process can substantially reduce variation and have a large impact on the median results. It also holds the promise of developing sustainable and desirable outcomes through continuous quality improvement. It can be used as a tool for capitated

medical groups to compensate physicians with appropriate incentives. It can be implemented with physicians who serve small populations because the frequency of service isn't the largest driving factor. A major disadvantage is the higher cost to develop the computer systems, the reporting systems, and your management process to effectively apply the whole concept. The potential for savings (we haven't tried to measure it) relates to a very basic question: how much of today's costs result from technology and appropriate patient demand versus improper incentives, lack of sufficient data, and lack of individual education?

MS. NANCY F. NELSON: The range of topics I will address includes: a look at changes in the managed care market over the last ten years; trends in capitation arrangements, with capitation used in the sense of prepayment to providers for accepting the responsibility of delivering a specific set of services to a specific population; other new types of provider organizations that are being formed in order to respond to the demand for managed care services; guidelines recently proposed by the NAIC to apply to situations where providers are accepting risk; trends in ways to integrate financial and clinical information; and Medicare and managed care. I think there are many other new things in managed care besides these, but these are the topics I've chosen to discuss.

To set the stage, I want to start by giving you some comments on where things are. I think the market has evolved very quickly over the last ten years with managed care products clearly dominating the market. My definition of managed care products would include HMOs, products with preferred provider networks (basically PPO products), and then point-of-service (POS) products featuring a network with a higher level of benefits if you go in-network versus out-of-network.

Fairly recently, the employer marketplace was dominated by a few national players. Now, there is much more of a trend of employers contracting with multiple plans and multiple plans in a single area using multiple vendors to meet specific needs. Examples include carve outs for drugs and mental health. Within the last ten years, focus has shifted from savings from provider discounts and utilization review to how care is delivered with a focus on primary care management and increasing standards for the delivery of care. I think, historically, and maybe continually, healthcare data can be problematic with inconsistencies. But, I also think there is now much more of a shift towards trying to standardize at least outcomes data to provide data from which to measure provider performance. As that becomes important, I think the data overall will become improved, with more information for everyone.

POS was basically a new product in the late 1980s. I'd say now it's pretty much mainstream, certainly mainstream for employer programs. I think probably very shortly it will also be mainstream for the types of managed care programs that Medicare eligible individuals will be enrolled in. Also, employees now are being asked to be active participants in managing their healthcare consumption.

Here's a few statistics on how things have changed. In 1970, there were about 30 HMOs with about three million members. There are some 500 HMOs with more than 50 million members. PPOs emerged in the late 1970s. In 1994, there were about 122 million people enrolled or eligible for PPOs. In the late 1980s, insurance carriers were making a major investment in managed care. The carriers continue to be dominant in size, but there is increasing gain in market share by independent HMOs. And, there has been a shift from

community-rated products to products which are experience rated, and to open-ended and POS-types of products offered by HMOs.

I would like to talk about capitation arrangements. Again, capitation arrangements are those contractual arrangements where providers are prepaid a fixed amount on a per capita basis in exchange for agreeing to provide a specific set of services to a defined population. Let me offer a few comments on the ideals that might be held out for capitation arrangements. I've split these into two categories: the payment system and the belief system. First, the payment system. Accountability for a specific set of services is assigned to those providers. Again, you're paying them on a projected cost of benefits, and you have a voluntarily enrolled population. The population's agreed to be in this delivery system. Hopefully, the prepayment will empower the providers to manage care and to compete on factors such as cost, quality, access and satisfaction. Capitation should also provide a cash-flow advantage to them.

The beliefs system that relates to capitation would include accountability for results, innovation, and an encouragement of teamwork and information sharing. Hopefully, the providers are rewarded for a better product or service. Also, the system should encourage customer focus and efficiency in the delivery of care.

Let's talk about some trends in capitation arrangements. I think primary care capitation will continue to be used, however, I don't think it's increasing as rapidly. I don't see it decreasing, but I think it's mainstream and is not going anywhere. Typically primary care capitations are payments on an age/gender-adjusted basis to family physicians, internists, and pediatricians for providing a fairly limited scope of services. In many cases, the primary care physician is being asked to act as a gatekeeper with responsibility for controlling access to specialty physicians, and hospital inpatient and outpatient facility services. The primary care physician may also participate in some type of a risk/reward mechanism relating to both the utilization and delivery of services to his panel of patients.

Capitating specialists for providing services is something that is increasingly common. A list of the examples of the types of specialists that I've seen under capitation arrangements includes ear, nose, and throat (ENT) specialists, allergists, dermatologists, urologists, cardiologists, orthopedic surgeons, neurosurgeons, ophthalmologists, and radiologists. My opinion is that, relative to the risk accepted by a primary care physician under a capitation where I think the biggest risk is their time, specialty capitations are potentially more risky because of the kinds of services that a specialty physician might need to deliver.

I want to give you a few examples of the types of issues that need to be considered by specialty physicians as they evaluate a capitation proposal:

- What are the specific services being capitated and how are they defined? Can they all be provided by the specialist or does he need to send some of them outside?

- Have they all been provided by that specialist historically or have other physicians also provided them? And if you're going to have a capitation, you need to define, in a narrow way, what the capitation will cover. So, for example, if you're going to capitate an ENT to provide ENT services, what happens with surgeries, like a

tonsillectomy, that historically may have been performed by a general surgeon? Do those now all come to the ENT, or do some of them stay with the surgeon?

- What basis do you use to make the decision on what is within the scope of the capitation? And, if the physician is now being asked to do them all, have they all been captured in the information used to develop the proposed capitation rate for him?

- How predictable is the need for the services provided by the specialty? In general, specialties that have more patient volume and a lower average cost per patient are more amenable to capitation, in my opinion, than are those with very high costs per patient, because there will be less random variation in cost. For example, dermatology should be a better candidate for capitation than neurology.

- What is the opportunity cost if the specialty physician elects not to pursue a capitation arrangement? For example, if there are two in town, and they are equally good and an organization wants to capitate one or the other of them, then you might not want to be the one that's not under the arrangement, even if you'd rather not have it at all. If you have a situation where you have a patient base of managed care patients that has been built up over time and your choice is take a capitation for them or lose them to your competition across town, it is a tough question.

Specialty capitation arrangements can be pretty complicated. It's typical to have them include some risk band with a settlement, if experience expressed on a fee-for-service basis falls outside the risk band. I'm also aware of very complicated arrangements. I think the most elaborate one I've seen is a situation where a grid of capitation rates was established with a capitation rate actually varying based on the number of surgical referrals and average lengths of stay for hospital admission during a prior time period. In the situation where this was used, it dramatically decreased referrals and decreased length of stay, and the physicians had a related increase in their capitation.

The use of capitation arrangements for total physician services or for all medical services, including both physician and hospital services, is also on the rise. Part of this increase results from the newly-forming provider organizations that I'll talk about shortly. Another factor contributing to the increase is more managed care organizations are increasing their market share in an area by locking in a tight relationship with the hospital and its related physicians. A third factor that contributes to the trend in total capitation is interest within a provider community of accepting responsibility for care management. Basically, providers agree to take the responsibility, to manage the care and hope to get the managed care organization off their back a little by saying, "We're at risk for it. We have the capabilities to manage care. You've reviewed what our standards are, and you've agreed to them, now, let us do it."

I've also seen interest in the idea of disease-based capitation arrangements. This is probably something that's the next generation of the type of episode of care arrangements that John mentioned. I'm not aware of any that are actually in place, but I think they're on the horizon. We've helped clients explore them in a number of situations, including capitations for such things as neonatal, cancer, and diabetic care, and for rehabilitation care following catastrophic incidents.

I have a few concerns with these arrangements. First, I think it's a real problem to decide when an episode of illness begins and ends and, therefore, to define the period for which a disease-based capitation should be in place. Do you pay it all the time, or does the capitation arrangement start at the point the illness occurs? In that case, is it an episode-of-care payment or is it a capitation?

Second, a disease-based capitation runs counter to the idea of having a primary care gatekeeper arrangement which is ingrained in so many organizations. When does the risk or responsibility for managing care transfer from the primary care gatekeeper to the specialty physician who might be accepting risk for the disease-based capitation, and then when does it transfer back? Or perhaps, maybe, it never transfers back. If you have somebody who's a diabetic who really needs special care, maybe the individual is better off not having the primary care and, maybe you don't want to pay a primary care capitation for that person. Perhaps you'd rather just pay some kind of a special capitation just for this type of patient.

Third, almost by definition, there is a huge potential for variation from year to year in the number of patients that might require treatment for any specific type of disease. The capitated provider cannot affect the number of people he or she will have to see. As a result, it seems pretty intuitive that a capitation should be less attractive than a case rate, as the case rate would reduce the physician's exposure. However, when we've had clients ask us about disease-specific capitations, the clients are typically providers rather than the managed care organizations.

Finally, I think for a disease-based capitation to work, it is probably even more important to recognize population variations through some type of severity of illness recognition than it is in more traditional capitation arrangements.

The last comments I have on capitation trends are on ways to evaluate results for purposes of determining incentive compensation payments. Historically, incentive arrangements have been driven by financial results in terms of such things as referral expenses relative to a budget or hospital utilization relative to a target. It's now becoming common to recognize other measures in determining a performance incentive. These types of targets include both utilization and member satisfaction measures. Examples of utilization targets that might be used include: dispensing drugs in compliance with formulary requirements; rates of lab tests, or X rays per visit; and frequencies of referrals for surgical intervention. Examples of member service indicators that might be used include: the rate of complaints about a physician, rates of transfers of patients to other physicians, evaluation of whether charting is satisfactory, acceptable evaluation on member satisfaction surveys, and an agreement to continue to accept new managed care patients under the capitation arrangement.

Let's talk about the evolving structures of provider organizations. The term physician hospital organization (PHO) is used as if it were a well-defined entity. However, I don't think there is any agreement on what a PHO is in terms of its legal structure, its capabilities, or its role in the delivery of healthcare. I think the only generalization that I'd want to make is that for the 500 or so PHOs that exist, each has been formed in a way that includes elected representatives of both physicians and hospital management and some type of a legal structure which is perceived to meet some type of need for both the physicians and the hospital. In some instances, the PHO becomes an entity through which all managed

care contracting for the hospital and physicians must take place. Some PHOs are structured to allow a blanket contract to be made which will apply to all of its members. Others only have authority to review contracts and pass them onto their members for individual review and signing.

My experience in working with PHO clients is that they all expect to be accepting payment under capitation at some point in the future. However, very few have the infrastructure to administer and manage themselves under a capitation arrangement and, therefore, they will need to either build or buy these capabilities. My opinion is that if a PHO is to be successful in the long run in managing under a capitation arrangement, then the physicians, who are in the position of being able to control the utilization of services, must have a great deal of control in the organization. The hospital needs to shift its focus away from a historical mission of filling beds in order to succeed under capitation.

Private practice partnerships (PPP) are organizations formed in order to create an affiliation among otherwise independent physician groups to allow these physicians to establish referral patterns, utilization management, and care treatment patterns in a way that lets them mirror multispecialty group practices. The organizations also have elected representatives, with staff hired to perform various management functions for them. A key to their success is developing ways to allow medical record information to be shared in a way that's very smooth as far as the patient is concerned. Basically, it will require building computer systems that will link these independent practices together.

The last trend in provider organizations is the formation of networks of specialty providers. Two examples that come to mind are radiology networks and cancer networks with providers not just in a single area, but in multiple areas, affiliating. I'm aware of at least one radiology network forming with individual practices being sold to a common parent corporation in exchange for stock in the parent. The expectation is that the parent corporation will play a significant role in the management of the individual practices and their direction in terms of managed care contracting.

Let's move onto providers and the assumption of insurance risk. I will talk about a draft bulletin that was released by the NAIC in August 1995. My understanding of the history of this bulletin is that it came about from work done by the Health Plan Accountability Working Group of the NAIC's Regulatory Framework Task Force. The working group was charged with developing a Model Act for Consolidated Licensure Guidelines for Entities Accepting Health Risk. As part of its process, the working group held a series of public hearings which highlighted the range of provider risk arrangements that are in use. As a result, and because of concern over the types of risks being transferred, the working group drafted a bulletin to regulators on the risk being accepted by provider groups.

The contents of the bulletin address the question, "When does the assumption of risk by providers constitute the business of insurance and, therefore, require an insurance license?" The situations identified were contracts between providers and an employer, or other groups or individuals, including both capitation arrangements and other types of risk-sharing arrangements. However, contracts that are between a provider and either an HMO or an insurer where risk is being transferred to the provider, do not require the insurance license.

Some supplementary materials were provided along with the draft bulletin, including clarification letters from Ohio and Minnesota where language similar to the draft bulletin was released in 1994. The Ohio letter addressed the question of whether there was some degree of risk that a provider could assume and not be subject to the insurance license requirements. The response was something to the effect that there's not a degree of risk that would be considered de minimus. The response went on to give a clarifying example equivalent to the comment that someone can't be a little bit pregnant—either you are or you're not. It's interesting to see that in a response from a regulator. The Minnesota clarifying letter addressed the situation of an employer paying for services on a substantially capitated or similar risk-sharing basis and stated that if this occurs, then the employer has purchased insurance and the employer is subject to the various benefit mandates, premium taxes, and other state provisions that self-funded employers are ordinarily exempt from.

Recognizing that there's a wide variation in positions of the different state insurance departments, what are the implications in states where this would be adopted? For providers, it means that accepting a capitation directly from an employer would be equal to accepting insurance risk. If they do so, they need to have an HMO or insurance license which forces them to meet all of the capital and other requirements for such an organization. And, again, for employers paying a capitation, it will be equivalent to purchasing insurance. The employer loses the ERISA exemption applied to self-funded employers and becomes subject to all of the state's requirements for benefit mandates, premium taxes, and anything else that's applied to an insured employer.

My next topic is the integration of financial and clinical information. This is something that I'm very excited about as I'm convinced that it is critical to have clinical insight into the evaluation of actuarial and financial information. As an actuary, I can look at various utilization and expense measures. I can recognize changes over time, I can point out items that seem different than the norm, and I can speculate about what might be causing it. But, I'm not really qualified to look at the data and say, "this is what it should be" or "this is how you can fix it to get a different kind of result." In Towers Perrin's integrated health systems consulting practice, we have four managed care physicians. Each of them has a great deal of hands-on experience working as practicing physicians and working in management capacities for managed care organizations. When we staff an assignment with an actuary and a clinician, we're in a position to help a client look at what can be done about a perceived problem and address questions about whether it is a problem at all.

I want to give you an example of the differences that adding a clinical perspective might bring. To start with I identified some of the factors that I'd consider part of a financial approach to reviewing claims experience data. Statistics, in terms of the consumption of utilization of services, would be tracked along with the cost of services and average cost per covered life. The overall goal might be to reduce the cost for covered life or to at least control trend. Historically, incentives would be based on financial measures of utilization and average expense per covered life.

If I want to take a look at what I'd call an *evolving integrated* approach to looking at experience data, I focus on the review of the experience of a limited number of conditions and procedures selected because they represent a very high amount of cost either in terms of sheer numbers or in terms of absolute dollars. In such an approach, you would first identify the target procedures and then go through and do an audit of historical practices

with regard to charting, claims coding, and claims payment practices. Then, with the results of the audit in hand, you would look at developing new referral patterns and utilization and case management procedures, perhaps doing this concurrently with the development of standardized pathways of care. Outcome measures would also be developed which would later be used to evaluate performance. As part of this process, there would be a strong emphasis on ways to deliver care of a consistent high level of quality.

Over time, the performance of individual physicians would be profiled relative to the target standards. Outlier physicians could be identified, and reasons for variations would be considered. The results of the evaluation could then be used to manage a network. In other words, if a physician had performance that identified him or her as an outlier and no explanation were available to justify this outlier status, the physician could be dropped or reprimanded in some way by the network for his failure to meet the requirements. Over time, compensation and other incentives would be aligned in a way that would encourage compliance with standards.

I'd like to give you a simplified example of looking at data a little differently by adding the clinical perspective. Let's identify types of information that actuaries might typically have collected on a historical basis on physician surgical expenses in a claims experience study. These items include the utilization and average cost for services provided in an inpatient, outpatient, and office setting. This information might be useful in an evaluation of past trends for projecting future experience. Next, let's identify the data to be collected with some modifications suggested by one of our physicians. The first suggestion is to drop place of service. This isn't intended to suggest dropping place of service in tracking facility claims. This suggestion is made because for physician surgical experience, place of service is less important because of the great deal of crossover between inpatient and outpatient settings for many surgeries. A second suggestion is to track utilization and costs for a variety of indicator procedures, in addition to tracking overall utilization. The idea behind tracking these indicator services is to collect data where utilization tends to vary widely. Low utilization may indicate a quality problem, and high utilization might suggest that providers are being particularly quick to use a surgical intervention. Some examples of these include hysterectomies, C-sections, coronary bypass surgeries, colonoscopy screening, knee arthroscopy, and cataract surgery.

The third suggestion is to look at variations in practices between areas, and between clinics and similar populations. So, for example, if you're a managed care organization and you're contracting with six different clinics, it's pretty useful to compare how they're doing on these indicators. Now collecting this additional information is not going to reduce the ability of the information to be useful in analyzing past experience and projecting future experience, but it is going to facilitate a process of identifying potential problem areas and tracking changes in these areas over time. It's also going to create a foundation of data for use in discussion with providers on changes to practice patterns which, in turn, might result in a type of review process that I described earlier.

My last topic is Medicare and managed care. To date, only about 10% of Medicare eligible individuals are enrolled in managed care plans, including HMO risk and cost contracts and healthcare prepayment plans (HCPPs). This year, there's been a great deal of interest by employers in managed care products for retirees and, as a result, many

HMOs that are not currently in the senior market have been evaluating the feasibility of entering the market and offering Medicare risk contracts.

The Healthcare Financing Administration (HCFA) also seems to be trying to make risk contracting more attractive by allowing plans to file base benefit plans with flexible co-payments. My understanding is that HCFA is also allowing plans to determine premium waivers without review and have different charge structures for the basic benefit packages offered under a risk contract. For example, one charge structure might have a high premium and a low co-payment. Another might have a low premium and a high co-payment. Co-payments now vary by type of service. Any variations in a charge structure, however, must be approved through the adjusted community rate filing process and must be actuarially equivalent. HMOs are also being allowed to negotiate with employer groups to provide high-option benefit packages for Medicare eligible retirees as long as the benefits provided to members of the employer group are either equal to or greater than the basic benefit package offered to individual Medicare enrollees.

Medicare and managed care has been in the news with all of the various discussion of Medicare reform. I think that any legislation that's passed is likely to have the effect of pushing Medicare enrollees into managed care products. It's also very likely to change the method used to calculate the payment rates to managed care organizations contracting on a risk basis.

One last thought on managed care for the Medicare market. A managed care organization can't just decide it's going to price a product and enter the Medicare market and expect to be successful. In order to enter this market successfully, there needs to be a great deal of planning to look at the special issues unique to this population of access, the demands for a different mix of providers, and a relatively high need for customer service.

MR. HULET: How many of you have prepared for a performance evaluation or have expected your employees to do so? I know that some of you are probably saying, "What does that have to do with managed care?" Bear with me while I make my point. In the performance review we do with our senior consultants, Dave Axene and I expect them to spend time reflecting on what has happened during the year, where their strengths are, where their weaknesses are, and we do the same. So, when we get in our review discussion, we can then make some progress towards identifying what they need to do to become a better consultant for the following year. We look at the salary structure and try to determine what would be an appropriate salary for each individual based on the value they provide our clients. We put them on the spot and asked them to do the same thing. It seems to me that they should have a pretty good idea of whether they're able to offer more value next year to their clients than they have in the past year. By discussing this we can jointly come to a conclusion regarding changes and what value will be representative of their abilities.

I believe most of you would agree that this is a reasonable way to go about it because we try to assess the value and put a price tag on that before deciding what a proper salary is. Compare that to another way of approaching it. If you were to look at your spending habits over the past year and try to decide, based on those spending habits, what your desired level of spending would be, that is, your progression in lifestyle, and come up with a salary, there's a good chance that you'd come up with a different figure. Now if you presented that to your employer as the salary you required the following year, you would

either be without a job or laughed out of the room, unless (and that's the word you need to emphasize) your spending habits and thus the request that you were making were well within the range of what had been prescribed as the salary guidelines for the company.

The way this relates to managed care is that historically, our healthcare system has followed the latter approach. Employers have let employees spend as they have pleased for healthcare services. The employees have done this with advice of the one who's supplying the services, the physicians. Then, each year the employer goes to their adviser, who's generally the insurance company, to determine what the premium requirement would be for the following year. That insurance company, in all its wisdom, would look at the past experience, add some additional margin to reflect what it expected the increase to be in the following year and would present that to the employer as the premium requirement. That's very much akin to asking your employer to support your lifestyle based on the salary that you would like to have because of what you want to spend.

If employers have been so willing to do that on the health insurance side, why does it seem so foreign then for us to assume that we could use spending as our approach to salary requirements when we approach the employer? We are their employee and should mean more to them than the third party who's a medical care provider and who, in the past, has dictated the spending on healthcare. If you ponder that inconsistency, you see that we really have the employers open their checkbooks so that the provider market can spend whatever it thinks appropriate. It can take advantage of the new technologies and even do much learning at the expense of the employers, who are paying the bill. Now, of course, there are other payers, such as the governments and some private individuals, but for the most part, we're looking at employers who will open that checkbook to the individual providers. Managed care hopefully will put some discipline into the equation so that rather than just looking at spending and identifying next year's requirement based on that spending habit, we'll look at a budget and say what can we afford to spend. Then, we may try to determine how to best fit high-quality managed care within that budget.

Let me shift focus again just briefly. How many of you know high school friends that are now practicing in the medical professions—physicians, nurses, hospital administrators? If you look back on your high school experience, would you say those individuals were in the bottom half of the class or the top half of the class? I suspect most of you would say they're in the top half, probably in the top 10%. If we look at that experience and realize that the physicians are probably highly motivated, have great understanding, strong mental capabilities, and a great deal of drive, it seems very inconsistent then for them to be unable to tackle the problems that we see now in our healthcare delivery system.

If we recognize that, perhaps, actuaries and physicians represent some of the best minds in our country, you would think that together we'd be able to solve the problem. We are both somewhat responsible for the problem we have. The physicians went about their work delivering care the best they knew how. They tried to produce high-quality care and, as a result of employers' open checkbooks, the cost of the whole system has regularly increased over time until it has got to a point where many people say we can't absorb that cost. As actuaries, we generally took the position that we had to protect the financial integrity of our employer, either the insurance company, some other plan sponsor, or perhaps a large employer client, so we thought we were doing our job by looking at our employer's financial situation and being sure our employer had enough money coming in the door to be able to pay these expenses our employer committed to. So, neither the

physician community nor the actuarial community took the view that we ought to be doing something jointly to manage the delivery and financial aspects of care. I think that's where we have let our society down. We need to do something to correct that. Nancy mentioned the idea of combining the clinical and the financial aspects of managed care. I believe that's very important, and that is the only way to keep the government out of the reform business we have seen so much of recently.

Just to give you an idea of what I would view to be the differences between strictly a clinical approach to delivery of care and an actuarial approach to delivery of care, I developed some examples. There was a situation where we looked at some tests. There was a panel of 15-chemical tests that were done routinely to help diagnose the patient's condition. As we looked at experience from different physicians, we found there were two methods of going through the diagnostic process. Method one would say, "Let's do a panel of seven tests, determine the conclusions that can be drawn from that and then, for those patients where we couldn't draw the necessary conclusions, send them back and do the 15-panel tests." The second method was to do the 15-panel tests on all patients. Now in both situations the physicians gathered the information they needed for diagnostic purposes, but the resource cost was significantly different. To make mathematics easy, assume that the resource cost of the 15-panel test was about twice what it was for the 7-panel test. This implies that if anything less than 50% of the patients were to be sent back for those additional tests, the resource cost in method one would be less than the resource cost in method two. It turns out that, in this case, there were only about 10% of the patients of those physicians that used method one who had to be sent back for the additional tests. Now their resource cost was probably about 40% less. It probably didn't make any difference to the patients or the physicians because the insurance company was paying for it. The co-payment that the individuals had probably wouldn't have been any different regardless of which tests were done, but the consumption of resources was significantly different. So, the financial motivation that we have in our system isn't conducive to having good resource use results.

We could have taken it a couple steps further. We could have encouraged the lab to set up a method so the physicians could do the seven-panel test to begin with and have just the additional eight tests performed in the cases that were needed, so they didn't have to repeat the first seven. There may be resource reasons why it isn't done that way, and I haven't looked into it to know for sure. There would also be another step that you could take if you looked at it from an actuarial perspective. That would be to try to identify for this particular type of patient which of the seven tests was really providing the information that was needed. Maybe you could whittle that down and have two or three tests. The process of packaging that has happened in many aspects of our healthcare delivery system, and it's not something that is easy to modify. It happens all the time in the hospital setting where the suppliers to hospitals have packaged things together and then tried to determine how to use that package for the most patients. In many situations, hospitals end up discarding a portion of the package because it provides things that are not needed for that particular patient.

Another example that I would like to walk through with you has to do with dialysis. I may have the clinical detail all wrong on this example, but don't criticize me for that. Try to get the concept and not necessarily the clinical details. The way I understand it, there are two forms of dialysis, hemodialysis (HD), and peritoneal dialysis (PD). HD is delivered in an institutional setting or a dialysis center, and it can also be delivered at home. PD is

primarily delivered at home. I don't know whether there's any short-term facilities that are set-up for PD or not, but it's primarily a home procedure. The concept is that through these dialysis procedures the blood is filtered, replacing the work that the kidney normally does. HD is a higher volume service, therefore, it takes less time to filter the entire volume of blood. The clinical approach to dialysis, that I discovered after talking to several physicians that specialize in this area, is that the physician makes a judgment when they sit down and talk to the patient about which form of dialysis is most appropriate. My understanding is that if you provided the information to ten physicians, there would be some who would insist that HD is the proper form of dialysis, some who would insist that PD was the proper form of dialysis, and some who would ride a middle ground and could be swayed depending on what arguments they heard from the other physicians.

The actuarial approach would be to identify the reasons the physicians decide that one modality is better or more appropriate than another. These reasons are in the back of the minds of the physicians as they go through this decision process, but from what we've been able to determine, the judgments are not always consistent and sometimes the reasoning is very different in the way they carry it out. You must recognize that there are lifestyle reasons and clinical reasons for using a particular modality. For instance, a homeless person wouldn't be somebody you would recommend for a PD; that is a lifestyle reason. They would need to go to a dialysis center. There are also clinical reasons. In HD you need a vascular access and in PD you need an abdominal access. If vascular access is difficult because of the condition of a person's veins, then you probably wouldn't want to use PD. Recognizing there are two specific types of indicators that would lead you to conclude one form of dialysis is more appropriate than another and that there are many more subtle reasons that would lead you to one form or another, the decision process should be one that would step through those various indicators to determine which form is most appropriate for the situation.

If, after looking at those indicators, you couldn't decide that one form was clinically indicated over another, then it would seem the reasonable approach would be to look at cost. If the cost of one form was significantly lower than the cost of the other, it would be prudent to look at cost. Most physicians have a very vague idea of what the cost difference is. They haven't ever been asked to look at the cost side, and so they don't know the details of the cost side. They don't have to pay for it; the patient doesn't have to pay for it, generally, because it's covered by Medicare, and so the cost is generally not a consideration. If physicians stepped back and thought about it, the cost is a consideration, because they pay, just as you and I do, through their taxes to cover those costs. It would seem the prudent action by a physician if the clinical indicators didn't direct them to one form or another, that they would look at cost and try to keep the cost to society for that procedure down.

If you sit down and talk to clinicians you'll find that the way they've approached care is not necessarily logical. They do not necessarily look at efficiencies. They do not look at cost. That's where we, as actuaries, need to interject ourselves so that we can help. The clinical knowledge that we can gain through such discussions can help lower the cost to society of what we deliver. We can incorporate the coverage as necessary for the uninsured and those others that seem to be left out of our insurance marketplace.

MR. CHESTER M. LOZOWSKI: John, you gave an example of someone having chest pains being directed possibly to a hospital emergency room. If the patient's not directed

there, but his instincts say, "I don't buy into that. I'm going to the emergency room." If he indeed does have a cardiac problem, what happens with the co-payment in that situation?

MR. PRICE: It's a good question and requires an effective customer service process. When the case comes into the plan for claims processing, it will be recognized as to whether the case is a life threatening emergency, based on diagnosis. If it is, then the lower co-payments would always apply. If the person hadn't phoned in and just went directly to the emergency room and it was determined that a life threatening situation did exist, we have sufficient information to apply for the lower co-payment.

FROM THE FLOOR: I think this is a question for all three panelists. Nancy talked about developing strategies for target procedures, looking at the data and establishing incentives. John's three principles indicate that it is extremely difficult to assemble credible data and that once the data is assembled there is much variability and, as a process with much variability, it is unpredictable or unstable. Then consider Dennis' questions about how you work with a combined clinical and actuarial solution. To me it sounds like credibility is lacking in there somewhere. So how do you get the discussion of credibility from the theoretical down to the process, practical, and pragmatic?

MR. PRICE: From our own examples, the statistical analysis tends to lead us, as well as the clinicians' instincts. For example, we may put some data together on a particular process of care and show the physicians what the data looks like. Our own data may show high variability, so we'll show them the data very gingerly and not very authoritatively. At the same time, they may also know clinically that a particular disease has a wide variation in the way it can present itself and the amount of resources it takes to treat it. Either they or we will often become aware that several variables have to immediately be recognized when we talk about a particular episode of care and the treatment involved in it. In our efforts, we try to stay away from the more extreme cases and just attack the ones that have more quantifiable processes and results so we can learn better how to manage them before we tackle the really tough ones. Clinical knowledge or just the variation and the statistics tell us very rapidly that we're tackling an extremely tough topic. We may move on to higher volume, less variable episodes of care first.

MR. HULET: I have two comments. Data can help you identify the variabilities and present it in a way the physician can see the impact of how they do it versus how some of their competitors do it. After you do that, it's generally a fairly easy step, if outcomes are good, for physicians to make the change to more efficient delivery practices. Physicians are not people who like to be second best, and if you show them that they are second best, they will want to change what they're doing to improve and move closer to that first-place physician.

The other thing to recognize is that looking at the delivery system on an exception basis can be valuable as we have found in actuarial science. Do as much as you can to define things that are definable, and then allow the physicians to use their clinical judgment to take care of those outliers. The analysis we have done on inpatient stays indicates that, according to the historical data, 10% of the people have a length of stay that would be appropriate for uncomplicated patients. Acuity analysis would indicate that maybe 80% of commercial patients should be uncomplicated, which means we've got the gap between the 10% and the 80% that are having excess days. So, it's a matter of trying to manage

everybody as though they were the best case and allow the physicians to use their medical judgment to take care of the outlier when they occur, rather than the approach that has developed which is to assume everybody's an outlier and do everything to take care of all those possibilities. That just beefs up the cost of the system and uses many extra resources.

MS. NELSON: I'd only add a couple things. With regard to the data issues, we have a project going on in our office now to help a client with some case rate pricing. We have collected data for patients with cardiology claims for a group of providers who all practice at one hospital. The hospital is recognized to be leading in this area, yet the variation between the doctors on some services is 4:1 and 5:1. The general approach is to take this information, evaluate it, and come up with a case rate; that's one way to do it. I don't think this is the approach that will be used here, and I don't think it would build a situation that would make any of the physicians happy. Rather, we will take the information, show the variation in what's going on, and then get either all of the doctors, or a representative number of the doctors, together and have them go over it. We'll let them say what makes the most sense and agree on it. We want them to evaluate a case of a specific type to identify the things that should be done and indicate the services the case rate should be built around. Hopefully, you also get to a procedure path that would have those treatments occurring.

MR. SANFORD B. HERMAN: A question for Nancy on the idea of specialty capitation. I know what capitation means for a member when you're talking about a primary care physician (PCP), but what would it mean for a member if you're talking about specialty capitation? Would the member have a complete menu of various specialties and check off who he or she wants to be a dermatologist? What would it mean in terms of referral patterns?

MS. NELSON: I think the most common thing is that you will have one or two. Say with the dermatologist, you've contacted one at the north end of town and one at the south end of town. The patient selects a PCP and the PCP is then going to refer all of his patients for dermatology care to either the south one or the north one. So, to the individual member, it will be transparent. What he knows is that he's buying into a limited network and that he has to be satisfied with what the PCP will do in terms of referrals.

MR. HULET: In looking at the capitation from the actuarial perspective, you always need to find out what people mean when they say *capitation*. Many times they don't mean a single-per-person payment. Often, they mean some form of a payment that is different than fee-for-service. So, be sure you get that definition before you get started.

MR. PRICE: When it comes to capitating specialties like orthopedics or some other discipline where the frequency of service is relatively low, it takes a much higher enrolled population to get to a point where the random fluctuations in the frequency of patients is fairly predictable and, therefore, the financial outcomes of the capitated physicians is tolerable. We have, on several occasions, run simulation models to demonstrate this variation to some of our clinics who want to subcapitate a particular surgical specialty to get out from under the heat of managing that risk by leaving it to the specialist.

MS. NELSON: You mention the idea of referring to a specialist under capitation as a way to reduce the worry about managing this. You also have the issue of what gets referred. Is

what you'll get to refer to them appropriate? If you're a specialist and you're at risk and people start sending patients to you that you really shouldn't be seeing, then your response should be, "Well, you shouldn't have sent me this patient." The specialist should tell the PCP, "You take care of this patient." From the member satisfaction perspective, potentially this causes a lot of unhappiness. I know it would for me if I went to a specialist and I got the message back from my primary doctor that, "Well, he doesn't really think he needs to see you."

MR. PAUL J. DONAHUE: I have one question and one comment. My question is on demand management services. It seems to me the direct advice about triage to a member incurs a level of exposure to malpractice risk that traditional utilization review has escaped by its reliance on the physician. Have you factored that into the estimate of net savings? My comment is it seems that provider capitation that would cover only services directly provided by that group of providers and the dermatology services for a dermatologist really has nothing to distinguish it from other more generic long-term supply contracts. It would be very difficult to argue as a legal matter that an employer was buying or a provider providing insurance in capitations so strictly limited.

MR. HULET: That's exactly the conclusion that was drawn in California with regard to the legislation for HMOs there. Basically what was found was a medical group could accept risk for physician services or a hospital could accept risk for hospital services, but they couldn't accept each other's risk unless they did the Knox-Keene filing and became an HMO. Whether or not that will change down the road, I don't know. To take the risk for yourself is fairly easy for people to accept. It's even easier to accept if you're talking about mostly your time at risk and not having to buy many things outside. When you start buying things outside, that's where it becomes insurance and requires a reserve.

MR. PRICE: On the question of liability, yes, it's something that has to be carefully factored. I work for a healthcare system, and managing malpractice risk is a routine part of its business. But, for any party that would undertake such an endeavor that's not experienced in managing those types of risks, it's something that needs to be weighed very carefully. As we looked at it, we ran across two legal theories as to whether or not to record the demand management encounters. One theory said don't record it because the information you discover may be worse than what you want to hear. The other said if you've done a thorough job in developing your protocols and algorithms and the instructions given the caller represent the best thinking of the physicians, you will be better off with that information saved. In our system, we do the latter. We save the recording of the encounter for a period of time and then discard it.

MR. HARRY L. SUTTON, JR.: Nancy talked about new types of organizations like PHOs, but one other type that really wasn't mentioned was this commercialization of physician practice where physicians sell themselves and their facilities to a for-profit in exchange for stock. Then, some entity takes over this company and negotiates capitations with HMOs for fun and profit. For example, Coastal was in the paper about dealing with Humana, PhyCor Pacific Physicians and other types of arrangements where the physician gives up being in private practice and sells his practice including facilities, and then some company is trying to manage it to make money on a capitation arrangement. You're talking about looking at the medical practice and trying to make it more efficient. How do these organizations intend to control medical practice to try to come up with the efficiencies and the quality of care that you all are talking about?

MR. HULET: We have worked with a couple of those organizations, and it's one of those issues where people have decided they have an opportunity to make some money by managing the groups and don't understand the dynamics of what motivates people to want to do a good job. What some of these clients have found is that once they buy the practice and put the physicians on salary, productivity seems to go way down. So, we're in the process of helping one of our clients try to identify some productivity parameters that can be used to help assess the level of productivity. The client hopes to get back to a level that's similar to what was in place before they put them on salary.

MR. ANTHONY J. HOUGHTON: I'd like to make a comment with regard to tests of managing things and getting clinical outcomes. Many cities have a large number of managed care organizations in operation. You can have a PCP who has 2,000 patients, and 1,000 are involved with many managed care organizations. Maybe the largest one has 300 of his patients, the smallest has 20 or 30, and he has different protocols with each of the different companies. It's almost impossible for him to exactly obey every protocol. He probably uses the one that's the dominant one or what he considers the best personal medical practice. When this PCP refers to a particular specialist, in some cases he's referring as a gatekeeper where he must give a written referral and the specialist gets that in some form. In other cases, he's referring as a PPO primary doctor, but he does not necessarily have to give a written referral. The person could have self-referral to that specialist. Sometimes he's referring on a fee-for-service where, again, a person could have gone self-referral to that specialist. The specialist gets all these referrals from the doctor. On some of them he's required to report back what he's going to do, what medication is given and whether he is to give further treatment. In others he doesn't have to refer back, but maybe just because of what he tends to most, he gives back to that primary doctor more information even when it's not required. That may improve medical care, but it also may create an abundance of transactions they never had before. It's this primary physician who just referred somebody who was on a fee-for-service basis, so they get the specialist providing more information than he is used to in the past. It's interesting and I've always talked to people who think they're going to have a unique protocol. I suggest that it may not work out until they get a very dominant physician with the doctors and hospitals they're dealing with.

MS. NELSON: What you mentioned is a very real dilemma for the healthcare providers in our communities. As managed care concepts evolve, everyone has his or her own best idea about how to get things done. It creates a painful time for the physicians practicing medicine, and it will probably last for some time until mergers and acquisitions or market penetration reach levels that these health plans have critical masses of members. And then, the physicians and other healthcare providers will end up choosing sides and likely be aligned with one or two systems so they don't have to remember all of the bureaucracy that each managed care system might develop. But it's a real problem in today's markets.

MR. HULET: One of the things that happens, which you referred to, is that whatever the dominant player is for their patient base is probably the one that gets the most attention. We tell our clients that you really can't force a whole practice to change if you're only offering two or three patients. On the other hand, if you are able to provide good educational material to physicians, even if they only have a handful of patients, they may take the time to understand that material and change some of their practices based on that. But until the financial incentive becomes enough to motivate them to make the changes that you're asking, then they probably will not make them. We got a request from a large

employer client who was concerned about the differences they were seeing among the various HMOs they contracted with around the country. They asked us to help, on their behalf, those HMOs improve their managed care efficiency, even recognizing that the employer's members in those HMOs probably represented a small portion of the total covered by those HMOs. The employer felt there was enough value in what it would save them on their employee benefit cost that it was willing to make the investment to help those HMOs improve their efficiency. There are people who take a more global view of the situation and try to do what's best. My long-term hope is that many of the managed care organizations will delegate much of that responsibility to the practitioner once they are comfortable that the practitioner really is adopting efficient, high-quality healthcare practices.