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## Session 128PD
## Shifting Focus: Financial Management to Patient Management


**Track:** Health
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*Summary: Actuaries have focused on the financial issues related to health benefits purposes; physicians have focused on delivering high-quality care—regardless of the cost! To be successful, we have to join the perspectives, shift the perspectives, and work cooperatively.*


**Mr. Philip C. Turner:** I'm with Milliman & Robertson, Inc. in San Diego. I'm an actuary and have been working in the group health field for a long time.

The topic is essentially how times have changed for us actuaries. In the old days we used to price products the way the claims came in, while doctors were out doing their thing and didn't know who actuaries were. Now, many of us are working together daily, although this is not quite as widespread as I might have thought. I work with doctors daily in my office.

Our three panelists are going to cover the actuarial side, the physician side, and then kind of bring it together at the end. Our first speaker will be Joyce Li, who is



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vice president and actuary at Blue Cross of California. Joyce is responsible for all the actuarial work involved with large group and with provider network support. She plays a very major role in negotiation strategy and pricing of various contracts for providers. Joyce is a graduate of the University of Oregon, with a degree in math, and is a Fellow of the Society of Actuaries (FSA).

Dr. Randall Vollertsen is a senior medical consultant in the Minneapolis office of Milliman & Robertson. Randy received his medical degree in Iowa, trained in rheumatology at the Mayo Clinic, and is a diplomate of the American Board of Internal Medicine. In 1992 he received an MBA at Stanford and was working with Kaiser Permanente in northern California at the time. Since 1994 he has been associated with Milliman & Robertson in a senior consulting role.

The third speaker, Dave Terry, is vice president of actuarial services for North American Medical Management, a subsidiary of PhyCor. He is responsible for determining and evaluating capitated provider agreements and negotiating reimbursement structures on behalf of both group practices and individual practice associations (IPA). Prior to joining North American, Dave was a health care consultant with one of the Big Six consulting firms, and before that was with Partners National Health Plans. Dave is the only native Coloradan on the program. He is an Associate of the Society of Actuaries (ASA), received a B.S. in statistics from Colorado State, and has a master of actuarial science degree from University of Nebraska.

**Ms. Joyce Li:** I'm going to talk about how the actuaries have shifted their focus from the traditional role and how to use actuarial skills to move to new areas. Some of the new areas that we're going to talk about are: how we work with the doctors to deal with medical management issues, how we deal and negotiate with the providers, and how we help the company to develop a provider payment strategy.

Traditionally, as far as health actuaries are concerned, the kind of work that we have done is in product pricing and development. We help the company to design the product, price the product, keep track of the experience, and we take a look at the underlying trend to see if it is going up 5% or 10%. Many actuaries are involved in the financial statement work, and need to determine the kind of liabilities that occur every month and forecast the financial picture of the company. So these are some of the traditional areas that health actuaries work in. We also look at product experience. We take a look at the end result: is the loss ratio good, and have we priced the product correctly?

The major focus in the past was on looking at whether the payment is appropriate to the structure. We pretty much said that we have a product, it's going to cost us

$100 an office visit, so we'll take $100 for granted and add that into our pricing. We didn't take a look to see whether we could influence paying $100 per office visit or whether we should only pay $60. Even though we did somehow control the cost and utilization through underwriting and benefit design, we did not take a very active role in determining whether the payment structure to the provider was appropriate. We didn't get involved in medical management to see how we could cut down the length of stay or even get involved in other areas.

So there was really no strong need for us to understand how people pay for things. For example, if you take a look at the billing structure from the physician, we actually have over 10,000 billing codes just to pay for the professional services, and there are many other areas. Look at the payment schedule that Medicare uses to pay for durational supplies or durable medical equipment. There are hundreds of codes and I think the actuaries can play a role in determining what is the right price to pay for each one of them.

The marketplace has changed a great deal in the last few years. We have shifted from the fee-for-service basis to health maintenance organizations (HMOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and point-of-service (POS) plans. All of those products require the health plan to negotiate with providers to come up with appropriate medical management with the right clinical criteria and again, negotiating with the providers to help actuaries who need to understand what kind of payment level is acceptable to the provider.

Medical management has changed from what we used to have. In the past we heard about case management. We talk about preadmission review, concurrent review and whatever retrospective review people do. Before, when you went to the hospital, case managers would say, "You're allowed to go to the hospital and we approve three days." But the kind of medical management that people perform is way beyond that. The doctors are involved in the health plan. Many health plans have medical directors and they need information to build clinical protocols. What's the right protocol to approve a transplant? Is a bone marrow transplant appropriate for certain stages of cancer? Those are the kind of questions that health plans have to answer which were not important in the past. So in those areas we need to work with the medical directors to deal with that.

Negotiating with the provider network can be very complex. When you look at the type of expenses, it is not so much what we pay for the doctor and what we pay for the hospital. If you look through all the different types of providers we have, you can have, for example, a range of mental health providers. You don't just negotiate with a psychiatrist or a psychologist. You can deal with clinical workers, and you can deal with family counselors, so it depends on the type of product you're dealing

with. There are a whole host of providers that we need to negotiate with, such as physical therapy.

At Blue Cross of California, we have over two dozen different types of networks that we negotiate with. Different groups of providers have their own structure, and there are issues related to how to work with each one of them; they range from hospitals to pharmaceutical companies. Allow me to give you the size of the network that we are talking about in California, at least for Blue Cross of California; we have over 400 hospitals that we negotiate with. Each one of them may have a different payment structure, and each one of them may have different payment schedules, depending on the type of product that we sell. We may have a hospital contract where one contract is for the PPO members, and one contract is for the HMO members. Then we have almost 40,000 physicians. You can see the kind of complexity we are faced with and the kinds of providers with whom you want to negotiate changes from day to day. In the past, most of the networks dealt with hospitals and physicians, but nowadays we move into ambulance companies. We can move into some therapies and other types of networks.

From an actuarial perspective, I think we have many skills that we can use in terms of provider negotiation. The first one is determining the payment level. What is an appropriate level to pay to a doctor? Again, in order to do that, you need to understand the pattern of billed charges that the doctors have. Most doctors charge $100 for an office visit, or they charge $5,000 for a certain surgical procedure. We can use our actuarial skill in terms of measuring the billed charges pattern. We don't just measure in terms of the overall cost and utilization trend of our professional payment. You get into much more detail.

As I mentioned earlier, you have 10,000 professional billing codes, and we need to determine the right payment level for each one of them. What we need to know is not that we spend an average $50 for professional payment. It's not sufficient in terms of negotiating with the provider. Determine what the other health plans offer to the providers. We are all competing to work with the same group of physicians. If you're in an HMO world and you want to have this particular medical group with you, you might want to pay them $40 capitation but it was paid $60 from somebody else. Know what you're willing to pay, and what they are willing to accept.

One of the areas that we need to pay attention to is what the government pays. As we look at how we pay the provider, it is critical to understand what the government pays. What does the Health Care Financing Administration (HCFA) pay? What do they pay on Medicare risk? What's the resource based relative value schedule (RBRVS)? How do we compare? Many doctors will look at those schedules as a comparison. Where are you relative to what the government pays, and where are

you relative to what the billed charges are. If the billed charges are $100, are you trying to get a 50% discount or are you trying to get 20% off. You need to know where you are in terms of your leverage.

As actuaries, I think we need to be actively involved in determining the payment structure. You look at your data day to day, and you understand the details more than some people who are going out to negotiate with the provider. You may see some pattern emerging from your billed charges, and you may see some things going on in the market that you want to push for, such as laboratory procedures. In the past, most of the health plans paid laboratories on a per-service basis: if they did a blood test, you gave them a certain amount of money. If they did other testing, you gave them a certain level of payment. Some of the health plans are having capitation negotiations with the different types of laboratories.

Think about whether a capitation deal is an acceptable alternative for your company. There are many different ways to pay the providers. You can go into global rate, case rate, per diem, capitation, or a percentage of billed charges; there are different styles. You need to be able to come up with something creative. Maybe a good way to work with your providers is to ask what they would be willing to accept. You need to be proactive in using what you know when you look at all the data and understand what the marketplace is willing to accept in order to recommend some payment structure.

There should be an optimal level of combination of payment level and payment structure. One good example may be maternity payments. Are you willing to pay people when they go to the hospital based on a per-day basis? It doesn't matter how many days they stay, you give them $1,000 a day. If they stay for ten days, you pay the hospital $10,000. When you think about global payment for the maternity situation, you may eliminate some of the work you need to do on case management. If you think you want to drive a one-day average length of stay, or one-and-a-half day maternity average length of stay, and you're willing to pay $1,000 a day, maybe you'll come out with a $1,500 global rate. Then if the provider and the physician keep the patient there longer than one-and-a-half days on average, you don't need to do anything. You're just paying them $1,500 for the whole stay and the provider will be at risk for keeping the patient longer. That may be some of the strategies you can think about. It is not just a matter of how much to pay them. If you paid them in a certain way, can you influence the utilization pattern of your patients?

Also, we actively participate in the negotiations with the providers. It is very similar for some of you who are working on the pricing side. You need to attend meetings with the underwriting department and the salespeople to explain your numbers.

We do the same thing. We'll go out with the negotiation staff and work with them to explain some of the numbers and convince the other side what kind of financial basis we have in coming out with our recommendation. But again, we need to think about whether it is easy to administer. You might want to do a diagnostic related group (DRG) for your hospital payment, but your company cannot administer that kind of payment structure. If it cannot be administered, you don't want to negotiate in those terms because it will probably cost you more money and you don't even know about it.

We do not just go out and determine how much to pay for the provider. We also need to know what is the right structure. In order for us to think about how to get a good quality network, we need to consider if it is cost efficient. Is it high quality? Is it easy for the member to get access? It is very critical for us to choose the right providers to be in our network. One thing we need to do is take a look at the profile information and the utilization pattern. Some doctors or some hospitals may treat certain patients and have longer lengths of stay or they ask the patient to come back more often than others. They might have some sufficient reason why they get the patient to come back, but sometimes different doctors or hospitals may practice with different kinds of protocols. How does that compare with what you want in your network? Just because a doctor has a great deal of visits, it doesn't mean that he or she is a bad doctor. You need to understand why they have so many comprehensive office visits with their patients. Is it justifiable? Do you need to give them some current clinical protocols to help them to treat patients differently?

You need to help the provider people select the right criteria. What are your criteria? Is quality important? Is cost important? What kind of assessment do you need to do and how do you want to compete with the other health plans? If everybody has a particular medical group, and all the employees want to buy the health plan because of that group, then you might need to keep that group in your network. Know how we pay what we pay, and the kind of provider in our network. Actuaries can take a very active role in developing a good provider strategy and a good product and marketing strategy.

One thing I want to emphasize is that the product and marketing side are not separated from the provider side. I think the provider side gives you the kind of ingredients for you to build a product, for you to sell some product to your customers. On the other hand, if you manage to get some unique ingredients, you might want to think about a new product and price or marketing strategy to maximize the return from your provider side. So I think those two sides have to work hand in hand in order to come up with optimum results for the health plan.

We also work with medical directors. As I said earlier, care management and medical management today are quite different from what we used to do, particularly when you look at the HMO side. You have National Committee for Quality Assurance (NCQA) standards that you need to meet. The providers and the employer groups are asking you for the Health Plan and Employer Data Information Set (HEDIS). They're asking you for information in terms of your utilization, member access, your enrollment situation, and a lot of questions to help your consumer understand the quality of your network. There's a great deal of work to be done in terms of answering what the HEDIS and NCQA require. You can use your actuarial skill to do that. We have many medical directors at Blue Cross of California and each one is responsible for a different area. Some are responsible for setting up the average length of stay, and, after looking at the information, and past history, deciding what is acceptable in today's market. They also help with the changes in clinical technology. We can help the medical directors to make some recommendation as to what is the right length of stay to approve for a certain kind of diagnostic situation. There has been a great deal of work on disease stage management. They may want to establish some clinical protocol, such as what is the right protocol if you have an asthma patient. Much of this work requires good analytical skill, and I think we can provide that.

Again, in order for people to understand the business nature and what happens to our claim costs, we need to understand severity measurement, which is something that actuaries are very familiar with. We may not know much about the clinical perspective, but we can work with the medical doctors who have the clinical expertise. We have the analytical expertise in doing that kind of adjustment. We do a lot of age/sex pricing factors, and we adjust by geographical location, and we adjust many things by demographic distribution. If you move yourself forward one more step, you can help them to adjust things based on clinical risk. We can do many things in terms of our normalizing experience. What is the average cost per unit, what is the cost per member per month, and what is the right cost for the course of treatment.

I just listed several examples based on our day-to-day work. There are many other things we can add to use the skills we have. How can we price a product? How can we influence how much we pay? Who is the right doctor and which is the right hospital for our network? We must work with our medical staff to come up with the right kind of clinical protocol to influence the utilization to try to deliver a good health plan product on a cost-efficient basis. We must also make sure that we create something that is acceptable from a clinical basis and that we have a quality network.

**Dr. Randall S. Vollertsen:** My part of the presentation is to help you better understand physicians. I think the fact we have a physician who is working for an actuarial firm and an actuary who is working for a physician management firm points to the coming integration of our two areas. I've always told people that the health care industry is complicated, and one reason that it's complicated is it isn't just one industry, it's four or five industries, none of which understands the other. As time goes on and competition heats up, these industries, along with several others, are going to be increasingly integrated, if not directly, at least in a business sense. I think it behooves everyone to have an understanding of the other industries.

The first thing I'd like to do is cover some of the problems with the current ideal model—I mean the staff HMO, employed physician, fully capitated, fully integrated model. I would like to point out some of the concerns of people in the marketplace as well as in academia and the public press. Then I would like to talk a little about physicians, their background and their training. Finally I'd like to close with some observations on trends that I see in the market.

A great deal of the data I'm going to talk about come from California. I've been working in Minneapolis. These two places are always cited as the cutting edge of changes, so I think it's worthwhile to look at the data and see what hasn't been done.

In the California market, there are still persistent variations, with implications for both the quality and the cost of care. For example, in 1994, the average hospital occupancy was still just a bit over 50%. There are still persistent wide regional variations in hospital costs and lengths of stay, and there are also wide variations in the frequency of procedures. Based on a study of the deviations from the national average in metropolitan statistical areas grouped by high, medium and low penetration of managed care, we note a decrease in the mean lengths of stay and costs from areas of high-to-medium and low penetrations. However, there are wide differences in the utilization of hospital days.

There are also some suggestions of compromised quality. Again, we'll turn to California. The American College of Cardiology believes that institutions that do open heart surgical procedures should do at least 300 annually. In 1992, only 57 of 119 hospitals in California that were doing these procedures did more than 200 annually, and only 28 met the College's recommendations. People are beginning to have some concerns about the cost savings. One concern, in terms of cost savings, is how much of the cost reflects economic trends.

Another question is, are the obvious, easy savings approaching the limits? What about selection effects? I think these are very important, and a fellow named Harold Luft has studied these quite a bit. He believes that these are subtle and sometimes not so subtle and unavoidable, as you know. What about the rate of growth after you have that initial decrease in the rise in premiums or the cost of medical care? The rates seem to parallel those of unmanaged care, so maybe all we have to do is create a time lag. Mind you that's still money, but what about decreasing the rate of growth? Finally, what about the costs of managing care? All the utilization management, all this extra negotiation, and all these computer systems are not without their own costs.

With regard to quality, most studies to date have shown little difference between managed HMO care and fee-for-service care with regard to quality. Certainly there are minimal clinical differences, if any. Most people in fee for service are more satisfied with their access; most people in managed plans are more satisfied with their costs. That's not very surprising. People are beginning to ask questions such as is the baseline comparison satisfactory? So you're better or no worse than what's out there. Is that still very good? Some of the variation in procedures would indicate that it might not be. Are there incentives to improve quality in the system? What are those? Are the measures of quality accurate? Joyce Li mentioned HEDIS, which I think everybody says is the gold standard, and NCQA. Many of their measures still focus on the administrative and process side. Although everyone talks about clinical outcomes, these are very difficult to measure, particularly for rarer diseases.

Finally, what about occasional troubling reports. A couple years ago in the *Journal of the American Medical Association*, an article was published analyzing the outcomes of breast cancer treatment in Orange County. They compared university, large-community, small-community, and HMO hospitals with one another. The university and large-community hospitals were more likely to offer women breast-conserving surgery. Although the survival rate wasn't much different over one or two years, after five years there was a distinct survival advantage for women who went to these two institutions as opposed to the HMO-based hospitals. Naturally, there was a flurry of letters to the editor about this. To be fair, another study showed that, in the Bay Area, you were less likely to have your appendicitis rupture if you were in a managed plan rather than in fee-for-service plan. Finally, there are these anecdotes in the media. I think you've all read *Newsweek, Time, U.S. News and World Report* in the last year. People are starting to raise questions about levels of care.

These concerns have led people to conclude that markets may be dysfunctional. In Minneapolis, that's certainly one of the concerns of one of the big market buyers.

Enthoven has referred to "carrier HMOs," by which he means areas where plans have roughly the same provider panel. There is no differentiation on quality under such a circumstance and competition can take place only at the level of price. There is no reward for investing in your network. Risk selection is greatly rewarded in the marketplace, and now risk is being pushed to providers. Many physicians have a very limited understanding of the risk they're taking on. And there is another concern about medical loss ratios, particularly those that are under 80%. Do these reflect risk transfer and shadow pricing or real savings?

People ask how can technologically driven costs be controlled? How can quality be improved, and how can we account for risk selection? Are the providers really competing or is this competition only at the plan level? Do consumers and patients really have a market choice? Is cost squeezing quality? One direction for answers to these questions is the further integration of the people who are responsible for the pricing and economic analysis of medicine and those who are responsible for actually delivering the care. The latter are mostly physicians. They control over 80% of the delivery, and of course, they account for about a quarter of that directly.

When you have a network of physicians, and you want to attract patients, you need to ask yourself, to use a very 1990s term, what's the "attitude" of the physicians? If you have doctors who are coming to work angry, who don't like the plan, and "bad mouth" it all the time, you do not have good marketing. If you have doctors who look at it as just another job—as a bureaucratic role rather than taking that extra call and seeing that extra patient—that plan is not going to be a competitive winner. If you have people who essentially show up for work and go home every night rather than work on the team with the other doctors and paramedical people to develop better health care, you don't have the best system either.

Physicians will probably be involved in the expanded role of the new models. First, they control a good share of the expenditures. Second, they do understand the clinical side and the clinical needs. Third, they have a direct relationship with patients.

Fourth, physicians are good learners. Medical school didn't teach analytic skills. Medical school is heavily based on rote memorization, learning by example, and experience. It encourages risk averse behavior. The most embarrassing thing that can happen to you in medical school or residency is to miss a diagnosis, particularly one that's presented at grand rounds or at a morbidity and mortality conference. In fact, the rarer the diagnosis, the more embarrassing it is to have missed it. What kind of behavior does that reward?

Finally, the medical training is economically unbiased. The physicians are taught to take care of the patient without regard to their ability to pay. That is generally a good principle. However, I think there are economic considerations in making clinical decisions. Costs and benefits have to be weighed as they do in every other aspect of life.

What do physicians know? They have a very good understanding of the impact of the system on the patient, and they have an excellent understanding of the individual's clinical needs. They also understand their own individual reward system. Mind you, they don't understand how that relates to the hospital, and how it relates to the marketplace, and how it relates to the other medical care providers, but they do understand their piece of the pie. They have some understanding of scientific thought. Medicine is not a science. It is scientifically based, but it goes beyond science. Physicians have some understanding of the way the government works, and they have some understanding of hospital economics. In other words, they know what makes their hospital economically viable and whether they can get their office and their scanners and all the other things the hospitals have traditionally bought for them. Physicians don't understand analytic decision making, although I believe that all medical decisions from the time you decide to phone the physician, to the time the physician decides on the exam, diagnosis, treatment, and everything in between, is all Bayesian. Doctors don't think in those terms, and they overlook prior probabilities. They don't understand actuarial principles. They don't understand insurance processes outside of their claims adjustment, and they look at them as "the enemy." As I said, they don't understand the economic big picture.

Well, what's going on out there? What do I see? I see some new trends in the marketplace. I think there is some "is-integration." I think some people are turning away from the staff model. I think Foundation Health Plan (FHP) has recently gone to a new arrangement with its physicians instead of employing them. Kaiser has sold some hospitals in northern California and they are now contracting for hospital beds. They would not have done that in the past. They've abandoned their "build everything" strategy in other regions of the country. I think these might provide some opportunities for those health plans that missed the initial rush into managed care when U.S. Healthcare, United Health Care, and Kaiser became dominant in their markets. Other players may have a window of new opportunity here.

The government is beginning to mandate care. We've heard of the "two-day delivery," mandatory network care, and the banishment of gag rules. The government is also very actively trying to transfer risk, both in Medicaid and Medicare. There was a recent *USA Today* article in which the lead editorial was titled "Finally HMOs Begin Easing Access To Specialists." The closing two paragraphs read "and not a moment too soon, every year a million more Americans join HMOs, and the

rising public clamor about tight-fisted health plans is beginning to attract the attention of state legislatures. So far the states have largely refused to interfere, preferring for reforms to come from the marketplace. But if HMOs don't begin to answer the frustration of their members, politicians are likely to do it for them. For the sick feeling that prospect gives you, there is no cure."

Employers are starting to change in advanced markets. I think people in California are starting to reexamine their strategies. The Buyer's Health Care Action Coalition in the Twin Cities decided that too much competition was going on at the level of the plans, that providers weren't really competing with one another, so they've come out with a new strategy which may or may not work, but the intent is there. They're going to try to push the level of competition away from the three big plans that dominate the Twin Cities, into the provider community. I was talking to the head of benefits for a large national firm a few months ago, and he said "We're not as concerned about costs as we were. We're now regarding our health benefits as a strategic asset to try to drive employees."

Physicians are consolidating rapidly both within and across specialties, and they're also forming private companies. You're going to hear from the head actuary of one of those companies in a few minutes. They're selecting themselves and they're starting to incorporate some utilization and quality measures into their own programs.

I think there's a great deal of negotiation to be done, and I don't know what the final model is going to be. I suspect there will be several models that will be tried, but I would think that the future portends more integration between those who manage the risk and market the plans, and those who deliver the care.

**Mr. David L. Terry, Jr.:** It has been very interesting because I've been involved in all phases of the spectrum in the health care field over the last 15 or 20 years. I have worked for various large companies and worked in the consulting practice. Employers were the main people that I was consulting with for a while. They are finally coming together in terms of a merger between the three entities. Basically my talk is to try to put a little bent on where we've been historically. Then I'll give you an idea of where we are at present and what the future might hold.

Again, we've talked specifically about actuaries and we've talked about the provider community. I think the other key element is the employers because obviously they're the ones who are paying the majority of the health care dollar. I include the government as part of employers, and the people that are receiving care, because that's where the rubber hits the road. We are all being reactive to the situations that are out there from those purchasers, and so much of what we're doing is that

reaction. I will also try to put in my slant on how all three of those are coming in these various sections.

I don't want to give the idea that there's actually a distinct cutoff between historical and present and future. No matter where you go right now, you can find various aspects of managed care, sometimes even within the same city. "Historically" has been defined as mainly premanaged care—the old traditional indemnity insurance business. Let's take a look at what that means in terms of the various players. Medical payments in that environment were basically all fee-for-service, and just for definitional purposes, I consider fee-for-service to be any form of a retrospective payment methodology to a provider. So it can be a DRG, a case rate, billed charges, and discounted charges; it means rendering a payment for service that has actually been performed.

Now from the utilization standpoint, which is controlled by the provider community, they had the historical view that they don't miss anything, i.e., more is better, and quality for quite a while was defined as more utilization. The more things we do, the more we provide for people, the better quality medicine we're providing. Actuaries were very astute in terms of saying, "Let's take the historical information that's out there, the fee-for-service, from both the utilization standpoint and the unit cost, and build elaborate pricing models."

Those who have been around in the business know that for years we talked about trend. I remember the last time I was at the Colorado Springs meeting I was on a panel talking about trend, and there were a whole bunch of sessions talking about trend. I don't think you heard anybody really talk about trend at this meeting. We're talking about what's happening in utilization, in unit cost, and management. We're not specifically talking about looking historically and building models to develop trends. So actuaries were just taking what had been out there and they said, "Let's build a model and we'll project the future and off we go."

There really weren't many controls early on in the premanaged care days until costs started going through the roof. Then employers said, what are we going to do? Physicians and providers as well as insurance companies, and basically everyone else said it wasn't their problem. The employers said, "We'll try to do something." So they started controlling it through product design and benefit design within the products. Specifically, the employers and the health care companies, whether they be insurance companies or HMOs, were taking predominantly the full-line risk in terms of making sure that these products were financially viable.

Let's move into the present. The present is different depending upon the marketplace. Let's talk specifically about managed care and about precapitation as one

phase of the present day. Medical payments are some form of discounted fee for service, whether they be in the form of per diems, DRGs or case rates. They are some form of just passing along the rate reductions in the form of one piece of the equation. We, as actuaries, and many of the people who were associated with the health care companies, were focused strictly on managing costs through the reduction of the unit costs or discounted fee-for-service business. The providers really did not have much incentive to change what they were doing at this point. They still had a very similar philosophical idea that more is better, and the employers were saying that's not acceptable to them. So the employers, along with the health care companies, started developing third-party or internal utilization management protocols and medical management protocols to try to not only make sure that they were able to control the discounted unit cost side, but now try to figure out some methodology to also control levels of utilization.

So that was an external force that was being put upon the provider community. Actuaries during this phase were still looking at historical data and trying to build models to project what that was going to do in the future. They were saying that what's in the past is still good for the future. I think you see an environment, though, where much of the pricing now is an interactive methodology with the health care directors, with the plans, and the sites. What are you going to implement next year? What are going to be the changes in the UM/QA process? Try to evaluate how that will impact next year's pricing so that you can build that in. Obviously anybody out there knows that it is a very competitive position in which to try to sell business. Trying to get your rates as low as possible to be on the competitive edge, as well as having been priced appropriately to achieve internal financial objectives is a real challenging goal. But still, the controls are coming from the employer, and they're coming from the health care companies, through either product design or different products such as point-of-service or HMO products. The health care companies are trying to control it through either co-insurance or deductibles and through an external UM/QA process. Still, the risk was associated mainly with the employer and with the health care companies.

Obviously, there comes a time where employers are really pushing hard. We started to allude to the employer coalitions that are out there, and the employer coalitions are coming back to the HMOs and saying we're banding together in big blocks to have mega purchasing power. We're coming to the HMOs and to the insurance companies and saying we still believe there's fat in the system, and we don't want to pay these continual high costs or increases on an annual basis. What continues to happen is there's downward pressure on the insurance companies and hence downward pressure on the provider community to take a lower and lower fee-for-service discount. At some point there's a spot where providers in the community just say that's it, we cannot discount it any further, that's the end of the

discount. Then everybody comes to a level playing field in terms of discounted cost. It's kind of a natural progression now for the health care companies to go into a capitated environment with the providers because they have to figure out a way to lower utilization further in order to stay competitive.

And so the concept is to put the providers at risk where they will have more incentive to control the utilization and find the optimal level of utilization, so that we can bring prices down.

From a pricing standpoint, it becomes much more difficult for actuaries these days to price products. On the unit cost side it's easier because most of our contracts now have a cost associated with them, and we know what the fees are going to be, but trying to determine what the utilization is going to be in many of these products becomes a highly technical task. We start working more with the internal medical directors, especially in the capitated program, where providers are only going to take risks if they're allowed to control much of their own internal UM/QA. So now instead of having one consistent set of medical protocols and one set of quality measures, if you're starting to subcapitate or capitate with various provider groups, each provider group is coming back to you with their own internal set of quality standards and utilization management processes. So now it becomes a more difficult task for the HMOs to balance the standards of a whole bunch of different entities and make sure that they can justify to the employer groups that they do have a fairly consistent process between groups. Then one member who goes to see an IPA on the east side of town that's capitated with their set of medical protocols is receiving a similar type of health care quality on the other side of town with a different IPA. So from the actuarial point of view, trying to figure out how to determine what your future utilization is going to be becomes a fairly difficult task.

Controls are being switched in terms of who is directing some of those. Before the employer and the HMOs, the insurance companies were directing the UM/QA and the protocols. Under the capitated environment, you have much more of that being directed out of the provider groups into the insurance companies. Obviously, we've now added a third party. Much of this stuff that is going to be capitated right now is capitated for prepaid plans and prospective contracts. So you really don't have many employers taking risk in capitated programs. However, specifically within our group, we have had half a dozen large employer groups come to us directly and ask to set up a capitated program directly with them. Most of the time we're not allowed to do that because of state regulation, but in a couple of instances we have gone direct at the employer's request. I think you are actually seeing HCFA too, in some of its most recent regulations, going direct to some provider groups to provide some risk contracts.

Again, we have the three customers out there—the health companies, the employers, and the providers. The employers and the government are really driving the changes that are going on because they're tired of continual increases and they keep forcing the rates down. Every time you read a study, you see that there is still up to 30% overutilization going on in the marketplace, and employers, especially the large employers, are not willing to pay for that additional cost. Even though, with the reduction in terms of the rate of increase in the employer dollars, there is not the push now that there was three years ago. I think the provider community has been scared fairly dramatically through health care reform with the last set of elections. I don't think they want to go through it again. So they're willing to make some dramatic changes in the way they come together and work with the health plans and the employers to make sure that they're able to have more direct influence on the future of the health care system.

What I want to really talk about though is what you have from each customer, from the employer, from the health care companies, and from the providers. The employers have said, "Our costs are way too high and they must come down." In the current day, they're not putting as much pressure on, but I can tell you that in the marketplace five years ago there was only a handful of health care consulting actuaries that were out there consulting to employer groups. If you look at how many actuaries are in the consulting field right now, consulting to employer groups, you'd see that it's a huge industry. I was there for several years and I know how big it is. I remember when none of the Big Six firms had an actuary. Now their health care consulting practices are full of actuaries. Those actuaries, health care consultants, and employers are out there on a daily basis dealing with these very issues. They're talking about bringing down costs, and the word optimal is one many people are using these days. It's something that's in the future. I don't know how far in the future that is, but that's where many people, especially the employers with their consultants, are trying to get to. They're trying to figure out how we move from today to some point in the future where we have the highest possible quality at the lowest level of utilization.

So you have many companies out there now that are trying to figure out where optimal utilization is. What are you going to negotiate after you've figured that out? What is a fair reimbursement price for that level of utilization? So here we are in the interim, and in some markets we could be 50% above optimal, and in some markets we could be at the optimal level. In Medicare risk the government's utilization rate is running at 2,500–3,000 bed days per thousand, and in the HMOs and in some really strong managed care areas it is running at 700–800 bed days per thousand. When you look at that differential, there's a great deal of utilization that can come down. Some of that might be due to favorable selection.

My role, in terms of working as part of a provider organization, is to start educating them. We start talking about where we are in the marketplace, about the actuarial principles of developing rates, and how rates are set, the underlying level of utilization, and the unit cost that develops those rates. We then start talking internally with the medical directors about where we're going to set our optimal level of performance. We start building models to generate what our optimal pricing level is, our floor that we're willing to negotiate, and what's in between. We can't move to optimal immediately, but we're trying to move to optimal in our sites as quickly as possible. And that's not only in our managed care business, but it's in our standard business, too. There's going to be one set of protocols that are for everybody. We're trying to say that between today and some point in the future, we're going to have to make this migration, because obviously the employers are going to demand it. It's better to get there earlier than having it forced upon us through possible legislation in the future. So our goal is to figure out what optimal is and move toward that end.

With the actuaries and physicians actually coming together, our role really is to start educating the physicians (because they do control the vast majority of the health care dollar that's spent), about what it means to take risk, and what the level of risk is. One thing I often talk about is just plain old utilization, but then I start getting into capitated programs. There are two forms of capitation out there, and the most prevalent is just a per member per month (PMPM) fixed-dollar amount. Say you're paying $40–$50 for all professional services. The providers are taking the risk to make sure that they can keep the utilization within those boundaries. You can develop those rates based upon historical experience, both from your own internal data, which is very difficult to do since providers do not have systems that put the data in a format that's really usable to compare to what the health plans are doing, and you can take historical data from the HMOs and negotiate a rate.

One of the areas that I try to help them understand is, when you get into a percentage of premium, you've now given the opportunity to the health plan to stop doing underwriting. That means the underlying health care data that's coming out of their system is good only to the extent that they continue to underwrite exactly the same way they've been underwriting. If they do no more underwriting and go out and sign up every uninsurable group that does not have coverage now at a standard average rate that was in your underwritten population (I don't care what rate we have for capitation), we're going to get killed. Our role is to start educating them on what risk is and what the insurance risks are. There's much more than just utilization risk in terms of pricing. They need to understand some capital requirements and all the various pieces and where all that comes from.

Obviously some providers are ready to jump in right now and be able to take all this risk. Most of them aren't. Most of them will have to phase into it, and so it's really important for them to have people out there that are going to help them understand how to phase in to risk and develop that. I think most of our providers want to do it on a shared basis. I think they want to see a long-term three-way partnership between the providers, the employers, and the HMOs and figure out a way that all three of them will have long-lasting, long-term partnerships.

One of the biggest issues right now is building the optimal pricing. Much effort is going into that with companies trying to figure out what are the most appropriate medical protocols. What's the best level, or optimal level, of medical protocol and the utilization associated with that. When they bring that back and work directly with all the medical directors and physicians in the plans, you then start building pricing models to try and figure out where your floor is in terms of cost.

The bottom line is we're in this transition phase moving from our current to the optimal pricing. We're trying to understand what's going to happen to all the dollars that are currently in the system and where they will be going. Since actuaries probably understand utilization the best, whether it be on the health care side, the insurance side, or from the provider side, they are a great conduit in terms of bringing both sides together to help understand how to make the transition.

I have no idea about the future! If any of you have any great ideas, I'd love to sit down and talk to you because I think it's wide open. I don't think that there is a model out there that I see being used over and over and over again. There is a hodge-podge of just about everything, and we're still trying to figure out how to make it happen. I think the future is still wide open. There's probably something none of us have even thought about that will probably happen in the future.

**Mr. Craig M. Arnold:** Regarding capitating directly with employer groups, I know there are variations between states. I just moved from Georgia and it seems like they're fairly strictly against any capitation or any direct arrangement between provider groups and employers. Do you have any information on what states you had problems with or are there any interesting situations? The second part of my question is, what special arrangements does your company have to make as far as reserves, to make sure your providers can handle that kind of arrangement?

**Mr. Terry:** In terms of the first part of the question, I think there are very few states that allow us to capitate directly with an employer group. So it becomes a tricky situation for us. If we have groups that have been in capitation for quite a while, it's easy for us to walk in and do kind of a retrospective methodology. It's not true capitation, but we'll set up some budget targets and work for a single financial goal

and then share somewhat in the surpluses on a retrospective basis. If the group has not been capitated, even though you're providing all the same information in the data management reports, they have a tendency not to move toward optimal as fast when they're not actually capitated. So you have to make sure you just move at a slower rate if you're not doing a fully capitated program. In terms of reserves, there are no legal requirements for us to actually have to set up reserves, but in terms of all of our capitated agreements, we're setting up full reserves pursuant to the guidelines and with sufficient margins both at the plan and at a corporate level to make sure that we're able to maintain and live up to any financial obligations that we have. I don't know if all of them are doing that. I can only speak for ours.

**Mr. Thomas P. Edwalds:** I recall when Milliman & Robertson released its managed care practice guidelines. I heard from a number of acquaintances and providers, something to the effect of "Why do actuaries think they're qualified to make clinical decisions?" How would you respond to that? Do you feel that there has been any change in the attitude of the provider community toward this kind of guideline?

**Dr. Vollertsen:** Well, first of all, the clinical guidelines were developed by clinicians at Milliman & Robertson, and there are certain caveats. I always tell people these are set up based on the assumption that you have all the supporting facilities available and while you might have those in a place like Los Angeles or Minneapolis, you might not always have that in rural parts of the country.

The other caveat is that if you look at these health management guidelines, there's family support for people as well. If somebody lives alone, they might need more care than somebody who doesn't, particularly someone who is older. Finally, the guidelines are set up with the idea that each disease is the only disease a person has. Of course, when you get multiple problems, as you often do, the guidelines won't be directly applicable. The guidelines really weren't made up by anybody. They represent observed practices that are being done in the health field. As for physicians and their attitude towards guidelines, of course they don't like them. Nobody likes to be told what they should do, particularly those in the professional areas. I'm sure engineers wouldn't like guidelines. I know lawyers don't like guidelines, and I suspect actuaries probably wouldn't like actuarial guidelines. On the other hand, it does help to see what other people do; it is a standard and a benchmark, and it should be used that way. You can buy many guidelines, not just ours. Most of the professional organizations within each specialty have guidelines for common problems. It really works best to get those and look at them, but then to have the group that's going to use them develop their own internal protocols. They have a chance to review them and learn them, and you get buy in. I hope that answered your question.

**Ms. Pamela S. Woodley:** Can a provider group really get to optimal much faster than their surrounding medical community? Can they actually be much more advanced from the rest of their local community?

**Dr. Vollertsen:** I'll give you two answers. Hopefully they'll be compatible. At least I think so. All this variation out there now indicates that they're all doing different things anyway. I see no reason why a provider group could not. Now, "can they" and "will they" are two different questions, and answering the "will they" is where it takes a little work. There's no reason they can't. In fact, as I said, there's already a great deal of variation among providers and physicians in the way they behave now. It's there. The question is, how do you determine the optimal approach, and how do you get the buy in. Those are the hard parts.

**Mr. Terry:** I don't think we can define optimal right now. People have protocols out there, but there are so many criteria, it makes it hard to actually dictate exactly how it's done. We're a strong proponent of the fact that every site takes a standard set and then uses or gets buy-in from every one of the specialties in terms of developing a goal and an expectation that they will manage. Once you get the physicians bought into that goal, they will move there quite quickly, regardless of what the rest of the community has done. As long as they feel that they've had input in terms of designing it and they feel like everybody is being measured by the same standard that they've all had input into, they will move toward that goal fairly rapidly. The key is site by site. How aggressive is that goal toward real optimal. (I think we were fairly consistent.)