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Session 81D
Ethical Issues in Managed Care: Where Do We Draw the Line?

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Summary: By rationing health care resources, managed-care organizations have raised ethical and legal issues not commonly found under previous financing structures. Both state and federal legislators have reacted to some of the managed-care efforts to reduce hospital utilization. Mandated minimum maternity stay allowances and mandated mastectomy site of service laws are examples of the public's reaction to certain efforts at managing care. These issues are discussed.

Mr. James J. Murphy: I'm a health care consultant and a manager of a health and welfare consulting practice in Seattle with Howard Johnson & Company. Our two debaters are not as they appear, either in the preliminary program or the final program, or even on the handouts.

This has been a very flowing and evolving debate. We have debating the issues on medical ethics, an actuary and a doctor. I'll introduce the doctor first. Dr. Tim Flaherty is here, thanks to the good auspices of Mr. Tom Reardon, who at the last minute had a conflict and could not join us. Mr. Reardon is Chairman of the American Medical Association (AMA). Dr. Flaherty is a member of the Board and the Executive Committee of the AMA and Chairman of the Finance Committee. He is well-versed in medical/ethical issues. He works with a radiology group in Neenah, Wisconsin and there they have about 12–13 managed care contracts, so

†Dr. Flaherty, not a member of the sponsoring organizations, is a member of the Board and the Executive Committee of the AMA and Chairman of the Finance Committee in Neenah, WI.

he's well-versed with that as well, as most physicians are these days. He is also a member of an insurance company board, so he has some understanding of that side of the aisle as well. He also serves on two advisory committees, the Advisory Committee for the National Business Coalitions on Health and the Advisory Committee for the Federation of American Health Systems, so he has, through the AMA and his own activities, been quite active and, hopefully, will be able to address our issues well. Mr. Dennis Hulet is a Consulting Actuary with Milliman and Robertson, out of the Seattle office.

We've identified a number of issues in medical ethics and managed care that we want to introduce to you and give you a sense of the issues and the different points of view that surround them and we hope that the debate format will help us do that. There are six issues we want to address: quality outcomes assessment, excess managed-care organization profits, gatekeepers' access to specialists and any willing provider issues, capitation and incentives for over- or underutilization, disclosure and economic credentialing, and report cards and profiling. For each of these issues we'll have a debate format with one of our speakers presenting some points related to the subject matters for approximately five minutes, followed by another speaker responding and adding to the issues. We'll allow a couple of minutes with each of the six issues for you to ask our debaters some penetrating questions, and then we'll move on to the next issue. Our hope is to cover all six issues and then perhaps at the very end of the presentation we'll have some additional time to follow up on some questions that we may not have been able to cover during the issues themselves.

You'll also find in the program booklet that it says that this session is for those of you who have no experience in the topic. To make that true, I'll say a couple of words about managed care, in introduction to our debate.

Managed care has been with us a long time, although it has most recently been thrust in the limelight, particularly for its use in controlling cost. Lately, I think the public, the employers, the buyers, the legislators, and regulators are giving more concern to quality, not just cost.

Managed care really blurs the line between the payer, the insurer, and the provider, as opposed to the traditional fee-for-service system. With managed care, you will see insurer/carrier groups actually setting guidelines for medical care practice. At the same time, you'll see providers under capitation, in effect, taking some of the risks. Managed care is a blurring of that, so that you see no real hard and fast lines between the elements of our managed care system.

Certain characteristics of managed care, are utilization management, provider financial incentives, and preventive care and disease management. These kinds of characteristics lead to some new issues in the area of medical ethics, and that leads to our debate.

The other issue I allude to is what we are seeing in the regulatory and the press environment these days, which I'll refer to as a Medicare backlash. More and more through perception or unfortunately, in some cases, reality, the public has seen some issues that have made them unhappy. That has translated into media and legislative attention, with mandated benefits, prohibition of gag rules, and so forth. One issue perhaps or response to this backlash is a focus on ethics in managed care, and I think that's one reason this topic is so important for all of us who may be working now or in the future in this country's medical health care system. Even those of you who may be from Canada, where I think the managed-care process will have to start being applied more and more to help control cost, will have to deliver care in a quality fashion at the same time.

With that as background, I think you've heard enough from me. My role now will be to keep us on schedule and limit our speakers to their allotted time. Let's get started with the first issue, which is quality outcomes and assessment, which will be presented by Dr. Tim Flaherty.

Dr. Tim Flaherty: I lost my compass for Washington, DC. I used to come out here a great deal, and I had a routine. I would go into the men's room after getting off the airplane, wash my hands, and get cleaned up for my next tour here and in Washington, but they don't have paper towels. They provide those air dryers, and, of course, we're against that in Fox Valley, Wisconsin because we're a paper country. But I'd push the hand dryer. And one day I went into the men's room and there was a message on the hand dryer; it said, "Push here for a message from your Congressman." I did, and I got hot air. Sometimes I get cold air and sometimes I get no air, so when I came to Washington, I always had a feel for the city by my hand dryer. Well, they've taken my hand dryer away. I don't have that compass anymore, but you are in somewhat of an unusual situation. You know, Disneyland North is what they call Washington, DC. The only city where a secret is telling one person at a time. It's as John McLaughlin defined it, a city with northern charm and southern efficiency, where one person does the work of ten or ten do the work of one. The interesting thing for you people who are actuaries, I noticed in the paper this morning that they don't know where $46 billion came from in our Federal Treasury. You know, $46 billion is a big miss. That's nice, but they don't know if that's a one-time situation or a continuous deal so they don't know how to budget. Try to help them solve that problem.

As you heard, I do chair an insurance company board, so I am familiar with actuaries. We have inside actuaries and outside actuaries. I work with medical liability and sometimes that's a tough guessing game to predict which way the trends are going. Our actuary is outstanding and recently during duck-hunting season, he was out hunting with our President and our Chief Financial Officer (CFO). One duck came across at a very high rate. The President shot ten feet ahead of the duck, the CFO shot ten feet behind the duck, and the actuary declared the duck dead. Basically, actuaries do help us out in some of those areas, but we're talking about serious things here and not foolishness.

The quality outcome is a serious deal. *The Wall Street Journal*, last Thursday, had a special edition on health care, "The Face of the New Era." *The New York Times*, yesterday, had "Smart Rules For Health Plans" on their editorial page. *L.A. Times* had it the day before, because there's a big emphasis on the quality areas in managed care. It has come at the impetus of the President, who has formed a quality commission. In fact, Mr. Reardon sits on that commission, which is tasked to complete a report that will go to Congress, hopefully for implementing. We see that more oversight has to be done in the whole area of managed care.

The AMA has come out with an ethical code in managed care for our physicians. But the issue of quality and outcomes assessment is a more difficult matter, I think. The ethics is mostly straightforward—the patient comes first in the patient/physician relationship. It's a fairly easy line of accountability that we've drawn and can pursue. The area of quality outcomes, however, is different. Everyone wants to know about and try to define quality. We have the National Committee for Quality Assurance (NCQA) that has the Health Employer Data Information Set (HEDIS) measurements, which are compliance measurements, but they try to differentiate between plans. We have the Joint Commission doing that in their network program and in the hospital situation. We also have FACCT (Foundation For Accountability), which does it on a federal level, so there's a number of different areas that are trying to define quality. We at the AMA have a new program called the American Medical Accreditation Program (AMAP) for physicians, who can benchmark themselves against other physicians to see if their practice pattern is parallel not only from a factual side—credentialing, their quality improvements, their office site, their environment of care—but also from their outcomes. Everybody is trying to get a handle on it.

One of the groups that Jim alluded to that I belong to is the Federation of American Health Systems, which represents the buying coalitions. If you ask the people in the 104 or so buying coalitions, that belong to the association, they insure or contract for 35 million people in this country, almost all in ERISA-exempt programs, but they are still the responsible party. Quality is usually assumed. The quality equation is

an assumed equation by the employer, the purchaser. However, when you hear the managed care horror stories, it reflects negatively on that employer. They have great sensitivity to that; consequently, they, as well as the President, the government, and the profession, are looking for areas where quality can be better defined and better assured.

How long will it be before we have some quality measurements that differentiate practitioners? It's going to be a while. Managed care plans are just beginning to address the issue of quality measurement. The Joint Commission has just recognized 241 different indicators. But until there's a core set of indicators that you can use to compare one group of physicians or one physician against another group of physicians, benchmarking is going to be difficult. What do we look for as far as patterns of practice? We look for compliance. We look for preventive medicine—immunizations, mammography, and other preventive areas that are defined by the HEDIS areas. If we see differentiations, it is role modeling and benchmarking for physician groups. It does change behavior, and it certainly changes behavior and plans because plans have to market every once in a while.

How many people in this room belong to an HMO right now? Typically about half. That's about right in the area of the country. There has been a big increase in groups. The question that comes up is how many people have a choice of more than one plan? About half the group that belong. That's something that everyone is trying to encourage—choice. Frequently, it's the same plan but maybe a point-of-service option or some other option that gets you in and out of it, but choice is a big deal. If we do surveys across the country, the consumer's number one issue is choice. Obviously, if you look at the ERISA-exempt plans in this country, which account in Wisconsin for 60% of the employee base, Wisconsin ERISA-exempt, frequently 80% of the time there is only one choice. Thus, choice is a big issue.

But from the quality standpoint, until we get a standard set, until NCQA, Joint Commission, AMAP and Foundation for Accountability (FAACT), all agree to a core set, we're going to have a difficult time. However, we're working toward that core set.

Mr. Dennis J. Hulet: Let me set the stage a bit. My experience in the ethical issues of managed care, I would imagine is somewhat different from your roles as actuaries. That may be because of the health care management guidelines that we, as a firm, published. These are clinical guidelines that are intended to help the medical community understand some of the highly efficient practices that others in their discipline are using in day-to-day patient care. Because of that, there has been a lot of discussion and various sources of media that describe the horror stories about people who have treatment according to some guideline that was

inappropriate for their situation. There's also a great deal of discomfort among some of the medical community in using guidelines because those guidelines are often dictated to them by a payor, rather than having it in a participatory situation, where they can have input in the creation of those guidelines. That aspect of my consulting practice makes it so that I've had to think about some of these ethical issues that might not come up in day-to-day actuarial work.

In my opinion, there is a ethical issue with the legal profession. There was an Internet discussion involving an attorney in New York who was looking for managed-care patients who had some adverse outcome in their care. He was of course looking for a case to pursue, and to reap some big bucks from the managed-care industry, and he made no bones about it. He was looking for that patient who was dissatisfied with what managed care provided it could be turned into big bucks for himself and the patient. That attorney wasn't looking for what processes were working, but rather where there was a failure in the system. It's those failures in the system that cause the quality issue to arise when we're using managed care. If the managed care industry didn't restrict choice, we probably wouldn't have as much concern about the quality-of-care issue through the managed care organization. But the fact that we do make some limitations in provider selection, and even in some of the things that have to take place before an individual can get certain kinds of care, causes the quality concern that we'll hear over and over again.

There are a number of media reports, like I said, that involve our health care management guidelines and how they're being used by various people in the industry. In most stories, they get the facts almost right, but build in something of a sensational nature because they are in the business of selling a story. There was a story on one of the major network's evening news magazine programs that featured one-day maternity stay issues. The reporter talked to one of our doctors about our guidelines and why we thought they were appropriate. They talked to a surgeon who happened to be a surgeon out of the University of Washington Medical Center who thought the one day maternity stay guideline was inappropriate. They then talked to a patient who had an adverse experience. My impression of that patient was that was not somebody that I would want to be my advocate in any type of a situation, but nonetheless, she had a horror story to tell, and that's what the news magazine program focused on. Even though the story was supposed to be about how guidelines were used in the managed care profession or environment, the story—about three-quarters of it—focused on this patient who had this adverse outcome. That's what brings about the quality-of-care concerns.

The insurance industry as a whole has been very poor at selling their emphasis on quality. All the public knows about the insurance industry is that their emphasis is on cost. Managed care organizations have been somewhat better than the

insurance industry in selling the case of quality and that they provide quality, but they still are viewed as being in the business of cutting costs, not providing quality health care. I think we need to get over those two concerns. Managed-care organizations and the insurance industry have to do it themselves. They have to become public advocates of quality.

Mr. Murphy: Would anybody like to pursue a specific question on the quality issue, relative to ethics before we move on? I do have one question. Do you believe that managed care and the quality of care, under managed care, is in some way, lesser than under the prior total fee-for-service system?

Dr. Flaherty: Yes, I'll answer the question. I think it's a difficult question to answer Jim, because when you say managed care, it's such a global term. If somebody has made the statement, I think it's correct that if you've seen one managed care plan, you've seen one managed care plan. There's tremendous diversity in the country. I come from an area in the Midwest that's heavy in managed care, but, again, we are primarily physician controlled managed care. There are large clinics, Mayo's, Gunderson, Marshfield Clinic, that provide the care, so there's an appeal situation that's very local. If I talk to a physician that has his 800 number in Iowa or California, but his office is in Wisconsin, he feels disconnected. Sometimes a decision making process seems to be removed, which is oftentimes blamed or attributed to some of the problems of managed care, but I don't think you can make that global statement. There has been some scientific work done in the Medicare community, in California primarily, where they thought that the care under the traditional Medicare led to a higher patient satisfaction under the managed care arena. But, again, there's so much selectivity in people that goes into managed care, and the Medicare group, the 65-year-old who is healthy, rather than the 65-year-old with chronic disease.

Mr. Murphy: There was a Society session a number of years ago entitled "Does Managed Care Work?" A representative from the insurance industry was giving a presentation and making the claim that managed care didn't work. My view on that is that managed care by definition works, but there are many entities out there that call themselves managed care that aren't managing care. There are many that restrict care and do other things to control the cost, but managing care means that we're taking a more proactive stance and managing the entire needs of the patient, rather than leaving it to a single provider, which in the past has been essentially the primary care physician (PCP), and trying to organize it across all of the various aspects of the delivery system, so that better care can result. However, we haven't done a good job of measuring that and so it's hard to show statistically that we have improved quality.

Dr. Flaherty: I would say amen to that statement. I think that's right on.

From the Floor: With respect to development of measures of quality, do you see a trend toward trying to link such measures to reimbursement, and does that create more problems than it solves? What are your opinions on that?

Mr. Hulet: There are definitely payment systems in place that purport to have an element of quality taken into consideration when they pay out incentives. I don't think we collect the right data and have it accessible in a way that lets us do a good job of measuring quality. I'm sure that will improve over time, but, historically, claims data is what we've used and we don't need to know about quality in paying claims. We just need to know that it happened.

Dr. Flaherty: Yes, and that's the one big area that's a tremendous exception. You can't risk adjust claims data very well. Actually, if you look at risk adjustment, it really is a secret. Who is getting the most challenging cases? Is it somebody that comes in with an uncomplicated case, or do we have diabetes and a number of overlying conditions that make a difference in the risk adjustment? Risk adjustment is the key.

From the Floor: Since we're on the topic of quality and outcomes, is this the point where we should talk about malpractice issues?

Dr. Flaherty: Yes, malpractice is an area that we have difficulty connecting to quality of care. Obviously, there are some outliers in every profession. We have them in medicine, as they are in every other profession. They tend to generate some suits, but, unfortunately, it tends to be the physician who takes the riskiest patients, the one who takes care of the neonatal-intensive babies or does the high-risk O.B., or the neurosurgeons who tend to get sued more frequently, which doesn't necessarily reflect a practice in their pattern, but a practice pattern of that specialty. That's a problem. Chairing a medical liability insurance company board, I can validate that for you. Frequently, 80% of our cases that are filed are settled without any payment, and that's typical of the medical malpractice industry. It doesn't really improve quality. We do think there is a tremendous avenue for us in patient safety areas; in fact, there's a new patient safety foundation at the AMA that has received funding from the outside areas that are looking at patient safety issues—the human factors research, the things that go into repetitive behavior, mistakes on the system. No one is perfect; unfortunately, in medicine we try to be perfect, but we have a blaming society. When something goes wrong somebody gets a finger pointed at them, and it doesn't really improve the quality of the system. All it does is take them out of the system.

From the Floor: What I was really trying to get at is, you've switched some of the roles on this package. I'm thinking about the Texas situation for example. Does the role begin to shift to the entity and the appropriate malpractice situation?

Dr. Flaherty: Well, the Texas legislature thought it did, obviously. They put some liability on the managed care companies. In California we had a couple of big suits and big payments that also fell within managed care—$89 million for the one case that went to the managed-care companies. I think it depends on how they're run. It makes a difference in who's making those decisions, obviously, in both the President's proposals or the quality commission's proposals and the ones that have come out of the principles of consumer protection, which is a combined group. They speak to this, as far as disclosure and who has the ultimate responsibility.

Mr. Hulet: I had a managed care client that told me he thought he was in a better position to fight malpractice claims than the single practitioner, because he has established guidelines for care within his HMO, and has a core of community physicians who agree with that type of quality care. That means that an attorney who wants to take an adversarial position against this would have to find those in the community who didn't agree that was a standard, knowing that his opposition could put any number of community physicians who were part of this organization on the stand who would say, "This is accepted in the community as high quality care." I don't know what the statistics are, maybe some of our casualty associates do, but I have never seen anything published that would indicate that managed care was better or worse as far as malpractice liability goes.

Dr. Flaherty: There are certainly more people buying another layer of insurance, because of the managed care situation. Almost all of our clinics take another layer of coverage now because of that issue.

Mr. Murphy: That's part of the blurring I referred to earlier among the various elements of our system, and as those lines blur, the relative liabilities spread out. Let's move on to the next issue. Quite different from the issue of quality. Again, to a financial issue of excess to managed-care profit. Dennis can introduce this one.

Mr. Hulet: I'm a managed-care advocate because I believe that we have done very poorly as a society and a medical community in organizing the way care is delivered, and that managed care has not made an attempt to apply some of that organization and gather the information that's necessary for one practitioner to learn from what another does well. Because of that, the results that I see in many managed care plans are somewhat distressing. We'll see a plan that makes a fairly substantial profit because they're able to convince providers to take discounted fees, and to be more proactive in managing care, getting people out of the hospital, and

using outpatient settings for much more of their care. And yet, when it comes to the distribution of those profits, it often ends up in the hands of senior management or shareholders, rather than the providers who have had to make most of the sacrifice in getting there.

In our consulting work, we use the concept called degree-of-health-care management where we try to evaluate the difference in the cost of a system, in moving from unmanaged or the typical fee-for-service type results, to a system that is well managed, as with the highest quality HMOs. Moving from one extreme to the other in that spectrum, we find that there's about a 30% difference in cost, not due to discounted contracts with physicians or hospitals, but due solely to the lower utilization that results because of the removal of some of the unnecessary services that have been typically part of our traditional system.

Those dollars associated with that 30% should be able to filter back into the system to assist in another way, either to compensate the providers for what they gave up in the discounts to cover the uninsured who still pose a substantial problem in our country, or to help subsidize the programs like Medicare and Medicaid, where we are dealing with individuals who may not have the same ability to pay as those of us who are in the workforce. It's very distressing to me to see the efforts of the providers who do well, in an organized managed care setting, disappear into the system, going either to the shareholders, or the upper management.

I would hope that Dr. Flaherty has an opinion on that, since he is a physician and might have experienced some of that distress himself. But I think that we, as actuaries, need to be sensitive to that when we help our clients look at financial projections and how the money is distributed, if the savings we expect do emerge. If they continue to disappear within the financial structure and fail to go to some of these other good causes, then I think we have failed as a managed-care industry. Sooner or later, the government will step in and say we need to take your money away so we can deal with these other situations.

Dr. Flaherty: I've been attending the meeting of the National Association of Corporate Directors, and you can imagine there they were talking about maximizing stockholders' returns. Oxford Health just lost 62% of its value after the little dip we've had in the stock market. Obviously, those issues are real issues. The physician community is incensed when they see $45 million here and $9 million there for someone who is running a for-profit, managed-care plan, as compared to having that money go for patient care.

One of the lists that's always good reading for all physicians is the medical expense ratio of HMOs across the country. It's published every year by our friends from

California who started it initially, and there is a trend that you can see in medical expenses, that is how much money is spent for medical care, as compared to how much goes for administrative cost profit, etc. It's not an absolute term, obviously, but a new HMO is going to have a higher expense ratio than a mature HMO. But there is a trend, and you can look at the California experience by itself—60–95% goes for patient care. That's a big swing. Most people think there's a 15% or 20% layer, the insured's layer in health care. Our friends in Minneapolis have been in some measure ahead of the rest of the nation in the way they do business. As you know, Minneapolis and St. Paul are the home of a number of major corporations. About ten years ago, they went back to the business buying group and said they wanted to do things differently. They put out a request for proposal (RFP) and said, "This is the basic benefit package, now you comply with it."

Over the years they got it down to three big systems. That's all that's left in Minneapolis and St. Paul, three big health care systems. All the physicians were in all three systems, so choice was not a big issue. They just darted back and forth each year. Well two years ago they decided to change the system and let the employees have the contracting choice, so they asked the provider group to split up. Now there's 15 or 16 provider groups in Minneapolis and St. Paul, and the employee makes the choice. The employer has gained a defined contribution. The employer is going to put so much money into it, and you make the choice of where you want to go in that system.

Obviously, they've also done something else. There's administrative costs that they plug in there, but it's 4% or 5%, not the other in between for aligning the health care systems. So there's no question that people are looking at it as far as what we're doing. One of the plans I belong to is a joint venture between a hospital corporation and a physician on an HMO, and we try to get rid of the insurance factor through it. There's no question that in the not-for-profits, more money goes for your care, the health care of the enrollees, as compared to the for-profits. I think that issue is going to stay out there. This is a capitalistic society. We're going to have for-profit situations, but the question is where do the profits become obscene as they like to say? It's in the eye of the beholder.

From the Floor: It was my understanding that those medical expense ratios have some problems in terms of consistency of data and how they're measured.

Dr. Flaherty: They do, especially from state to state. I think for states, usually the Commissioner of Insurance defines the rules for reporting. I looked at the rules from Wisconsin and they seem to be fairly close, as has been my experience. Because California is more experienced, the rules would be fairly reliable, but they certainly may be in other states. Are you from California?

From the Floor: No. But I just heard that you have different rules for the HMOs than for the ones that are managed care, not necessarily HMOs in California. It gives an advantage to the HMO.

Dr. Flaherty: The question is, can the HMO gain the system? I think the answer is probably yes, because they have smart people like you working for them. I don't know how much gain there can be. Dennis probably knows better than me.

Mr. Hulet: The issue of how the gain is shown on a statement like this and how it actually emerges is always an interesting exercise and certainly any formal report is going to be subject to manipulation by those who are reporting, so that it shows them it's the best place possible. But I think that change between the high and the low is important when you look at it. If somebody can make 35% profit versus 5% profit, you know that there's some slush in there somewhere that is either going into shareholder pockets or management pockets or being used for other activities in the community.

Dr. Flaherty: I'll make one other comment. These are trended over a 5-year period, so when you see medical expense ratios going from 84 to 86 or 67 to 62, things are going the wrong way. As the plan matures, they should be going the other way.

From the Floor: There are a number of states that do have these loss ratio disclosures, and one of the big debates we've seen is that a number of HMOs have insisted that they believe that the cost of managing care and the cost of the network development should be thrown into claims. I think a patient would argue the opposite because they're not getting any care for that.

Dr. Flaherty: Yes, that's a significant issue. Another issue is that when you start the plan, for instance if you're the Marshfield Clinic and have 550 physicians and only 15% of your HMO population, how much cross subsidy do you have in that scenario? Obviously, you have a lot of cross subsidy. It's very difficult to define.

Mr. Hulet: In the efficiency view of a managed-care organization, it's my opinion that the value that you get from a service like the utilization management group has to at least show that they can reduce claim costs not to justify their existence. If we get systems where the cost of the utilization management aspect is exceeding the savings that can be produced from that, then we need to get rid of that administrative function. I don't think that it should be included as part of claims, but it certainly should be highlighted because that is a way that they use that to reduce that claims component. I think it's improperly categorized if we put it with

claims, but, on the other hand, we need to know how big that component is over the entire administrative expense.

From the Floor: Do you put the administrator's involvement in care as part of the claim cost or administrative cost? Another part that muddies the waters is when the HMO capitates virtually all medical services to another organization, which then turns around and pays providers, and each of the organizations in the layer takes out say 12–13% for administration and expenses. You've now doubled that to 25%, but in the HMO's report, it will show that they're only taking out 12% because they're paying a capitation, which then turns around and layers more administrative costs.

Mr. Hulet: That's a good point. The organization that's accepting the risk has to have some administrative structure in order to manage those patients in the risk, so a capitative entity has to have some administrative function. The duplication, hopefully, is minimal, but we do know there's duplication there. The thing that I encourage my provider clients to do is make sure that anything that was built into their assumptions for premium, that is to pay for that administrative function, has an appropriate piece passed on to the capitation to the providers of care for what they're being asked to do. If they're the ones who have to have a utilization management function, then they ought to be paid a portion of the administrative overhead to do that rather than having it come out of the patient care dollars.

From the Floor: This is more of a comment. To some extent the excess profitability will be managed by market forces. If the managed care organizations are competing for patients, the ones that are expensive aren't going to sell and the ones that are willing to take less profit will be able to sell their product, so we've got that force working. I'm from Milwaukee. We saw a large health care organization and a large provider group part company, over this issue. I was wondering if you could talk about that for a while.

Dr. Flaherty: That certainly is true in Milwaukee, and it does happen. If you look at urban managed care markets, 25% of people change every year. That's tremendous change. One of the big issues is, do they change their provider? In Minneapolis they didn't. They'd go from one group to the other, but not change their provider. In Milwaukee, that choice was given to them, and I can't remember what the defection rate was, but it was a significant defection rate from the plan because of the change in the provider, both hospital and physician, that they had to realign with. I think that's the issue—the issue of choice and that lack of choice. I think the next subject will touch on that issue specifically, talking about gatekeepers and access to specialists. I think that's a real issue, the question of the churn, who makes the decision? Is it the employer who makes the decision? The ultimate

consumer, the patient making the decision? Or the employee as we're going to do in Minneapolis? No. That's an interesting vignette. And, obviously, if you talk to the coalition groups, to be competitive they want to have a competitive environment. American Express and that wonderful lady Luann Cash who runs that now, contracts now for about 6 million lives for their cooperative deal across the country. They'll go into communities and ask for bids, and they'll try and evaluate the quality of each plan. Then they usually put two plans into the mix. Some areas they are forced into a plan. If they're in Phoenix, they have to have Mayo, because Mayo is an icon and you can't have a managed-care potpourri from American Express' standpoint, in Phoenix without having Mayo Clinic there, so I think those issues will come up too. That same choice issue.

Mr. Murphy: With that, why don't we segue into the next issue, that of gatekeepers, access to specialists, and any willing providers—somewhat the workings of managed care?

Dr. Flaherty: I hate the name gatekeeper. Most physicians hate the name gatekeeper. Care manager is more appropriate. Gatekeeper suggests you're locking people out or keeping people out. As Dennis accurately said it before, it's a question of who is managing the care? Is it the physician? The physician group? Who is doing the care management? As you'll see, if you haven't already, in the principles for consumer protection, which is jointly developed by the American Association of Retired Persons (AARP), Group Health Cooperative, Kaiser Permanente, the HIP 50, and Families USA, access to certain specialists is considered primary-care access. You cannot separate that access for an obstetrician from that enrollee. Maybe pediatricians are the same way. Some groups have found that it's less expensive to have direct access for people like dermatologists, ophthalmologists, and ears, nose and throat (ENT), rather than going through a PCP. Those are decisions that are made from a group standpoint, which I think probably direct themselves to what is the best care rather than how you can save the most money. I hope they'll do the same. I think the best care usually is a money saver. If you have a restrictive formula, as Susan Horn from the Intermountain Healthcare showed, at least for treating ear infections for children, it's going to cost you more money than how people adequately treat it. So the issue of how much protection, how many fences you build, is a big issue. But if we can talk about care managers rather than gatekeepers, everyone should have somebody who they rely on as their physician.

A physician whom you identify and feel comfortable with either in your age bracket or your background, whatever it happens to be, but at least somebody you trust. People do better when they have good relationships with their physicians. They have better outcomes. So, again, I think we're turning the corner. I think both in

the President's proposals, the Quality Commission's proposals, and the one that's been distributed by the Principles for Consumer Protection, we're talking about more direct access to certain kinds of providers, so-called specialists.

Mr. Hulet: I think the term gatekeeper was important at the time it was initially used. At that time, we had systems that had no control over patient access anywhere in the system. Basically a patient could decide if they wanted to enter the system through the emergency room, by going to a cardiologist, or by going to the orthopedic surgeon. They looked at those systems that organize themselves to say we want the entry point to be this PCP as a control point in the system. And if you view it as a control point, then gatekeeper is as good a term as any.

But I think what Tim is indicating here is that it's offensive because the patient believes that the HMO is restricting the care that can be provided and is withholding that care from them by not providing access to the specialists or the in-patient facility if it's needed. Thus, a terminology that would be more patient-friendly like a patient care manager or a patient advocate would certainly do the trick. Most of you have probably heard one discussion or another on what Oxford did, where they basically allowed the nurse practitioners and physicians assistants to be the primary point of contact for entry into the system. Certainly, you can't use the same term for that as you do for the traditional relationship that we've had with our PCP.

But the important feature of that is that consumers are not educated on clinical matters to be able to make good decisions on what part of the system they need to access, so they need to look to somebody who has the clinical training who can help them do that. If we refer to them as gatekeepers hopefully, people will understand that's a friendly gatekeeper who is trying to organize their care. Certainly a different term like patient advocate or patient care manager would send the right message to the patients.

Specialists have a very difficult position in the managed care environment. We know that one of the best ways to reduce the overall cost of care is to limit the access to specialists. Limiting the access to specialists doesn't mean that we limit it inappropriately, but we do try to limit it to what they have specialized in and what their expertise prepares them to do.

The traditional fee-for-service system has said, it doesn't matter how you're trained the more you can do, the better you're going to be paid. So, the specialists naturally would look to expand their area of expertise as far as they could, and broaden the services that they provide as much as they could. If you look at what some of the specialists have provided, as far as the description of service goes,

much of what they have provided could be done by a PCP if they applied their training in an appropriate way.

Therefore, if what we need to do is decide what care is appropriate to deliver, then the appropriate setting and expertise are what we need to provide high quality care. Sometimes that will leave the specialists out of situations that they have traditionally handled. That puts a squeeze on them, on top of the discounts that the managed care organizations try to get them to agree to, so we need to think about that when we're out there helping a plan structure their system by identifying the right processes to assure high quality access to specialists, not just to keep patients away from the specialists.

The any-willing-provider issue is one that I think affects the actuaries as much as anybody because we've got to deal with the financial implications of those regulations, and it's very difficult to have a high quality group if you let everybody into that group. In my way of thinking, any willing provider legislation goes directly against the efforts to organize care as per the managed care organizations.

Dr. Flaherty: I should have told you, the AMA has a policy against any-willing-provider. But the policy is that people should be judged on their credentials, as far as taking them into the plan or opting under the plan. But we do not favor any-willing-provider. I think it depends on the care. It's important that if you're talking about a large group practice, they may be able to deliver care in a different manner than someone who is a managed care group; that the individuals are small groups and it makes a lot of difference in their setting. I think that befalls the medical director and the people who design the plan to make those accommodations to that delivery system.

Mr. Hulet: And it always works better if it's done internal to the medical profession, rather than being dictated by a payer to the medical profession.

From the Floor: The issue of open access plans has come up and from what we've seen in the Northeast and somewhat in the Midwest, the actuaries' managed care companies are pricing these remarkably close to the gatekeeper models. I'm surprised—the whole purpose here is to restrict inappropriate access to specialists—that the difference between these kinds of plans only comes out to be 4–6%. It does seem to be a little mind-boggling.

Mr. Hulet: The open access plans are as much a marketing scheme as anything else. Individuals hate to be restricted; therefore, if they can be in a plan that removes those restrictions, then that's very attractive to them. However, when it comes down to getting care, by and large people will listen to their PCP and what

they recommend. So to the extent that they have built their relationship with their PCP in the managed-care portion of the open access, and that managed care physician is a true advocate of well-managed care, there will be little need to go outside of the system.

I think the statistics that are available show that there's much less use of nonmanaged care providers in those open access plans than perhaps we as actuaries, would have expected just through our financial projections. I think that's mainly a result of the fact that people get into them not because they want to use the non-network providers, but because they don't want to be excluded from using those non-network providers.

Dr. Flaherty: It's interesting in our situation, that point of service is a big issue. Almost all the plans in our area have some point-of-service option. And the group who you cannot sell a plan to without point-of-service options is health care employees. Hospital employees all want point-of-service; there's just no question about it.

From the Floor: One relatively recent issue that I think relates to this area is the concept that has been called demand-to-management, perhaps the use of RNs on the telephone receiving initial calls and a triage approach to directing patients in a particular direction. How does this relate to the issue of the care manager and the care or patient advocate in this context? And is this good or bad?

Dr. Flaherty: In our area, every plan has some kind of phone access situation, a nurse health line, and they work off protocols. I think they do provide a real service. I've never seen a validated background. As far as the economic effect, I think it's part marketing and part help, as far as direct help is concerned. I think it's generally positive.

Mr. Hulet: The employers I've talked to look at it more as an employee benefit than a way to keep costs down. The charges made by those services are somewhat exorbitant compared to what they can save you on health care, but they're rather modest as far as an employee benefit goes. And the employers do get a lot of mileage out of having that kind of a program for their employees. The system, the nurse system, or in-service, can be very valuable to patients, particularly during off hours, to help them make the determination whether they need to go to the emergency room or if it's something that can wait until the next day when they can get a hold of their PCP. From that standpoint, it does consumers a lot of good.

They aren't going to be able to receive the same kind of quality triage there as they could by seeing a physician or nurse in a live setting, where they can look at the

symptoms as well as hear about them. But it does at least let you do that first level of review, to help us who don't know the clinical aspects of things to feel reassured that we're making a wise decision to wait until the next morning or to rush to the emergency room.

Mr. Murphy: Dennis, while you're speaking, could you move on to the next issue and take the presented role on capitation incentives and over-/underutilization?

Mr. Hulet: How many in this room think that capitation is a good way to pass on risk to the providers? How many think that it is a method that insurers should use to pass it on to providers? OK, there's some of you.

It's amazing to me how many meetings I've been to over the past three or four years where capitation is presented as the answer to all of our risk problems. What is usually left out in the discussion is that whoever accepts that risk on a capitated basis, now has to deal with the same things that the person who had set up the contract originally tried to pass off. In most instances, we pass that risk on to a provider group, who has less ability to handle the financial implications of that risk fluctuation than the insurance industry that set up the capitation arrangement in the first place.

To me, that causes a particular turn of events that I would term an ethical issue. Why should we in the name of controlling our risk as a health plan or an insurance company, place that risk onto those who can't control it well, who don't have the financial wherewithal to deal with fluctuations; therefore, impacting the end user, the patient because of the concerns the provider of care would have over those large fluctuations.

Some of our incentive systems do the same kind of thing. They set up the criteria for deciding who gets the incentive. That is counter to the objectives that we really want if we're looking for high-quality, well-delivered health care. There are a number of systems I've seen out there that basically look at the fee-for-service costs, and those that have the highest fee-for-service costs get the largest piece of the incentive budget. That's counter to what you want if you're really looking for a cost-efficient system.

In the discussions that the insurance commissioners are having and the federal government is having in regards to risk-based capital and other forms of risk protection among those who are taking risks, it's going to become very evident to those who are accepting capitation that they're taking on a substantial financial risk that in the past they probably wouldn't have had funds to protect themselves from.

That's an issue that we as actuaries are going to have to deal with; to help them understand, first of all, what the level is that they need to have set aside to deal with those risks, and, second, to give them some tools to manage that risk.

One of the big forms of work for our casualty actuaries has been risk management programs and the kinds of insurance that they deal with. I think we, as health actuaries, are going to be asked the same questions to help providers deal with their risks. The capitated form of payment to providers is a temporary form at best, in my opinion, because once that risk is passed on, we've also passed on all the financial control to that other entity. If they learn to manage care well, and we continue to capitate them, that means they get the profits, and I don't think there are many insurance company executives who are going to want that to continue over a long period of time.

It also causes a problem with the large employers who want to be experience-rated. They want their rates to reflect their employees' experience because the experience under a capitated program is that capitation rate that's paid so it doesn't matter whether the employer has particularly healthy or adverse employees. The capitation rate generally remains the same. We get ourselves back in that situation where we ask the question, do we have risk adjusters that will adequately adjust the financial payment to reflect the patient base that's being passed on? If insurers continue to take the position that they don't need to worry about the risk because it's capitated, I think we'll find a provider system that is very much in crisis because they can't deal with those risk aspects the insurance industry has traditionally handled.

Dr. Flaherty: I just would like to join the amen chorus in response to what Dennis has said. Capitation, as Dennis alluded, was a temporary situation put in place, I think, for some valid economic reasons. But it has given physicians bipolar behavior. Basically, it takes incentives and this changes your incentive base. If you're a physician who has 60% of your practice in fee-for-service and 40% in a cap formula and you're trying to make that decision and base that, you're in serious ethical trouble.

Consequently, it's an issue that gets managed from the side, and as Dennis has also said, people gain the system in capitation early on. It's not a system that's good for the insurance company because you're giving us X number of dollars and if we can manage it either by good selection, as far as the enrollee base is concerned, we're going to make some money in that as a define month. I see the mature markets getting away from capitation. California has come full circle. We had capitation for the PCPs, then we discounted fee-for-service for them and we capitated the specialists. Both of them sent signals that, I think, were wrong signals. There is no

question that there are some cap rates that are perverse. And if you're talking about 90 cents a month for mental health coverage, you can't provide mental health coverage for that amount. It's a cap rate that is just perverse. What you're saying is we don't have any mental health coverage, and that's wrong. We see that in the country with capitation rates that are just there.

The other side of the issue is when you're forming a physician group, the provider service type group, where you're going to get into the business and what you can do as far as providing equity or a surplus rate. Can you provide sweat equity in the hospitals? Physicians argued that they would keep providing the care even though they weren't getting reimbursed for it. Some place down the road, if we do a bad contract—another issue but one that ties into it. But I agree with Dennis that capitation has come and gone, and that probably is a good thing. It's certainly a good thing for the provider community because of the incentives that it appears to present, but they are also going to be a real cause for concern as far as the ethical areas of care. Are you withholding care because you know you have a cap rate that you will be stuck with?

Obviously, it has been a big bloomer as far as some of our focal groups, niche insurance company players with the whole business about stop loss for plans. I don't think anybody is doing individual capitation anymore. I think it's all plan capitation, but you can make the argument, and some people do, that if you have a big group, if you're the Mayo Clinic and contracting, you can probably take a cap rate because you're going to do the same kind of care provisions, spread over the whole group. It makes no difference as far as the reimbursement for the physicians in that scenario. Some of my clinic friends make that same argument for smaller groups. But that's probably the only situation.

From the Floor: Yes, what kind of incentives do work to encourage physicians to—

Dr. Flaherty: I think big areas where you have a primary care, you have the so-called care manager or gatekeeper, and he's capitated. The question is, can I take care of more things that I would take care of in a noncapitated payment? If you have somebody who has an inner ear infection that doesn't seem to respond, the question is should you keep on treating or should you get an ENT referral? Are you trying to take care of more than you normally would? Because if you send them outside of your system, it's going to cost you money or your cap rate.

Mr. Hulet: From a financial standpoint, I think there's a principle that we can follow as actuaries, and that is to look at what things are in the control of the person receiving the money. In many situations, somebody has decided that capitation is a good thing. Specialties are the ones that I'm just amazed by. If specialists accept

the capitation, many people say that will help them control their costs. But we are capitating an event that the specialists have no control over whatsoever. They cannot control how many cases are going to come to them. They can't control how many individuals are signed up for the health plan who need those specialty services. And so, we are putting risk on them if they have no ability to affect this at all. The thing they can affect is what happens when one of those patients is referred to them. So, if you want to look at it as a case rate situation, that may be appropriate for the specialist, where they get the patient, they provide and organize the care of that patient who needs the specialist involved and then give them a payment based on that. But to capitate them per head, for those that come into the plan, is just a very perverse way of doing it because they do not control that. It's the marketing people, the way the plan is promoted, and things like that. That may produce the frequency of event that those specialists have to deal with.

We need to think about the underlying statistical nature of what we're trying to capitate and determine that it is reasonable to do so. Primary care where it's very high frequency, and a very low cost may make sense to pay for on a capitated basis. When you get to infrequent events, very high cost events, it's the wrong way to do it, in my opinion.

Dr. Flaherty: That's why there are certain specialists who have never been capitated, such as neurosurgeons. How can you capitate a neurosurgeon? You can't do it.

From the Floor: I think capitation can work in certain situations where you have a large provider group that's accepting the capitation and they're not passing that on to the providers. Whenever I hear a discussion like this, I never hear about provider excess insurance, which is basically the providers taking on risk but they turn around and pass it off to somebody else. Can you talk briefly about provider excess and how that enters the capitation discussion?

Mr. Hulet: That is certainly a way to dampen the risks that they take on, and there are companies out there that provide that kind of coverage. Some of the HMOs will actually provide that to a provider group when they're working on a capitated basis. The thing that you have to keep in mind is that the organization that is best able to take the risk is not the provider group. They generally don't have the kind of reserves that will allow them to continue to meet their financial needs, the ones of the individual practitioners within the organization, and deal with the adverse events. If you get a group of really sick patients, if we get an epidemic that must be dealt with, they're not structured in a way to have those financial reserves that are necessary to continue doing business if they get those adverse events. Even the fact that they can pass the high-end risk to somebody else doesn't mitigate the number

of cases that they may get that fall under that threshold. So, if the insuring organization, the one that is out there marketing the insurance, whether it be the HMO or the insurance company, has the financial structure that inherently built up those surpluses to take risks, it seems like we should keep the risk there, rather than trying to pass it on to somebody who hasn't been financially structured to deal with that risk. I did an analysis for a group in Northern California where there was a medical group. There was a hospital and an HMO that were closely tied financially, and they asked the question, do we have the right reserves? When I think of reserves as an actuary, I think of Incurred But Not Reported (Claims) (IBNR), but that's not what they want to know. They want to know do they have enough business reserves to stand any fluctuations and continue operating? So we took the risk-based capital formulas and did the calculations for each of the entities and found that the HMO was adequate. The hospital, because of the reserves they built up for other things, had more than enough to deal with their risk, but the medical group didn't even come close. And I think you would find across the country, that there are very few medical groups that have the financial wherewithal to handle the risk that insurers or HMOs are passing to them.

From the Floor: If capitation isn't the preferred way, we know that fee-for-service is what got us here. I'm confused! What mechanism is going to align all of the incentives for all the different parties to distribute these limited resources, that is premium dollars, equitably?

Dr. Flaherty: The reality is fee-for-service in the industry. What the ideal is as far as the medical community is concerned is to have a more responsible consumer, so we are looking for a defined-contribution type situation where you make a decision how much funding will be from the employer side, put that money out there and then you make a decision about what you're buying. Right now ERISA plans are outside of the mandates from the states and there is a high frequency of ERISA or exempt plans in the states. Some of those options are there, and some of those options aren't there. But, obviously, the closer we get to where we have the consumer making the informed choice, the better off we will be, as far as what they want to buy. You make a different choice when you're 18 than when you're 80. If you have a problem as far as a long-term illness, such as arthritis or diabetes you will have a choice that's going to be very important to you. So, again, we would like to see a defined contribution into the plan and the consumer making the choice.

Mr. Murphy: That comment leads into the next topic, which is disclosure. At the rate we're going, this will probably be our last topic, so I think we should give this topic full consideration. We'll start with Dr. Flaherty.

Dr. Flaherty: There's no question that consumers have the right to receive accurate and full information about the plans written in a real language, so that people can understand what they're buying and receiving. That is an issue because there's no standard way of defining what the plan is right now, but you should know what your covered benefits are, what cost sharing you have, and what kind of dispute resolution you have in your plan. All those things have to be available, what kind of access or specialists and so on, which are all covered in the President's group on the quality initiative and also covered in the other proposal I mentioned earlier.

You also have to know who the health professionals are. What are their credentials? You need some kind of tracking on them in the plan, too: who they are and what kind of procedures they've done in the past. And you have to be able to ask those questions to get good answers. You have to know about the facilities that are available to you. You have to know if they're there or not.

And you have to make sure that the provider base is free to give you that information, and to give you their best opinion about what your health care needs are and how they can be satisfied without having some sense of impending retribution for asking. Obviously, that's what caused all the comment about the gag clauses and the cover of *Time* some time ago. The question, can you be free to recommend the care that you think is best for the patient, led to some big suits in this country. I think the level has been raised very high as far as acceptance from it and not only from the government standpoint, but they've already put the clause in the managed care programs for the Feds. It's coming through the pattern right now. It's voluntary as far as many of the associations and plans are concerned. But I think the disclosure has to be full, complete, and understandable for the consumer.

Mr. Murphy: How many attended the session on technology and health care yesterday? There you heard some of the discussion about how we're using technology to gather information; therefore, introducing an additional area of sensitivity which is who should have access to that information and what is going to be done with that information. The fact that traditional data that's been collected in the insurance industry has dealt with claims payment and not treatment of patients means that we have to have a different structure set up for gathering information about patient care. There are a number of organizations that are working on medical records so that they can have an electronic database to use in the collection of information and the care of patients. That becomes a very sensitive item, once we have everybody's information in that form. There certainly can certainly be unintentional leaks of that information that could be used in the wrong way. But even those when collected for the right reason, we have to decide as a society how we want that information used. One of the ways that it can be used is to help the physicians and other practitioners be able to anticipate our health care needs and

treat some things before they become a big problem, therefore saving dollars, but we have to have that information collected and in their hands.

If the information is collected and available to them, who else might see the information and how might they use it to our disadvantage? One of the ways they might use it, is to disclose some information to an employer about what your future health care costs are expected to be. They may do it in the name of cost control. We can manage these patients because we have this information; therefore, we can lower that long term cost, but if you're the employer and you know that you have a high-cost employee, where the incidents that will cause those high costs are out in the future, by a few months or years, wouldn't you do your best to send that employee to another employer before those costs hit your bottom line?

The other situation that you have is discrimination. It could be in selection of somebody to be insured. If we have that information readily available, there may be ways for an insurance company, an HMO, or some marketing organization to get hold of that information and decide that you're a bad risk and should be placed with one of the high-risk pools set up by a state, rather than the commercial insurance area.

So, having the data to manage effectively leads to that potential for use in ways that are not beneficial to the patient and society, and I think we have to deal with that, because the disclosure aspects are very critical. There was a piece in *U.S. Today* about a new movie in which you could engineer your child. Basically, you have two segments of society—those children who were engineered and those children who were accidents. And of course, those that were accidents in this movie were presumably the lower class, because they didn't have all the characteristics that you would engineer—high intelligence, good health, and things like that. The fact that we're playing around with genetics in the medical profession will make that disclosure a real issue, say in 10, 15, or maybe 5 years. I think the insurance industry needs to take a position on that, so that as the discussions proceed in the health care industry and in the legal environment, we will be able to speak with a voice that shows what we need versus what the doctors may need.

Dr. Flaherty: I'm glad Dennis brought up that subject. I misread the disclosure business just a bit. But it's a huge issue, especially with a gene a day being discovered. The question is, how useful will they be? There are a lot of predictors that are out there right now, in addition to the other things we do. Obviously, we all get tested every day by our life insurance policy for an AIDS test, and because of the laws that have passed the states, frequently it's not disclosable, but, obviously, it's information that is available. But the next step, what you're going to do as far as that information, will be huge. Also, we have to go forward with trying to

standardize not only the provider identifier for the federal government into one standard, but also the fact that almost everybody is on the big computer up there in the sky. It really is a huge issue for us. And it's going to be an ethical debate that will go on for, I think, for a considerable period of time. Right now, when we're just at the diagnostic part, not the therapeutic part of the genome area, of course, it's probably the time to make those decisions.

From the Floor: One of the big issues we're seeing now is in disclosure is the patient's right to know whether the physician himself is being capitated. Can you comment on that?

Dr. Flaherty: Yes, that is in both plans. Both the President's plan and also in the plan that came out of the other group of consumer advocates plus providers. The full disclosure, as to the methods of the incentives and disincentives as far as the provider is concerned, has to be there.

Mr. Hulet: In a rate hearing I attended in New York, there was a physician who came to the mike and described how this HMO had eliminated him from a panel of physicians who were participating in the network. He felt that was undue restriction on his ability to make a living. I think they were well justified in eliminating him, but, nonetheless, it affected his ability to make a living because so many of his patients were associated with this HMO. There are issues for disclosure of performance measures that are very sensitive as well. If we go through and identify a lot of outcome measures, and then somehow post them by physician, that will become a very useful tool to the patient in making decisions of whom do they want to see, but it would be very adversarial for the physician who didn't measure up. Often in those measures, it's impossible to adjust properly for the extenuating circumstances, so how do we build and report measures and still make the unusual situations known to those who are going to view the measures? That could be true if we put measures on hospitals, health plans, or any other form of provider or insurance company. We need to have some way to get good information to consumers about whom is available to them through their plan, what the options are, and yet, protect that sensitivity on the other side so that the physician's opportunity to make a living isn't adversely affected unless there's good reason for that.

Dr. Flaherty: The strongest motivator for a change in physician behavior is role modeling. There's no question that no one likes to be an outlier in that situation. Having been a medical director of an HMO in the 80s, I know that if you are an outlier and you have that pointed out to you, usually the behavior modification happens. And it's usually a positive modifier. That's really the basis of the AMED

program that we're doing for the AMA—to try to have some benchmark standards so people can match themselves against that benchmark.

Mr. Murphy: In effect, your last couple of comments have slipped into the last topic. Dennis or Tim, would you like to make one or two final comments on the subject of economic credentialing report cards and profiling, which is really what you've just been talking about.

Mr. Hulet: I talked briefly about the need for patient care data and choices of provider data, and I think that we're going to see much more of that data becoming available. Dr. Flaherty mentioned the organization FACCT. How many are aware of this organization? FACCT works with the employer community to come up with some measures of performance that can be released to the public so that employers and employees can make decisions about their health plans and providers. That hasn't gone a long way yet, but the people who are supporting it tell me that they will become a force, another NCQA-type organization, so we need to understand what's going on there and how it may affect us in our particular roles as actuaries. The NCQA is also collecting information I wouldn't call outcomes measures, but they like to call it that. But anything we do to measure performance has a potential for affecting decisions we make as consumers and the behavior of those who are being profiled, so we need to have some data-based decision making, but it's very difficult to do that and recognize those extenuating circumstances I was talking about. I think it's going to become a much greater issue for the insurance industry because if you don't have those profiles to see who the best performing providers are, then you're going to be at a disadvantage to those systems that do collect that information. However, what we do with it is something that needs further discussion because it is a very sensitive area.

Dr. Flaherty: Yes there's no question that every physician is profiled right now by some plan someplace. With either Medstat or Equifax, which is now Marketing Management, Inc. (MMI), it's basically on your performance as far as your billing structure is concerned. Some are much more advanced than that. FACCT is doing it. Bruce Bradley, who is the benefits manager from General Motors, has done some of this, using NCQA data. They've tried to incent their employees to go to certain plans that they think are better than others because of past performance. Certainly the same efforts have been used in some of the other areas. That, I think, is within the bounds of propriety. What bothers me is when a plan takes 600 physicians out of Central City, Kansas or Kansas City, Kansas, and they take most of them from the inner core, changing the market in that situation for strictly economic reasons. That I don't think is within the realm of propriety. And those usually get objected to. There usually is an appeal, either to the press or to the courts, and some are reinstated. But there's no question the economic credentialing has been done. It's

been done in mass in some areas because you've become too expensive of a provider. There are a number of court cases still going on, one in San Antonio, Texas, that will probably get settled, I imagine, rather than go to trial. But again, that's it. We're all being credentialed. We like to be credentialed on the basis of the quality we perform, not on the basis of how much it costs the plan, because we can't really control who we are taking care of in that plan. There's no question that the best test is the underwriting test for the person who subscribes. If you get the young and the healthy, you do relatively well in situations. If you get the young and the unhealthy, you don't do as well. Don Burwick, who is a quality guru from the East Coast, has a wonderful line that I like. He says, "The enemy is disease, not each other." That really is true. That's the situation that we face frequently when we're going through this evaluation.