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Physician-Owned Health Plans—Managing the Paradox

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Summary: Physician ownership of health plans creates a paradox. As providers of care, physicians optimize their financial position by increasing revenues. As investors in health plans, those revenues are health plan expenses that must be controlled in order for the health plan to prosper and to maximize shareholder value. The panelists address the actuarial, business, clinical, and ethical issues that must be dealt with in order to survive this paradox.

Mr. James T. O'Connor: We have two guest speakers who will work in rounds today. Our first speaker is Dr. Robert Dannenhoffer, a pediatrician with UMPQUA Pediatrics, and the medical director of Douglas County IPA and SureCare HealthPlans in Roseburg, Oregon. In addition to having an active medical practice, Dr. Dannenhoffer has been an instructor in the Department of Pediatrics at Harvard Medical School and an assistant professor in the Department of Pediatrics at Uniform University of Health Sciences, while serving at the Bethesda Naval Hospital. We look forward to hearing Dr. Dannenhoffer's comments on the paradox of physicians owning their own health plans.

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Mr. Jon Harris-Shapiro: Dr. Dannenhoffer and I are going to try a slightly different format, a dialogue back and forth, and we'd also like you to participate as we go along.

At least until recently, it seemed as though everybody wanted to own a health plan. The nature of the owners was not necessarily an exclusive club. Why does physician ownership of health plans create a special interest? First, the proponents of such a form of ownership suggest that physicians control virtually all the health care services that are expended. Some studies suggest about 80% of the health care dollars can be directly influenced by a physician. On the other hand, the opponent to such a form of ownership suggest that this is a case of the fox in charge of the hen house. The tension between those two extremes creates an interesting dynamic that may enable physician-owned health plans to create a more efficient delivery system.

Dr. Dannenhoffer and I have been involved with SureCare HealthPlan for three or four years since it began, and we would like to begin by telling you a little bit about our experiences.

Dr. Robert Dannenhoffer: SureCare started in Roseburg, Oregon, it's a small rural county south of Eugene and north of Medford. Oregon is a state that has incredible national beauty and a great deal of physician entrepreneurial and political activity. Actually, the governor of Oregon, John Kitzhaber, is a physician from Roseburg. In 1994 the Oregon health plan was approved by federal officials, and this was basically going to be a Medicaid insurance product for the poor. Oregon was one of the first states to do that.

The physicians in Douglas County decided that we probably should run this ourselves, rather than letting one of the big insurance companies do it. We were more than a bit naive at the time, when we started on this venture. We started out with Medicaid managed care and now have moved into commercial managed care, as well as a 24-hour product integrating workers' compensation and health

insurance. We are now the largest insurer in the county, but we're now spreading to the rest of the state, where physicians have wanted to do the same kind of thing. Since we started in 1994, there are seven other physician-owned groups in the state who are running the Medicaid insurance products. At least in the state of Oregon, physician ownership of health plans is a big deal; it's probably a great deal, but it's not an easy deal. As you'll see, most of the lessons learned have been somewhat negative. We hope we will tell you about some of the mistakes we've made, so that if you have to consult people in the future, you'll be able to predict their mistakes and look like geniuses.

Mr. Harris-Shapiro: The presentation addresses managing the paradox. First, we need to define the paradox. There are those who say a conflict of interest is created when a physician or any provider owns a health plan. The revenue to the physician's practice is an expense to the health plan. Any time the health plan sets out to reduce costs, the practice is going to take a hit, in terms of medical management and how quickly you pay. There's a completely different cultural orientation toward the flow of money from one organization to the next.

Dr. Dannenhoffer: This is really the essence of the analogy of the fox guarding the chicken coop. I've been approached with that analogy numerous times and I've always tried to think of a less unflattering way to describe physician ownership of plans. If you were able to teach the fox that the only thing he could eat was that one chicken coop and he could really learn that, he might become a better consumer of chickens. Instead of greedily going in and killing all the chickens one night, he may actually go ahead and develop a rationing system. The second thing that's nice about the fox guarding the chicken coop is that you know that the fox will be a visual defender of the chicken coop. He's not going to let other foxes come in and destroy the coop. The third thing is that foxes like chickens. Basically physicians love medicine. This is a group that cares desperately about what goes on in medicine and really wants the best to happen. People realize this is their future, and just as foxes love chickens, physicians love medicine, and they love the patients they take care of. Although there is a paradox here, it is not all negative.

Mr. Harris-Shapiro: If you accept that health care has to be reformed before the system implodes upon itself, and that physicians have to learn how to change their behavior when they own a health plan, that creates a certain dynamic. There's an expression that the mice learn the maze much more quickly when you throw a cat in there with them.

The philosophy of the health plan as we know it as actuaries is long-term equity, building reserves, building lives, and building value for our shareholders or for the company or our members, depending on the form of ownership. However, on the

other side of the table, in the physician-owned health plans, you have cash based enterprises. Physician offices and clinics are phenomenally orientated toward cash. At the end of the year, they view their financial performance by what's in the checking account at any point in time, regardless of what their receivables are. If you're late paying, they think they're being killed by your health plan, even though the receivable is there. At the end of the year, they take all their cash out and have a party.

Dr. Dannenhoffer: Part of what I do during the day is I work in a pediatric practice, and we get to the end of the year, and we say, "How much money is left in the checking account?" and just give that all out to the partners as a bonus. This is so different from what we have to do as an insurance company, in which we have to have reserves and surplus, and a very difficult thing for physicians to understand. Just looking at the cash basis of what goes on, everybody thought we were doing so great the first month, because we got all this premium money in from the state after we started Medicaid, but we hadn't paid any expenses yet. They were thinking, "Isn't this great, this is the best thing in the whole world, we can just stop right now and be $5 million ahead." It takes a little while to teach physicians that they will get bills. It is a radical switch in thinking to switch from the cash base economy that they've always been on, to the idea that there may be bills ahead and to explain that Incurred But Not Reported (IBNR) nastiness.

Mr. Harris-Shapiro: The other focus that becomes an issue is the difference between members and patients. Physician offices see only the people who need health care. When you're talking about per member per month rates and per capita costs and all the different kinds of actuarial measures that we use in managed care, they forget, or they don't necessarily understand, that the denominator includes all these people who never show up in the office.

Dr. Dannenhoffer: I see three kids in the practice who have cystic fibrosis. And to me, as a physician, those three patients are very important. I know their names and their families and everything that goes on with them. The critical, important thing for the insurance company is that three of 1,600 patients that I care for have cystic fibrosis, and that number is three times the national average because of all different areas. Physicians never think of it that way. They think of it as: "I have three kids with cystic fibrosis and two kids with AIDS, and these are the kids I take care of," and the denominator part of what you have to do in insurance is absolutely a foreign concept.

The other concept that is very foreign, as Jon mentioned, is the idea that there are many patients we care for in the health field whom we never see. We talk to doctors and we say, "You're responsible for this group of 300 patients," and they

always tell you about the 10 or 20 patients that they're seeing all the time. It's difficult for them to focus on the fact that there are maybe 100 of those 300 patients who never access health care services because they're young and healthy and have no other problems. To get physicians to go past their patient focus, or to keep the patient focus, but at the same time look at it from the other point of view of the number of focuses, is very difficult.

Mr. Harris-Shapiro: Consistent with that is the way in which the insurance company and the physician look at health care. Obviously, the insurance company takes a statistical approach. We look at frequency rates and cost of service and come up with some rates. We need large populations to develop credible statistics. Physicians are sitting in a clinic office with a patient across the examining room from them, and they need to make a decision on a one-by-one basis.

Dr. Dannenhoffer: That means statistics only work in a certain way. The chance of having a rare cancer is maybe only 1 in 10,000, but if you have it, you have it 100% of the time. You can't be only partially pregnant. It's an all or nothing phenomenon for the patient who has it. The physicians see their encounters with their patient population on an individual basis. Looking at it in a nonstatistical way is very different from the way the plan needs to look at it. We talk about large numbers in the plan. I think we don't even want to look at statistics until you're talking about many thousands of member lives. Consider the very busy physician, who may care for a thousand or fifteen hundred patients. In a whole year they have only 10,000 or 15,000 member lives. If you have all the patients in their plan, then the number of patients in any one particular plan for a doctor may be only 1,000 or 2,000, which is not nearly enough to get any kind of statistical validity in that practice. Again, it is very difficult for the physicians who own this company to understand the difference between those 20 patients he or she saw in the office today and the 20,000 patients that the plan covers.

Mr. Harris-Shapiro: It takes a great deal of creativity. We were talking to the obstetricians about their C-section rate, a commonly focused measure. It was rising very quickly and peaks at certain times of the year. We were taking our averages over longitudinal with the whole plan—I think we had three years of data—and it became very problematic when we were talking to the obstetricians and they were saying, "I've got this patient in front of me, and she presents me with these situations. What am I supposed to do?" There's a tension between the one data point and the statistics.

The corporate culture or the culture of the physician office and the insurance company are also completely different. Physicians are trained to operate in a solo

environment. Actuaries and health plan managers are accustomed to a little bit more of a group mode of operation.

Dr. Dannenhoffer: The captain of the ship philosophy is inherent in medicine. If something happens in the operating room (OR), the surgeon in the OR makes a decision, the surgeon is responsible for what goes on, or the pediatrician doing resuscitation of the baby is ultimately responsible for what goes on. Physicians develop this leadership skill, and, interestingly, it probably determines where physicians go in medicine. People with the strong need to be in charge become surgeons. Those people with less of a need become anesthesiologists, and people who like kids become pediatricians. Physicians pride themselves on being great leaders. However, they are not very good followers. Unfortunately, in the plan, it's hard to have a plan with 100 leaders. You really need to have one or two or three leaders and 97 followers, and that's the hardest part. It's not that physicians don't have good leadership skills; they have terrible followership skills.

Mr. Harris-Shapiro: The paradox could be summed up with an opening line I was going to use for a board meeting and was asked not to. The context was: I was delivering some news on where trends were going that wasn't so good, and my opening line was going to be, "Today I have good news and bad news. The good news is that your practice revenue is up; the bad news is the loss ratio is up too."

Dr. Dannenhoffer: Why have physicians organized? The statement on "Do it before somebody else does it to us or for us" is exactly the right answer. We knew Medicaid managed care was coming in the state of Oregon, so there was no alternative to that, and it had to be run by somebody. If it wasn't run by us, it was going to be run by one of the insurance companies, and physicians have this problem with insurance companies, because they see all of the problems with insurance companies. We've learned that some of those problems with the insurance company are inherent in the business and not necessarily the nefariousness of insurance companies. Nonetheless, physicians had this really strong sense that insurance companies are not their friends, and maybe if we ran this thing, we could be a bit more friendly to ourselves. That's the reason we did it.

Physicians who run the plan, those three people who become the leaders of the plan, they can become the worst enemies of the 97 other people. It has that potential to be so, but it hasn't worked out that way in Roseburg.

Mr. Harris-Shapiro: There's a major difference in my mind between having ownership in a health plan and buying shares or investing in a health plan. The model that Bob and I represent is one in which the physicians are actively involved in all layers of plan management. This is not a group of lay people who went out

and got physician backing and are launching a health plan. This is a health plan in which the physicians have committed enormous amounts of time. The board is all physicians except for a couple of community representatives. They are involved in all the committees and I don't think there's a part of the organization that physicians don't have a hand in.

Dr. Dannenhoffer: The physicians really run the train. Every aspect of the company has physician involvement from benefit design to claims administration. Physicians really have a great say in what goes on in all of those things. In some ways that's good. Our benefit design committee is an example where clearly physicians understand some of the gaming that goes on in health benefit design, because they've done it; this is their life. On the other hand, it really does gum up the works a bit, because, again, they have a hard time being the followers rather than the leaders in these situations.

Mr. Harris-Shapiro: These physicians have ponied up real money, so we can't underplay that there is an investment here. The base entry fee was $5,000 to enter the plan, plus they signed on for the privilege of a capital call down the road. Then there are other physicians in various financial instruments who ponied up a good deal of money, major portions of their retirement funds and major portions of their personal wealth to get this program off the ground. What's interesting is they have very little focus on dividends. While they're looking to take the cash out of the company on the one hand, they recognize that the reason they invested was not for growth or dividends. The reason they put their money in this plan was for control. That's the payoff. That's the dividend.

Dr. Dannenhoffer: Actually it's more money than you think. Everybody contributed $9,000 to get in, and then people put up another $22,000 for reserves. People have put up more and more money along the way because they believe in it. This is one of the areas in which they think they're going to benefit over some of the for-profit companies, in that they're not looking for huge returns on investment. They would also hope that by not having to have such high returns, they could put more of their money back into health care, and health care means practice income.

Mr. David L. Terry, Jr.: How do you convince the politicians or the people on the other side of the fence that that's really your objective, and not to get into the real paradox of minimizing control to make a profit?

Dr. Dannenhoffer: That's been extremely difficult. Just as physicians distrust insurance companies, the regulators have distrusted physician-owned companies, and probably with good reason, because there are some companies that have done it. It really has taken the board to look out for the long-term best interest of the

company, which sometimes conflicts with the best short-term interests of the providers.

It turns out that the amount of money you can return for health care services on a physician-owned company is probably greater than the amount that you can do on an investor-owned company that needs the big return. However, we are early enough in the business that we have not yet been able to show a remarkable difference in the outcomes of care. That's really what people are looking at. How much you spend on health care is not a particularly good indicator of how good the care is. You can see that the rates for health insurance are markedly different throughout the country, but the kind of care that people get, or the outcomes that you look at, are not markedly different.

We have had a very difficult time convincing the regulators that just because we're doing it, we're going to be able to do it better. That's going to be one of the challenges of the future, to really show not only that can we do it in a cost-effective way, but also that we can provide better care. I don't think the data is there yet; I think it's still a work in progress. That's really the appeal: having a say in what goes on and having a say in what goes on in the future of the company. This is the part that takes significant management skills, because, on the one hand, physicians having a say—100 physicians now nitpicking on what goes on—that could so hamstring the company that nothing could ever happen. In addition, if you let people have their say in a town-hall kind of forum, saying you want us to pay for this or that, it's going to make a system that not only doesn't make any sense but also may not be the best way to run the business. The job of management is to take the important things that physicians have to say and the important group things that physicians have to say that really make a difference in health care, and to pay attention to those while trying to push away the things that reflect individual self-interest, interest of groups of people, or things that are just going to gum up the works. This has been the hardest thing that the board has had to do, because we want to listen to physicians when they have specific concerns. On the other hand, we don't want to delay the work of the company for a week because somebody thinks that the resource based relative value schedule (RBRVS) system for appendectomies is too low. You can see how the groups could actually get bogged down in the concern of the individual say of the people.

Mr. Harris-Shapiro: What have we learned so far through the process? What we'll tell you comes not only from our personal experience in Roseburg, but also from physician-owned health plans and other types of organizations throughout the country. I don't know how many times providers have said to me after a seven-hour board meeting, "This isn't as easy as I thought it was going to be."

Dr. Dannenhoffer: Actually it's more complicated than they thought. This is one of the aspects of physician arrogance, and I think we manage this well by getting physicians who have actually learned a fair amount about insurance. It is not nearly as easy as it looks. Physicians say the hardest thing in the world you could ever do is an appendectomy. Think of the thousands of steps that go into an appendectomy, getting the anesthesia and everything else right. However, in retrospect, an appendectomy is simple in comparison to putting together rate tables or things like that which we have to do. The appendectomy has many changes along the way: different things that might come up, different complications that might come up. On the other hand, there's a good deal of work that needs to get done to make the basic health plan function. Insurance is much harder than physicians originally thought, and this has been a rude awakening. I think we've handled it well, but as you're going to be consulting with other companies, you certainly want to have physicians talk with people who have done it, and we will be the sober bearers of the news that it isn't quite so simple.

Mr. Harris-Shapiro: The challenge comes from everything: from building infrastructure to building critical mass, managing the risk to managing the finances. Physicians take great personal risk when they go inside someone's body and do something, but the financial and the business risks associated with running a health plan, for many physicians, is completely alien.

Dr. Dannenhoffer: Medicine is incredibly risky on an individual basis. I do two things: I take care of babies and I resuscitate babies. So the baby comes out and the baby is dead, and I know over the next ten minutes that babies can turn out to be alive and healthy, alive but terribly disabled and the family will live with that disability for decades, or the baby's going to be dead. That amount of risk is just enormous, and my heart rate gets up to about 200, and most times it turns out well, thank God, but it's very difficult. That's the risk, but it’s very different from the kind of business risk that the insurance company has. The insurance company business risk is going to be “We're not going to get enough lives” or “We're going to sell too low,” or “We're going to spend too much, how are we going to do these things,” which are grinding risks that go on.” Those kinds of risks are different, and physicians need to recognize that while they may be big risk takers, to go in and look at a dead baby and resuscitate this baby, it's a totally different kind of risk. This again has been a difficult thing to teach physicians.

Mr. Harris-Shapiro: As we said before, there was a perception that it was easy. I was always told about “the suits” up the road who were just soaking the health care dollar, taking 25% or 30% of premium for administrative costs, when it should be done for 6% or 3% if they're looking at Medicare statistics. Why are they taking so much off the top? They quickly learned it's not that easy cutting the waste out of

the administrative dollar, nor is it easy to cut the waste out of the health care dollar when it's your neighbor, your peer, or yourself.

Dr. Dannenhoffer: One guy's waste is another guy's convenience. For example, one guy asks, "Why do we have so many elective surgeries?" Elective surgeries are nice, because when you do them electively, they don't become emergencies down the line. The more people look at waste, the more they realize waste is very much in the eye of the beholder. Much of the assumed waste of insurance company marketing and the waste of insurance companies' spending all this money on provider relations becomes really different when you run it and say, "We're spending not very much money on provider relations," and they say, "But that means when I call, no one answers my phone call right away. I sometimes have to leave a message and have them get back to me." That's why the waste really needs to be looked at carefully, and we have learned that it's not quite so easy to cut as much perceived waste as people think we should be able to.

Mr. Harris-Shapiro: One example is the use of brokers. Every single provider plan that I have talked to thinks they could sell directly to the employer without the agents and without the burden of the commission. I don't know of any plans that have developed a successful business model without those players at the table.

Dr. Dannenhoffer: Nor do I.

Mr. Harris-Shapiro: The health plan learned that lesson the hard way. The capital time and administrative requirements are huge relative to what it takes to run a physician office. These physicians run full-time practices, and then they come in and run a health plan as board members or part-time staff members. The administrative requirements are the infrastructure. Medical offices are typically run on a shoestring. The staffing ratios, the salary levels, the compensation packages are all completely different from what you see in a competitive managed care environment for the health plan. The capital requirements are an old story. Physicians are notoriously reluctant to pony up their own cash, and obviously you need a great deal of capital to begin a health plan.

Dr. Dannenhoffer: It does cost a great deal of money, but one of the things that is very different is the time requirements. I think the physicians thought they'd just come in about once a month, spend about 30 minutes, and then have this thing figured out. We have many meetings during the month, but the whole board meets once a month. These are enormous time commitments from enormous numbers of people, but the reason is because there are important things to do. I don't think the board dallied at any point, but there were just enormously important things to do. You should say to any physician group whom you might advise in the future, they

need to find a big enough cadre of people who will do this and are willing to put in the time. We have been lucky in having a very active board with very high attendance and people who don't doze off or leave halfway through the meeting. Physician groups that are going to go into this and think they can run it like they run their PC, or with a one-hour meeting once a year, are sadly mistaken.

Mr. Harris-Shapiro: On the marketing side of the table, there was a strong sense in Roseburg and other parts of the country where I've talked to people that the network would sell itself: build it and they will come. That's not really the case. There are major price issues. I think we all would agree that in health benefits, the most important issues determining whether an employer is going to purchase a plan are price, price, and price, and who owns it and who controls it are probably a close fourth.

The other aspect of the marketing that was very difficult to overcome was the fact that physicians don't market. You don't have—at least in too many places—doctors with billboards, doctors running ads in the newspapers, doctors sending fruit baskets to the agents. This was very difficult, because the health plan is very closely identified with the individual physician shareholders in the community.

Dr. Dannenhoffer: I don't want to make this all sound negative, because actually this is a great health plan and things really go well. We started off with the first slogan, which was, "Buy SureCare, Ask Your Doctor." We thought this would be great because they would ask their doctor and their doctor would say good things. What happened was the doctor would say, "I hate all insurance companies." They would say, "Even your own?" "Well a little less than the others, but I hate them all." That didn't work particularly well.

Mr. Harris-Shapiro: I thought the doctor hated us more than the others because we own it.

Dr. Dannenhoffer: Then they'd ask the doctor some specifics like, "Can you tell me about your pricing structure?" or something simple, and the doctor would say, "I don't know anything about that." While the doctors on the board knew those things, the individual doctors who owned the plan obviously didn't, just as I don't know very much about IBM's pricing structure. To suggest that because you own the company, you're now going to be knowledgeable enough to sell, was a total overestimation of what went on, and we retracted pretty quickly.

Mr. Harris-Shapiro: The lesson was that the health plan probably needed to bring in an external marketing skill set earlier than they did, but there was a reluctance to

do that. You try to listen to your board and be responsive, and we had to do a little remedial work in catching up on the marketing plan and the marketing skill sets.

Mr. Terry: When you build your network, are you capable of generating enough critical mass just to market yourself, or do you have to allow your providers to contract with other external health plans? If that's the case, are you finding it very difficult to get the other plans to negotiate with you because of the proprietary nature of owning your own health plan?

Dr. Dannenhoffer: That is a big problem. One of the big problems in our areas is that almost all the physicians in our area own the plan, and thus we've needed to be sure that they're available for other health plans because of antitrust issues. Because of that, it's difficult to distinguish our plan's panel from the Blue Cross panel or the Pacific Care panel in our area, which are very much the same. That is a big problem, because physicians really want to believe that the distinguishing fact of a health insurance plan is whether they're in it. Since they're in almost all the plans, it's hard to distinguish among them. That is a big marketing issue, and one of the things that physicians needed to recognize was that they couldn't market our plan and then not in the same way support the other plans that they were in. That's been very difficult.

Mr. Harris-Shapiro: Surprisingly, we don't have health plans avoiding us. They're all at the table, and this is true in other parts of the country where you would expect the provider or owners to be fearful of attracting too much attention because they'll lose their contracts. I have not heard about that happening.

Another lesson: the medical folks who own this health plan want to seed the health plan with themselves, their own group, and also the ancillary medical organizations that are in the neighborhood, the hospital employees and the mental health organizations that are in town. You can imagine—for those of you who are intimately familiar with underwriting different types of industries—what your community rate looks like and what your pool looks like when you start off with two or three thousand lives, and they are doctors, nurses, their families, mental health workers, and their families, and so on. It's a major challenge not just in terms of managing that risk, but also because you're more than likely going to cut a special deal. You can't have your shareholders and others going to the competitors. It's a political issue. You start off with a group that is horribly overutilizing their care at bargain basement rates.

Dr. Dannenhoffer: I hear this all the time. I get calls from around the country, and they say, "Great news, we started up and we enrolled two thousand members." Who are they? The doctors and the hospitals? Isn't this great? Usually not. You

will wind up with high loss ratios on those groups. They always demand preferential rates. We're going to be your providers and we seeded the money here and we would not like to pay our true underwritten rate; we would like a rate that would be a little lower. Because of that, it's a risk to companies to start off with poorly underwritten groups that are high utilizers of services, as well as people who are savvy to the notions. You may have somebody who is a machinist, who would need a procedure. They might say, "I think I need this, but let me talk to my doctor." You can be sure that doctors and nurses and hospital employees note the last name in the journal that it was in. They become very savvy consumers, and it's then a difficult group to underwrite. This doesn't mean it shouldn't be done; it's very reasonable as a selling point to say, "We insure the hospitals and doctors and everybody else." I think the point is that it has to be properly underwritten, and the board has to have the backbone to say, "We're only going to write this plan if it's properly underwritten."

The problem we've seen is that the other companies who have come into town and given sweetheart deals also offered sweetheart deals to all the medical groups in town, because they could probably take the loss on those groups, and they would love to market that piece. The doctors don't even insure themselves with their own insurance company. This is an area that is risky, very risky for groups, and you need to know before you go in that this might happen.

Mr. Harris-Shapiro: It's a pill that you have to swallow and, you hope, dilute it by building up the critical mass.

Mr. Bruce E. Palmer: On the question of physician coverage and their offices, our plan assumes that doctors and their employees can get professional courtesy. What is coverage for physician services?

Mr. Harris-Shapiro: Unfortunately, what we see is that it's not really the physician services that kill us on the physician plans, it's the surgeries and the drugs and the other kinds of things that have been very expensive, as well as that the physicians and their families frequently seek care outside of our group. They want to go to the Mayo Clinic, or they want to go to Seattle for this or that.

Mr. Palmer: The provider groups were started off with a flat $10 prescription co-payment. Many have renewed at a 25% co-insurance to try to bring the drug costs down to something lower.

Mr. Harris-Shapiro: This goes back to the fox and the chickens. You have a utilization management (UN) committee overseen by physicians that is trying to

manage physicians. The challenge and the lesson: How do you manage yourselves?

Dr. Dannenhoffer: If this were just a fox and the chicken coop, you could probably understand it, but imagine a pack of foxes, and now the lead fox needing to say, "Wait a minute, you can't raid the chicken coop either; we all have to be on a diet here and eat chickens at a reasonable rate." That's the hard part: trying to go ahead and manage other physicians. Some physicians have a group mentality, and some don't, and that's difficult.

From the Floor: A marketing question that comes to mind: you said you needed to have somebody with marketing expertise because the physicians didn't have it. In the lessons learned, I have not heard about having managers. Instead of a fox guarding the chicken coop, having a guard dog may be better for the chickens' health than having foxes managing it.

Mr. Harris-Shapiro: How do we make a difference? Why are we different from the next health plan on the street? There's a gap between the insurance company and the clinic, or the actuary and the medical director, depending on how you want to conceive of this. I deal with massive amounts of data, look at medical trends, decide where things are going, and try to come up with some solutions that might work. The medical director is personally dealing with a clinic and with his or her colleagues in a clinic, with patients sitting across the examining room with them. We're trying to build a bridge between the clinic setting and the insurance company setting, but in a way in which you look at health care. There's a fundamental difference from the way that you look at your assets. Many health plans will consider their primary asset to be their data. I've heard that from a number of different players around the country. I believe a physician would think that the primary asset is the delivery of care. The license that's hanging on the wall is the primary asset. You need to bring these two orientations together and understand, in effect, the combined business that you've created.

The board of directors needs to be able to make the hard decisions, and they need to be able to provide the leadership, and perhaps be very unpopular. To make a difference they have to be very committed to consensus building. If anything, we've learned that the board can make an executive decision, but sometimes they don't carry the flag or the message out to their peers on the street, and the health plan runs the risk of going in a separate direction from the membership. It's a very democratic organization in that regard.

Dr. Dannenhoffer: I think the strength of the board is really going to be the key determining factor in whether a plan makes it or not. If the board had gotten

bogged down on little issues, if the board did not support the decisions of management, if the board were looking only at the short term and not at the long term, this plan wouldn't succeed. I think physician-owned health plans are so much more dependent on the quality of their directors and on the commitment of the directors. Again, if you get the chance to consult on a plan like this, and they really haven't figured out who would be on the board or who would be interested in doing it, it's not likely to do well, and you should spend some time, and they should think about board development before they do it.

Board development is also a difficult thing. Most physicians have, interestingly, never been on a board of directors. Here we are, now creating a company, and we have all novice directors. One of the things that we recognized early on—or that the state recognized for us—was that we had to have some lay members; we brought in as lay members people who had been on other boards, and the physicians found them to be enormously helpful in teaching people how to be on the board of directors. A company wouldn't necessarily select a board just because they happen to be around. They would select a board for different expertise; they would select a board maybe with some experience. That's going to be one of the real keys in a physician-owned plan: that the board has to decide that they want to do this; they have to take the time to do it, and they have to learn how to be good directors.

Mr. Harris-Shapiro: The shareholder physicians need to have a sense of ownership. I was presenting news at one board meeting that wasn't so good. In the back of the room a physician put up his hand and asked a question, basically saying, "I'm the patient advocate, I'm going to do what's right for my patient, I don't care about this health plan." The discussion then turned around to questions of why did you invest? what is quality health care and how is that linked to owning a health plan? and why is this patient any different than a patient insured by Blue Cross?

Dr. Dannenhoffer: Remember why people invest in IBM or Microsoft. You don't invest in Microsoft because you're going to expect to tell Bill Gates what to do. You invest in Microsoft because you think you're going to make a great deal of money. Again, you should realize that the physicians invested in this for some control, and thus as shareholders, I think they expect a higher degree of say in what goes on than they would if they were investing for equity return. That's the difference in the group here. The plan needs to be responsive to these shareholders, because these shareholders can make or break the plan. We have a very different orientation from other companies.

Mr. Harris-Shapiro: Plan management has new challenges in terms of telling the story and marketing itself to its own providers. It's all part of consensus building

and bringing a unified mission to providers. You have the usual challenge of telling your story to the market place and selling the agents, brokers, and employer groups and telling your story to your members or prospective members. But one of the unique challenges is that you have to commit to working with your own shareholders and doing some internal marketing to your owners. What does the data mean? You have to get the data out, you have to give them access to the data. What are valid measures? What's meaningful? Where's the money? These are the kinds of questions that you need to spend time with. We have folks meeting with various physicians on a weekly basis just to discuss reporting: what kind of reports do they need? do they want to manage the dollars so they can see that they're making a difference?

Plan management also needs to be more inclusive in how decisions are made: how staffing is done, UM decisions. It's not the suits over here and the clinicians over here. The plan management needs to be more open and inviting. Perhaps by bringing those two things together we'll be able to create a more efficient delivery system, because we don't have opposing forces.

Dr. Dannenhoffer: The plan management absolutely needs to be either the lead fox or the hound dog guarding the foxes so that they won't be raiding the chicken coop. The other thing that has to happen is that the board has to have enough confidence in the CEO, so that at the first bad news they don't get rid of the bearer of the bad news. That's hard to do. We have been remarkably stable in our plan. We had the same CEO from the beginning, and the same medical director from the beginning. But there's always the fear that if the medical director says, "Look, we need to change this, this is something that we're not doing right, for quality reasons, for utilization reasons, for cost reasons, we need to fix this," the board won't say, "We know how to fix this; let's just get rid of the medical director." There also needs to be considerable confidence in the plan management.

I work without a contract; I basically work on the day-to-day approval of the board, so I do keep my day job. Plan management really needs to be strong in this, and probably much stronger than in other kind of plans. That's another struggle with a physician-owned company.

Mr. Harris-Shapiro: The interesting story was that I've never had data challenged. The physicians are always willing to listen to how they can change and how they can improve. They need to be brought into the decision points along the way.

To build success, I think some key things need to happen. First, we've talked about consensus a number of times. There has to be a common vision as to why we're doing this.

Dr. Dannenhoffer: One of the things that we did very well is that the physicians did get together, did understand the vision early on, and while we maybe strayed a little bit along the way, we've been able to keep the vision in mind. It's possible to get distracted from the vision along the way. You see a big pot of money here, and you say, "I know the vision was to have physicians in control of the health care system, but that big pot of dollars really looks pretty inviting: let's go away from the vision and take the bucks." Sustaining the vision is the hard thing to do, because these are people who are doing it in their spare time, and, like any hobbies, they may not be lifelong advocations. They may be things that we're really excited about for three to five years. Again, you have to be really sure that you can sustain the vision, which you can do by bringing on new people. That has really been a struggle. We were really picking from a small pool of people who could actually be the leaders, and it's hard to sustain the vision when you have a small group of people to draw from.

Mr. Harris-Shapiro: Physicians never expect to lose money, and in an insurance business you have good times and bad times.

Dr. Dannenhoffer: Will physicians stay on when you go through an underwriting cycle and lose some money? In Oregon, at least over the last 18 months, most of the big insurers in the state have not done quite so well, because I think there was a move to bring prices down below the sustainable level. The questions are: Will physicians stay on when the going gets rough? Will they stay on when the going gets good, and when you get an offer for the company at huge returns on investment, will they leave? When you look at many successful physician companies, they've been bought out for amounts that appear to be large to start with, but in the whole scheme of things, the companies probably were underpriced. It is a risk, that after three to five years people say, "I'm tired of doing this, I'm tired of sitting at board meetings until midnight; we have this offer on the table, let's just take it." That, I think, is going to be a risk of physician-owned plans.

Mr. Harris-Shapiro: Physicians and the plan management need to reinvent the tool kit or to apply it differently. There are only so many tools in the world to create a more efficient delivery system. The utilization management techniques that we all know and love if we've been a member of a managed care plan need to be applied by a physician or under a physician's control. Having physicians at the table probably gives you a little more latitude in terms of the leverage that you can pull to realize those efficiencies that you need in the health plan. I sat at the table on a number of investor-owned and other health plans in which the physicians were just under contract, and when the loss ratio climbs, they can put on stronger pre-certification requirements; they can narrow the panel and give out some exclusive contracts in exchange for lower rates; or they just cut the rates across the board.

There's a subtler impact that a physician-owned plan can have when the physicians understand the problems and even start discussing it among themselves. We saw our laparoscopy rates tripling over a very short period of time. We put a graph up on the board and had some discussions and went around the table a few times and wrestled with it for a while and then went on to another agenda item. Six months later I updated the graph, and that point we had been at was the peak. It started falling because attention was being paid. Maybe we don't need to do all these laparoscopies; maybe it's not an alternative for a more expensive therapy, but it's an additional service item that we may or may not need.

Dr. Dannenhoffer: Managed care is probably here to stay. I think the days of we'll just pay for anything are gone. Managed care, at least for a segment of the market, is going to continue. I don't think Medicaid can exist on the total fee-for-service system that existed before. People have understood that managed care is going to be here, and now physicians can say, "How can we do this best? This is the thing that, I think, we do the best." Physicians meet together, they talk together, they're honest enough to talk about financial motivations as well as patient care motivations. This is the thing that is really heartening; this is really the ultimate success of a physician-owned plan: people getting together, being honest about it, not gaming the system, and making a system that works.

There may have been a somewhat negative tone earlier, but I think this is the real success of a physician-owned plan: physicians can take the tools that are out there, and they can apply those tools and make a great job of it. It's just like the craftsman, who can have only certain tools, but what a good craftsman does and what I do with the same saws and drills are truly very different. I think physicians really can put together success in this way.

Mr. Harris-Shapiro: Our physicians, I believe, have learned how to say "no" to one another when they want to do something—a procedure, an elective—and one physician feels it's the best thing for the patient, and another physician says it's not. I think they've learned now. The negative tone you referred to before is just a normal learning curve.

Finally, we talked about leaders and followers before, and that physicians are born solo leaders. In a health plan they need to agree to be governed by an elected board of their peers.

Dr. Dannenhoffer: That's a risk, that people will not agree to be governed, that they will go ahead and snipe at the board. We've been able to avoid that, and that has to be a key part of any new plan that would start.

Mr. Roy Goldman: You're still talking about, and I guess you haven't made final decisions yet, how the physicians are going to pay themselves.

Mr. Harris-Shapiro: It's evolving.

Mr. Goldman: You haven't decided to move to capitation?

Dr. Dannenhoffer: We had been in a primary care capitation environment, and there were real physician concerns that primary care capitation did not serve the patients in the plan as well as it could. They've moved on to a different plan, which I can explain later.

Mr. Goldman: I was also going to ask what the relationship is between your physicians and the other providers, such as the hospitals, and what determinations are being made as to how you contract with the hospitals, pharmacies, labs, and everybody else?

Dr. Dannenhoffer: There has been a strong provider focus on all of those groups. For example, when we contract with pharmacies, the pharmacists are actually involved in the contracting process. These are like little foxes guarding little chicken coops. In the end, we say we have certain business needs that we have to have: our pharmacy budget needs to stay in these areas; which group can we contract with to do that best? Assuming that we can't print new money, that's always the basic assumption that we start with. We can't print new money, but how can we do this and do this best. Again, with the pharmacists, there was a way to work with them. With the primary care providers, there was a way to work with them. I think they just need to be in the process.

Mr. Harris-Shapiro: We have them in the decision-making process, and sometimes we bring them in as providers. Our initial pharmacy benefit manager was owned by the state pharmacist, and for a variety of reasons, including some service issues, we needed to move on from that relationship. We do have a mixed model. We have some of our nonphysician providers under capitation, and we have some under fee-for-service and various forms of risk sharing between those two extremes.

From the Floor: You've touched lightly on a couple of things. I'm wondering if you can come back and give some details on something we see as a real problem for providers taking risk. That is, it works really well in the network where you are, but how do you deal with and how do you resolve the issues of the out-of-area, such as the out-of-area emergency, and even in your own network, the high-tech claims. I'm wondering how you've elected to deal with those kinds of issues that

can maybe not kill the plan, but can really financially harm and cause the CFO a lot of heartburn.

Dr. Dannenhoffer: We have out-of-area contracts with out-of-area providers, as well dealing with other physician groups in other areas to provide services to our members. In Oregon, there are seven physician-owned groups who do this, so we have sharing arrangements with them if one of their members comes to our area and gets ill, or one of our members goes to their area and gets ill. We have arrangements to do that. Catastrophic claims are hard. Remember, we're in a rural area, we don't do bone marrow transplants in the backyard here, so we have to send those out. Catastrophic claims are an issue. We do risk reinsurance to handle those claims, and I don't think we handle them that much differently than other insurance companies do. I think that's one of the problems that physicians have to see: risk reinsurance is not the salvation of the plan. Risk reinsurance is really just a way to manage your losses.

From the Floor: Could you spend some time talking about your philosophy on choice of providers, gatekeepers, and so on? I wonder if you had a chance to think about those things yet.

Dr. Dannenhoffer: We have thought long and hard about those kinds of things. One of the things that we would really like to have is maximum choice of providers, because this seems to be not just something that patients want, but probably also leads to better health care. One of the things that is very clear from the physician's point of view, but may not be so clear from the insurance point of view, is that health care is in many ways a personal relationship. Kids come to see me, and I take care of them and their families know about what goes on. It's not really so much a commodity. They probably could have somebody else look at their ears, somebody else could look at their sore throat, but that personal relationship makes the process of care so much easier. If I tell somebody I've been seeing for years now, "You have headaches, but I don't really think you need a CAT scan; you have none of the warning signs," or whatever, then I'm far more able to convince somebody of that than somebody I've met for the first time. The changing of providers and this provider roulette that goes on in many areas are probably not in the best interest of the patients, and probably not in the best interest of the plan.

We have tried very hard to include as many primary care providers as possible. For specialty providers, with whom you presumably are not going to have that same kind of arrangement, we again have tried to have the widest panel possible. We do use a gatekeeper approach on the primary care side, with the idea that, in many cases, patients will not know the best place for them to go. On the other hand, what we've done is to simplify the referral process, so that if somebody comes and

says, "I really think I need to see the allergist for my terrible allergies," we have simplified that process so there's no real barrier to doing that. We think we're in a plan now, in which, with a wide group of providers and relatively easy referral patterns, we have been able to satisfy both of those needs. It's a work in progress, and that's something that we deal with on at least a monthly basis, to look at this again and try to do better.

Mr. Robert J. Myers: I speak as a naive consumer or patient, and perhaps as a naive actuary. I've always heard statements similar to what you just said about the personal relationship, and for that reason a physician-owned managed care plan seemed to me to be much more preferable to a generally owned managed care plan in which the managed care company was, in essence, trying possibly to hold down on the patient and on the physician as well, despite a great deal of glorious advertising that the thing they care about most in the world is your health and not their bottom line. As I say, I like the idea of the old-fashioned fee-for-service, where you've had a family doctor for many years, and he's doing the management of your care; to the extent that a physician-owned managed care organization would do that, I think it's just fine. Of course, as I think you indicated, you can stray from that, and that's not so good. As I've heard your most interesting description today, it just seems to me there's so much administrative overhead and work and so forth with your board and your managing director and the actuary. Is this really going to be a more cost-effective way of providing health care for people as compared with the old-fashioned way of just straight indemnity insurance and the individual going to his friend and physician whom he or she has known for many years?

Dr. Dannenhoffer: That's a great question, and an unsolved issue. I think straight indemnity, in which people's interests are not aligned, probably doesn't work, because if you work on the assumption that there's a fixed pot of money, what happens in the systems that have had that pot is either a ratcheting down of physician rates, which has led to increased volume and not necessary increased volume in the right areas, or explosions in payments. I think that's what you've seen clearly in Medicaid plans. However, if you can get people's interests aligned—and I'll assume that you've taught the foxes that they can only eat so much as a group—can you now pay them fee for service? Interestingly and predictably, as you figured out, when the doctors got together, that's what they decided. They decided among the primary care physicians that the way to do it was to go back to paying the physicians fee-for-service, but at a low rate, so not at a rate where people are going to get rich. In addition, then you pay physicians for the good kind of behavior that probably led you to pick your physician in the beginning. You probably didn't pick your physician from the phone book. You probably picked your physician because a trusted friend said that doctor is great, just the perfect person to see, or you had

high patient satisfaction, or because they were board certified or had continuing medical education.

The plan that our providers came up with was to pay providers on a fee-for-service basis at a low rate and, in addition, to reward physicians for those kinds of things that patients equate with quality: patient satisfaction, board certification, continuing medical education, appropriate use of resources, availability after hours. If indeed you have the Marcus Welby that we all would like to have, not only would that doctor get paid fee-for-service, but he or she would also get a bonus for those other attributes. Somebody who was running the Medicaid mill and skimming the system might make some money on the front end from fee-for-service, but he or she would get very little money in that quality arrangement. That was something that took a group of eight physicians about six weeks to work through all the areas, but it's where physician-owned plans can really make a difference. You could have somebody from the actuarial department or from the marketing department say, "If we did this here and did this here, it's going to come out most cost-effective. However, that may not really reflect what patients want. I see patients every day; I know what they want. They want me to be there on time, they want me to be available after hours, some of them care whether I'm board certified or not, they want me to be up to date on what goes on and that's the difference. The people making the decisions are the people who actually deal with the patients. It's interesting you predicted that, yes, we did go back to fee-for-service on primary care, but not old-fashioned fee-for-service, where the idea was just run up the bills as high as you can and make as much money as possible. In this case, we want to be sure that what we're paying for fee-for-service is actually necessary, and then, in addition, rewarding people for those other behaviors.

Mr. Myers: Again, being naive, I don't think that most physicians under a fee-for-service plan would just try to run up the bill any more than I naively think that actuaries do the same thing when they're in consulting work. Maybe I'm wrong, but I believe this, and I also believe that if actuaries are asked to solve a problem, they come out with the same answer, no matter which of the party is involved who are paying them.

Dr. Dannenhoffer: I wish that were the answer; then Medicaid would never have needed to move to managed care. Look at variations in practice, people come in with the same issue, but what happens to those patients is markedly different. When you look even at some very standardized issues, what physicians do is different. I'll give you a good pediatrics example. Somebody comes in, and there are two ways to deal with the problem. One of the ways would be to say, "You've got chronic ear problems, and we could talk about ways to deal with that and try antibiotics and try this, and it's probably the safest way to do it in the long run,

maybe the most effective way." Or we can say, "Let's just put tubes in the ear, and it's $1,000 a pop to put them in. It takes me 20 minutes, and now I don't have to do any more discussion." There are probably some kids who definitely don't need tubes and would never get them under any scenario. There are probably some kids who definitely need tubes and would get them in this scenario. But there's probably 50% in the middle where, depending upon how you wanted this to go, you could make it happen either way. The power that a physician has is enormous. When I go in and I say, "You have a couple of options here: we could do this or that," I try to present the options evenly. You can easily see that you only have to change the discussion a little bit to get people to decide what they want to do. Circumcision is another great example. Depending upon how you present it to a patient, it makes a huge difference to what goes on.

I wish I could say that, as physicians, there's no variation in practice, that the only variation in practice relates to patient quality. But it's very clear to me that there's variation in patient practice that relates to economic incentives.

Mr. Harris-Shapiro: I've also had physicians explain to one another in front of me that they could get all this equipment simply by sending three patients over to this x-ray machine or this EKG machine they just bought. The one physician said, "I don't know if I have that many patients a month to make that payment," and the other physician said, "Pick three and send them over to make that payment."

From the Floor: I think it should be pointed out that one of the main problems with the old indemnity insurance scheme is not the doctors running up the bills, but the patients receiving services but not paying for them directly. There's a strong incentive for patients to say, "Whatever you want, whatever it takes, go ahead and do that procedure or run that test," and if they're not footing the bill right away, then the doctor certainly has little incentive to say no. It's the disconnect between the payer that had in recent decades become the employer, the sponsor of the health care plan, and the purchaser or the consumer, the patients themselves. One of the things that you need to do if you're not going to go back to the truly old-fashioned system, which is not only fee-for-service medicine but individuals often without insurance, paying for health care just out of their pocket, is some kind of control so that you don't have people just spending money that's essentially not theirs.

Dr. Dannenhoffer: That's exactly an issue that we face. I think one of the reasons that the Medicaid system was so out of control was that there was no patient responsibility. Finding the right balance between patient responsibility, provider responsibility, and plan responsibility is key. That's one of the things that a

physician-owned plan can do, because they're consumers, they're providers and they're owners now, and they can hopefully balance the three.

Mr. Harris-Shapiro: I think the physician community must bear much of the blame for some of the excess utilization that we have experienced in the fee-for-service system, but that blame is somewhat innocent in many situations, because we haven't trained them to understand financial consequences with some of the recommendations they make. They don't have a list of the cost of all the services that they're recommending. They don't know the cost of all the drugs they're recommending, so they may be doing what they think is the best for the patient, and not know the financial consequences of the alternatives they may be able to pursue. We need to equip the medical community with the right kinds of tools to make those wise financial decisions, as well as educate them on what their peers are doing so they may be more efficient in treating the same diseases.

Dr. Dannenhoffer: Absolutely. That's one of the advantages of owning the plan. That's the cat in the maze, which really does encourage you to learn much faster.

Mr. Craig M. Arnold: The question you've talked about the individual profit motive of the doctors versus the profit motive of the health plan overall and the struggle there—is that something you had to deal with and resolve once and for all where you wanted to go, or has it been an ongoing struggle? I can see where that would make it hard to establish a business focus on where you're going if you don't really resolve that. Were you able to keep both of those?

Dr. Dannenhoffer: That is again one of the underlying difficulties of having the providers do it. Recall Jon's little joke, "We have some good news and some bad news." That has been one of the problems. We don't have the statement that answers that forever; however, that is something that gets looked at every time we look at our financials.

Mr. John H. Harding: I have a question that goes back to one of your early statements regarding resuscitation of the newborns. You got into the three obvious categories, those who live, those who die, and those who live but in a very impaired way. Do the economics of this practice at all affect how the physicians really deal with that issue?

Dr. Dannenhoffer: I think that it doesn't affect me at all, but you would say clearly that one of those outcomes is nearly free, one of those outcomes is very expensive and one of those outcomes involves long-term ongoing costs. Clearly, it could have that impact. Actually this is one of the things in the political landscape in Oregon you may have read in *USA Today*, that Oregon is having a ballot initiative about

physician-assisted suicide. One of the fears brought up by the opponents of physician assisted suicides is that insurance companies and doctors will decide to kill off sick patients because it's the cheap way to go. It is a difficult thing to do, and I think it's a battle. On the other hand, if you have to have someone who is going to make that decision, I think patients maybe feel more comfortable with my making the decision than some other insurance company.

Ms. Shereen J. Jensen: No matter how good your planning is and how good your pricing is, there's always a risk that the initial capital won't be enough to support the plan and meet the minimum capital. Did you have a plan up front? I know it's probably very difficult to go back to the providers and say, "Everybody's got to ante up another $2,000 because we're not meeting our minimum capital." What kind of a plan did you have for that?

Dr. Dannenhoffer: The way we raised the capital initially is that people put up personal loans of $22,000 each to support the capital, and that worked. The point is that now as we begin to grow, we need additional surplus requirements, and the board spent most of Wednesday and much of Thursday morning last week discussing exactly that. That is a big issue in growing plans: to have the capital that you need to do it. One of the risks of physician-owned plans is that they will be undercapitalized, or that they will get their capital from venture capital, and if so, then they'll have to pay that bill, which is going to take away the control of the profitability of the organization. It is a difficult situation, and physicians have to say, "If I really want to do this, then I have to be willing to put up the money in the capital and maybe risk it." That is one of the joys of this roller-coaster ride.