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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. John K. Heins: I'd like to welcome all of you and welcome back Jon Harris-Shapiro and Dr. Bob Dannenhoffer. These two gentlemen did the same session in 1977 and we received such rave reviews on it we thought a rerun would be appropriate. Bob is a pediatrician with Umpqua Pediatrics and medical director of the Douglas County Individual Practice Association (IPA) and SureCare Health Plans. Jon is president of Harbor Health Management Services. He has more than 15 years of experience with managed care organizations.

Mr. Jon Harris-Shapiro: The last 12 months have been a very stormy period for provider-sponsored health plans in general, at least for one Pennsylvania delivery system, and also for SureCare health plans, the subject of our case study. We've revised much of this talk, so if you're a veteran from 1977 you'll see some things that are familiar and you'll hear some things that are new.

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In the health care debate there's one issue upon which there's no disagreement: the health care system needs to be fixed. The question, or the lively debate, is who or what should be in the place of leadership and assume the risks that go along with that? It has been suggested recently that physicians should be in that role since they're the ones who control how care is delivered and make the day-to-day decisions regarding a patient's care and the services that affect the outcomes and the cost. However, at least while health care providers continue to worship at the alter of fee-for-service payments, provider-sponsored health care will suffer through a number of paradoxes, and that will be the subject of this discussion.

We'll use SureCare as a case study. We'll first look at how SureCare came into being. We'll define some of the paradoxes that we're talking about. They're less than obvious. We'll talk about the actuarial, clinical, managerial, operational, and governance issues that need to be addressed when you put a bunch of physicians or providers in control of the health plan. Then at the end, we'll bring you up-to-date on what's happened over the last 12 months—what lessons we've learned, and how we're going to move forward.

I think the history lesson begins about ten years ago when Dr. John Kitzhaber was president of the Oregon Senate and the Oregon Health Plan was at the focal point of the health care debate. Bob, since you lived through it why don't you give us a capsule summary?

Dr. Robert Dannenhoffer: I'll give you a little story. I live in Roseburg, Oregon, which probably nobody's ever heard of. It's just a very small town in a rural part of Oregon about three hours south of Portland and about an hour north of Medford. It's a beautiful place with teaming streams. The Umpqua River, is full of these enormous fish. It's just a beautiful place to live. It's a relatively rural county with about 100,000 people in it. Back in the early 1990s, Oregon went through a part of Medicaid revision. One of things they did was to start the very innovative Oregon Health Plan. It was one of the first states after Arizona to go to Medicaid managed care. And as they did this it became clear that there was going to be managed care for Medicaid in every county.

In our county, a bunch of us got together and said if it's going to happen in Oregon and it's going to happen in Douglas County, why don't we be in charge of it rather than someone else? Well, the application process was ridiculously simple. It was like applying for a video card membership. So we did it. We got together and said we'll be a contractor. And thus, we became a contractor for the Oregon Health Plan. In retrospect, we didn't quite know what we were in for, but we did it. In the first couple of years it was wildly successful—excellent care, happy providers, and we made boatloads of money. People said this was great. Since we did it on the

Medicaid side it was just a narrow step to doing it on the commercial side. We took that wide chasmatic leap. We went to the insurance commissioner and got an insurance license and did all the things that we needed to do. By the fall of 1995, we had our insurance license and started selling managed care lives.

Now, the idealism here was spectacular. People really saw what they were doing. They really saw physicians in charge of the health care system doing so many of the right things. Physicians have always bristled at the idea of a pre-existing condition clause, which many of the insurers in Oregon still have. Pre-existing conditions from a doctor's point of view are pretty silly. Here's somebody who's sick, we know they're sick, but we are basically going to wait until they get sicker before we fix what's wrong. So, in a very idealistic way, the doctors said let's get rid of pre-existing condition clauses.

In addition, they recognized how difficult it was to have a cumbersome referral process. We made a very easy and streamlined referral process.

Doctors bristle at the idea of calling 1-800-ASK-A-DOC for permission to go ahead and do something they need to do. So, we said, why don't we control this locally? Here I was the medical director—I practice pediatrics most of the time—and people would call me at home and say hey we have this kid who needs this kind of thing done and we'd sort of figure it out. And it was great. It was really, from a practice standpoint, nearly perfect. Patients got the care that they needed, and there was local control of what went on. In 1995 and 1996 we were quite idealistic. The other people in the state saw this was great and other doctor groups throughout the state decided that they wanted to join us. This is exactly where we were by October 1997, when we last gave this talk.

Mr. Harris-Shapiro: The actuaries like numbers, Bob.

Dr. Dannenhoffer: You want some numbers. It's a small county—100,000 people—and there are about 10,000 people in the Oregon Health Plan, about 10% of the population. We had all of those members. In addition, within two years we became the largest *commercial* managed care plan in the county. So, within two years we had 20,000 of the 100,000 people in the county under our plan. We were pretty successful, at least in our little county.

Mr. Harris-Shapiro: What was the initial investment to get to those 20,000 people?

Dr. Dannenhoffer: It wasn't huge. Basically, we had about 120 doctors in town who put up $1.9 million. Not a huge capitalization, but for 100 doctors it was a fair amount of money. The way it was initially sold was, this is about the cost of a new

car. Do you want control of what happens in the future or would you rather have a new car, which in three years will no longer be new? Indeed, we sold it to every single doctor in the county. It was really quite an idealistic start.

Mr. Harris-Shapiro: So $1.9 million got you 20,000 members?

Dr. Dannenhoffer: Yes, it got us 20,000 members.

Jon has been consulting with our plan from the beginning. As we started, we got a lot of advice from people that starting our own plan was not a particularly smart thing to do because the people who do insurance and the people who do medicine have very different views of the world. Indeed, that's very true. I've come to recognize that even more so in the last year. We put together a number of paradoxes about the idea of physicians owning an insurance company. One of them is—

Mr. Harris-Shapiro: Cost containment versus revenue enhancement. This meeting's keynote speaker, Lester Thurow, said that capitalism is about chasing the dollar. For the health plan or the insurance company, the main objective is to reduce health care expenditures below the target and the premium rates. However, medical practices have a very different view of what those expenses actually are.

Dr. Dannenhoffer: Physicians make money by seeing patients, so we want to enhance our revenue just as much as we can. A creative tension existed. The people who ran the insurance companies said they had to live within their budget. The doctors argued there should be no budget. Somebody early on remarked that it was like the foxes guarding the chicken coop. Indeed, that's a good analogy. I tried to come up with a counter to that analogy but it was hard to do because that really *is* the analogy. As I thought more about it, I realized the-foxes-guarding-the-chicken-coop concept could work for a couple of reasons. First, if the foxes know that the only chickens they have to eat are the ones in that chicken coop, they'll be good shepherds of the chicken coop and won't let anybody else in. Second, since foxes really like chickens, this is something that they like to do. They wouldn't mind being around a chicken coop, and they may want to have their hand in it. So, the foxes are there in the chicken coop. The question is: Are they going to be so greedy that they're just going to kill all the chickens the first night and then go to another chicken coop? That is one of the big questions that we'll try to answer.

Mr. Harris-Shapiro: Keep in mind that what you have is a physician owning two entities. In one entity, there's an expense. In the other entity, that expense is the income. These two entities have opposing interests. Traditionally, they're in a vendor relationship.

Dr. Dannenhoffer: The second problem we faced was the problem of the long-term equity on the insurance side versus the cash basis accounting that most doctors use. Almost all of the doctors in our county, and in the state, are on a cash-based accounting system; thus, the dollars in the door are really what makes a difference, rather than any bills you've accrued or anything else. This was a very difficult problem. Doctors want to have money in the door the next day, regardless of whether they are going to get it down the line. The idea of long-term equity building in the system versus having the money in the door has been a battle that we have faced every month.

Mr. Harris-Shapiro: There was constant pressure to pay out any surplus in excess of the statutory requirements. It was extremely tough to sell the doctors on the idea that you want to keep money around and pay taxes on it to fund product development, to give you market power so that you have the ability to maneuver when the big elephant comes to town from down the highway, and to weather adverse underwriting cycles. Look back at the Oregon experience. This plan got started after several years of very positive underwriting results by competitors. Like many businessmen, doctors have short memories.

Dr. Dannenhoffer: Doctors have never expected to lose money. The one thing that you can't do in a medical practice is lose money. It's almost impossible! People come in and they pay you and unless your overhead is 100%, which is nearly impossible, there's always some money in the end. You may not make as much money as you want, but since your cost of raw materials is pretty cheap—those tongue blades really don't cost very much—you can never lose money. So, the idea of losing money and having money in the bank to make up for a down cycle was a really foreign concept. Another concept that was born was the member focus versus the patient focus.

Mr. Harris-Shapiro: We constantly needed to remind the shareholders and the board that we were dealing with members, not with patients. In fact, the mission statement didn't address membership—it addressed patients. Members include patients, but they also include people who don't access the health care system. Physicians are focused on the users. As underwriters, we need to be focused on the nonusers because these are the people who contribute to the bottom line. In fact, we heard one speaker who talked about how we stacked the system against, not the nonuser, but the seldom user, the people who might get sick once a year. We make it extremely difficult for them to get the one set of antibiotics they need, and we force them out the door. This speaker was almost suggesting that we create some adverse selection there.

Dr. Dannenhoffer: Indeed, it's true. I don't think about people on my panel who I never see. I really think about the kids who I do see. I know them, I know their families, I know their faces, and I know their diseases. But I don't really think about the people who I don't see. It's the people who I don't see that obviously contribute the premium. This also made it difficult for doctors to understand the idea of a premium of $120 per member per month (PMPM). They said, "Wait a minute it must cost much more than that because I'm seeing all these people five times a month. Well, of course, you ask, "What about all the patients you're not seeing?" This is just a totally foreign concept to doctors, at least until the last five years.

Our next paradox is sound actuarial practice versus the profoundly nonstatistical matter of medicine. When I look at a patient, I certainly think of statistics. What's the chance that this disease is there? What's the chance this goes on? But, for patients, it's not statistical. Either you have cancer or you don't. You're pregnant or you're not. You're not 87% pregnant. So the story is that, when you think of patients, you're thinking of one. I tell this story because the reaction to it from people on the insurance side is so very different from people on the medical side.

There was a plan in the state of Washington that had a physician who was really statistically terrible. He had high cost, his patient satisfaction was low, he had far more complications than anyone, and his hospital days per 1,000 were high. This guy was a bum, and they wanted to get rid of him. They marshaled all these statistical forces and hired a biostatistician, somebody from the University, to come. They presented what they thought was a compelling case that this guy should be out of the panel. Eventually, they got him out of the panel. He sued the plan, and the plan went to court. They said, "We have our ducks in a row. It's going to be a slam dunk." So the statistician presents the lovely Z scores and the idea that this guy is really a variant and they should get rid of him. The doctor's lawyer comes up and says, "Doctor, one of the patients you're accused of spending too much on is Mrs. Smith. Let's call Mrs. Smith up here." Mrs. Smith says, "Oh when I was beginning to have a stroke when I was in church, he drove me to the hospital and he waited there. Maybe it cost a little bit more because he really cared about me. I brought him a pie when he was done." This kind of thing won the case, so the plan lost.

They actually lost fairly big in this case. When I present this to insurance people they say, "Oh, stupid anecdotal people." When you present it to doctors they say, "You see, that's right." People look at that story in a totally different way. That's the difference between how you have to think of it in insurance and the way that doctors think of it. They think of an *n* of one, whereas the actuaries need to think of the big picture.

Mr. Harris-Shapiro: There are also some other issues, that we've alluded to before, that were very new and taught us some painful lessons. Physicians have no concept of selection bias. It was completely beyond their comprehension of how important it was to manage the bias. I'm not necessarily talking about going out of your way to achieve favorable selection. The reality is that you need to avoid being adversely selected against. Not only did the plan decide that it took the high moral road by not putting a pre-existing clause in their contracts, but they went a step further and put it on the radio—in a guaranteed no underwriting, guaranteed issue, noncancelable marketplace. Other carriers may, in fact, have eliminated their pre-existing clause too, given the Kennedy-Kassebaum requirements and some of the other things that went on in Oregon, but this was the only plan that put it on the radio.

Dr. Dannenhoffer: Another issue is corporate structure versus individualism. This is very difficult. To get into medicine, you must have extreme self-confidence. Probably any of you who have ever dealt with physicians recognize that they're an extremely self-confident lot. This can be good, but it can also be a hindrance when you're in a group and you're trying to get a group of doctors to do anything. People talk about herding cats; it's more like herding cheetahs. These people are very aggressive. Everybody is an individual and everybody has a view of the world. Thus, when we tried to do this with 100 doctors, rather than electing a board to make decisions for the group, each of the 100 doctors wanted in on every decision. Well, you can imagine with all these decisions, there are always going to be dissenters. The dissenters wouldn't say, "Okay, I guess I got voted down. I'll wait till the next one." It was, "I got voted down and now I'm going to save my case." You can imagine that the more things that the group as a town hall began to vote on, the more areas there were for problems.

Now, this sounds like a formula for disaster. However, it really did work well, but you can imagine some of the battles we went through.

Mr. Harris-Shapiro: We knew about these paradoxes going in. In fact, I remember some of the early meetings. Why did we do this?

Dr. Dannenhoffer: Yes, why did we do this? Well, the first thought was we knew it was going to happen, at least with the Oregon Health Plan, and we were pretty sure it was going to happen in the commercial business. The rallying cry was, "We'll do it before somebody does it to us or for us." The thought was that if we could control it ourselves, we would have much more control over what went on and we could do it better. In a lot of ways we did. At the same time, on Oregon Health Plan—the Medicaid plan—Blue Cross did it and PacifiCare and other big carriers did it in our state. No other carrier was nearly as successful as we were in

terms of high satisfaction, high quality, returning withholds to doctors, and being able to do the extras that we were able to do. That was the impetus for plans in seven other counties in the state to go ahead and do the same thing. Now, in the state of Oregon, the predominant delivery system, for Oregon Health Plan at least, is physician-owned health plans.

Mr. Harris-Shapiro: The other key element was to have an ownership or equity stake. We're not talking about an investment where you would send your check off and be a part of this health plan much as you might send your check to a Merrill Lynch account. This was structured as a very limited stock offering. We were looking for a sense of ownership and participation. And, as we've tried to expand the company, that has become a double-edged sword.

Dr. Dannenhoffer: Indeed it did and really what people wanted as a return on investment was control of the process.

Mr. Harris-Shapiro: Never was there any discussion of dividends.

Dr. Dannenhoffer: I don't think anybody ever thought they were going to make tons of money by owning the insurance company. The idea was that they would control what went on rather than actually have money in the bank. This again was another problem because with people unconcerned about money in the bank, there was then no reason to retain any money in the plan.

Mr. Harris-Shapiro: There wasn't the sense that you needed to build up a war chest to maintain market position and develop economic power in the long haul. Of all these objectives Bob—market forces (do it before someone does it to/for us), ownership & equity, return on investment (control)— which was the one that the doctors found most appealing?

Dr. Dannenhoffer: I think all three. The guarantee of having a say in what went on was really what sold the plan. These were the lessons that we had learned as of October 1997. We've learned a lot more lessons since then. The first lesson was: Boy, it's not as easy as it looks.

Mr. Harris-Shapiro: The gap between perception and reality was huge.

Dr. Dannenhoffer: Yes, physicians say, "I can't understand why the insurance company spends all this money and has all those people there, because it's pretty simple to run an insurance company. What in the world are they doing with all of our premium?" I think what was clearly recognized by the people who were on staff, but took a long time for the doctors to know, is that it really wasn't as easy as it

looked. Claims systems are remarkably difficult—the regulatory stuff is remarkably difficult. You have to tell doctors who have the view that "I'll just do it with two guys in the basement here" that it's not going to work.

Mr. Harris-Shapiro: Especially when it came to the commercial product, where there was a whole underwriting component in terms of the rate setting. On the Medicaid project, the downside is that you have only one client. But from a political standpoint and a cultural standpoint, the rates were set by the state and published in a rate book format. It was a take-it-or-leave-it game, so the whole idea of setting your rates was shifted to, "How do we live under these rates?" which is a qualitatively different discussion. But the toughest lessons I think were risk management and underwriting—building enough critical mass to support the infrastructure.

Dr. Dannenhoffer: The second was the challenge of cutting enough waste. There were varied views—as you can imagine—as to what waste was. It turns out that the insurers in our state, and probably in many other states, are among the leading charitable contributors in the state. People then began to realize—as we started hiring people and becoming a business in the community—that those things initially seen as waste were expected of businesses in the community. Obviously, you couldn't have your insurance company here and then not sponsor things. You couldn't have it and not do things for the school. You couldn't have it and not donate your computers to the school. Those things that they saw as insurance company waste were really the costs of doing business.

Another cost of doing business is the agents. The doctors said, "Oh we don't need agents. We'll just freeze the agents out and wouldn't that be great because then all of that money that we would pay to agents could go right to providing medical care. That sounds great!" However, without agents it was, of course, very difficult to sell. Some of our perceptions that what goes on in the insurance companies is mostly waste became perceptions that these are costs of doing business, so our ability to get rid of waste was restrained by the fact that the waste was much smaller than originally expected.

The next lesson we learned was about capital, time, and administrative requirements. This group knows that that the amount of capital, time, and administrative effort it takes to run a health plan is enormous. To Oregon's credit, the Medicaid plans didn't require nearly as much as the commercial plan. This was one of the things that was not really anticipated, that running a commercial plan was actually much more difficult than running a Medicaid plan.

Mr. Harris-Shapiro: There was a sense that it could be done for about 6% of premium.

Dr. Dannenhoffer: Right.

Mr. Harris-Shapiro: We can talk about where that came from, but we can also just sort of laugh and move on.

There were a lot of insidious issues here. You needed to bring in a talented administrative staff to do things that you don't do in a medical office. However, the physicians had a really hard time understanding that you can't recruit talented staff and pay them with the same pay structure and benefits that you pay your medical office staff. That created a huge cultural divide between the administrative arm of the organization and the medical arm of the organization. Two bullets that we should add to this list are:

- There's a strong sense in physician-owned plans, especially the ones that are more rural based, to buy local
- Do it on your own. We don't need to bring the crew in from out of town. We can just do it ourselves. Unfortunately, unless you bring in people who have the right experience, you're doomed to reinvent the wheel. There isn't enough room in the health care economy, especially in a competitive commercial environment, to be constantly reinventing the wheel.

Dr. Dannenhoffer: Other lessons we learned were in marketing. The thought was that if doctors did this people would just come, much like that cornfield in Iowa in *Field of Dreams*. Just build it, and patients will come. It turned out that that was not really the case. What's really remarkable is that I've heard this from every doctor- or hospital-owned plan. If you just do it, people will come. Actually, it has turned out to be tragically incorrect in every market where it's been tried.

This is true for a couple of reasons. One, doctors have this ethical thing that they can't outwardly sell. There's really been a view in medicine that selling is somewhat beneath the profession. Two, they overestimated the appeal. The reality is that doctors owning the plan was seen as a negative thing by some people. Consumers are smart. They understand the fox-and-the-chicken-coop analogy much better than the doctors did.

Their view was, "Wait a minute, if the doctors own the plan, are they going to have a conflict of interest when they provide care to me?" This was something that doctors did not in any way view as a likely outcome.

Mr. Harris-Shapiro: It took about six months to recognize that this thing wasn't going to sell itself. It took about another three or four months to turn it around. We brought in an experienced marketing consultant and started gaining acceptance in the marketplace probably 12 to 15 months after we opened the doors on the commercial product. One of the biggest mistakes that I think all provider organizations make is that they insure themselves. The first thing every physician hospital organization or provider entity that has created some kind of insuring organization does is say, "Oh, great! I can spread all my administrative costs over the hospital, nursing home, medical office employees. . . ." The list just goes on and on. Well, we all know that these people aren't really good risks for your pool in a community created environment or otherwise. Moreover, these are your shareholders and they are demanding—and sometimes their plan administrators will go a step further than demanding—a most favored rate. When we did a postmortem on our commercial block, the worst and the largest piece of that block was the medical industry employees, running at a 112% loss ratio. There was, in effect, a subsidy going on between the insurance company and its operations and the employee benefit costs of the medical office practices.

Dr. Dannenhoffer: For anybody who was at the earlier session (Session 13PP: Managed Care Effectiveness), there was a presentation on the goals of health care delivery. The goals were illustrated in the shape of a triangle with the points representing fast, cheap, and good. You're supposed to triangulate somewhere in there as to what kind of services you want. I can tell you, when medical people are on that triangle, cheap is not there. We've created a new geometric figure where fast and high quality are really the only two things that count. That shouldn't be unreasonable. Here were people who weren't really looking to control costs. They knew where the highest quality was and wanted it right away; thus, trying to put that somewhere in that triangle was difficult.

Another thing we learned was the problem of physicians controlling themselves. The idea was that if doctors could talk among themselves, they would be able to control some of the utilization issues and practice variation issues that insurance companies aren't able to manage. This, I think, is still a hope that's out there. When the insurance company says to me, "Dannenhoffer, you're terrible because you spent too much on drugs and your patients spent too much time in the hospital." I would answer, "Well, that's because I take care of all the AIDS patients in town." Then we would have an endless debate. The thought was that if doctors talked to doctors, they would say, "Look, I know you don't take care of any sick patients and yet you have the worst kind of utilization. You send everybody to the emergency room (ER). I know that because my patients come to see you and they say, 'I couldn't get into to see him and he sent me to the ER.'" The thought was that doctors working among themselves could solve this problem. I think it does work,

but I also think that it doesn't work nearly as well as everybody had hoped. You can make big inroads, but you can't fix the problems. There are some problems in the delivery of health care that are beyond what I can do as a physician.

Mr. Harris-Shapiro: Some of that had to do with learning how to present data. The standard actuarial reports that we have grown up with just don't work. Doctors do not understand them. You need to build a bridge from the actuarial perspective that Bob and I have talked about to the clinical perspective to help them understand what is happening and why it is important. Even if it's clinically sound medicine, you still have to live within the budget at the end of the day. We did see impact. For example, we had seen a threefold increase in laparoscopies. By following the actuarial report, we saw the line come down. We did a lot of graphical work for obvious reasons. The problem was once we stopped talking about it the line would go back up.

Dr. Dannenhoffer: What kinds of things can you do to make a difference? I think the first, and one of the most exciting parts of this, was the ability to use the medical input and Jon's statistical and computing skills to actually make reports that would make a difference. Other insurers have tried it with all of their great computing power and still to this day the reports are useless when they come to my office. They may show where I am in a group of other physicians, but it doesn't adjust for anything, which is important. It really doesn't show anything that I can change. I can't change what diseases my patients have. If I have more diabetics than anybody else in town, it's not as if I can get rid of diabetes. I'm certainly not going to get rid of the patients. We were able to create some reports that I think really did make a difference and were clinically useful. I think they also served as a template for what other insurance companies have done. Several other insurers—big insurers in the state—have copied those reports.

Mr. Harris-Shapiro: I didn't know about that.

Dr. Dannenhoffer: No, really, in terms of relationships this is one of the things that happened. Whereas the medical director could provide the clinical expertise, you could provide the statistical expertise. It really did help us.

Mr. Harris-Shapiro: As actuaries, we have to remember that the numbers and the bits and the bytes that we're working with are a mirror representation of something. It's easy when I'm staring at my computer screen to think that the number is the end in itself, but, in actuality, it's a representation of something that happened in the past in a medical office, a hospital, or on the side of a road for that matter. We need to understand what that representation is, and how flawed that representation is of the actual truth. Our goal is to figure out what's going to happen tomorrow.

By wedding what happens in the offices to what's happening on the computer, we've been able to put together some good presentations.

By way of example, at one point I thought there was a problem with immunizations going up 30–40%. Alarm bells started going off. I talked to Bob and found out that the state had just issued new immunization guidelines, whereby what would have happened a year from now is happening this year because they've accelerated the schedule.

Dr. Dannenhoffer: In addition, many of the trends we see in health care today we knew about six or nine months ago because of actuarial data. We predicted this enormous rise in drug costs four years ago well before the inflection of the curve. As we reviewed the pharmacy reports we began to see that 10 years ago there were almost no medicines that cost more than $100 a month. Now the top ten medicines that are used all cost more than $100 a month. Four years ago, we saw Prilosec get introduced and go from short-term to long-term use. So, we did pretty well in predicting some of the trends.

One group that was really important to talk to was the board of directors. One of the things that happens in physician-owned plans is that the physicians want a majority of board members to be physicians. This was, at one time, an opportunity but also a challenge. I can imagine most insurance company boards have people who have some background in business and insurance; thus, the idea of talking about actuarial things is not going to come as a great surprise. But, our board, being relatively inexperienced in those areas, truly needed an actuary's input to help them. I can tell you that they may not have believed what they heard, but it was really important that they got that input.

Mr. Harris-Shapiro: I had a number of sessions with them, and I started titling them—when I could see what was coming down the road—"Hell is truth seen too late." They all understood why they were titled that way, but it took them a long time to swallow it. I began to understand what some of the challenges were. I'd get my 10 minutes at about 11:30 p.m., if I was lucky. On one site visit, they scheduled a board meeting only for the actuary. I actually got sick of the numbers before they did, and I have a pretty big appetite.

Dr. Dannenhoffer: What kind of things do you need to build success? The first thing was sustaining consensus. Will people still have the same vision and maintain that vision or will people have a short attention span? This is one of the challenges that we saw from 1997.

The second was, will doctors and providers have the staying power during the downsides in the cycle? As things go bad, as you begin to lose some money, are people going to say, "Well that's just part of life here? Let's just keep going another couple years until the cycle goes up," as it will. Or will the staying power go away?

Mr. Harris-Shapiro: I think very much related to that is the access to capital. If you're maintaining your reserves right at the statutory level and you go through a down underwriting cycle, that becomes a rather urgent need.

Dr. Dannenhoffer: In this group, where ownership was control, you obviously didn't want to have other people come in and buy it because then they would be owners and you would share control. But, obviously, if we couldn't have other people come in and buy shares, then you couldn't have the capital you need, so the staying power is really an issue.

The next requirement for success was, could you really reinvent the tool kit of managed care? Could you really change managed care to make it work better? I think in a lot of ways, we did. This was, perhaps, one of our successes. However, the question is if you can't do everything else, is that improvement enough to sustain you?

Another key—one that was very important—was, would people agree to be run by an elected board? Could you really elect people and have them speak for the doctors in town? You'll see later that this became a major problem.

Next was the commitment to learn. Actually, this was another of the great successes that we had. People really were committed to learn. Certainly, I was learning some of the actuarial concepts, such as lag tables. "Actuary 101," if not lower than that. But what was also important was for the actuaries to learn the clinical issues; for instance, the fact that you would expect immunization rates to jump every August because kids need shots to go to school in September. Something else to understand is some of the ideas of pent-up demand versus a lag in initial claim rates. As people join a Medicaid plan, there's been the debate about whether costs are higher than average the first two months or lower than average the first two months.

We argued about this. In the beginning we said, "Look, these are people who for the most part haven't had coverage before. The first two months on Medicaid, they're going to get everything done." Others said, "Well, maybe it's not that way because in medicine there's certainly a time lag to accessing services." Actually most of the time lag is not sitting in the doctors office, but there is some time lag

there too. But, there is a time lag until you actually do it and get the bill and whatever. Those are things we're actually looking at.

Another thing that we can look at—but that you really can't look at individually—are the effects of payment mechanisms. What's the difference when you go from a capitated system to a fee-for-service system? Those are some of the things that we're learning.

Mr. Harris-Shapiro: We'd have this back-and-forth dialogue—you need to understand *this* and you need to understand *that*. It was not adversarial; it was very friendly and productive. And that's just who Bob and I are.

But there are also some very insidious things that came out of these discussions in terms of who moved to town. One of the reasons we saw one of the procedures go through the roof and quadruple over an 18-month period was because a physician moved to town with those skills. All of a sudden, boom, we had this procedure way out of line with any historical benchmark that we had. That sparked a debate—a very interesting debate consistent with what's gone on nationally—as to whether or not this procedure was an alternative to a more expensive procedure done in a surgical setting. We found that the answer was no, that it was additive. The invasiveness was so low that it was much easier to yank someone's gallbladder out using laparoscopy than to go in through the abdomen. The incidence rates just went through the roof, and that stuff isn't cheap.

Dr. Dannenhoffer: But then you have the difficult clinical decision, is that better in the long run? These are debates that we obviously didn't answer, but these are questions that are being played out in the long run. Bigger plans with more numbers could answer some of those questions.

Mr. Harris-Shapiro: There are also some insidious issues in terms of vacations. Obstetricians go on vacation and, instead of covering for one another, they induce all the women that are due for the two-week period. One December they were lined up in the cafeteria. You can imagine what our reinsurance rates did after that.

Dr. Dannenhoffer: There were some role issues, but I think that got played out pretty well. Let me fill you in on what happened at the end of the story. We were here at the SOA meeting in October 1997, in Washington, D.C. At that meeting there were a couple of very good comments at the end of the session. One was from somebody who asked, "How do doctors believe that they can really run an insurance company with really no experience in the business? This is a complicated business and you really need to have some more expertise." I took that as a bit of a warning. The second thing I heard was from somebody in the

insurance business who said that "you're just too small and you're going to get eaten alive." We were a bit worried last October. But we had great plans to conglomerate with other physician groups throughout the state to form a larger group that would have some of the expertise and some of the capital to do the things that we wanted to do.

A couple of things have happened since October. One is that, to the north of us and to the south of us, much larger physician-owned plans went under. The California Medical Association—I'm sure you know about that story—had many more physicians but far fewer lives, and they went into receivership. To the north of us, the Washington Medical Society had a plan replicating many of our mistakes and they also went under. So, to the north of us and to the south of us physician-owned plans didn't do well. Because of that, these other partners that we talked about got cold feet. That's not surprising when they see California Medical Association, with ten times as much capital, and the Washington group, with five times as much capital, go under because they were undercapitalized. The physicians, rather than rallying around us, decided that this was perhaps a problem.

The other thing that happened was underwriting got increasingly tight in the state, creating market pressures to keep rates low. Many of the plans, for the first time in years, began to have underwriting losses. The big companies also had big investment income, so they didn't lose any money during the year. With a very small reserve, our investment income was small, so our underwriting losses were there. By March 1998, the insurance commissioner said our statutory reserves were low and we needed to increase them.

To the great credit of this organization, the doctors said, "Look, the most important thing is for this to continue and nobody to get left in the lurch." The doctors basically said that they would work for nothing for three months. During that time, the money that would have gotten paid to the doctors got put into reserves. By building back the reserves, we built the company back to financial solvency.

We definitely learned some lessons. Physicians may be an arrogant lot, but they're not stupid. They finally learned the lessons that we talked about in 1997. They were faced with the decision, do we really want to grow up and become like an insurance company? Or do we want to leave this for the people who really have the insurance expertise? Again, to their credit, they made the second decision. They left the commercial business to the professionals. HMO Oregon, which is one of the Blue Cross/Blue Shield plans in the state, picked it up.

I think, in the end, no members got hurt. Some doctors got hurt financially, but there were a lot of lessons learned. They learned that it is a tough business and you

can't run it like you run your office. You must have money. You must have capital. The plan continues to do Medicaid managed care because that was where the physicians' hearts were. This is a plan that was going to occur with or without them, so we continue to do the Oregon Health Plan and we are very successful in that. But, the lesson learned on physician-owned health plans is: Watch out!

Mr. Harris-Shapiro: This reflects what I've heard in other markets. First, that government programs are somehow cleaner than commercial products. Providers with hospitals and physicians can deal with Medicare and Medicaid. They can deal with the government as a payor because the rates are pretty much set and there aren't a lot of market realities they have to deal with. But commercial business is somehow too dirty. The agents, the brokers, the underwriting, and the variable premiums are too difficult for them.

And the other issue is, from what I've learned talking with people around the country, it seems that if you partner with or hire individuals with the right experience and you stack your board accordingly, you can wed the two skill sets. Exiting the commercial market wasn't necessarily the only option. It was the best option for SureCare at the time, but other markets have been able to partner the skills and get access to capital.

Dr. Dannenhoffer: I've obviously played this out in my mind several million times on how it could have gone differently and other things we could have done along the way. There are clearly many different paths that we could have taken. The point of this presentation is that you will be on the other side. You will be working for the insurance companies and saying, "Why in the world are these physicians doing this?"

Mr. Harris-Shapiro: Some will be consultants working for providers.

Dr. Dannenhoffer: Right, or consultants working for providers. You can say, "I went to this presentation. Let me tell you about some of the things you need to know before you do this." I hope this will help make it work for you.

From the Floor: I'm 88 years old. I'm a member of a family care retirement community and have been for seven years. The problem there is similar to those you are talking about. I think the difficulty we are faced with has been, so far, an unwillingness to look a long way ahead. They're very happy to look at next year's budget. But it's very difficult to make them think of the profit situation in 2008 and 2018 and to build up the actuarial resources that enable a forecast over long periods.

The second point I want to make is that I'm sorry I didn't bring along a dictionary. Because I think the items that you were calling paradoxes are really dilemmas, which are an entirely different matter. A paradox, in my language, is an absurdity. A dilemma is an inability to arrive at the right one of a pair or more choices.

Dr. Dannenhoffer: Absurd, I would agree. Actually, it probably comes somewhere in between those things. There probably is a right answer you can triangulate for different groups, but it was difficult to find.

Mr. Harris-Shapiro: One person corrected me and said these aren't paradoxes—these are conflicts of interest. But, I won't go there.

Mr. John D. Stiefel, III: My question is on "sweat equity", the ability or willingness of physicians to work for nothing if a provider-sponsored organization (PSO) or other physician-owned health plan gets into trouble. Do you think that is sufficiently reflected in current risk-based capital requirements? I'd like both of you to answer.

Dr. Dannenhoffer: We got our physicians to do it and it was very much to their credit. I think this was one of the first times that this has been put to the test. I was at an American Medical Association (AMA) meeting about three years ago and the whole leadership from the AMA at that time was really behind PSOs. There was this conference and all the board members from the AMA stood up and said, "Yes, you can definitely put sweat equity as money in the bank because physicians will do this." But, I can tell you that it was a lot easier said than done.

Mr. Harris-Shapiro: A large bitter pill.

Dr. Dannenhoffer: It was a large bitter pill. And it took every ounce of salesmanship, every ounce of calling in chips, and every ounce of threats to make those physicians do it. I think, in this case, physicians did it because it was the least disagreeable of some very ugly options, one of which was that otherwise some of the people were going to be financially on the hook. You shouldn't count on the sweat equity in any model of valuing plans. I think it's something that could happen, but I think it is certainly something that you should not, in any way, count on.

Mr. Harris-Shapiro: Given the separate corporate nature of the entities—the practices are over here, and some of them are significant clinic-type organizations; you have an IPA over here, and you have an insurance company over here—it's not an easy task to make this thing happen. It was very difficult and the political costs were extremely high.

I was very pleased when this solution emerged, because it was probably the first time that that aspect of the health care debate had been tested. However, I don't think it's something in which you can say, "OK these guys can work for free. They provide 80% of the care under this PSO, so we can write the reserve down for 80%." No, I think it's a last-resort-type approach.

Ms. LeeAnna M. Parrott: Along the same lines, can you comment on when the plan first experienced underwriting losses? How did you deal with the finger-pointing that might have been going on between, say, poor underwriting work or actuarial work that eventually led to the physicians?

Mr. Harris-Shapiro: The actuarial work was perfect.

Ms. Parrott: Was there anything like that going on as far as why are we having these losses? Was there a concern or any finger-pointing? How did you deal with that conflict?

Mr. Harris-Shapiro: One of my biggest fears was the slippery slope, that once the board started meddling with or querying the underwriting process that we'd be done. In fact, I was prepared to resign my role if they started meddling in the underwriting department and saying, "Set the rates here. Why are you setting the rates there? It's your job to fix the revenue. It's not our job to fix the costs." At that level, it didn't happen. The crux of the problem was that we'd launched this commercial product thinking that it could be capitalized downstream. The "build-it-and-they-will-come" mode. You launch a product, you get acceptance in the marketplace, and your capital requirements far outstrip your available cash. The tenor of the discussion, I believe, was on another plane.

Dr. Dannenhoffer: There was some finger-pointing at the actuarial work. But, actually, one of the biggest problems with the actuarial work was that, early on, we didn't have a clue as to what the real experience would be on the Oregon Health Plan. So, when we started on Oregon Health Plan we had a very generous reserve for claims incurred but not reported (IBNR). As that IBNR got let out, it looked as if we were doing great. People assumed that would just continue forever, but it didn't. There was some finger-pointing when that stopped. Obviously, you can't let the IBNR go down to nothing.

During that time there was some finger-pointing at the underwriting too. However, the counter to that was to show that the underwriting for the nonmedical groups was perfect. The problem was the underwriting for the medical groups who put pressure on the board and pressure on the staff to give them preferential rates. For

example, there was one small medical group in which the wife of one of the doctors had fertility treatments and got pregnant with triplets who were delivered 13 weeks early. You can imagine that 27-week-old triplets were a relatively costly experience for the plan at a time when things were otherwise going badly. That group—because of their power on the board and whatever—negotiated for no rate increase after that came through, despite a loss ratio of 300%. That basically was forced through because those doctors controlled the board. This happened right at the time things started to crumble. Anybody who looked at that point said, "anybody that would do that deserves to crumble." Some of that was lack of business expertise.

Mr. Harris-Shapiro: It was clearly recognized that the clinic administrators were leveraging the plan on the premium rates.

Ms. Sharon Roberts Rivais: What do you do when you have the dilemma of defining what your covered services are, especially when you're covering your own physicians? What are you going to say is a covered service?

Dr. Dannenhoffer: It's very interesting because Oregon has the Oregon Health Plan and part of it is a prioritized—some people call rationed—list of diagnoses and services. If appendicitis is first on the list and you have appendicitis, we'll take your appendix out because we think that appendicitis is important and taking your appendix out is going to work. The list has, say, 710 lines, the first 587 are funded; while the ones after that aren't. If you have warts removed, their removal really doesn't change your life. That's below the line of funded services.

The coverage in the Oregon Health Plan was nearly black-and-white. It was pretty easy to do. That was one of the areas where we had success. However, once we started to get into the commercial population, we were faced with tremendous battles about what was covered, and not just what was covered, but what was covered where. We had a fairly intact panel for Oregon Health Plan. But, as you got to doctors they said, "I don't really want to see any of the other doctors in town." "My family wants to go out-of-area." "I know someone really good at the Mayo Clinic." That was one of the big problems.

That is one of the real difficulties of selling a managed care plan to physicians. In retrospect, what physicians really should have is a high deductible indemnity plan. If you really think about it, physicians for themselves want—in that triangle of fast, cheap, and good—good and fast. They shouldn't necessarily want cheap, so they should go for a high deductible indemnity plan. One of the things that we learned is that managed care may be good for some groups, but not all. Actually, the groups that we had the most success with were small groups; the mom-and-pop

pizza store who had five or six employees and wanted to provide them low-cost, but fairly comprehensive, health coverage. They were actually our most successful groups because they were probably buying the right product. I think the physicians and the hospitals were clearly buying the wrong product. We were probably complicit in that because we sold it.

Mr. Harris-Shapiro: The small groups were also purely community-rated, which I think had something to do with it. Once the state approved the rate book, you couldn't touch it for a penny. When we talked about issues that we had to educate one another about, PMPM was a really tough issue for the physicians to understand, but a benefit book was also a tough concept for them to grasp. When they said, "Well, I want another pair of glasses this year" and just wanted to change the benefit book, we had to tell them, "We don't think we can do that."

Mr. Steven J. Sherman: I had a question that pertains more to Medicaid than physician-owned health plans. It's something that's been coming up for me in more than a few places. One of the things that's arisen with some clients of mine, who are hospital-sponsored and probably have more access to capital than your people, is the question of whether we want to set up a contingency reserve if we think that our state legislature is going to squeeze down the rates next year. The reason I bring that up is that if you ask a lot of people in politics they will tell you that it is immoral or amoral or just simply wrong for anyone to make profits serving these poor people. There's been a tendency in several states that when the program rolls out and plans get profits, the rate might actually lower the next year, even if the state's Medicaid fee-for-service provider payment rates increase. We've seen this in Missouri and expect to see it in some other states as well. I don't know if there's a real answer, but that always concerns me, when we look at our contingency reserve or our capital in terms of variance in claims, that it's almost impossible to hold a sufficient capital reserve for the state sticking you, so to speak, to give you a rate next year that might be insufficient relative to continued performance. I wonder if your people have brought that up to you?

Dr. Dannenhoffer: Yes, that's a big issue in Oregon. The fear would be that for the first couple of years the rates would be great and they'd draw everybody in, but then the rates would get tighter. Indeed, that's happened to some degree. However, as Oregon Health Plan was set up—and I could go on for hours about Oregon Health Plan—it was really an incredible plan. It has brought Oregon's rate of uninsureds way down. It has put everybody into managed care, but in a very enlightened way.

I have a curmudgeonly pediatric partner here who's been doing this for a long time. He states begrudgingly that, yes, people on the Oregon Health Plan have the best

health care. Not just the best coverage—because people on Medicaid have always had the most extensive coverage—but he said they have the best health care of anybody in his practice. Indeed they do because they get called back for immunizations, they get called in for their baby care, and they have nurse case managers who shepherd them through. They really do have the best care. The Oregon Health Plan has been very innovative, but one of the things that was stated from the beginning was that this was not going to be smoke and mirrors. They would have actuaries involved and they have used Price Waterhouse Coopers. We're really going to fund this appropriately throughout each of the sessions. They really have done that. There's been a little bit on the edges, but generally they have not played that game as they have in other states.

Mr. Harris-Shapiro: The debate between the health plans and the Oregon Medicaid agency and their actuaries has been at the healthier end of the spectrum. Yes, they've had their disagreements and the contractors do wield a certain amount of leverage at this point because there was a market consolidation. But the debate has been healthy. In other markets I do agree that the rates tend to go through some cycles, where they tend to go down. Rate setting—whoever the state's actuaries are and with all due respect—is not a perfect science. It takes a great deal of diligence on the plan side to ferret out any rate-setting errors. One person's error is another person's conservatism. If you're going to be in it for the long haul, you need to have the stomach to weather possibly two bad years until you can get relief, either through the legislature or through the actuary.

Mr. James Gutterman: I believe you said that you wanted to get statistical reports that are clinically useful. Can you give me a couple of concrete examples?

Dr. Dannenhoffer: One of the examples was ER usage, which I think is an important thing to look at. Obviously, it costs the insurance company a lot of money for somebody to go to the ER rather than to the physician's office. That makes sense. But, there was a problem with looking at ER costs in many of the reports we got from anybody else. They showed your number of ER rates per 1,000 or your costs, but they weren't adjusted for severity. They've not been adjusted to consider true emergencies versus false emergencies. If all of my patients with heart attacks go to the ER, that's really appropriate care. And if it costs a lot of money and there are a lot of them, that's OK. On the other hand, if I send everybody who has lice to the ER because I'm too busy, I'm out of town, it's 5:00 p.m., or I don't want to see them, then that's very inappropriate. That should be looked at. One of the things we've done, for example, in ER rates is look at the times of day that people go. That's something that you just can't get, or can't easily get, from raw claims data. Obviously, if everybody shows up between 5:00 p.m. and 7:00 p.m., that

shows an access problem with the practice rather than people who are going at 4:00 a.m. for high intensity illnesses.

When we look at them, we spread them by the day of the week, the time of the day, and the severity or nonseverity of the claims. You begin to see patterns. For example, when we recently looked at this, we found out that one guy had very high ER rates. He had 800 ER visits per 1,000 member-years, which was high because the average for our Medicaid plan runs between 300 and 500 and our commercial plan ran between 100 and 110. Why did this guy have so many? As we looked through this it became obvious. This person was doing part internal medicine and part oncology practice. If you looked at the people who went to the ER, these were people with cancer and no white cells and clearly needed to be in the ER. When you looked at the number of people who went at 5:00 p.m., there were none. So it turned out that, although his ER rates were high, they were very appropriate.

But, right behind him at 793 visits per 1,000 member-years was somebody who had a slew of patients. These patients went to the ER between 6:30 p.m. and 8:00 p.m. They didn't cost very much. We asked, "Why are they going between 6:30 p.m. and 8:00 p.m.?" The reason was he advertised that his practice was open till 8:00 p.m., so people would come at 6:45 p.m. thinking they could be seen. However, his practice had the pattern that once they put you in an appointment time, and once the appointment times through 8:00 p.m. were filled up, they basically said, "Sorry, we can't see anybody else." If you got there at 6:45 p.m. and there were six people in front of you, then—since you were already out and since his practice was right next to the hospital—you just migrated over to the hospital's ER to be seen.

Separating these out in terms of time of the day and severity of illness was very helpful. It really made the case that even though their rates were similar, the patterns and the changeability of what you could do was very different between them. Another thing that we've looked at—I was just doing this report this weekend—was the use of first- and second-line antibiotics in a practice. If somebody comes into my practice with an earache, I could say, "Well, you need an expensive, new, just-off-the-shelf Cephalosporin," or I could follow the practice guidelines, which is to use amoxicillin for ear infections the first and the second time. Amoxicillin is free. These other antibiotics are $50 a pop. I've not seen that breakdown from any other plans.

They talk about my drug costs. They look at my practice and they say my costs for anti-infectives are enormous. That's because I take care of all the kids in our county and each of them is on $1,200 of anti-infectives a month. It doesn't take very many of those kids to make my anti-infective use look enormous. When my data comes out from other insurance companies, it looks horrendous. However, what we do in

our plan is look at the first- versus the second-line antibiotic use. Are these people really thinking about what they're doing? Are they really following guidelines? If you were to follow the guidelines, you should be prescribing the first-line antibiotic about two-thirds of the time. Only about a third of the time should you be prescribing a second-line antibiotic. By doing that, you can actually see the things that really make a difference and really change them.

I can't cure the AIDS inside these kids. I must put them on those expensive medicines; thus, the overall cost is not very helpful. But this first- and second-line antibiotic concept could be very helpful. If every time somebody comes in with an ear infection and you just pick what the drug representative brought in last week, then you're not really thinking about what's going on. That's something you can change. You can follow the practice guidelines. Those are the kinds of differences we see between the reports we've gotten from other companies and the reports that we can generate internally.

Mr. Harry L. Sutton, Jr.: I've lived through some of that in my lifetime. I do know one other instance, in Albuquerque, where the physicians worked for six months with no pay because they spent the whole year's premiums already. However, the plan closed a couple of years later. One thing you didn't talk much about was the hospital. I assume there was at least one hospital in this county. Did the doctors ever think about trying to raise money from the hospital to keep the plan going? How did the physician group and the plan relate to the hospitals in town? I think you mentioned that referrals out of area are always a problem if you're not in a really large metro area with all kinds of resources such as the Mayo Clinic. What is the relationship of the hospital system in the area to the plan?

Dr. Dannenhoffer: The hospitals are clearly a major player in what goes on. Our biggest monthly check goes to the hospital. So clearly they are players.

Mr. Harris-Shapiro: There are two in town, which is one too many.

Dr. Dannenhoffer: Right there's one too many. They're both similar kinds of hospitals. As we started the plan, they were about equal in size and market dominance. We tried initially to have the hospitals as partners with us. We wanted to have both hospitals as partners to make this work. It did not work for a multitude of reasons and we went on without the hospitals. We started at the hospitals with a fee-for-service system but moved to a capitation system. During that time, one of the hospitals became the market winner. As they became the market winner, they worked with us and basically we now have a capitated rate with that hospital. For a fixed amount of money per month, they provide all of the outpatient ER and inpatient services. On Oregon Health Plan, this works spectacularly because

people understand that this is where you're supposed to go and this is what you're supposed to do.

The commercial plan was much more difficult because obviously doctors may decide that they do not want to go to this hospital for whatever reason. Or they knew the nurses too well and didn't want to bare their butt. They wanted to go elsewhere.

Mr. Harris-Shapiro: The commercial market, in general, dictated that we work with both hospitals. One of the advantages that we had with that commercial product was that the Blues and PacifiCare and some of the other competitors did not have both hospitals. You had to have both hospitals to survive in the commercial market, at least from the marketing department's view of the world. It has to be recognized that deciding to enter into that exclusive contract and to cut off the other hospital took many, many, months and lots of angst.

Dr. Dannenhoffer: It was an incredibly clear business decision. To give you the order of magnitude, we had a request for proposal for a capitated bid. One hospital came in at $48 and the other came in at $28. The hospital that came in at $28 was the one who had the better presentation and the predominant market share. It sounds as if this was a tough decision. Still, it took three months of haggling to get people to make that decision. That was one of the big problems.

In many of the stories of physician-owned plans that you will hear, it is the hospitals that sink them. It is clearly not the story here. If anything, the hospitals were an even player in this, so we can't blame the hospitals. We can blame ourselves, but not the hospitals.

Mr. Alan Y. Weiner: How was initial physician compensation set, especially with respect to the primary care physicians and specialists? Was that a big problem? How has it migrated to other systems?

Dr. Dannenhoffer: This is a very interesting question because it really has migrated a lot. Anytime you're going to be dealing with physicians, how you pay them is going to be an issue. We started with primary care capitation. Basically, the primary care people got about $10 PMPM, and the specialists got paid fee-for-service. Actually, this was a reasonably stable plan that lasted for about three years. However, as other things started to unravel, there were calls for change of payment mechanisms, including specialty capitation and primary care fee-for-service. Since that time, it has migrated all over the field. We're back now to a point where there's fee-for-service both for primary care and specialty providers. This is an issue that is definitely not resolved. What's the best way to pay people? I don't know the

right answer. It may be like the statements about democracy—that it's a terrible way to run things, but it's just better than all the others. We just haven't figured out the payment mechanism that's terrible, but still better than all the others. As far as I'm concerned, they all are less than adequate.

Mr. Harris-Shapiro: It all has to be put on hold until things calm down a bit. Even if you can find the theoretically correct answer in terms of structure, the political turmoil and people would sandbag whatever you put out there right now.