RECORD, Volume 25, No. 2*

Seattle Spring Meeting
June 16–18, 1999

Session 17PD
Open Access Plans

Track: Health
Key Words: Managed Care

Moderator: TIMOTHY J. FEESER
Panelists: KYLE P. BRUA
DAVID E. NORTON
Recorder: TIMOTHY J. FEESER

Summary: Open access means an HMO with in-network-only coverage, but no referral requirements. There is no gatekeeper to whom risk can be transferred, so other cost control devices are needed.

Panelists discuss the "under-the-hood" provider contracts and administrative systems that are needed to support an open access plan in a cost-effective way. Discussion and questions from participants follow panel input.

Mr. Timothy J. Feeser: We're here to discuss the issues surrounding open access plans. To help us do that will be our two distinguished panelists. Mr. Dave Norton has been with Towers Perrin's consulting division in the health care area for over 25 years. Actually he has been there ten years but has over 25 years of consulting experience with the HMO industry. Our second panelist is Kyle Brua from Reden & Anders. He has been with Reden & Anders for five years as a senior consultant and also serves as the actuary for the Buyer's Health Care Action Group in Minneapolis. Kyle also spent five years at CIGNA. I'm also with Reden & Anders, and I will be the moderator.

What I would like to do is set the groundwork a bit before we get into the actual discussion from the panelists by defining what we're talking about today with respect to open access. The term *open access* is used to mean different things. While I was mingling with some of the folks in the hallway, I overheard some people saying, "I think I'm going to attend that session on the point-of-service (POS) plans." Well, we're not going to be talking about POS today, and I'll define exactly what we will be talking about in a moment. I'll get into the growth of open access

plans that we've seen over the last few years. Then I'm going to throw out some comments that have been made in the trade press over the last 18 months. This will give you a feel for how many different perceptions there are on what open access means, what it might do, what the ramifications are for payers, providers, employers, and participants in the health care industry.

When we say open access plans what we mean is members are allowed to self-refer to specialists within their network in an HMO lock-in product without authorization from the primary care provider (PCP) or the health plan. To distinguish between HMO and POS open access, in the HMO, you would have basically two distinct paths. There is your traditional lock-in HMO in which there's a need to be referred to specialists from either the PCP or the health plan, or the open access HMO in which you're self-referring to specialists within the network. It's locked in. There's no coverage for out-of-network benefits when we talk about an open access HMO. In a traditional POS, you still need a referral inside the network, but you are covered if you go out of network, but there are some cost-sharing ramifications. Then in the open access POS product, you can self-refer to specialists within the network. Today, we'll focus on the open access HMO, in which there is self-referring to specialists and no coverage out of network.

Open access plans have certainly been growing over the last few years. According to a publication from Interstudy we've seen growth from 1996 to 1997 of about 27% or 7.8 million members. In California, the Blue Shield plan, back in the fall of 1996, began to offer its Access Plus product. Once it offered this product during the first half of 1997, their enrollment jumped to 76,000 members in that particular plan, and, according to some of the plan representatives, there was a 20% growth in enrollment for the year.

For those of you who may not be aware, United HealthCare has historically been the mainstay of the open access models. However, some of the other major players have, in the last few years, started to investigate and provide an open access offering. Players that have typically been considered gatekeeper plans, such as PacifiCare, have moved to an open referral program. Humana now has a Freedom and a Freedom Plus plan; Freedom is its lock-in or open access HMO, and Freedom Plus is the POS. As we mentioned, Blue Shield California has its Access Plus program. What's fueling this growth? Clearly, it is the employer side. The consumer is saying that freedom of choice is a big issue, hence the growth in POS products, say, in the late 1980s and early 1990s. Now you're seeing HMOs just move to this open access model concept, although United has been doing it for quite a while.

Now let's lay the groundwork for our discussion. In preparing for this, I read through several articles on open access to see what the various industry pundits were saying; what were their perceptions from the provider as well as the payer side. Here are some of the comments that have been made. I think you'll find them quite interesting. Some of them are extremely passionate in their views. Here is a quote from one of the trade journals: "Open access plans. A gimmick by insurers to pretty up their products on the backs of doctors." No strong feelings there. "The demise of MedPartners is due to the elimination of the gatekeeper in spring of 1997." How many are familiar with MedPartners and what has been happening with them over the last year and a half? Has anyone read that article in *Fortune* (June 21, 1999 issue, Volume 139, Number 12) where it got into details of what happened with MedPartners? There's probably a lot more that happened there other than the elimination of the gatekeeper, but someone used this as a statement to fuel their passion on what they thought of open access.

Another quote: "Now the providers who are globally capitated are stuck with having to manage a much looser benefit with the same amount of money and face potential financial disaster." Again, I think we're getting a little flavor of the provider side here. Your general comment: "Too early to tell whether open access products will attract sicker patients," which is something to keep in mind as we move forward. When Blue Shield of California was developing its pricing for its Access-Plus product, it forecasted that utilization for certain specialties would increase roughly 15%. As information came in over the early stages of the product, it found that utilization actually only went up somewhere around 1–5% based on the specialty. Furthermore, this resulted in only very negligible cost increases on a per-member, per-month basis. Now, in these articles there are no data or statistics to support this. These are comments thrown out by plan representatives quoted in these journals.

I spoke with some of the United folks about their experience in the 1980s when they were buying up health plans, especially in markets where they already had a presence and were competing with a competitor that was a gatekeeper model. In purchasing that gatekeeper model they did studies in looking at the actual experience of that model versus their own open access models and found there were really no cost differences. The physicians that were in the open access network were also in the gatekeeper networks, and so they came up with a belief that the physicians are going to practice the same regardless of what model they're in.

Here's something that I found really interesting that I read in one of the journals. Typical reimbursement for the open access plans is paying fee-for-service for primary care and capitation for specialists. Dave's going to cover some of the

reimbursement strategies under open access. Specialty utilization is higher since there is less utilization management by the health plan. Open access affords greater access to specialists, but there are still restrictions on how specialists treat patients as dictated by the plans. In one sense, we're saying it's unmanaged, and in another sense we're saying it's managed. Maybe the types of management implications that are put in place are different.

I just thought I'd throw out some industry experts' comments regarding open access to get you thinking. We'll let the stars of the show take us through their insights on open access.

Mr. David E. Norton: In my part of the presentation, I'm going to try to do a couple of things. First, I think it would be helpful to look at a brief history of the PCP in the HMOs and how open access evolved because I think that gives us a lot of clues about what we need to do to make the product work. And then, as your agenda promised, we will try to address some of the issues of how to actually make these types of products work. It may be more about things not to do: how to make them not work, but at least maybe you can avoid some of the mistakes of others as you work with your own open access products. I'd like to take the opportunity at the close to spend a couple of minutes looking at where we may be going in the future and how this product may continue to evolve in the future.

Let's go back to the very early beginnings of the HMOs. I think a lot of people who have been in the industry or just watching it for the last 10 or 15 years forget that back in the 1970s we used to sell PCPs as a good thing, instead of apologizing for them. One of the real goals of the early HMOs was to try to improve access to care because that was perceived as being a major problem. At the same time, we were providing affordable care. To that end, the PCP was designated as being someone who the patient knew, had an established relationship with, and guaranteed them access into a very difficult-to-understand and difficult-to-navigate health care system. If you go back to the early 1970s, most of the HMOs had PCPs, but they were not gatekeepers. Frequently you did not need a referral from your PCP to see a specialist. You were encouraged to use him or her. He or she was there to help you, but he or she wasn't there as a requirement.

The role of the PCP was also to encourage health prevention, early detection, and, as I said, to be that overall care coordinator. Over time, particularly as some of the specialty cost began to get out of control within the HMOs, the role of the PCP as a gatekeeper to reduce unnecessary or inappropriate care began to increase in significance.

As we moved into the 1980s, pushed largely by U.S. HealthCare and others that followed suit very quickly as Individual Practice Associations (IPAs) began to grow in popularity, the HMOs started to broaden their overall appeal, primarily through large provider networks. With medical inflation running in double digits, some years close to 20%, the role of the HMO as a controller of medical cost began to take on more importance. That caused a shift in the role of the PCP. The PCP's role then became to control cost. Whether that was by controlling access to the specialty care, by directing care to the most efficient providers, or by eliminating unnecessary or inappropriate care in his or her role as gatekeeper, the PCP became more of a controller of care than a coordinator of care.

But at some point in the late 1980s and early 1990s, I think most observers of the managed care industry believe something went wrong with this system. A couple of things brought that on. First, the HMOs that were around in the 1980s were offered on a dual-choice basis, and until the mid-to-late 1980s, they were usually the high-cost option. People who joined an HMO did it voluntarily. They paid more money to join, but they felt that the higher benefits were worth it. But with the advent of POS plans in the late 1980s, managed care came more into the mainstream, and as many employers shifted their entire health plan to a POS health plan, many members were brought into managed care who didn't ask to be there.

In the 1970s and 1980s, everybody who was in an HMO had volunteered to be in that plan, and they had a choice not to be. In the 1990s, you had a lot of people who were in managed care who were being asked to select a primary care physician who did not ask for that choice.

The second reason something went wrong is you had broadened networks. Virtually every physician was in a managed care company, and you had a lot of PCPs acting as gatekeepers with no training to fulfill that role. As much as anything, the payers worked more and more to try and control larger volumes of patients and larger volumes of primary care physicians. They created administrative tools and referral authorization tools that were extremely cumbersome and created delays, conflicts, confusion, and just generally upset the member and the physician alike. Both members and physicians started asking, "Is there a better way to do this?"

The last phenomenon I think that's important is that as managed care came into the mainstream and the payers had more clout, they were able to get huge discounts from both physicians and hospitals. Most of the cost differentiation was more in terms of how they contracted with their providers than how well they controlled outpatient utilization. As a result, the role of the PCP as a gatekeeper had less of an impact on the total cost of the health plan and its competitive position than some of these other factors. Those plans, most notably United, were able to open up their

system and have an open access system. However, because of aggressive contracting with both PCPs and specialists, control of the hospital utilization, and some other things kept the cost of their product competitive. But all of this led us to give the members basically what they wanted, which was unrestricted access to a wide choice of providers. The members just didn't know which to go after first in terms of trying to take advantage of these products. Hence, the growth that Tim referred to a few minutes ago in the open access products.

Tim discussed the definition of open access a minute ago, and I think it is important that we keep in mind exactly what we're talking about when we're talking about open access. In its original pure form, it referred to HMO plans that had no out-of-network benefit but also no primary care gatekeeper. There was pre-authorization for in-patient care and possibly a limited number of outpatient procedures, but other than that, within the physician setting, it was unrestricted access. The member could go to whichever physician he or she wanted to go to. When we talk about open access today, however, there are a number of different approaches that go into open access that have evolved.

Tim said we weren't going to talk about POS products, so I'll talk about POS products. We do now have open access within POS. There is something that applies to the in-network POS portion only because the out-of-network portion has always offered open access. If you have no gatekeeper in order to receive specialty care on an in-network basis within a POS product, then you have an open access POS as opposed to the more traditional gatekeeper POS, which was the way the initial POS products were designed. In my way of thinking, there's really no difference between that and a PPO. The only real distinction is the level of utilization management on the in-patient side. In fact, with PPOs becoming more aggressive in utilization management, the traditional distinctions between a PPO and an open access POS get very difficult to distinguish.

There are some open access products where the access is limited to a capitated specialty network. Again, we have open access but only open access within a fairly limited network as opposed to an entire panel. In a more recent phenomenon, we have seen what are called network-based open access products. The member joins the HMO, selects a network, maybe a particular physician hospital organization (PHO) or IPA that's a subset of the HMO's total network; their access is now limited to that selected network, but it is open within that network. You've got a smaller amount of selection, but it is unrestricted within that network. I think these have been built traditionally to take advantage of the global capitation of PHOs and IPAs, and other provider organizations. They allow them to more efficiently manage an open access product. One of the real conflicts that the providers are having is that frequently they're being asked to accept capitation for a group of members that have

open access to go outside of the network accepting the capitation, which is generally an unacceptable compromise.

And the final item is traditional open access plans, but with some referrals required for certain high-cost providers or procedures. We have seen some open access plans that allow you to go to everybody but the orthopedist without a referral. It might be orthopedic care because there may be specific problems with the orthopedists in that community or the health plan had historical problems with that specialty. They may require open access. Sometimes I've seen it restricted to cardiology. You have open access but within some framework.

Before we ask, how do we control the problems of cost control in open access?, let's look at what it is that open access is trying to achieve. First and foremost, it was designed to reduce the hassle factor and give more choice to members. It gives providers and patients more control over their care. Also, I think an important thing it's trying to achieve is equitable reimbursement among PCPs, specialists, and hospitals. Obviously, if it's going to succeed, we must encourage the delivery of appropriate care in the most efficient setting. We must provide needed assistance to the less healthy patients. The open access plan is generally not too concerned about the healthy patients. They can go where they want to go, and it doesn't really matter whether they have a gatekeeper or not. It's the less healthy patients who consume the bulk of the dollars to whom the open access product has to orient itself to control the cost.

What do we do? What are the tools we use? I think it begins with the plan's relationship with its physicians. From a contracting standpoint, you want to have a contract with your physicians that has the appropriate incentives to encourage the physician to deliver the right care in the right setting. Things I've seen mess this up are as simple as fee schedules, which just aren't equitable either between primary care physicians and specialists or within specialists or sometimes within the appropriate setting. If the physician is rewarded more for doing something in a facility, he or she goes into an outpatient surgical facility, and he or she is reimbursed. The outpatient facility is reimbursed for all the supplies. If that same specialist can do the procedure in his or her office but receives the same fee, and he or she is expected to pay for all the supplies out of that fee, then there's no encouragement to do it as an in-office procedure. The specialist is going to go to the outpatient surgical facility, which is more expensive for the plan than paying a modest increase in fees to cover the supply cost within the office setting.

Risk-sharing on key performance measures. You need to set what those key performance measures are. Look at what you are trying to accomplish. Is it looking at the average cost per visit, the amount of ancillaries that are done in that visit?

The number of call-backs? What are the things that are causing the cost problem in a noncontrolled setting? Determine what those are, measure them, and then reward the physicians based on achieving those measures.

There is also the adherence to protocol. I'm going to talk a lot about protocols because good, evidence-based, clinical protocols that are then monitored fairly closely largely eliminate the need for the primary-care gatekeeper. In fact, they perform the primary-care gatekeeper's role much better than the gatekeeper did historically.

Another approach, and probably the simplest and the one used by those plans that have been most successful, is capitation. Again, the PCP's role was primarily controlling access to the specialist and appropriate care once the patient got to the specialist. If you capitate that specialist, you've controlled that cost, and you don't care. The only issue you now have is quality. Your cost is fixed. To the extent that you can subcapitate specialists, the cost problem is solved and the need for primary care as an economic gatekeeper goes away. I think a lot of specialist physicians have decided that per-member, per-month subcapitation isn't necessarily the best thing for them.

Contact capitation, which is growing in popularity, I think maybe addresses the situation more appropriately. Contact capitation is an approach where the specialist is paid a fixed amount of money for each patient seen. Rather than being addressed on a per-member, per-month basis across an entire population, they're paid only for those patients who come to them. It is based on the theory they don't have any control over who comes to see them. They do have control over how much cost is generated by that patient once they get there. Again, this is a way to offer a broad choice, and not worry about the fact that this cardiologist is going to attract more patients that need catheterization because that's what he or she is good at. This cardiologist over here is going to see those patients who need less invasive care because that's what he or she does. There's a difference in what those two should be expected to do. A contact capitation structure, if done correctly, can pay one more than the other, and they can both be treated fairly and cost effectively.

The clinical protocol. I think the objective of any HMO trying to control cost is to limit specialty-practice variation. My doctor friends always tell me you can't tell me exactly how to practice medicine. Different patients have different needs. There may not be one way to treat every patient, but there are not 17 best ways either. Good protocols that can limit that to the two or three best ways to give care in a set of conditions is the best practice. It's not only good quality but also good cost management. Finally, I think physician evaluation and deselection is the area that HMOs, historically, over the years, have had the most trouble with. Measure the

physicians. Evaluate the physicians. And then maintain only the quality physicians. Even if you've controlled the cost, you still need to control the quality.

I think the last area, and again I would probably hold United up at least in the early part of this decade as the poster child for doing a good job in this area, is capturing data and reporting it to physicians in a meaningful way. We see too many health plans that do an excellent job of capturing data. They report an awful lot of data, but they give very little information. The analysis has to evaluate whether the care was appropriate. Was the right thing done in the right setting? You need to look at both clinical and procedural outcomes in order to evaluate that. Then you can do meaningful profiles and give the physician information that he or she could actually use in making specific practice decisions. To give a cardiologist a profile that says here are the 37 cardiologists in our network, and you are number 32 in the average cost per patient seen, doesn't tell that cardiologist a thing. There's not a single thing the cardiologist can do with that piece of information that would help him or her to move from number 32 up to number 2 on that list. Instead you can give the cardiologist more specific information on patients that present themselves with these particular situations and diagnoses, and tell the cardiologist that he does a procedure 90% of the time while colleagues in that same situation do that same procedure 10% of the time. That's information the doctor can do something with. The doctor can change the way he or she practices medicine, and bring down cost.

When we're looking at controls we can't ignore the patient. From a plan design standpoint, that means motivating the member to use the system properly, whether that be a copayment differential if they go open access versus going through their gatekeeper, or extra copayments for unauthorized visits back to specialists. I've seen several different variations on that. There should be clear definitions in your product as to what can be accessed without restriction. Both the physician and the patient need to know what the rules are. Appropriate assistance for patients that need care is important. If you've taken away the primary care gatekeeper, you don't necessarily take it away completely. You can take away the restrictions. You can take away the gatekeeper role, but you don't necessarily want to take away the primary care designation role. You can have other forms. If you're not going to use the PCP as a care coordinator, use 24-hour nurse lines or other types of triage programs to help the patient. For the more chronically ill, have disease management programs. You can enroll patients in those programs and follow them very closely. The last point is demand management. Again, work with the patient through either nurse advice lines or case management or whatever the tool is to help the patient understand what his or her needs are, what the role is for the patient, and help the patient to be a wise consumer.

Finally, don't forget the other approaches that work in any model, whether we're talking about open access, gatekeeper, or whatever. Good technology assessment, one of the high-cost items for health plans, is appropriately assessing and reacting to advances in technology. You must quickly set up protocols for that. Pharmacy utilization is the fastest-growing cost area in any health plan. General physician education is also essential. Of course, a process to generate reliable cost projections is also necessary.

In closing, I think I'd like to ask the question: can we do better than today's open access models? I think it's agreed that the market insists that we maintain choice and continue to reduce the hassle. I think physicians are going to resist any system that puts more outside restriction or interference on how they treat individual patients. In my opinion, the one thing we don't do well enough is recognize that different types of patients may need different systems. There are a lot of different choices of plans but very little differences within plans. Most health plans design a product and then expect every patient, regardless of whether they're chronically ill or have short-term acute needs, to work within the same utilization management and referral management system. If we're going to develop different systems, we need to recognize those differences and train people who can provide the care coordination depending on the patient needs. Finally, I get back to the protocols for any system. The practice variation in the physician offices has to be reduced both to control cost and to control quality.

The model that I would like to suggest is what I would call a more patient-centered model. Imagine a truncated pyramid. At the bottom is the general routine care, which represent about 40% of the cases, where just general consumer education, some demand management, and maybe a good triage system are all you need. These people don't interact with the system very much. They're not expensive. Don't spend a lot of time trying to control them. As you move up to the next level of the pyramid, the functional impairment, you may want to start limiting the access. Those who have functional impairment need a little more care, and a little more attention. They need providers who are certified in best practice protocols for that type of patient who can work with them. Then you have the chronic patients, like the diabetics, the asthmatics, and so forth where your disease management programs work. There are carve-out specialty networks such as in the mental health area. Then you have your more serious cases that represent about 15% of the total population in any given year, where you may look at procedure-based centers of excellence. They no longer have access to the complete system, but if you need some type of cardiac care, we have two cardiac hospitals in our network that handle that, and we limit it to that. Finally you have the 5% of the cases that generate 40% of your dollars as a health plan that are the extremely serious, life-and-death kinds of situations that are very procedure-based. I think it behooves the network of

the health plan, from both a quality and a cost basis, to become very active in controlling what happens to the patient at that level and to use focused centers of excellence or a limited number of providers with an extremely tight protocol to make sure that quality care is, in fact, delivered.

In order to make this work, some of the same issues we've talked about with open access come up. They include a good definition of the program so both patients and physicians understand it. We need more trained patient coordinators, and not necessarily physicians. In fact, physicians are often not the best patient coordinators. We need good evidence-based protocol to guide physician behavior. In those areas where you're giving more unlimited access to specialists, they know how to behave. Another issue is the appropriate incentive as far as both reimbursement to the physician and benefit design for the plan. We need better education of consumers so the consumers know not only what they can do but why, and I think consumers are showing a willingness to become educated.

I have two final points. First, we must improve system integration. I think if we're ever going to get there, we need to see integration and the merger of both financial and clinical data. In my ideal system of the future, you would have a single system that handled appointments for the doctor's office and claims coming from the doctor to the health plan. Protocol and medical records would be tied in. There would be a single, seamless system that captured all the information on that patient that is accessible to both the clinical and financial side. My second and perhaps more important point is the need for the will to make it happen. In some cases, the health plan may know best about how to control certain types of patients and about the care given to those patients. Perhaps it is appropriate to restrict access and limit the choices that are available in those cases.

Mr. Kyle P. Brua: In almost all the articles I've read regarding open access there is a question that is always raised and just sort of thrown out there that really doesn't ever get answered once and for all. That is, do open access plans cost more than a gatekeeper plan? Even if we put the United studies aside, most of the articles are suggesting anywhere from a 3–10% increase in cost over a gatekeeper plan to no measurable difference. What can make the difference in cost? There are at least two things that could be happening, and there are probably more, but I'll throw two out there. One is that the gatekeepers are managing care more efficiently and leading to a measurable amount of savings relative to an open access product. The second theory could be that the open access plans are simply attracting a sicker population of people, and it would not be possible to manage them to the same level of cost.

My presentation is based on one case study. It is an attempt to answer those two questions, as well as a couple of others.

We are assessing the financial implications of open access versus gatekeeper model HMOs. We are examining utilization differences, illness burden differences between the two populations, all other things being equal. What differences do you see after normalizing for these? What are the reimbursement differences? Does the gatekeeper model result in utilization differences versus open access products? Is it utilization driven or is it potentially something else? In addition, are members more willing to pay more for open access products, and if that is true, why is that the case?

The control group is the Buyer's Health Care Action Group (BHCAG). As I think was mentioned in the introduction, I do work with the BHCAG in Minneapolis and function as their actuary. BHCAG is a large employer, self-funded, healthcare purchasing coalition in Minneapolis-St. Paul. It is also making inroads into the out-of-state regions. They even have a presence now in Sioux Falls, South Dakota.

Large employers are banding together and sort of creating their own healthcare delivery system for their employees and their dependents. BHCAG has contracted with 21 care systems. To be a care system in the BHCAG model, you have to either have a contractual relationship or simply be able to provide all types of care from in-patient to ambulatory. It's up to the care systems to decide how their care is delivered or how and what requirements are necessary. In the 21 current care systems, six of them have structured themselves as open access, meaning no referral is necessary to see the specialist. Fifteen, which is the majority of them, are functioning as a gatekeeper model.

Just to give you an idea of how many members we're talking about here, in 1997 there were 117,000 members and in 1998 there were130,000 members. This gets back to what I mentioned earlier. Some of the stuff that we'll be talking about is based on the BHCAG population, and those conclusions should not be expressed beyond the BHCAG group to be representative of the entire industry.

Another item that makes this study more interesting is it does not matter which care system you're in. It has a uniform plan design. Many open access plans will charge a higher copayment. If members have self-directed themselves to a specialist, there may be a $15–25 differential in that office visit copayment, whereas if they get the referral, it's a $5 or a $10 office visit copayment. Again, in this model here we're talking about the same plan design regardless of the care system. It eliminates one of the caveats that you may have in doing a study like this if you were to do this on

your own: That is, what is the impact of that $25 differential on the utilization for those specialist services where no referral is necessary?

As far as how BHCAG is structured, the care systems annually submit a claim target, and they submit a claim target that they are measured against throughout the year, and their reimbursement is adjusted quarterly to make them regress over time to that bid amount.

I really don't want to get into the complexities of the care-system bid amount, but what you need to understand is that it's a competitive model. The care systems bid a target based on a risk-adjusted population using adjusted clinical groups, which we'll discuss later, across the entire BHCAG population that normalizes to one. Annually, the care systems submit a claim target that they are then measured against and held accountable to on a risk-adjusted basis. What this means is if you are a care system that, for whatever reason, is attracting the chronic cases, your adjusted clinical group relative to the bid amount will be increased proportionately to that score. (I'll talk briefly about how that's determined.) Care systems that are attracting the sicker lives are being measured against a risk-adjusted target that is higher than the BHCAG average.

Annually, the care systems submit a claim target, and annually the members select which care system they want to be in. Obviously, they have many choices, but how they access their specialists would be a significant factor. Certainly if you're a diabetic or have any chronic condition, the referral process would be a nuisance, and you would want to have that more direct access so you may be more inclined to elect the open access care systems.

There are also out-of-pocket cost differences to what care system you elect. In other words, the care systems annually submit a claim target which are then divided into three cost categories: high, medium, and low. If you're electing a high-cost care system, your out-of-pocket contribution is greater than if you elect a low-cost care system. This varies by employer, and I think there's only one employer who does not require employee contributions to differentiate based on which care system employees elect, but for the most part they do. That's important as we contemplate the issue of whether people pay more for open access. We'll get into that a little bit later.

The care system target excludes out-of-network claims. There is an out-of-network benefit to the Choice Plus plan design. Given some of the lingo we've been using, this would be an open access POS product. For some of the costs that we'll be viewing, I want to emphasize that they're in-network only because, from the care

system's perspective, they're only held accountable for the in-network cost that they bid on an annual basis. Their claim target does not include out-of-network claims.

There is also a stop-loss provision for the care systems, and all of the dollars that we'll be looking at later on will be net of stop-loss. Again, keep in mind we are looking at this from the care system's perspective when we are looking at cost. You're not looking at this as if you're the employer. What really would represent the cost for your coverage? The stop-loss provisions are $30,000 for in-patient and outpatient hospital combined. This is based on BHCAG's contracted facility reimbursement rates. These are not charges. It may seem low, and it is low because BHCAG really does not want to put the care systems, some of which are very small, at significant risk for these catastrophic cases. The thresholds are low for that very reason. The thresholds for pharmacy and physician are $10,000. The care systems are at risk for 10% of the cost exceeding these thresholds.

As I mentioned earlier, because of the care systems that tend to attract more of the sicker lives, they implemented this model so that their targets would be adjusted to reflect the illness burden of their specific population. But their target or their bid amount on an annual basis is bid across the entire BHCAG population. It permits the reimbursement mechanism to hold their reimbursement or their average per member per month (PMPM) over and above those populations that are measured as being less sick through the ambulatory care group measure. I don't know how many of you attended the Medicare session, but that risk adjustment mechanism is based on the in-patient diagnoses only. In the BHCAG model, there are a couple of important differences that I'll highlight right here. The most significant is that in the ACG model, both in-patient and outpatient ambulatory International Classification of Diseases-9th Revision (ICD-9) or diagnosis codes are used. There aren't any of the issues that are related to having only an in-patient diagnosis. The other is that with Medicare's Principal In-Patient diagnostic cost group model, it's a diagnostic cost group. With the ACG they are bucketed into clinical groups. I think what you need to know is the difference lies in how they categorize them by cost. In the ACG model, it's really not that way. There's more of a clinical relationship from ACG to ACG.

The ACG model has been developed by the Johns Hopkins School of Public Health. The inputs are diagnoses, age, and gender, which determine which ACG category you're in. For those of you who want to know more there is a Web site We take the 14,000 ICD-9 codes across the whole BHCAG population, and the resource consumption data are the diagnosis codes and the costs, net of the stop-loss threshold or net of stop-loss as we discussed earlier. They're combined into 32 diagnostic groups and then, based on their age and gender, are assigned to one of 93 ACG groups.

Once we've assigned each member an ACG, and we have the enrollment and the claim history (since the reimbursement mechanism for this population floats on a quarterly basis and regresses towards the bid target), there is a need, when you're developing the weights for this population, to go through and reprice the claims so that everybody is on a standard unit cost basis. This is one of the interesting things about this model. It permits us to talk about whether the gatekeeper is saving money, or whether it is a higher risk population, and so on. We can normalize for benefit plan, we can normalize for unit cost, and we can develop these weights, which are truly absent of any other type of bias that might be in there. The potential applications of this model, in terms of answering the issues we've been discussing, are really only relative to where there's an open access and a gatekeeper product in the same market. If it's a gatekeeper-only market, it just wouldn't be pertinent or there'd be no reason to talk about it, although you might want to talk about what would happen. But some of the conclusions we'll see as we look at some of the BHCAG experience really only would apply where you have both products.

Now after setting the stage, the question we'll try to answer with the BHCAG data is, does the gatekeeper model result in lower cost? The fact of the matter is that's what we'll see. There will be lower cost. Does the gatekeeper model result in lower risk population after normalizing for population risk? The answer there is that's still debatable, which would mean, for those who might be skipping ahead, that the relative risk of the open access population is significantly higher in this population when compared to the gatekeeper members. Remember the description of the low-cost, medium-cost, and high-cost group care system. Within each of those categories the high-cost people or the people who are paying the most out-of-pocket gravitate quite significantly towards the open access model.

We'll be looking at the repriced results. We've gone through and repriced each individual claim to a standard conversion factor. Most of BHCAG's reimbursement to the providers and facilities is based on a standard conversion factor. It is very easy then, if the mechanism is simply a conversion factor, to go through and reprice these claims. There is a measurable component of the PMPM claim cost that is referred to as Category 2, which does not flow through the same reimbursement mechanism and could be distorting the results. In 1997 we're looking at repriced, incurred PMPM claim costs by gatekeeper versus open access relative to the total for 1997 and 1998 (Table 1).

TABLE 1
INCURRED PMPM REPRICED
TO STANDARD UNIT COST

HMO Model	1997			1998		
	Non-Rx	Rx	Total	Non-Rx	Rx	Total
Gatekeeper	$86.18	$14.63	$100.82	$92.98	$18.19	$111.16
Open Access	90.22	17.00	107.22	95.90	21.45	117.35
Total	**87.74**	**15.55**	**103.28**	**94.12**	**19.46**	**113.57**

What you see is that for both 1997 and 1998 the open access care systems on a standardized basis were around $6–7 PMPM, higher than the gatekeeper product. Without looking into this any further, does open access cost more than the gatekeeper in this kind of closed model? I think you'd conclude that it does, but what is really interesting is why it does.

After assigning the ACG category to each of the members and weighting across all of the 93 ACG categories to a 1.0, in 1997 the gatekeeper membership measured 0.980 and the open access was at 1.032, which is a 5.2% difference (Table 2). The illness burden measure is 5.2% higher than the gatekeeper. In 1998 it's 7.7%. What I've also included on this table is the increase if you hold the weights constant from one year to the next. Is a population getting sicker over time? That's sort of an aside or just an FYI, but the gatekeeper population's relative illness burden increased 1.4% for 1998 over the 1997 number. In open access, it was 3.7%. Across both populations, it was 2.3% higher. What is that? That is aging. That's the fact that members are in the model longer. Their relative illness burden will increase over time, and I think that's something most of us who do pricing anticipate. We anticipate it whether we're looking at demographics or what have you. We'll see the average age increase, and there are many different ways to refer to that, but that's just an interesting aside. Knowing what the risk scores are and what the repriced claims PMPM are for the two populations, we can now adjust for the risk of each of the populations to assume a risk score of 1.00.

TABLE 2
RELATIVE RISK ADJUSTMENT

HMO Model	1997	1998	1998/1997*
Gatekeeper	0.980	0.971	1.4%
Open Access	1.032	1.046	3.7
Total	**1.000**	**1.000**	**2.3**

* Increase in illness burden as measured by ACG weights.

So, in 1997, when you adjust for risk, the gatekeeper plan is $87.95 PMPM for non-pharmacy and $87.45 for open access (Table 3). I've got to tell you when I first did this I did 1997, and this is kind of what I was expecting to see. But I did not honestly expect them to be within 50 cents of each other. What you see then in

1998 is, on a risk-adjusted basis, that open access is actually $2 less expensive than the gatekeeper model. So again, what we're starting to conclude from the BHCAG population is that the open access care systems are indeed attracting an illness burden that is greater or more significant than the gatekeeper model.

TABLE 3
REPRICED RISK ADJUSTED RESULTS

	1997			1998		
HMO Model	**Non-Rx**	**Rx**	**Total**	**Non-Rx**	**Rx**	**Total**
Gatekeeper	$87.95	$14.93	$102.88	$95.73	$18.72	$114.45
Open Access	87.45	16.48	103.93	91.70	20.51	112.21
Total	**87.74**	**15.55**	**103.28**	**94.12**	**19.46**	**113.57**

Are members willing to pay more out-of-pocket? Again, remember those in the high-cost groups are paying the most out-of-pocket, and 64% of them are choosing open access. I think there's probably a whole lot more behind this. I was able to pull the information in Table 4 at the last second. I thought it was interesting enough to present here. There's a whole demographic study that I think could be done right here in determining that. We get into some socioeconomic debates in terms of whether the open access people, who have a higher illness burden (who are, on average, older), can simply afford open access? Is it that they like the idea of choice? I'll set that whole discussion aside, but I think it is interesting to note that the people selecting the high-cost care systems are electing open access 64% of the time.

TABLE 4
MEMBERSHIP DISTRIBUTION

1998 Cost Group	**1997**			**1998**		
	Gatekeeper	**Open Access**	**Total**	**Gatekeeper**	**Open Access**	**Total**
Low	54%	46%	100%	58%	42%	100%
Medium	88	12	100	84	16	100
High	36	64	100	36	64	100
Total	**61**	**39**	**100**	**61**	**39**	**100**

What have we concluded from the control group conclusions? I just want to say one more time that this is based on the BHCAG population. I don't want anyone quoting me as saying the gatekeeper isn't worth anything. It is simply very interesting, and it's a data set that permits you to really look at this type of thing. This is all market driven, and it's locally market driven. Everyone has his or her own local market considerations. I'd beg these people to consider that before they start quoting me. But we've concluded from the control group that open access attracts the higher risk members, all other things (plan design, unit price) being equal. After adjusting for unit price and the relative illness burden of the two

populations, I think we can conclude there's very little cost difference between the models. We did see in 1998 that the open access was less expensive, but, again, what's important is to measure that they're both regressing back towards each other when we take into account risk. Membership will indeed pay more for open access, and I firmly believe that if somebody will pay more for it, then you should charge more for it. By all means charge more for your open access, especially if people will pay for it.

As far as conclusions on open access, I don't know if I can conclude anything. I do think it's worth looking at further in regard to the need to price for differences in risk between your populations. I think one of the things I'm trying to do up here is to promote risk adjusters in general. I think the Health Care Financing Administration is obviously moving towards it, and we get into, as actuaries, looking at differences in products. We may look at demographics, but I don't think we've evolved to the point where we now have these new tools available to us to look at these things. In addition, the providers who have been screaming for this information would provide you with a tool to do these measures on your own population. Obviously you can only study your own population and not your competitor's, but I think there's a significant advantage with your providers to be able to provide them with this type of information and not react to it when your competitor does.

Are care management fees for gatekeepers appropriate or are they simply managing healthier patients? When you're looking at your cost between the two products, you might be concluding that the gatekeepers are holding costs down 5–7% relative to our open access product. Clearly they're worth that $1.50 PMPM for their administrative burden or for whatever reason they've been able to negotiate that in their markets. I would suggest that it would appear that the gatekeeper model is attracting healthier patients. It would depend on a more detailed study. Be careful how you quantify how gatekeepers are saving a plan's money.

Many times, if PCPs are acting as gatekeepers, they will negotiate above and beyond either their fee-for-service or their capitation for the medical services they're providing. They'll also get an extra $1.50 a month because they're performing recordkeeping. The specialists that they're referring things to will send out a diagnosis and send information back, and they can act as the clearinghouse or the data warehouse of all the patient information. They've been able to negotiate additional payments. I'm not suggesting to you that that's not an administrative burden to them, but, again, they get this because they're managing the care. I'm not suggesting they're not. I'm just saying it deserves a closer look.

Open access should cost more for a couple of reasons. It appears that the relative risk of the membership is worse than a gatekeeper product, so their costs are going

to be higher, and, as I mentioned earlier, people are willing to pay for it. Careful pricing strategy is needed if you are currently offering one model and would like to offer the other. If you had an open access model right now and, for market reasons or for whatever purpose, wanted to implement or needed to implement a gatekeeper model, you have to be careful about how you're pricing it. You will be taking your open access members and migrating them to a gatekeeper model. That means the healthier people are gravitating towards the gatekeeper model. You've got to be careful that when you net things out you're not dropping revenue relative to your medical costs.

There are some other considerations outside of what we've discussed. The administrative costs for a gatekeeper are higher because, again, they are housing all of the patient information. Many of the trade publications give a different percentage but are suggesting that 85% or greater of the referrals once sought at a primary care physician are indeed granted. If 85% or 90% of the time they're going to a PCP and getting the referral to move on to the dermatologist or the other specialist, I think there's a lot of logic to all that. Is that really worth it? You have the added cost of the primary care office visit as well as the office visit of the specialist. But everyone has a claim system. We're not going to pay that claim because we didn't get the primary care referral. Patients have to get the primary care referral, and, as I was mentioning, the super majority of those referrals are granted anyway. There are some administrative issues that could probably become easier if this referral were not necessary.

The impact of open access on physician specialists. We've heard a lot about how there is increased financial risk for the specialist as you move towards open access, but again you must understand what this risk is. We've all heard this before. If there's increased risk, then there's increased opportunity. It's basically being smart about how you are pricing these products relative to one another and understanding the differences in the populations. Are they driven simply because one model is able to manage utilization more effectively or is it simply the way the populations themselves are structured?

Mr. David J. Hutchins: Kyle, did you take a look at the data on a pure age/sex basis in addition to age/sex and ACG? In other words, how much extra information does ACG give you?

Mr. Brua: Yes. There is a demographic difference of, I think, 3–4%. If we just measure it from a pure age/sex basis, absent any diagnosis or study involving risk adjusters, or anything like that, the obvious thing to do would be to look at the demographic differences in the two products and to use that as a measure. But yes, I think it's a 3–4% difference.

Mr. Hutchins: Is that based on 1998 demographics?

Mr. Brua: Yes, the demographics I looked at when I did that was 1998.

Mr. David L. Terry, Jr.: Were the providers exclusive to each one of the care groups or could they participate in more than one care group?

Mr. Brua: The way it's structured, the PCP can be aligned with only one care system. The tricky part there is obstetrics and gynecologists because I think they can float from care system to care system. Regardless of whether it's open access or gatekeeper, a member going into this model has to choose a physician who will act, essentially, as their primary care physician, and that's what defines the care system. Every PCP can only be aligned with one care system.

Mr. Terry: Within the care systems do you know how much of the care is delivered on a capitated versus fee-for-service basis?

Mr. Brua: All of the care is delivered on a fee-for-service basis. The only differentiation then is, if you're in a care system, and there are seven hospitals that are part of a care system, some of those hospitals may elect to be fixed, meaning that they do not want their fee-for-service reimbursement to float along with this quarterly adjustment mechanism. What that really means is if 50% of your hospitals are fixed and 50% are floating, the quarterly adjustments are going to be leveraged as your experience comes. If it's 50/50, and you're a dollar off your target, that impact on you is really two dollars because the floating piece of the reimbursement will be adjusted to compensate for the fixed as well so that, again, you move towards your bid amount.

Mr. John P. Burke: I thought it was a good analysis. I have a couple of things. You mentioned that the product design was a POS, but you only considered the in-network cost. I'd be curious as to whether there is any information about what the out-of-network costs are by open access or the gatekeeper model. I would venture to guess that the open access model would provide less of a reason for someone to self-select out of the network if he or she weren't happy with it.

Mr. Brua: I would agree with that. It's just that I have access to all these wonderful data and information, but I had only a few days to prepare for this wonderful event.

Mr. Burke: If you can add that, I think it would add a lot to a final conclusion about whether or not the total cost is lower. Another point I'd make is with regard to contracting with the specialists. I think the product and the contracting are

interrelated, and I think that you'll tend to have more success contracting with specialists if you don't have a gatekeeper in your product design. You may be able to get a reimbursement level at a lower rate, but you excluded that too, because you normalize to a unit cost or standard reimbursement.

Ms. Christine Sarah Purnell: If a member went to an in-network doctor without a referral under the gatekeeper product, would that be in your data?

Mr. Brua: It would be in the data. However, I believe a care system is more than a contractual relationship. They're truly all part of the same hospital system and one thing that this care system model does promote is everybody on the same side. You don't run into the PCP versus the referrals, or any sort of antagonistic issues. I'm not saying you don't, but you're far less likely to because of the contractual differences. I believe this to be true: if you wanted to make an appointment with a specialist, you would not be able to make that appointment because the specialist understands he or she is a BHCAG member and how the care system is structured. The patient would not get that far without the referral.

Ms. Purnell: I have one other point as an extension of the last comment. In the pricing of non-gatekeeper products in a POS environment, I believe that not having the gatekeeper would actually encourage members to use out-of-network care because they're not being guided by a PCP to go to the network doctor. Indeed, by looking at the total product, you may find that open access is a lot more expensive considering those in-network and out-of-network claims.

Mr. Brua: Right, and I do agree with that. There is a significant out-of-network penalty, as with most POS plans, to mitigate that, but I understand your point.

Mr. Geoffrey C. Sandler: Kyle, could you comment on the plan designs of the BHCAG groups? When David was speaking he talked about some benefit design differentials, and I think Tim referred to them also. Some of the plans you see around the country may have penalties for self-referring within the network of a gatekeeper plan. Do all these plans have similar copayment structures or is there a penalty for self-referral?

Mr. Brua: Again, the plan design or the member copayments for office visits are the same regardless of care system. It's one uniform plan design across the entire BHCAG membership. It's all flat. It's the same copayment whether you've self-referred or whether you've gotten the appropriate referral. There isn't any difference in plan design if you self-refer versus being referred.

Mr. Norton: I'd just like to add one comment. In some plans that I've seen there is a copayment differential between a self-referral and a primary care referral in an open access plan. The rationalization of that has been that there's a high-cost difference for the open access, and the higher copayment revenue would offset all or part of that extra cost. I think Kyle's data points that out and that may be a false assumption. Second, I think that that's more of an approach to try to make an open access work without looking at the fundamentals of it. What can we do to keep the cost the same?

Mr. William R. Sarniak: What recommendation do you have? Is this a viable product for a company in a market that may find it difficult to pay their PCPs fee-for-service, and are specialists capitated if they are going to go with a capitated PCP model? Do you see this as a viable product, and, if so, do you recommend reducing your PCP capitation, and by what magnitude?

Mr. Norton: I honestly don't know how you could calculate a capitation for the PCPs in an open access. Even if you had a lot of data and experience and knew that, on average, it's going to vary so much by PCP, you would have a particular problem if you had any internists, particularly double-boarded internists, that were serving as primary care physicians. In fact, I believe that one of the advantages of the open access system is it allows you to incorporate those double-boarded internists that can handle the diabetics, the asthmatics, and the cardiac patients, and pay them on a fee-for-service basis. Let them fulfill the primary care role without the trap of getting family practice level primary care capitation payments.

Mr. Brua: I would love to be a PCP who, when somebody called me to make an appointment, could refer the patient to Dr. Smith down the street and still get $12 a month for giving that advice.

Mr. Sarniak: In summary, it's not viable.

Mr. Peter K. Reilly: Do you have any information about how the different care delivery systems used optimal recovery guidelines or practice protocols? Is there a difference between the gatekeeper models versus the open access models and the way that was applied, and whether that could explain the relative uniformity of the cost after risk adjustment?

Mr. Brua: As a policy, BHCAG does not tell their care systems how to practice medicine. There could be 21 different approaches to that very item. As far as the data goes, it's very limited in structure. One question I'm surprised hasn't been asked is, why didn't you just run the specialty cost PMPM across both populations and either risk adjust or demographically adjust them and compare them? Are the

primary care costs significantly different from one another? The data are not available. The data I had do not provide referring specialists or a referring physician or even a specialty code for me to be able to do that. That information will be out a couple of years down the road, but we'll have to wait and see. I don't know if I really even answered your question.

Mr. Reilly: Yes. There was an earlier discussion about how clinical or practice protocols can potentially take the place of PCPs in actually determining optimal care patterns. I was just wondering whether or not the open access providers were, in fact, more rigorously applying those types of techniques. That would explain why the costs weren't different or whether or not the individuals were able to just self-refer as efficiently as the PCP would be able to refer. Because I think there is a pretty substantial question as to why wouldn't there be a difference in this case after risk adjustment. Are you saying that the individuals do as good a job in terms of self-referring as a PCP could, or are there other explanations for that?

Mr. Brua: I don't know if there are other explanations. What I've been able to see in this study is that, first of all, because of 10- or 15-minute office visits, the physicians do not have time to determine what the rules are for this particular encounter. They develop what they would typically run into or what would be the norm. Other than that, the data are not there. As I said, there are 21 different care systems, and I'm sure 21 different approaches to how some of these common and less common practices are performed.

Mr. Feeser: One of the reasons some of the other players that have traditionally been gatekeeper models have moved towards feeling out open access features in some of their products has been when they looked back at some of their data as far as the percentage of referrals that actually get approved. As I was reading through the literature, I noticed that one of the plans said that it found that 95% of the referral requests were getting approved anyway. Rather than taking two weeks to have that happen and ticking off all the members, the plan just moved to an open–access system and let that go through.

From the Floor: And most of the denials are approved on appeal.

Mr. Feeser: Yes. That's one of the reasons that the authorization process slows it down and has led to dissatisfaction and moved this back to an open access. I think a lot of physicians are used to open access in the markets; that's what we have traditionally practiced under. They just have a feel for how the patients or the patients in working with their physicians know when they need to see the cardiologist versus the dermatologist and so forth. It happens appropriately. In Minneapolis, when you need the eye exam, you call into the clinic. You expect

you're going to see a PCP, but you go right to the eye care doctor. It works naturally. United has the typical managed care guidelines of how to treat certain illness burdens as well as programs and mailings out to the patients to let them know that they haven't had a mammogram and need to get in. The managed care fees are still there in the open access models. It's not like it's just a free-for-all and the patients are determining what they need and just showing up every other day at the doctor.

Mr. Michael D. Bahr: We have both gatekeeper and open access plans, and we did an analysis. It was not the same as yours, but it had the same type of adjustments, using different methods. Maybe you already answered part of my question, but we found very similar results on the risk selection. We did find a cost difference in the gatekeeper model. We found that our PCP office visits went down very little in our open access. It was less than 10%. Our secondary care almost tripled, and the pharmacy cost associated with the secondary care was much higher. Were you able to look at any of the data or were data on areas where the cost actually went up or down not available?

Mr. Brua: Yes. If I could have run this by specialty or specialty code or even by physician, I would have. I would have loved to have shared with you what the adjusted primary care physician service costs were relative to the other. Now, what I suppose I could do is start looking at this on a procedure code basis, but I don't think we're going to see much difference there because I think the same care is being performed. It's just a matter of whether it's on a primary care or a specialty care basis.

Mr. Norton: I would like to comment, getting back to the prior point that was made in terms of whether the difference was due to physicians following similar protocol. Therefore, the cost per patient seen was the same with or without the gatekeeper or whether the gatekeeper is doing a good job. Certainly those factors are going to vary significantly from community to community and from health plan to health plan. Studies like the one Kyle did are likely to show different results depending upon the situation you're analyzing.