RECORD, Volume 25, No. 3*
San Francisco Annual Meeting
October 17-20, 1999

Session 5PD
Physician-Owned Health Plans—Managing the Paradox

Track: Physician-Owned Health Plans
Key Words: Managed Care

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Summary: This session will take you through the birth pains and subsequent growing pains of SureCare and discuss the types of problems that arise when providers own their own health plan.

Mr. Stuart D. Rachlin: I'm a managed care consulting actuary with the Tampa office of Milliman & Robertson. Jon Harris-Shaper and Bob Dannenhoffer are going to tell us an interesting story, a cautionary tale as they told me, of a physician-owned health plan. I think you will find it very interesting.

Dr. Robert Dannenhoffer: I guess I am the only pediatrician in the room. I am the medical director for this physician-owned health plan. This is the third year we've given this talk. The first year was very optimistic. The second year we were on the cusp. This year it's being labeled a cautionary tale. In a small plan like this we didn't have many layers of management, and that's how Jon and I got to know each other.

Mr. Jon Harris-Shapiro: I'm Jon Harris-Shapiro and a principal of Beacon Managed Care Services. SureCare Health Plans and Individual Practice Association (IPA) were of our original clients. We provided them with a wide range of analytical and actuarial support services in both the Medicaid product and the commercial product. As we move ahead, our focus will be to a greater extent on the commercial product design.

Dr. Dannenhoffer: In the last 5 years there have been about 100 physician-owned health plans throughout the country. People ask, because we were one of the first ones, why in the world would you want to do this? We put together this little talk to help you understand why this is such a paradoxical situation.

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Mr. Harris-Shapiro: To some extent, even though this is about physician-owned health plans, by extension it could also include any type of health plan that is owned by any type of provider, whether it be a hospital or a physician hospital organization (PHO)). SureCare was owned by an IPA of physicians, which is probably one of the more loosely managed care entities that are out there. Proponents believe that provider sponsorship of health plans would integrate financial and clinical decision making and perhaps move beyond the fee-for-service mentality and bring the health care system to a greater level of efficiency. Opponents have accused provider-sponsored health plans of conflict of interest and putting the fox in charge of the henhouse. It's definitely a dilemma that is tough to manage and solve, and we thought that a good place to begin would be to talk about where some of these paradoxes or conflicts exist. In a traditional fee-for-service world, the primary conflict of interest is having a physician who presumably is owning an interest in two organizations. In one organization you have an expense that's revenue in another organization, so the health plan is paying the doctor. The health plan, which is owned by the doctor, is paying its shareholder a fee for service. The health plans interest is to control expenses and to practice the most efficient manner of health care possible. The office setting is revenue-based and looks to enhance it's revenue. One person's expense is another person's revenue.

Dr. Dannenhoffer: It was very hard for physicians to understand the cost containment side of health care. This is one of the battles we've seen in each of the groups—the feeling that the more we did in the office, the better the quality of care. Physicians even to this day have the view that more is better. More is certainly not always worse, but more may not be better, and it was difficult for physicians to understand the idea that cost containment had to be one of the principles. You absolutely had to provide less care than the revenue you received.

Mr. Harris-Shapiro: The other issue focused on almost a cultural issue. Insurance companies, as we all know, are focused on long-term equity and building reserves and market strength. Physicians' offices have a very different focus, and it was a real eye-opener for me when Bob and I started working on data and operational issues and tried to understand how to improve the system that focused on cash and revenue. From an accounting standpoint virtually every medical office is a cash-based accounting enterprise.

Dr. Dannenhoffer: Even larger enterprises such as hospitals are still mostly cash based. They may have other forms of accounting, but basically they're looking at cash—what's coming in the door, and what they're spending this month—not what's going to be happening down the line. When we looked at our community there were very few physician organizations in our community or within the state that actually retained earnings from year to year. So, for physicians a cash-based system really made it very difficult for them to understand the long-term needs for capital acquisition and look at incurred but not reported claims (IBNR), which we'll talk about later.

Mr. Harris-Shapiro: Two major issues are IBNR and building the capital to move ahead and to weather the cycles in the business. One of the issues that we spent a lot of time on in the beginning was distinguishing between a patient and a member.

In fact, the mission statements, themes and the strategic planning sessions were always focusing on patients. From an insurance perspective we also need to understand and look at the members, and the people who don't use the health care services because in a community-rated environment those are the people who serve your bottom line.

Dr. Dannenhoffer: This is for people who aren't physicians and don't see patients every day in the office as we do. The people who come to the office are the people you think about. The diseases that you see are the things that you think about. It is hard to think in the statistical sense, especially in a metropolitan area. I practice in a small town where you get the view of the other kids in the school whom you don't see, but really you focus on the patients whom you do see, and this has been a very difficult thing for physicians to understand that you have to pay attention to the large part of the population that uses small amounts of health care rather than just focusing on the small part of the population that uses most of the health care.

Mr. Harris-Shapiro: At least from our perspective, we were looking at broad actuarial issues: per member per month (PMPM) costs and loss ratios; things that we take for granted in the actuarial profession. A clinician on the board was sitting at the table, and his day-to-day decision-making process involved what to do with Mary Sue on the examining table at the moment and connecting that decision to reducing days-per-thousand, or improving the loss ratio. That was a huge gap. There is a different cultural view in the way that business decisions are made on a day-to-day basis.

Dr. Dannenhoffer: There's nothing I can add to that. That's exactly correct.

Mr. Harris-Shapiro: And the bottom line here speaks more in terms of organizational focus and operations. Insurance companies, as we all know, tend to be very large corporations, bureaucratic and focused on the group and the greater good of the group. Physician offices tend to have a different focus.

Dr. Dannenhoffer: The focus in a patient encounter is a very individual focus. It's one doctor, one patient. Decisions really aren't made by a group. For example, I come in and make the decision whether or not this child needs an appendectomy or tonsillectomy. The decision is made very individually and privately, not in a public focus and clearly not in a corporate focus. If the corporate-focused insurance company said, for example, "we need to bring down the days-per-thousand or we're doing too much of this elective procedure," each of those decisions is really an individual focus, and physicians really chafe at that. Physicians really had a very difficult time applying the corporate structure and some kind of broad picture onto the individual encounters they had with their patients.

Mr. Harris-Shapiro: To some extent the paradox that we're talking about is the good of the group versus the good of the individual, and I think that's a theme that we'll be coming back to.

Dr. Dannenhoffer: So, the question is if it looked so grim when we started, why would anybody want to do this? And the answer would be that there are a lot of groups that have wanted to do this. This has been a strong view among physicians that this was where we should go. If you look on the West Coast, there were two groups in Washington, very strong groups, that put a lot of time and a lot of money into physician owned health plans. In Oregon there were several groups. And in California the medical society and other groups decided to do it. Why did they do it? They did it for a lot of reasons. First, they wanted to do it themselves before somebody else did it to them. In the mid-1990s people were recognizing that managed care would be a potent force in the industry—the view was that physicians could control the process and do it better than the health insurance and HMOs companies could. Ownership in equity was a very small interest in this, so we can understand one of the problems that many of the groups had faced because this was not seen as a way to make a lot of money. It was more of a way to control a process than to make a lot of money, so physicians did not put a lot of money into it to start with, and the firms were likely undercapitalized—really the ROI that people wanted was control. In an early focus group we presented to physicians the opportunity that they could make 10% on the money that they put in or they could make nothing on the money but have control over the process. They all overwhelmingly chose the opportunity for control. However, what they didn't recognize was that that was going to cost a whole lot more than they thought. Really the appeal was the guarantee of having a say.

Let me tell you a little story about what went on with our group. Our group is a small group of about 110 physicians in a relatively rural county in Oregon. It was largely a fee-for-service market, but it was pretty clear that over the next several years that managed care would become a potent market force, among other changes. One of those was the institution of the Oregon Health Plan, a managed care plan for not only the Medicaid population but also a newly eligible population in Oregon that would make up about 11% of the population throughout the state. In addition, the insurers in the state were in a state of flux. They were rapidly introducing managed care products into areas outside the urban areas; thus it seemed like a reasonable way to get in. So, the group of physicians formed this organization called SureCare Health Plans and began to market and go on from there. First we got an insurance license, which in Oregon at that time was a relatively easy undertaking. They funded it with personal loans that the physicians took to capitalize the organization, and they hired a staff of professionals and other physicians to run the group. At the same time there were parallel efforts in several other states. Florida, through the medical association, tried to raised several million dollars to do the same. A physician services group in Bremerton, Washington, which would seem like a brethren organization, had been doing this for awhile and was beginning to get into managed care. The Washington Medical Society put together an organization with a fair amount of money and fairly high-powered leadership to make this work. PACC, which was another physician group in Oregon, was doing well at the time. And in California there was a similar group. So, really throughout the West Coast there was a loose confederation of these groups that were all doing the same thing.

One of the bases that all of these groups had is that managed care, as it was being practiced in the mid-1990s throughout the country, had a number of serious flaws.

Those flaws included problems with overly strict utilization management and a lack of accountability for health plans and problems with physicians not being involved in the decision making. Our group, like many other groups, instituted some policies which would deal with those reforms. For example, patients had the right of appeal in our plan. So, if a patient thought he or she was being injured, rather than having to sue the corporation, there was a ready access to a panel of physicians who were not involved in the day-to-day finances who could override the decisions of the company. This was very popular among members, and it is actually one of the things that is being debated in the current bills. In addition, our group decided that preexisting condition clauses for people on managed care were a big barrier to people getting appropriate care; thus the plans were written without these clauses. The other thing that physicians saw was that drug formularies in many cases were being used in a very restrictive way and were harming patient practices; thus a formulary was not instituted for these patients. For patients it was great. For doctors it was great. But business-wise, some problems lay ahead.

Mr. Harris-Shapiro: One of the clear lessons that the organization learned was articulated to me by the medical director at the time who spent two or three hours going through the financials, trying to understand the data. This doctor turned to me and said it simply is not easy as it looks or as he was led to believe. The physicians felt that the health plans had such huge expense ratios that there was no reason to spend that much money on administrative costs, that their claim payment systems were just so bad, and that it would be very easy to trim a little bit off the top and make a go of it.

Dr. Dannenhoffer: And it clearly is not as easy as it looks. I mean, it truly is, in retrospect amazing to recognize how naive some of the groups were and continue to be and how difficult the whole organization was. I can remember in the first year we did this one of the older members of the SOA asked, "How do you think you guys can do this?", adding "I've been in this business for many years, and now after 25 years of doing this I'm finally on a board of directors for a small insurance company, so I understand after 25 years of moving my way up how hard this is. How do people think they can do this if their jobs are totally different? They're pediatricians and orthopedists and neurologists. How do they think they can do this after just a few months of on-the-job training?" We should have learned from that. It's clearly not as easy as it looks.

The second problem was the challenge of cutting enough waste because waste is seen in different ways. What the company might see as waste—for example, excessive referrals or nonuse of a formulary—are seen as conveniences for patients or things that patients like on the one hand. On the other hand it's seen as waste by someone else. Other things that physicians see as waste—for example, loss of money spent on getting the contracts exactly right or extensive legal fees that companies pay—are in the end, you'll realize, not necessarily waste but absolutely necessary business services.

Mr. Harris-Shapiro: The amount of capital, the amount of time the physicians needed to spend overseeing the operations through the board and its committees, and as well as the administrative operational requirements—things from the

capacity of a phone system to T1 lines—completely overwhelmed any expectations of what the physicians expected when they compared the operations or tried to compare the operations off of a large medical practice. Last night I was having dinner with another pediatrician unrelated to our relationship here, and he was talking about buying a $1,000 computer as being a major capital investment. Think about that in terms of the cost of a solid claim system or an operation system, let alone the call centers and the other things that we need. The other issue that we hear is that provider-sponsored health plans don't need as many capital reserves. The solvency issues are mitigated when the providers themselves are simply putting their time at risk. I'm seeing a lot of smiles and nods. Sweat equity is what it's called. And they should be given credit for sweat equity since they're just paying themselves. They're just paying something else. We did find that sweat equity works when the plan needs to recapitalize. However, we also learned that it only works once. The organization comes out looking very different from the one it was before the situation.

Dr. Dannenhoffer: One of the problems with these groups is that almost all the physician groups that started were either severely undercapitalized or capitalized at a very low rate. Of all those physician plans I talked about, none of them had reserves of more than $40 million, which would make them a really tiny group in the whole scheme of things. So, these groups were largely undercapitalized, but the thought was that they could do it.

Mr. Harris-Shapiro: The goal was to get to the statutory requirements, and this is before risk-based capital.

Dr. Dannenhoffer: Well, what else did we learn? One of the things that we learned is that although the plans that the doctors put together were very popular with patients—in fact, we had very high satisfaction among patients and among doctors—it was also clear that doctors don't really do the selling in an insurance plan and that really the people who do the selling in the insurance plan are the employers and the agents. Those were generally the people who did the selling. The doctor appeal was estimated to be enough to cover the difference of the other advances and the other benefits that we had such as a no preexisting condition clause—the fact that your patients would be happy, that the doctors would be happy, and that that would be worth something to employers. We had estimated that the appeal there would be enough to make up those differences, which would be at least 15% of premium. It was very clear that it was not going to be nearly that, and it was clear as we sold that those advantages were probably worth maybe 5% of premium. We had some estimates as low as 3%.

Mr. Harris-Shapiro: That's what underwriting told me.

Dr. Dannenhoffer: Yes. So, the problem was, unfortunately, that we overestimated the appeal of not only the doctors themselves but the appeal that it would have to patients not to have those hassles, the appeal not to have a formulary, and the appeal to cover preexisting conditions. We sadly overestimated that. The other implication was that of insuring doctor groups. It was pretty clear that a good group to start with would be the doctors themselves. They were one

of the big employers in town. The hospitals are big employers. And it was difficult to get people to recognize that that's not certainly the group that you'd start with. These were sophisticated people who used medical resources at a somewhat higher rate than the rest of the community, and even they were not willing to put in the additional dollars needed to do so.

Mr. Harris-Shapiro: Trying to negotiate an arm's-length deal with your shareholders and their business relationships was a bit of a challenge. Related to the marketing there were a couple of lessons that Bob alluded to. Many of the provider-sponsored health plans start off trying to go direct to the groups with the brokers, and it's a mistake that has been repeated over and over and over again. Probably three to six months went by before the local management realized that this just wasn't going to fly. You have to hug and kiss the brokers and make up for the ill feelings if you're going to have any acceptance at all in the community. The other mistake they made was that their marketing consultant, in trying to build a program that would distinguish the product from the very well-accepted and very well-established commercial products, decided to feature not only that the program was physician-sponsored and physician-run but also that they took care of all preexisting conditions. Now, at this point in the marketplace nobody had preexisting conditions, but that was not the perception of the consumers. This was a point where the perception superseded the reality where we created a plan that was perceived to cover all preexisting conditions when the market—and everyone—still perceived the other plans, the commercial carriers or whatnot, as having the usual preexisting exclusions, which was a very subtle point.

Mr. Rachlin: Jon, have you done an analysis to really indicate what that really was worth? How much extra risk did that give you? Do you have some feel for how much that was?

Mr. Harris-Shapiro: It's difficult to quantify because it's rolled up in the health plans covering themselves. This was such a large piece of the business at the time. You'd almost have to look at all the healthcare industry as a separate piece and then look at the commercial piece.

Mr. Rachlin: Is that significant?

Mr. Harris-Shapiro: Yes, and at that point when you're a fragile, young babe in the woods a 1% impact on medical cost is significant.

Dr. Dannenhoffer: We'll see if anybody can predict what the outcome then was. Obviously, from the way we presented it, it's a difficult and cautionary tale. Actually, some of the things that came through were amazing. One of the things is that there was incredibly high patient acceptance. In fact, when we decided at one point, to stop selling commercial insurance, not so much the employers, but patients were really quite upset, and they were willing to go to the mat to help us. The second thing that happened was, as we began to see increasing costs and troubles in different ways, physicians were willing to work for about three months without being paid. That was a significant amount of sweat equity, and it was a significant reaffirmation that sweat equity works. However, the cautionary part on

that was that sweat equity, as Jon said, works once, and people were not willing to do that again. The other things that we saw on this were that some of the things that we had done with carefully managed drug costs but not formulary or preexisting condition clauses are now being enacted into legislation, and, in fact, in Oregon some of those things have, indeed, come to pass.

So, what happened? In 1998 we began to see that the costs were increasing, and we posted some losses. With a company that was undercapitalized we decided that we could not go on any longer, and we just basically continued the business that we had, finished business in 1998, and did not renew any policies for 1999. By the time 1999 came the policies that were there dwindled, and we came out in the end. Business-wise, we came out about breakeven. We didn't make a lot of money. We didn't lose a lot of money. We wound up about even, even though you'd have thought that we'd have lost a ton of money doing things the way we did.

Mr. Harris-Shapiro: Four years with a commercial license, right?

Dr. Dannenhoffer: Right. We came out about even, which is interesting because the other commercial insurers in the state actually had underwriting losses during that time. The biggest players in the state, the Blues, actually had considerable underwriting losses during that time. We came out at about even. The point of this is not that it couldn't be done. The point is the way we did it. The next time these things raise their heads, which I predict will be in the next two or three years, there probably will be lessons to be learned and ways to do it better.

One of the things that we did learn from this is that physicians are very bright people. Physicians are very good at taking care of sick people. But physicians really shouldn't run a complicated business such as this, and I would be happy to talk with your consulting groups and physicians and try to convince them that there is a place for physicians in this market, but not as it has been done by these groups. Now, I told you about the groups in Washington. The Washington Medical Society group went out of business after spending quite a bit of money. The Physician Services in Bremerton which was a very well-organized group, is now in receivership. PACC, which was the other group in Oregon, has sold out. The California Medical Society went out of business after insuring fewer people in all of the state of California than our group did in rural Oregon. In comparison, many of the other groups throughout the country have gone out of business. So, the mistakes that we made and the problems that we encountered were not only with our group. They were with other physician groups.

Mr. Harris-Shapiro: To some extent it's a lot easier when the physician can turn to the patient and say you can't have that because ABC Health Plan out there won't let me—there's a nurse or a clerk on the other phone that is really controlling this. It becomes a much more challenging problem when it's your own health plan and the patient knows that. You're on the board. Why can't you get me that service?

Dr. Dannenhoffer: If you were to do this again, how in the world could you make this work? Because I'm sure that there are going to be attempts again to do this,

and there are going to be variations on this attempt. For example, there'll be PHOs that will attempt to do a commercial business. There's one in Oregon now that is trying to do this, and there are several other groups that are going to want to do this. There are groups that may not do the whole thing. There are groups that may be doing fully capitated arrangements with insurers. And if you are going to do it, what did we learn? How in the world could you make this better?

Mr. Harris-Shapiro: Let's talk about the organizations that have had a little bit more success and some of the characteristics that they've had.

Dr. Dannenhoffer: Our organization still exists. It still does the Oregon Health Plan, which is the Medicaid market.

Mr. Harris-Shapiro: Every Medicaid life in the county, right?

Dr. Dannenhoffer: Every Medicaid life in the county, and, in fact, about half of the Medicaid lives in the state of Oregon are managed by small physician-owned plans. So, about half of the lives in the Oregon Health Plan are covered by the big insurers, and the other half are covered by small physician-owned plans very similar to ours. The plans that have succeeded have certain characteristics. One of them is a group where somebody else makes the rules and you follow them. For example, on the Oregon Health Plan side there are strict rules as to what's covered and what's not and how it's covered, and strict rules on how much you get in. You don't have to market this. You don't have to couch your prices. There's a fixed amount that comes in. So, it may be that in markets that are easier structurally and easier administratively that these plans may succeed. In the state of Oregon there are also some groups who are doing full risk capitation. So, the insurers are doing the selling and the marketing, and the doctors are providing services for a fixed fee. Those seem to be successful. And there are several groups that are doing Medicare. It'll be interesting to see what happens in the next few years, but at least for now they're successful.

Mr. Harris-Shapiro: I think Oregon's experience is typical of what we see elsewhere; the Medicaid programs that are being operated by small plans, whether or not they're provider-owned, is a separate issue. The provider-sponsored organizations seem to provide focus for these niche markets where the commercial

carriers have struggled with them. The capitated or percentage-of-premium contracts, while they're not all 100% winners, definitely show some signs of success and possibly point to a formula that, if we were to do it over again, this is what you would need to do to make it succeed. What are those signs?

Dr. Dannenhoffer: Well, the first one is bridging the gap between the actuary and the medical director. Those paradoxes, which we pointed out in the beginning, are important and are all-pervasive. I was at a lecture the other day, and I said that culture will win; that basically it's really hard to move the cultures. It would be a very long time until the culture of medicine is similar to the culture of an insurer. One of the ways to bridge the gap is to recognize that there are differences and that you're not going to have doctors thinking in a statistical way with every patient

they see and to recognize that that gap is there and hope to bridge it before you get started rather than thinking that everybody's going to be thinking the same within a year or two.

Mr. Harris-Shapiro: And this really affects the practice of the actuary, whether the actuary is in-house or a consultant. The most productive exercises that Bob and I went through were when we got line-by-line into the data and numbers and would say, "Immunizations are going through the roof." and Bob would respond, "Well, you'd have to account for the fact that the state just changed the immunization schedule." This isn't necessarily an indication of abuse or bad practice. It's an indication that the whole state of medicine just changed overnight. And I would go back to the data and tease it out and say, "Yes, Bob, that's true for the pediatricians, but we're seeing this run-up in immunizations and supplies in the adults as well." Therein lies the problem. So, by wedding the examining room view of the world with the data view or the actuarial view of the world we're able to create some very effective analysis to point to some change that wouldn't have occurred if we hadn't bridged that gap together, and Bob's exceptional to the extent that he has a very strong facility with the data.

Dr. Dannenhoffer: One of the things we recognize is that showing the data to physicians doesn't always mean that they're going to change their practices. For example, we saw a huge run-up in cost for laparoscopy, which is a great diagnostic procedure but clearly is quite elective. It's certainly not something that needs to be done in every case. Every laparoscope doesn't need to be in use every minute of the day, whereas some physicians thought it needed to be. So, presenting the data and showing the data, and comparing it with trends, while compelling, did not compel doctors necessarily to change.

The second thing was the use of the board of directors. One of the issues is that these physicians were quite reluctant to have outside help on the board of directors. If we had to do this again, we would ensure that the board of directors clearly represented the medical focus but also represented the other groups that clearly needed to be heard and would have noted some of these problems quite early on and would have directed the board of directors in a much more reasonable direction.

Mr. Harris-Shapiro: There was a lot of reinventing the wheel and a reluctance to find somebody who's been down that path before to save them from some of the pain of some of the trips that they made. And the same thing happened on plan management—the operations and the administration. There are a lot of very experienced people out there who can run a claim shop, a lot of very solid financial systems and supports, and it was all home-grown. They weren't so available in 1991 and 1994 as the operations went through some of their early evolutions, but now there are some very solid vendors that'll provide back-office support with high-end claim systems that a small start-up plan could never hope to afford.

Dr. Dannenhoffer: The other thing with plan management that was difficult, and one of the things that you should anticipate, is that physicians are very highly compensated. That's probably appropriate, but there are other people in the world who are highly compensated also for very different talents than physicians would have. One of the problems we had was the idea that the actuary would make

almost as much as a physician. I mean, it was just difficult. I didn't think actuaries would make almost as much as the physician. Then we would say, "Well, actuaries come with an incredible knowledge set that you couldn't hope to duplicate and if these guys charge $200, $300, or $400 an hour for the services that they do, that's OK. The surgeons are charging clearly that amount." But it was hard to convince one group of professionals that there's another group of professionals that should be paid more than they are paid. So, this is a difficult thing, and if you're going to do this, again, you have to start off and say, "Look, this is what actuaries cost." You need to have people who know what they're doing. This is not something you can do on your home computer.

Mr. Harris-Shapiro: We didn't quite get it onto the relative value scale of physician services, but there was some attempt to get there.

Dr. Dannenhoffer: In the end the question is, What was really the vision here? Was the vision here really to own and run an insurance company, or was the vision here to really do the best for patients and to provide the best amount of care with a limited amount of money? I think what happened is that the original vision was to do this for Oregon Health Plan, and for Oregon Health Plan the vision stays alive and strong because with the Oregon Health Plan there is a certain amount of money that you get every month to provide care for the 11,000 members of our county who are poor and who need care. With that we were able to sustain the vision. The vision on the commercial plan that got very disjointed was the vision to build a big company that would enable you to become rich. Was the vision to become the next Blue Cross? Was that the vision of this company? I ask those questions because we could never really sustain the consensus on the vision of the commercial product; it floundered. One of the things that I would strongly encourage anybody else who will be in a consulting situation like this is to get people to understand really what the vision is. I wouldn't let them out of the room until they could really understand and decide what the vision is so that you can move on into the future. The second is staying power. The staying power on this is long-term. Obviously, the time frame on this cannot be one year, two year, or five years. If people are going to do this, they need to do this for the long term, and that was something that was hard to convince people.

Mr. Harris-Shapiro: It was very difficult. In the beginning it was easy to make sure that the good of the group took precedence over the good of the individual. Individual practices were subservient to the interests of the group, the insurance company, or the IPA—whatever the topic was at hand. But as the company diversified and had interests in workers' compensation and was dealing with the political issues of operating a commercial health plan, the stakeholders started lapsing back into putting self-interest and the immediate moment ahead of the long-term interests of the group. So, being able to stick with the vision in the tough times is very critical. And when we were comparing notes, asking what do we take away from this and what would we advise another group, I think one of the key pieces would be to have a outside business partner that could provide some of the capitalization, and management expertise and provide some stability to the group so that the group would basically behave and keep it on a businesslike level. And since it's not just the local family getting involved, some of these board meetings were like holiday dinners when the family all comes back together again.

Dr. Dannenhoffer: One of the things that was most positive about the whole thing was reinventing a managed care tool kit. Basically, what we mean here is that once the physicians were clearly aware of their financial incentive in this and their financial role in what went on, a lot of things that they read in the managed care literature about changing things, such as disease management, etc., clearly came into focus. Unfortunately, the other business priorities eclipsed them, and things fell apart just as we were beginning to understand that some of the things that managed care does were pretty crude. They're crude because there hasn't been enough talk between the people who are actually performing the services and the companies that are doing them. We were just beginning a dialogue to figure out where we were able to get reports that really made sense.

Jon had talked about some changes in services. We were able to get to the point where we were able to get a group of people who were, as we were performing the services, able to look at data and be critical then of what they were doing. They started off seeing this as a protective function—that we're going to do this to protect ourselves from managed care—but as we started to move on this, they began to realize that some of those things made sense. For example, spending a tremendous amount of money on diabetic care, which is going to be one of the big expenses in the future, misspends a lot of money. It was being misspent because we were doing too much for some people and not enough for others. This may seem incredibly obvious to some people, but it became obvious to the people who were providing the care, and as the people who were providing the care, they were able to actually make the differences. So, one of the things that was actually exciting is that when physicians really became involved in it and really wanted this thing to work, they were able to make some of those changes that we haven't seen before or actually since. Unfortunately, the state of the dialogue between managed care companies and physicians at this point is ugly. If you go to any of these meetings, it's really not pretty. Because of that, nobody is really working at things that seem to be obvious.

So, there is a place, I think, in the future where physicians and insurers can work together to really make managed care work better. I think managed care has been somewhat of a disappointment for physicians and a disappointment in the country because we haven't worked closely enough together to actually make the differences. There are, for example, some things which are very expensive that you can't do a whole lot about. Somebody is going to wind up with a liver transplant. There's not a whole lot you can do other than maybe negotiate the cost once he or she's going to get that liver transplant. But there are things that you can do along the way that are highly discretionary. In fact, we looked at a bunch of services that were fairly low discretion. I mean, if someone's going to get their appendix out, they're going to pretty much get their appendix out. You can spend a lot of time and a lot of effort working on changing your appendectomy rates or changing the rates around that, but it doesn't do very much good because it's a lot of work, and no matter what you're going to do people are going to still get their appendix out when they have appendicitis.

There were other things we saw, however, which were highly discretionary; things that really, by putting a little bit of time and effort in, can make a huge difference in

discretion. For example, laparoscopy was one of them. By following guidelines and agreeing to guidelines we could actually really change the rates by which laparoscopies were done and actually improve care by doing that. And that is actually one of the successes that we had. Unfortunately, it was too short-lived to see the results fully.

Mr. Harris-Shapiro: Which speaks to the long-term view.

Dr. Dannenhoffer: Yes. Now, what are the successes? One of the successes is that it takes a long time for physicians to understand some of the basic actuarial concepts. In groups of physicians there are only a limited number of people who even want to do anything outside of just practicing medicine. And, within that group, it takes a long time to learn the kinds of things that you need to do to be even the least bit knowledgeable about what goes on. Thus, there's a real commitment to learn among the physicians. Jon took a lot of time to learn the clinical issues so that actually the discussion between physician and actuary was a great discussion. It was very enlightening and would have led to something had we been able to take care of the other issues.

Mr. Harris-Shapiro: The two of us got very good at conversing with each other, but to some extent we were in an ivory tower, and we had to get the gospel out. We had to spread the word. And that was starting to happen. Unfortunately, it just takes a huge operational commitment to disseminate that sort of thing. Also, the physicians need to start understanding actuarial implications.

Dr. Dannenhoffer: So that's what we learned. What are the points from this? The points are that this is going to be a recurring trend in American medicine. This wasn't the first time this happened. Basically, during every insurance cycle, the physicians have decided that they wanted to do this. This last cycle was disastrous, but I think it's going to come again. I can see actually in Oregon several groups forming to do the same thing as we did before, and I just implore people to learn from some of the people who already have been through this. I imagine some of these groups will come to you and say, "Hey, we have a great idea. This is the idea. We're going to put together this group of physicians. We're going to start an insurance company. And we're going to help them understand that they really need to work through some of the basics before they decide to do this." They need to understand what their vision is. Is their vision to control? Is their vision to make money? Is their vision to protect patients? Once they understand their vision, they can get together the expertise, the people, and the learning so that they can hopefully make this thing a success the next time around.

Mr. Rachlin: I just wanted to add a couple comments myself regarding what I've seen. In my experiences I'm seeing more provider groups getting more educated about risk and the actuarial concepts. I think in the old days it was a lot of "show me the money" and "gimme, gimme, gimme." "You're going to give me all this money to just manage this— no problem, Ill take it." Now I think they're stepping back and understanding the need to do some analysis here. We need to understand what revenue is coming in. Is it going to be enough? Understand the demographics of your population. Who are you insuring? Everybody thinks they

have the better risks. Well, everybody can't have the better risks. Someone has to have the worst risks.

Dr. Dannenhoffer: That's interesting because the doctors always feel they have the sicker patients, but they have the better risks. People on both sides of the table at the same time is a very interesting phenomenon in this business.

Mr. Rachlin: Understand clearly the roles that each player is going to have. Who's paying the claims? Where are the tertiary providers going to be? There are a lot of different pieces to the puzzle that have to be understood to make it a success. The benefit design. What's covered? What's not covered? The providers clearly have to understand what the risk is that they're taking on. They're taking all this revenue to cover exactly what? Are the transplants a common carve-out? That's very expensive. And, finally, the use of reinsurance. You didn't really touch on that. Maybe you can. Stop loss, specific or aggregate, is a very important concept.

Mr. Harris-Shapiro: What was interesting is that the group had individual stop loss. I think it started off at a $25,000 threshold, and it was through a commercial carrier. I guess there were a couple of things that were learned. First of all, you need to procure it through somebody who's very active in that market—not just somebody's brother-in-law—so that they understand the nuances of the provider stop-loss product and such. There was also not a real strong understanding in what was an appropriate deductible or threshold amount. As the stop-loss carrier had a couple of good years, meaning that there were not a lot of recoveries, the health plan left the deductible drift upward to cut some administrative costs since they weren't making the claims. Well, along comes a few high-cost cases, and even if the deductible hadn't changed, the frequency of those cases created really severe hardship. That was happening all at the same time in terms of some of the pressures on capitalization where, yes, we had stop loss, but at a threshold of $50,000 or $75,000 when you're a small, fragile entity even the deductible part can hurt real bad.

Mr. Rachlin: We will open this up to questions now.

Mr. Harry L. Sutton, Jr.: I think I've sat through this before, and I enjoyed it just as much this time as I did the first time. The physician habits and biases don't seem to change over the years. You said that when you closed after four years the plan broke even. Now, does that mean the physicians broke even with their investment? Did they get it back? And two, did they have to cut their budget? I can't believe that the physicians didn't give up a good amount of sweat equity to get out of there without owing anything at the end.

Dr. Dannenhoffer: What happened was "yes." The physicians basically worked for a while on sweat equity and got $1 million worth for the physicians in town. In addition, people lost their investments, and there was about another $1 million in personal money that physicians lost. And people also took reduced fees. So, there's no question that physicians individually paid for this, but the company itself didn't have to go bankrupt. None of the covered beneficiaries lost any services, and people got covered to the end. So, basically in the end, this was a $2.5 million investment by the physicians in town that didn't go anywhere.

Mr. Harris-Shapiro: Although it didn't feel like it at the time, it was a very orderly unwinding. There was a point at which the group decided that this wasn't where we wanted to be and put together an exit strategy over nine months.

Mr. Dean E. Fiscus: How did you manage with the physician who was going to be in your network? What about credentialing? Could all physicians join the network?

Dr. Dannenhoffer: It was a fairly open process, and that was actually one of the issues, which is great from the patient point of view. Basically, it covered all the physicians in our town and in the three neighboring towns. So, it basically maximized patient choice. However, it did not allow the company to prune out those physicians who were bad actors. Because of the guarantee which was not exactly written, and while they felt that all the providers would be in this, it really tied the hands of the company to prune out any nonperformers.

Mr. Sutton: I had another question about structure. In the area, which was relatively small, was there only one hospital? I'm wondering about competing hospitals and negotiating with the lowest cost hospital. Did physicians have to change allegiance to which hospital they usually used? What was the extent of those problems, if they related to the results of the health plan?

Mr. Harris-Shapiro: Well, there were several hospitals in town, and actually we had great contracted rates with both hospitals. So, actually hospitals, which in many cases are the downfall of plans, if anything, cushioned the blow because the hospitals were willing to take relatively low rates. Everybody was sort of pulling behind this thing. The hospitals wanted this to work. The doctors wanted it to work. The community wanted it to work. And that maybe softened some of the blow.

Dr. Dannenhoffer: On the plus side it is a community. These people have to live with each other. Their kids play with each other, and they may golf with each other—whatever doctors do when they're not working. On the negative side when the tough decisions had to be made, such as kicking out a nonperformer, these are the people you play golf with. Your kids play with their kids—that sort of thing. One of our recurrent lessons learned is that there seems to be a strong role for an outside player to be the bad guy. It doesn't seem as though the system has moved beyond that yet.

From the Floor: Can you elaborate on how you limited the use of the laparoscopy?

Dr. Dannenhoffer: Yes. Laparoscopy is, for the nonmedical people here, a great new technique. It allows you, by use of a long telescope, to make just a little incision by the belly button from which you can see the entire abdomen. Laparoscopic surgery has really revolutionized abdominal surgery in a couple of ways. For example, in taking out gallbladders, which has been one of the most common abdominal operations for the last 50 years, in the past you made an incision that started at the side and moved all the way to the middle. You spent a long time yanking on those areas there. The recovery after the surgery was long,

and it made it difficult to do the surgery. Now the surgery can be done almost on an outpatient basis. Many of the patients either go home that night or go home the next day, and the recovery time is reduced. Because of that the percentage of the population getting their gallbladders out has increased tremendously. In the past when it was big surgery people would look at it and say, "Well, that's a big surgery. I'll be off for two weeks. Maybe Ill leave with the pain and it'll go away," as it sometimes will.

Now with it becoming easier, the idea was that more people needed this. So, the number of people in the population who have gotten their gallbladders out has increased threefold. Well, the surgeons clearly recognized that they were doing more gallbladder removals than they had ever done before, so it seemed as if their goal was not to have not a gallbladder left in town. But, when they began to see that the number of laparoscopies was going up, and that the limiting factor shouldn't be the number of gallbladders but really should be the best care, they began to realize that maybe everybody shouldn't have a gallbladder operation. Actually, the gallbladder surgery rates of those really stabilized once they became aware of what the numbers were and what the trends were both nationally and in that group. We then began to look at some practice guidelines. Some of the practice guidelines would suggest that although it's easy to do, it's not necessarily the best thing to do. The other companies in the state have tried to do that in sort of a punishing way: "You have meet these seven criteria, and if you don't, then we're going to not pay for it or somehow make it difficult for you." This was a more proactive way where they got to look at it. They got to make decisions on how they would do it and who they would do it on, and they were able to moderate that. Was it remarkably improved? No, but at least it stemmed the tide.

Mr. Sutton: You can call this an anecdote. I worked with a very large medical group whose plan was very successful. The stock was traded on the New York Stock Exchange and went way up. We had somewhere between 50 and 100 physicians, but we had a problem of physicians retiring and wanting to get their money out. Eventually they sold the HMO and their clinic. They got $40 million. So, each one of them could have gotten something like $500,000, but they sold to the new plan that bought it out. So, once the new plan got in there they lowered the capitation rate to the physicians and had a hard time negotiating. Of course the physicians no longer had any incentive to manage anything because they didn't own it. They subsequently had a noncompete agreement, so they all quit and had to move to another state, and probably waited the two years to move back. Physicians don't have an understanding of the long-term equity or how to maintain the value. What do you do when somebody's going to retire and they want their share of the pie? It used to be just the buildings they did that with. Now it's with the health plans as well.

Dr. Dannenhoffer: Nobody had to move because there wasn't so much money to come out, obviously, so, thankfully, we avoided that problem. Nobody had to move.

Mr. John E. Ragan: I'm from a Blue Cross/Blue Shield plan. The question I have is, how do you look from a physician standpoint at the impact of preventive medicine and preventive care that potentially can increase your costs long-term if

this is a long-term setup? If a member doesn't have an illness now, you might actually have one down the road or an even greater cost for care being performed.

Dr. Dannenhoffer: Preventive care is a fascinating subject, and being in pediatrics, doing mostly preventive care, we've had a long time to think about it. Preventive care is overall a good investment for society. When we look at immunizations, for example, the number of cases of measles, German measles, mumps, and meningitis have gone away in a pediatric practice in the span of my career. I can remember as an intern seeing a kid every night with meningitis, a terrible disease which left kids mentally retarded, blind, deaf, or deceased. We have not had a case of meningitis in the state of Oregon in three years. That's how impressive immunizations have been. So there's no question that preventive care works.

However, how good an investment is it for any one plan? The answer is it's probably a terrible investment for several reasons. We tried to look in our small area where there weren't that many companies and ask, "How likely would it be that you would provide a preventive service and that you would then be responsible at the time that they would have their illness? The answer is very low because there's so much moving around from one insurer to another, and the returns on preventive care are in many cases way down the line. For example, if we look at diabetic care, it is very clear to me that good diabetes care prevents long-term morbidity and mortality. If you take care of kids with juvenile diabetes, get them in good shape. It does cost a lot of money. The care in the old days of diabetes you could do very cheaply, but if you're going to be monitoring the blood sugars four times a day and giving an expensive insulin it's very expensive. The rewards on this are way down the line. They're 15, 18, or 20 years down the line at the earliest. And most of the benefits in preventive care actually don't accrue to the plan. Most of the benefits in preventive care accrue to the individual.

Mr. Harris-Shapiro: Or to society.
Dr. Dannenhoffer: Or to society. So, yes, the fact that a kid may not get meningitis may save you medical costs, but really what it does is to save the societal cost that this kid will be blind and retarded. And treating a diabetic saves the societal cost of a child who now as a young adult won't be able to work because he or she is blind or an amputee.

Mr. Harris-Shapiro: The health plan couldn't figure out how to accrue that to the bottom line.

Dr. Dannenhoffer: Yes. It's very difficult to accrue that to the bottom line. And one of the things that this plan did was to have unlimited preventive care. So, the thought was that if you did a preventive service which was within the guidelines and had accepted care, that was to be rewarded and encouraged, and we had great care for our diabetics. We had 100% prenatal care for our members, and we had a 97% immunization rate among the children. So, we met all of those goals, and that was great. However, that cost us in the bottom line because we only did this for three years. We probably didn't see any of the benefits in diabetic care. We probably saw very few of the benefits of the immunization care.

Mr. Harris-Shapiro: When we saw the primary care model switched from capitated to fee-for-service in the throes of a lot of changes, we saw preventive care go through the roof, and what we think was happening was that the larger offices with sophisticated computer systems were going through their rosters, their primary care physician (PCP) assignments, and calling people up they hadn't seen. Well, under capitation PCPs just kind of leave them out there. And how do you tell people not to do physicals? How do you tell a PCP that too many physicals and too much preventive care is not sustainable? It's a very interesting debate.

Mr. Gary L. Brace: One of the things that I always talk about in terms of bringing managed care initiatives to market, whether it be a new product roll-out or whatever, is whether or not it's best to be the first one on the block or not. You had mentioned that you're primarily a rural plan, so it strikes me that you might have been really the first managed care foray into your area. And you commented further that sometimes it's better to have a whipping boy or somebody to be the bad guy—that third person, that mean medical director of that HMO who tells us to behave this way. I wonder, if there had been another plan in before you guys to kind of tenderize the physician, so to speak, would you have had better luck?

Dr. Dannenhoffer: Not enough.

Mr. Harris-Shapiro: Yes.

Dr. Dannenhoffer: There was a great deal of discussion at some point from the public as well as from the medical offices and the hospital offices themselves about how terrible we were. The physicians and the management team, who were tuned into what was going on 50 miles north, understood that there was a bad guy coming down the highway. But, for the people in the day-to-day operations, you don't really think about how much a billing clerk is going to affect your success. When people complain in a small community it builds. It's a whisper campaign just about. And these are people who don't have a clue what it's like to deal with a huge billion dollar managed care company with offices up the highway or across the country. And, in fact, as we unraveled the commercial product, all of a sudden we found a whole lot of fans who were detractors a day before because all of a sudden our products weren't overpriced. All of a sudden our customer service was outstanding. I don't think claims payment ever got praised, but there may have been timing issues.

Mr. Harris-Shapiro: But I think, clearly, having a bad boy or somebody to be mad at seems to be one of the necessities in managed care these days.

Mr. George Calat: You mentioned some of the difficulties with those things—for example, with preventive care—that don't accrue to the bottom line of the health plan. What are some other difficulties? If you were able to magically design what you two feel to be the perfect health plan designed in the perfect way with perfect dynamics, realizing that preventive care doesn't accrue largely to the bottom line of the health plan but your focus was to provide the best care for the best value, best care, and best price, do you think you could truly affect costs substantially from where the best plans in the country are today? Do you think you can make that big of a difference if you were just able to design that best plan?

Dr. Dannenhoffer: I think benefit design is absolutely critical to where we're going. I think that's what I've seen certainly from the practice side of view, as well as from the measurement side of view, is that the current benefit designs, which have a very low patient cost-sharing, are very detrimental to what goes on. With the low co-pays and easy-in-the-door, no deductibles, there really is a sense of entitlement. There really is a sense of "I'm paying for this, so I'd better get my money's worth," and I would think that one of the benefit designs that you might make would be in discretionary care with an increase in deductibles. You might still do preventive care because in the long run the preventive care didn't cost that much. I mean, when you really look into it, we have spent a lot of money on immunizations.

Mr. Harris-Shapiro: It's low tech, though.

Dr. Dannenhoffer: But it was low-tech. If you do all the immunizations, it's not like people are going to come in for extra immunizations. People are only going to come in for so many immunizations, and getting a rate of 80% or 100% on immunizations, which makes a big difference in the amount of disease that's out there, didn't cost that much money. Doing mammograms or doing good care for diabetics in the whole scheme of things didn't cost that much money. So, preventive care wouldn't be it. But what really did seem to cost a lot of money was the person who had the knee injury who went to the doctor and said, "You know, I heard that pro football players when they have a knee injury get an MRI that day, right?" They get an MRI and somebody looks at it, and they see the orthopedist that day. You recognize that probably only 1 knee injury in 100 really needs an MRI, and probably only 1 knee injury in 100 needs a laparoscopy, if that were the case, why do the pro football players get their stuff done the first day? Well, it's not because of the medical reasons. It's because of the benefits that accrue to their team, and their team is perfectly willing to spend that money to do it. Now, what we saw was that you could try to put in practice guidelines that would say if you have a knee injury, what we'd like you to do is to wait on it for two weeks, see the orthopedist, and if the orthopedist didn't find something immediate to wait another four weeks and then do an arthroscopy. That is probably the most cost-effective approach. But, what we found was that it was highly irritating to patients because there were some people that said, "Look, I'll even pay the difference. I just want to get this thing fixed." And what we were seeing was that there was not enough patient ability to do that. Our plan and most plans don't even have a way to let you do that. Because of that lack of patient choice that was a problem. So, I think a benefit design that would work would have more patient choice, as well as more patient responsibility, probably with higher deductibles. We in Oregon are seeing that in the commercial market now just because the premium rates are increasing at such a steep rate over the last several years that employers trying to look at leveling their costs are increasing deductibles and co-pays to keep the same premium price.

Mr. Rachlin: I think we're seeing more of that choice in the increase in PPO and point-of-service products as well. That's certainly giving the members a choice to pay for things on their own without the referrals, the open access plans, and things of that nature.

Mr. Harris-Shapiro: We kicked around an idea although we didn't have the capital to develop it—some kind of flexible plan almost like a flexible account that participants could draw on if they wanted to go ahead and accelerate the practice guideline. It was a little too revolutionary for the time. From an insurance company perspective or from the underwriting perspective, I do a lot of work with provider organizations. I do a lot of work with commercial and Blue Cross-type organizations, and although the problems are the same, the solutions can be very different. When I'm talking to a commercial or a Blue Cross plan, the only options to improve the financial performance are to reduce the fees, go out recontracting, and narrow the network. When we sit down with a provider organization we can start looking at behavior. How do we make the delivery more efficient. We're affecting its price, volume, and mix in terms of what's driving the bottom line. Instead, we now have two more levers whereas a typical commercial plan only has one lever, meaning price.

Mr. Timothy D. Lee: I have one anecdote and then one question for you. You mentioned earlier on that you tended to overestimate the value of the physician-patient relationship in the marketing aspect of your plan. My anecdote builds on that. Actually an example that I'm aware of is a health plan in Texas where I live and work that's a hospital-sponsored HMO. They recently sold a case to their local city employee group of 750 employees. It's a relatively new HMO. They also had a companion PPO product that went along with that. So, the employees actually had a choice. I guess I should add that there was an IPA in town that was not in the network, it was actually in the HMO's network, that served most of these city employees, and the IPA did a lot of campaigning saying that this was a bad decision for the city employees and that they were not going to be able to maintain the provider relationship if they chose the HMO. As it turned out, after final enrollment was done, 725 of the 750 employees chose the HMO and to forgo their current physician relationship, even though they had a PPO option available to them that would have allowed them to continue their physician relationship. I guess the kicker is that the PPO option was no more of an out-of-pocket payroll deduction than the HMO.

Dr. Dannenhoffer: What about the co-payment?

Mr. Lee: It was simply for the potential benefit difference. They might have to pay a deductible. They might have some coinsurance if they needed medical care, and that was enough motivation to go ahead and make the move for 97% of the employees. My question for you, though, is why did you decide to wind down the health plan? Financially, I assume that the efficiency of the care that was delivered by your physicians was no worse in your health plan than you were delivering for the Blue Cross patients that you saw and other commercial insurers. I assume that your network had reimbursement rates that were every bit as competitive as Blue Cross and other carriers. Maybe your administrative expenses were a little higher, but what was it that allowed you not to be able to charge an adequate premium in that market, or were your competitors simply undercutting you and losing money but had the financial resources to absorb those losses?

Dr. Dannenhoffer: The third.

Mr. Harris-Shapiro: Yes.

Dr. Dannenhoffer: I think basically everybody lost money in the market, not just our rural market but basically throughout the state. All of the insurers had lost big money, and basically the biggest insurer in the state has had two years of underwriting losses and two years of investment gain so that they've been about break-even. So, yes, the story was big underwriting losses.

Mr. Harris-Shapiro: And even if we met the price, first of all, there was a certain amount of cherry-picking going on, especially if they had the group in-force. They'd let the losers go to us or to the commercial plan. They bid a lot harder on the winners. But even if we met the price, sometimes just because you are the new guy on the block you need to do better than meeting their price. I'm going to take a risk and move my employees, whether it be 2 employees or 200 employees, to this new revolutionary concept.

Mr. Sutton: I have one question. I'll give you an example. One of the clients that I had was a very well-known, large medical group, a separate one from before. They decided to hire a cardiac surgeon, plus the nurses and other doctors that worked with him. Once they got in there we found out that they did about twice as many coronary artery bypass grafts per 1,000 in the population because they wanted to build up that practice, and they even did it on their own prepaid patients, which didn't make a lot of financial sense. But I wonder if you spotted things like that. Did the doctors see physicians who were doing too many hip replacements—too many of this, too many of that—and did they ever try to get them out of their plan, or couldn't they face that?

Dr. Dannenhoffer: Well, we were a small group. It was hard to get people out of the plan. Again, there's cohesiveness; the doctors work together and are together. It is hard to get an individual out. However, we were able to change some practices. For example, there were two physicians who were doing most of the laparoscopies, and they could sort of be shown by their peers that they were doing an awful lot. Did they really need to be doing those on everybody who'd had it? And their point was, "Gee, we hadn't even really thought about this in the past." They came in. We could do it. We did it. And now when they were thinking a little bit more about being prepaid, as the insurer was, they were able to change those things. So, there was a little bit of peer pressure that went on, but it was very hard to get rid of someone like that. For example, in the group with the cardiac surgeon, maybe this is a medical secret that people don't know, but when somebody comes in there's only probably a third of the time where it's really obvious what you're supposed to do and about a third of the time where it's really obvious that you shouldn't do. But it really is up to the salesmanship or up to the coercion or whatever of the physician to know what to do with the middle third. It is truly remarkable to me how much people in their individual discussions with their physician believe and trust in their physician, and if the physicians says, "Really, I think you should have that gallbladder out," how rarely people say, "Well, I read in *Consumer Reports* that if you have a single stone, and I'm under 40 years of age, if I do this and this and this, that my chance of having a recurrence is low; do you really think I need to do it?" It just doesn't happen.

It may be that consumers and patients are not nearly knowledgeable enough and feel it's such a knowledge deficit when they go into the office to actually question that. So, it's pretty clear that that middle third is the place where there is some potential movement of things. For the third that you have to do, you have a big, inflamed gallbladder you have to take out. Everybody's going to agree on those. And, for the people who come in with no symptoms at all, people are going to agree that those don't need to come out. For that middle group—and it's the mysterious thing that happens in the consultation room that really changes things—I'm sure that's why they were at twice the rate of everybody else. That physician was probably good at convincing people that they should have their coronary arteries replaced.

Mr. Harris-Shapiro: On more of a macro-scale, when the fee schedules were ticked back for obvious reasons, utilization went up to compensate, and in this particular case it was one-to-one. I think the Health Care Financing Administration Office of the Actuary did a study, and it came out to be roughly a 30–50% offset. This was a 1-to-1 offset where the fee schedule went down 30%, utilization went up 30%. And the PMPM didn't change at all. I personally felt vindicated and could give an "I-told-you-so," at least to my buddy over here, but it didn't help the bottom line any.