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Session 157PD
What's Happening In The Provider Risk-Taking Market?

Track: Health

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Panelists: WILLIAM J. FOX
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Summary: Panelists discuss new developments related to provider contracting and the impact of these new strategies from the providers' perspective.

MR. STUART D. RACHLIN: Let me first jump on the agenda. I am going to start with an introduction and give you a general overview of the topic of provider contracting strategies. Then we'll switch to Dave. He will talk about the history from the provider perspective. Then Will will jump in from the carrier perspective. And then we'll jump into a couple of case studies.

Let me start by introducing the panel. Dave Terry is a senior consultant in the Atlanta office of Reden & Anders. He has over 20 years of actuarial, operational, and management experience in the managed care industry. He specializes in strategic planning to help managed care organizations determine their organizational structure, rating, underwriting philosophy, and contracting reimbursement strategy. He also works extensively in developing and negotiating contracts. Prior to joining Reden & Anders, David was the chief actuary of a national physician practice management company.

Will Fox is a consulting actuary in the Seattle office of Milliman USA. He joined the firm almost 10 years ago. He specializes in helping health care organizations understand the risks for which they have contracted by developing benchmarks and creating programs for delivering health care to enrollees as cost effectively as possible. Will helps develop provider incentives and fee schedules to encourage the efficient utilization of resources.

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

I'm a consulting actuary in the Tampa office of Milliman USA. I joined the firm in 1998, and I work with the Blues, HMOs, and provider groups to help them with their hot managed care issues. Prior to that I was the chief actuary for a large regional HMO in Cincinnati where I served senior management in a lot of strategic functions, as well as pricing, product development and reserving.

There are two sides to every story, and we're going to try to give you a balanced view of the struggle between the carriers and the providers. Historically they've been at odds over reimbursements, which really comes down to an important struggle for the almighty dollar. It really has been a tug-of-war. Carriers historically have been in control, especially in the commercial marketplace.

The bottom line is, there is only one bag of money, as a clinical consultant friend of mine says. The more the players realize that, the more they can work together and create a situation beneficial to both sides. No matter how much pushing and pulling there is, it's still a fixed amount of money being split up. The carriers need to remain competitive. They're not going to continually raise their rates to meet the needs of the providers. It's just not going to happen. On the other side, the providers need to be able to survive. They need to have a fair reimbursement for their services, so there needs to be that balance. The government is not going to just continually increase the reimbursement levels, either.

Typically the bag of money we're talking about comes from the premium on the commercial side or the government in a Medicaid or Medicare program. Each side wants more, but there are situations that can exist in which everyone wins. The question is, though, what is the proper balance? Can it be achieved?

There have been numerous changes in the last few years regarding reimbursement arrangements. Several government reimbursement changes have had a significant impact on the landscape—diagnosis related groups (DRGs) on the inpatient side a while ago, ambulatory payment classifications (APCs) for outpatient more recently, and the Balanced Budget Act. I'm not going to discuss these changes now, but they have had an impact on what's going on.

In terms of a general overview, there have been changes to the commercial marketplace, which have been driven by a lot of these reimbursement changes. One such change in the commercial marketplace is capitation going down. Is capitation dead? Creative solutions are being attempted to make it a win-win situation. There are new ways of sharing the risk, and that's what we will address today.

The pendulum continues to swing. It had swung to the carrier side. More recently it might have gone to the provider side. The providers have gained some power. The real issue is how to get the pendulum in the middle, creating what we believe is a win-win situation.

What are the reasons for these swings? Doctors got burned in the past and are more cautious now. Were the doctors ignorant in the past? I know of situations where provider groups took capitation contracts and they didn't even know what the scope of services was! They felt that they could manage it, but as most of us now know, they couldn't, which caused a problem. Another problem I see is the lack of appropriate risk adjusters in the reimbursement methodology.

We are seeing some areas in which providers are banding together to get a little more powerful. They may create possible antitrust issues with that provider power, especially in the more rural marketplaces where there's not a lot of competition. So that is the landscape as I see it.

Some questions for us to ponder: Can we create an environment where if that pendulum is in the middle, it's truly a win-win situation? If we do, is everybody going to be better off by it? The providers? The insurance companies? HMOs? Health plans? The employers who have to pay the premiums on the commercial side? And what about the patients? Are they going to be better off if it's a win-win situation and not a continual struggle? Are there new strategies out there? I'll turn it over first to Dave Terry, who will present it from the provider perspective.

MR. DAVID L. TERRY JR.: I've spent the last five to six years dealing strictly with a practice management company, physicians and hospitals, looking from their perspective at what it takes for those types of organizations to move into risk-type arrangements. I bring a different perspective than a lot of people because the majority of us work for the health plan industry. Very few of us focus on the provider. I'm going to try to bring you that perspective.

Where do we think risk arrangements are going in the future? I really think it's important for us to understand what has happened in the past, what has worked, and what hasn't worked, and to see if what has worked in the past can be replicated for the future. I'm going to take a look at the history of the provider risk-taking market so we can get an idea of what we should focus on if we feel it's appropriate to go ahead with provider risk taking.

Why have providers taken risk? There are a lot of different reasons, but in the very beginning a lot of the providers didn't really understand what they were doing. Most of them wanted to protect their market share. They were afraid that if they did not take capitation, the health plans out there would bring other providers into the organizations that would take capitation. So in order to protect their market share they went ahead and took the money and would figure out how to do this after they get the money and figure out how to survive. Most of them have realized that that was not a very good strategy. Looking back at it, I don't think most of them would even realize that that's why they failed.

But the real key is, why would a provider want to take risk? What would be the element that they would like to control, that they would like to manage that in the

end was successful? In addition to protecting their market share, obviously, money is extremely important to physicians and hospitals. They're looking at it from the perspective that if I'm going to get in a risk arrangement, I should make more money. When the whole program's done at the end of the year, I should be better off financially than I would have been if I would have stayed in the fee-for-service program. One of the key drivers was if you're going to take risk, there should be a reward. Obviously there is the probability of loss that's involved with it, but if you don't really feel like there's going to be some probability that you're going to make more through a capitated arrangement, then you might not consider it. One of the other reasons to get in there is obviously market share. The other one is to have some control over their own day-to-day utilization management process or medical management delivery.

From a provider's perspective, in large markets especially, if I am a provider organization taking risk with ten different health plans, I will have ten different utilization management processes, manuals, and procedures that I have to follow. For that individual provider to say I am going to follow all ten of these to the letter is overwhelming. They want to practice one set of medical management processes. They want to follow one set of procedures. For example, let's say that they're prescribing drugs. If I have ten different formularies, I have to recognize that for this health plan I give this drug, for this health plan I give that drug. How do I tell my patients what's right? I tell different patients different things, and it's only because there's a difference in formulary. It's not a difference in procedure for that individual physician. It causes a lot of confusion as to how they really should practice medicine if they do not have a standardized medical management process or utilization management process. This can happen if they are delegated a lot of the utilization management, and there is some flexibility on the payer's perspective to work with them to modify some of those processes.

Another form of standardization is on the reporting side. Again, if this provider group is dealing with ten health plans, they get ten sets of management reports as to how well they're doing. If you go in and look at them, it's hard to make heads or tails of them. When I put all ten of those side-by-side and try to figure out how well that provider's doing, I can't do it because I have one health plan that's rating them as an A+, and I have another health plan that's rating them as a C-. How does that provider understand how well they're doing in the managed care environment when they're being evaluated on different components, and the reports aren't telling them that they're doing anything consistently? By bringing risk into the equation and being able to be delegated for certain functions, they can aggregate all those functions together in order to provide consistency or standardization in the utilization management and reporting process, which is extremely important for them in managing the risks that they're taking.

The bottom line is, if they don't make the money that they could have in the fee-for-service environment, capitation or risk taking is a dead issue in the long run.

They're not going to do it for long. They will do it for a short period of time, but they will not do it forever.

The key critical success factor is for a provider to be in a risk program. Certain elements have to be there in order to assure that in the long run providers are going to stay in the risk program. What worked in the beginning for those providers that understood it was that capitation works best where you have a high premium dollar in a marketplace. They also understood that high premium dollar is predominantly driven by high utilization, but it's in controllable procedures. When a provider group goes in and takes risk, the provider group is going to lower the utilization. It's going to create additional surpluses or margins that can be used for a lot of different functions. It can be used to help increase the provider's fees as a reward for doing well in controlling utilization, or it could be used for reducing premiums to employer groups.

To demonstrate my point, look at Chart 1. Let's split the premium dollar into four categories: administration, professional cost, facility cost, and, if we price the product right, surplus. After risk, the administration is going to probably be close to the same, probably a little bit higher because we're adding another layer or complexity in the administration process. The professional cost depends on where you are in your marketplace. It might go down some, but it's not going to go down dramatically. It might even go up because you might be in a position where you're going to be adding a lot of preventive services that haven't been there before. The cost of those services may outweigh the professional settings in terms of avoiding invasive procedures. Where you typically see the biggest reduction in cost is going to be on the facility side, particularly on the outpatient surgery side, where you're really going to manage those days. You're going to manage the surgeries and try to move things from an invasive inpatient setting to more drug and other type lower-cost facility settings, while still providing a higher quality product.

The idea is to set up risk arrangements with those providers such that when all is said and done, they're adequately capitated for the services that they perform, and they're getting some type of reward for managing the services that aren't directly under their control, but they still influence, such as inpatient days per thousand.

The last three key critical success factors are extremely important: physician willingness, hospital willingness, and payer willingness. There needs to be a win-win situation involved so that when everybody gets down, they all make a little bit out of it. All three parties are equally disgruntled with the program because in this environment, I don't think anybody's ever happy when they're done at the end of the day. We never seem to hit our targets. We all want it all. That's been the problem with capitation. The physicians want it all, the hospital wants it all, and the payer wants it all, and nobody's willing to share. Where capitation has been successful, the three groups have come together, and they've figured out a way to share in that bottom line through the risk arrangement. If one party's not willing to participate, you jeopardize the ability for any party to participate.

MR. WILLIAM J. FOX: Health care is still an insurance risk business. I don't think I'd get any arguments from anyone about that. And yet, for some reason, over the last 10 years we've continued to treat health care as a budgetable expense, where we can carve off certain pieces and treat them as separate stand-alone items. As we carve off risk to providers in terms of capitated payments or other risk measures, we're figuring that they can reduce the unnecessary procedures or reduce the administrative cost and make additional money. But we're forgetting the fact that there's still insurance risk on all the health care costs. They have to be factored in, and they have to be treated as a non-budgetable or insurance risk business.

I think we also have to consider that provider risk-taking is not just capitation. Providers can take risk at all kinds of levels in terms of just case rates or other incentives. Originally we had withholds that would allow the providers to do some risk-sharing and incentive measures to improve their performance. We need to open back up to more than just capitation. How do we get the providers involved and incented to improve the efficiency of health care, but not necessarily take on the insurance risk that they can't really handle?

I want to step back a little bit and talk about the history of the insurance business. From a carrier's standpoint, I think it's important to look at what has happened in the negotiation between insurers and providers to understand where we're at now. We need to understand what risks the providers are willing and able to take and what risks the carriers are willing and able to distribute. As actuaries, I think it's important for us to understand and help guide that decision-making process and make sure that the appropriate risk transfers are taking place with the appropriate infrastructure to support those things.

Originally everything was all billed charges. The providers could bill as much as they wanted year after year after year. They continued to increase what they billed. Originally, before insurance was prevalent, there was still some supply and demand, so the rates were market-based. In the '60s, as everyone became covered with some sort of health insurance, it was purely an indemnity process where nobody actually paid those rates. The insurance companies paid them. The premiums were still low enough then that the physicians and hospitals could bill as much as they wanted. The increases were double digit. Any sound businessperson would increase rates as much as he or she could get away with and make more money. The only controls at all were that the insurance carriers finally put in some reasonable and customary limits to take care of the outliers and those providers that were outside of the norm. The result was steady inflation, and it was much higher than general inflation. We started getting runaway health care costs until finally we got to a point where our physicians' incomes were much higher than in other countries.

I've done some studies and seen some things that show physician incomes in the '30s were about three times the median wages in the U.S., and now they're over

seven times. The hospitals have used their increased money not necessarily in higher salaries and wages for their personnel but in a proliferation in the number of hospitals all across the country, to improve their technology and infrastructure. The billed charge system has created a system in which, historically, we haven't had the cost controls. We've treated the patients with all the resources we can, or to keep something bad from happening, but we haven't really looked at how to be efficient within those resources.

As medical cost inflation got high, the employers got tired of the high premiums, and then the media got involved and had lots of stories on runaway medical inflation and costs. The insurance carriers at that time were broad national plans that really didn't have an ability to manage care efficiently. There were some small HMOs around, but the number of HMOs grew in the '80s in response to these developments. Then PPO networks popped up to be implemented by the large carriers that would allow you to get a smaller subnetwork of physicians and hospitals. Your providers would then accept lower rates. The problem was that in these small networks, the physicians and hospitals that were contracted with became larger in order to increase their market share, and there was really no difference between all providers and what was in these supposedly limited networks.

Originally, the providers could do whatever they wanted. They billed whatever they wanted, and they were well paid. Because the providers were afraid of losing market share, they accepted whatever the carriers were talking about to reduce costs. The carriers began dictating some decrease in rates, and the providers accepted it because they were worried about market share. The pendulum had swung from the providers to the carriers. Over time, though, hospital margins have been eroding. Some of their war chests and capitalizations have decreased. Physician incomes, while they haven't really declined in terms of dollars, their growth rate has flattened. As a response to this, the contracts have become more complicated, getting to a point where the carriers are trying to pass that risk. The hospitals and the physicians want to take the capitation or other risk rather than on fee-for-service, under the assumption that they would get paid more.

Other payment concerns include patient mix issues. With negotiation capitation, all providers feel that they treat the "sickest" and "most expensive" patients, and they need to be paid appropriately. The hospital contracts have become more complicated or detailed in terms of having case rates for certain procedures, per diems for others, catastrophic provisions, and pass-throughs. Supposedly those things would help them get paid more appropriately for the mix of services and patients that they see, but in the end it has created an adjudication process that has gotten so complicated that it takes longer for the providers to get paid. The delay has increased the administrative costs on the carrier's side and also increased the costs on the provider and hospital side because now they need personnel to audit and review the contracts for the adjudication problems.

Carriers are still very afraid to reduce the size of their networks. Their negotiating power is very limited. It seems like the in-vogue negotiation is now just to terminate. Termination letters come by every month, and really the plans have no choice but to negotiate something with these hospitals because they don't have the clout within their community to not have these hospitals in their network. Either that or they pay billed charges. Prompt pay laws are one byproduct of this situation. The legislators got involved to try to help make the carriers toe the line and pay more quickly, but that's still not working out very well. The negotiations have become very contentious between the carriers and the providers. There's one bag of money, but they don't see it. They still feel like they can win by taking more from the carriers.

For a long time the physicians had to accept one flat rate for all services, but more and more, different specialty groups and other physicians were also able to negotiate. Some of the hospital-based physician groups and some surgery groups were able to demand higher conversion factor reimbursement or capitation rates and got what they're looking for. Unfortunately, as these hospitals are dictating negotiations, they really don't know what they're looking for, and that's one problem. They're just trying to increase certain things or add catastrophic provisions that will get more onto a billed-charge basis, but all of this is moving to a situation where we have an inequity in the payments that we make to different hospitals for the exact same services.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction sets, which are the standard coding for electronic claim submission and provider communications, are going to help in going forward with contract negotiations. The carriers are able to set up their contracts in ways that are much more automated. Hopefully they'll be more efficient and will save the physicians administration time, too. A big part of the demand for the physicians to take on the risk and take on more than they can handle is to get rid of the adjudication and administrative hassles.

For so long, supply and demand went out of the health care economy because the consumers were not involved in terms of understanding what they were paying for, and they weren't involved in the payment for the services. Two things are bringing back supply and demand, both having to do with flexible networks. The first is that carriers are setting up tiered coinsurance levels in which certain hospitals will get a 10% coinsurance, while others will get a 20% coinsurance. They can't go to a point where they have a limited network, but they can say that your costs are going to be lower if you go to certain facilities. It's kind of a compromise. But it also allows the hospitals and the carriers to have some negotiating flexibility in terms of whether they want to negotiate at a higher rate but then have their patients pay a high coinsurance. Do they have enough clout within their community to get away with that?

The second thing bringing back supply and demand through flexible networks is defined contribution (DC) models. There are a bunch of different DC models, but the one I really like is the one in which individual consumers or employers are able to choose the providers that are going to be in their network. They'll have a core group of providers at cost. And then if they want to add certain providers that cost more, that's going to increase the cost of their network, but at least they can make that choice and then pay for their individual choices. The big thing that I think is very positive is that it allows resource-based relative value schedules (RBRVS). RBRVS is the perfect mechanism for the underlying fee-for-service reimbursement on the physician side because it allows the physician groups and individual physicians to set their fees at a higher level, but as long as their consumers are willing to pay that higher level, that's okay. The market forces are bringing those back into play to be a part of the health care economy.

We have one bag of money. How do we get fair and equitable incomes and profit margins on each of the services? We need a standard reimbursement so that we can have fair and equitable reimbursement. The RBRVS has really helped everything on the physician side because in having that standard for payment, we evaluate all of our risk contracts and other things on that RBRVS basis. The big problem on the hospital side from the carrier's standpoint is that they've tried to address that by making the contracts more complicated, adding case rates, carve outs, and special catastrophic provisions. But this really isn't making it equitable from one hospital to the next because they aren't properly accounting for the differences in patient case mix and severity at each hospital. I'm seeing more and more attempts to find ways to simplify that contract and adjudication, have standard contracts that can be adjudicated automatically as we get the electronic claim submission, pay more quickly, meet the prompt pay laws, and improve the provider communication and coordination.

MR. RACHLIN: Now we're going to get into a case study on both sides, the provider side and the carrier side.

MR. TERRY: I have an example of a fairly large and successful group of providers in a large metropolitan area that took risk for 10 years, and for eight years they did extremely well, but in two years they did not, which caused their demise. I want to walk through the elements as to why that happened, so we can look at how we might restructure some opportunities going forward. They had commercial members that grew over a six-year period, to over 125,000 commercial members and 60,000-plus Medicare members. In terms of risk agreements, they basically had shared risk, which would mean that all the physicians were in individual practice associations (IPAs) that were capitated for all professional services. There was a shared pool, with a three-way split with the hospitals and the carrier for all institutional and facility services. Pharmacy risk was typically the risk of the carriers. The members that went to the IPAs that were associated with a hospital system that was not capitated were in that shared risk agreement. The other half of the members went to primary care physicians who were associated with a hospital

that also was part of a global capitation arrangement. We're going to focus on what happened in that global capitation arrangement, what happened in the marketplace, and how and why we created profits in the beginning and lost them at the end.

First of all, you have to look at premium increases over that 10-year period because that was one of the more dramatic pieces that happened. In the commercial marketplace in the last part of the '80s there were some fairly significant rate increases going on. Chart 2 is published every year by the Mercer organization, and these are the surveys they do with all their employer groups to show what the average percentage increase is in their overall health care programs. Where the providers got into these programs, there was fairly high revenue. The commercial premiums were high. The Medicare adjusting average per capita cost (AAPCC) were extremely high, driven by high utilization in these marketplaces. The providers went on risk arrangements and basically did their job.

They cut utilization dramatically in both the commercial and Medicare markets. In the beginning these programs they made a lot of money because the amount of savings that were in those institutional pools was huge. The risk-sharing agreements that were in place to either share it or funnel all the savings into these provider organizations created windfall surpluses for the providers. Their fee-for-service equivalencies when they first started, the first four or five years, were huge. The health plans recognized it, and they either froze or had very minimal premium increases. Over a matter of eight years, the fee-for-service equivalencies from the beginning of the program to the end dramatically decreased every year. Their level of fee-for-service equivalency kept going down. Even though they started at a very high level, they never saw it stabilize. It just continued to drop.

The margins that were helping to subsidize and reward the provider community for participating in these programs were dramatically shrinking. The payer willingness was really not there to continue to put some of that margin back into the premium. They took the margins every year and gave them back to the employer groups to increase their market share. Over time that created less and less money to be shared, which created lower and lower fee-for-service equivalency. On the hospital side, especially in the carrier that was 100% capitated, those margins came at such a low level that they could not continue to support staying in the capitation arrangement.

Over the last two or three years of the program, their average per diems dropped from, say, the $1,000 to $1,200 range at the end of '98. The premiums were not keeping up. Fees were going up that were underneath these arrangements. And the hospital had gone down to less than a $775 per diem arrangement. The hospital said it can't live on $775 average per diem in these programs and said it needs an increase. Over a period of 18 months, they tried to negotiate. The negotiations fell through. The contracts were retroactive to the last effective date, which was about

nine months earlier. The hospital's per diem increases went from about $775 to $950 to almost $1250 over a very short time.

The providers left holding the risk, which were the physicians obviously, wound up absorbing the huge increase on the hospital side. You can imagine what that created in terms of the losses that would have been in those facility pools, which had to be absorbed all by the physician side. Their profit margins on a physician pool had eroded as well, and they were basically in a break-even situation on their physician pool. Now they were absorbing huge losses on the institutional pool. Needless to say, it took a very short period of time, less than 18 months, to go from making several million dollars a year to losing $20 million in one year. It just shows that due to the two parties' unwillingness to continue to work through it and to work through it over a period of time, it put the physicians in a position where they were not going to be able to recover and sustain those types of deficits.

The rating differentials between HMOs and PPOs during this period also caused some of the carriers to be unwilling to keep those margins up. In the very beginning, there were relatively few providers that participated in "strong form" managed care HMO programs. Therefore, you had a few willing providers out there who were making dramatic changes in the overall utilization levels in these programs. As these programs became very successful, it was almost their demise because as they had to add more providers, and as the networks became larger, they lost their bite. Improved utilization was not attainable in a large-scale environment. They were attainable when they had very small networks, but as they got bigger, everybody had a tendency to move toward the mean. You also get the residual effect, which is what I call the fact that the providers do not manage differently. I was a true believer in that I thought providers would practice one way for one type of program and a different way for a different type of program in terms of maximizing their reimbursement arrangement. After working with them for over five years, I realize that is not true. Most of the providers hate trying to do any manipulation of that sort. They want to practice one way, and they practice one way only. It's evident in what happened in the marketplace in that the PPO utilization dramatically came down over that same period of time.

You saw PPO utilization in the late '80s, early '90s, probably being three to four times the level of utilization in those early HMO programs. When you get down to it, in the last few years the utilization differences between the PPO programs and the HMO programs is not that dramatically different because you have the physicians that practice in the HMO practicing the same way they do in the PPO. As a result, you're not seeing huge differences in utilization, at least not large enough utilization differences to compensate for the fact that the PPO programs have deductibles and coinsurance, while the HMO programs are basically first-dollar products.

One of the dynamics was that the PPO rates were coming down to be very close to the HMO rates. In some cities, the PPO rates are lower than the HMO rates, and that incented the health plans that were offering HMO rates to continue to try to be

more competitive. They weren't willing to pass along some of those margins and increase their premiums because they couldn't stay competitive with the PPO environment.

We had a lot of different dynamics going on that were really causing these margins to disappear. Without these margins, the incentive to stay in a program where you're going to take risk is removed. Why would you put up with the risk if the greatest amount of your reward is no greater than a fee-for-service equivalency? Why not just be in the fee-for-service business? If there's not going to be the margins for you to play with, then why be in it? A lot of the providers have come to that conclusion. They came to that conclusion not because of analyzing it; they came to the conclusion because they lost a lot of money, and they've bailed out. The successful providers have been the ones that have analyzed the different components of those critical success factors I talked about and were able to manage the differences. On the other side of it, all the partners that have been participating—the hospitals, physicians, and the carriers—recognize that there has to be a balance and that you have to have a long-term strategy. If you're looking at it to survive from one year to the next, that's when you make inappropriate decisions in terms of whether you increase rates, increase caps, or pass along the margin.

What does this means for the future? From a provider perspective, I think there's going to be a strong, continued pressure on managed care companies to continue to relax their utilization programs. I don't see that changing in the near future, which will translate into the fact that the margins are going to disappear in all these HMO programs. The controls are not going to be in place. The utilization is going to go up. I do not know of one health plan that I've seen or worked with that hasn't seen a fairly distinct increase in their utilization pattern in the last 12 to 18 months. I don't think it's an intentional increase on the provider behalf, but there's the lack of pressure. There's the lack of margins, the fact that they're not making their fee-for-service equivalencies. They just say they're not going to work as hard as they have been and, therefore, they take their eye off it a little bit, as we saw. In a very short period of time they can lose a lot of money if they don't have all the management tools in place to manage it.

I still think the hospitals across the country do not want to be in any form of capitation. There are select marketplaces where I think there are integrated delivery systems that are still very much into making an integrated delivery system work. All these comments are not universal in nature. They don't apply to every part of the country because health care is localized. I do think that there are some places where they have a better grip on what's going on, but in other places, a lot of the large hospital systems are looking to take advantage of the situation and increase the rates that they're getting. They really don't care about the impact that that's going to create on the system. They're going to get it now because they recognize there's some reform coming up. They need to build back up their margins, and they're going to do what they need to do.

Trend increases will only keep up with increases in utilization and cost. I don't know if trend increases will even keep up with just those two items in the next couple of years. I think it's going to be difficult for health care companies to pass along the trends that they're seeing in their underlying experience, because I don't think a lot of the employers are going to absorb all of it. If you're going to be capitating or you're going to put providers at risk, there is going to have to be some level of margin because the providers have recognized that if they don't have that ability to make what they're making in the fee-for-service world, they are not going to take risk and take capitation.

I think it's going to be very difficult for risk-taking providers to stay in it in a broad sense. It's going to be very localized. There are still a lot of providers doing very well. There was a recent article from the American Medical Group Association pointing out that there are still pockets of providers that are doing very well under capitation, and they expect them to continue. I believe these are areas where we have that three-party willingness among the carriers, the hospitals, and the physicians to try to continue to work with the employer groups to manage the whole population. Where that has been successful, I believe it will continue, but I do not believe that we will see any new areas really popping up with providers clamoring to jump at any form of risk. I think they're going to be looking to move into the fee-for-service environment until things stabilize.

MR. RACHLIN: Now Will will address it from the carrier perspective.

MR. FOX: There's really a limited appetite out there in the provider community in terms of the level of risk and what they want to accept. As for physicians, I'm seeing a pushback to get to a point where we can ensure equitable payment. With RBRVS, that's really happened. As for hospitals, how do we pay them fairly and equitably for the patient mix and services that are delivered there?

The case study that we're going to focus on is the RBRVS for hospitals, which is a methodology that's been developed by Milliman U.S.A. We've created a detailed relative value unit (RVU) set of schedules for the acute care services, for all hospital services, so we can use conversion factors to evaluate and compare contracts. The DRGs that came out for Medicare in 1983 were a great thing. Some commercial payers tried adopting it. However, there were some problems. For one, it's not totally appropriate for a commercial population. It's also hard to manage within the length of stay and the outliers and other kinds of problems. It's not detailed enough for each patient type. But if you look at RBRVS on the physician side, the key difference is that it was detailed enough that it went down to the micro level of detail and that it paid fairly and appropriately as an RVU for each service delivered. All payers have basically adopted RBRVS as a way to evaluate and pay for physician services.

We can use it now to look at Medicare, Medicaid, HMO, PPO, and indemnity. It takes into account the patient mix differences for any different patient type. By

having a baseline structure like that on the hospital side, we can get down to a detailed and an RVU level and a conversion factor. It allows us to make sure our payments are fair and equitable to all the hospitals. On top of that, we overlay any risk and incentives on their performance measures there. The appetite is down in terms of taking risks, though, but if we can make sure we put a baseline of payment, it's going to improve the willingness of the payers, the willingness of the hospitals, and the willingness of the physicians to work together.

This conversion factor mechanism simplifies the hospital contracting, the evaluation of the contracts, and the implementation and adjudication. Once the rates are loaded up, it's easy to load different populations and hospitals. And it improves the equitability of payments. That's the big thing, having it pay fairly for similar services. The problem in the past was with hospital schedules. They weren't detailed enough to account for patient mix and relative resources required to deliver the care. A flat per diem is not the same from one hospital to the next. There are all kinds of problems with the current hospital contracts. We need to get more detailed. Conversion factors, however, are very easy to compare. The population behind the contract doesn't matter. Assuming that your RVU schedule is detailed enough to take into account the mix of service differences, the claims adjudication is simplified and the contracting is done right.

The two case studies are (1) a mid-sized HMO and (2) a Michigan Medicaid program. The mid-sized HMO wanted to simplify its hospital contracting process. They had a hard time evaluating and comparing all of their network, and even non-network facilities, and understanding how much they were paying them. They're on a percentage of billed. Some are on case rates. Some are on capitation. And so we used RVU schedules to come up with conversion factors for their contracts so that they could compare the different facilities and come up with a network average. By doing that, we could then go back to the hospitals and provide our network average. We're trying to bring everyone together. We have to at least show them their revenue-neutral conversion factor. Let's say we paid you a $1,000 conversion factor last year, and we're proposing a $1,200 factor this year. That's a 20% increase. It should be easy for them to see. We could show out the detailed revenue-neutral calculation on it.

For the first time we could see the differences, but those that are coming down don't want to come down. Those that go up would be happy to go up. You have to start with those that you have to bring down and make sure you can get them negotiated first. We also had a lot of problems with sole community hospitals where they have tons of bargaining leverage, and they don't want to move at all. They're saying, "Here are our rates. Take it or leave it." The one thing that this did for the plan is they were able to go to these sole community facilities and say, "Okay, that's fine, we understand where you're at, and your rates are 40% higher than our network average. We'll accept that rate, but it's going to create a 20% area factor for the employer groups in your community." They'd go back and communicate that

to the employers to start getting some pressure from the employer community to help them finally negotiate with those hospitals

It's also very important for a lot of the hospitals to understand the proposed rates in terms of Medicare. Our conversion factors are shown for Medicare and for what they're being proposed, as well as the network average. We're trying to get to a simplified mechanism. It became very easy for them, as they expanded into other communities, to produce a new quote for that community, a conversion factor, and an RVU schedule. They didn't have to come up with the per diems appropriate for this community. What kinds of services do they deliver? What would the case rates be for this community hospital? What types of services do they deliver? We have a detailed enough schedule. We can use the conversion factor and know that it's equitable and fair within our current payment structure and that it would work within our premium structure. We would know how we price and charge premium in that community. If they demand higher rates, we can accept that as long as we can have area factors in those other communities.

At this point, we have separate conversion factors and schedules for acute care, inpatient services, emergency room services, outpatient surgery, and outpatient diagnostics.

We use a table of DRGs that use RVUs to predict costs. For example, one is DRG 143, chest pain, which has a base RVU of .911 and pays for the first day. With any additional days, another RVU of .387 would apply. Thus, if you had a $2,000 conversion factor, you'd understand there'd be about an $1,800 payment for the initial case and about $800 for additional days. We've done this APR DRGs, AP DRGs, and APR with severity. HCFA DRGs are not homogeneous within it, so there is still some averaging within it. But it does take into account some of the severity impacts by DRG, by making additional payments for longer lengths of stay and by cutting out the need for outliers and catastrophic provisions. If it's detailed enough, it also takes into account any need for pass-throughs. There are a lot of pass-throughs for prosthetic devices and high-cost technologies and drugs. As we refine our RVUs for individual procedures, we take into account those changes in resources necessary to deliver the care.

Let's walk through a financial calculation example, given an example DRG, to understand the process, how the schedules work, and the pros and cons. Let's use DRG XXX: base length of stay, three days, and average length of stay, five days, base RVUs and additional RVUs, 3.8 and .6, conversion factor, 2000. If you had a five-day stay, you'd get the 3.8 RVUs plus two days at the .6 RVUs, getting you to a total of five RVUs times $2,000 to give you a $10,000 allowed charge. That's for the average patient. But that breaks down as you get different facilities and different patient types. Different facilities may get simpler, less complex patients or more complex patients. It doesn't make a fair and equitable payment if you use the other mechanisms.

Let's look at two examples showing a three-day length of stay. The case rate still pays $10,000. The per diem only pays $6,000. On the RVU schedule, we're seeing $7,600. We're saying that there are higher costs in the initial part of the stay as you perform the surgery or the base procedure as somebody gets admitted, and there are lower costs on those additional days. With a flat per diem payment, you're getting a high margin and overpayment for those services on the end part of the stay, but a case rate is not appropriately reflecting the fact the resources are lower as the length of stay decreases. And as the patient goes longer, the case rate still stays flat at $10,000, underpaying for the resources that are necessary to deliver a 10-day stay, but the per diem overpays because it has five more days at $2,000 each, which is usually a lower cost and high margin on those days. The acute RVU schedule comes in the middle. Again, the idea is to show that there's flexibility that'll account for different types of patients and different facilities.

Now let's look at an example of the outpatient surgery schedule. It's very similar to an ambulatory surgical center (ASC) schedule used in Medicare. Eight categories of payment, CPT codes, and procedures mapped into those have expanded to 14 categories because ASCs are not comprehensive. We also had some disagreements in terms of the relative resources, which procedure should go into which level of payment. The goal is to have every procedure mapped into one of the categories, and by using the RVUs, we can go into historical charges and come up with the contract equivalent conversion factor that was paid historically. We can come up with a proposed rate that would account for all surgeries, not just some portion like ASCs, and then the fair and equitable payment as different facilities perform different types of services.

Finally, let's look at an example of the ER schedule. There were 1,513 total cases and an average allowed per case in the emergency room was $257.44. The result shows to the hospital what this schedule would give you, if you had the same mix of services and the same reimbursement. It's not appropriate for all ERs because they get different types of patients. It doesn't provide the appropriate incentive for doing the rapid treatment and observation services. You need a more detailed schedule to pay the hospital appropriately for the types of services they're delivering and then to evaluate and compare what you're paying to one facility and what you're paying to the next.

This particular plan developed incentive programs that overlay on top of it, depending on what the reimbursement was at each hospital. If they're lower, they get a higher proportion of the gain sharing. If they negotiate higher conversion factors, they get a lower proportion of the gain sharing at the back end. Most of the contracts now are just based on their performance, but you have to come to some point. It's kind of like the old withholds on the physician side. If you accept a greater withhold or a lower initial reimbursement, then you should get a higher end of any back-end incentives or performance measures.

The other example I wanted to run through is some work we did for the Michigan Medicaid, where they had come up with DRG case rate RVUs using HCFA DRGs. Based on historical charges, they would just come up with the relative payments for each one. They had conversion factors that varied by hospital that take into account patient mix issues because all the hospitals were saying, "Our patients are sicker, so you have to give us a higher conversion factor." The state was heavily criticized over the years for their development process using the low-volume DRGs. The smoothness of the relative values would change from year to year. They had a hard time keeping up with it.

By implementing this detailed RVU schedule, it reduced their time, effort, and disputes regarding the development. By coming up with revenue-neutral conversion factors for each hospital, we could look at those by region for teaching versus non-teaching, tertiary, and by size of the facility, and start bringing the conversion factors tighter together to make sure the reimbursement is fair and equitable among the different hospitals. They did end up going with an APR DRG schedule, and they wanted to be as detailed as possible so that they'd pay appropriately for each service that's delivered.

MR. RACHLIN: I'll start the questions and answers by following up on a point Will made about limited networks. I am starting to see it too, and my position is that if the providers want that higher reimbursement, fine, we'll give it to you. Network A can be the broad network that has the higher reimbursements, with obviously a higher associated premium. We're also going to build Network B, a subset of Network A, and we're going to negotiate for better rates. If, Mr. Provider, you want to be in it, that's fine, but here's what you have to do to get reimbursed. If you don't want to be in it, that's okay, too. You'll stay in our broad network. In some places I've seen, the employers who want that low-cost option are driving it. Sure, there are cost-sharing differences as well, and you can pass more of the costs onto the members, but if you can also develop a more limited panel and get some stronger discounts, you can have a premium product in that regard, too.

FROM THE FLOOR: I have a question about risk adjusters. Do you think that the doctors are starting to realize that reimbursements need to be risk-adjusted? In the past they may not have understood what that meant. Do you see that changing?

MR. FOX: From my standpoint, the beginning part of this is that we shouldn't be trying to budget out the medical expenses. We're getting a lot better in the risk adjustments, but there's still an insurance risk element that you have to be careful about—what types of things we can't pass on to the providers even if you do risk adjust it. I think risk adjustments are helpful from a performance, measurement, and incentive payment standpoint, but unless we get to the high-volume, low-cost procedures like primary care, we will not have great success.

MR. TERRY: I would agree with that comment, but from a totally different perspective. The providers want risk adjustment. They ask for it all the time. The

problem with the risk adjustment is they don't understand it. I've seen areas where we've tried to do risk adjusters in various types of either the reimbursement arrangements or the reporting elements. It takes a very, very sophisticated provider organization that would actually take what they get and turn it into something that's meaningful. What I find to be much more useful in the provider groups is to give them something that's relatively simple and easy to understand. Then it's more face-to-face working with those providers versus sending them a detailed report that has all sorts of very complicated adjustments to it. You're going to be much better off in dealing with providers to keep it simple and to have more face-to-face contact so that they fully understand the impact of medical management and utilization management.

MR. TIMOTHY D. LEE: Have you seen much backing off of providers or health plans from giving risk to providers that have bonuses and such that are based upon the actual utilization of services coming from a fear of litigation?

MR. TERRY: That started really a couple years ago with the personal injury protection (PIP) program in terms of the health plans becoming very concerned about meeting all the criteria of that program. Of the majority of the bonus programs for services that aren't directly under the control of providers, less than 25% of their bonus is based on any type of financial performance. The majority of their bonus is based on hitting quality criteria.

MR. RONALD BECKER: As the patients' bill of rights is now written, it would only allow you to send the payments to providers that are in accord with current Medicare laws. If the patients' bill of rights were to pass, what changes do you think we'll see in the market?

MR. TERRY: I think it goes along with the previous question. A lot of the real bonuses that will be paid will be structured more around quality issues than around any type of financial arrangement. The key is developing the risk arrangements such that you're going to stay within your pricing guideline. For a provider to have a capitation that's fully self-sustained and that's going to hit the fee-for-service equivalency, it's going to be very difficult without at least having enough margins in it on the back end so that you can reward them for hitting their quality and medical management and other types of utilization performance measures.

MR. FOX: The other thing is that Medicare will allow performance payments as long as you do the patient satisfaction survey. There is a lot of flexibility.

Chart 1

Example Premium Distribution

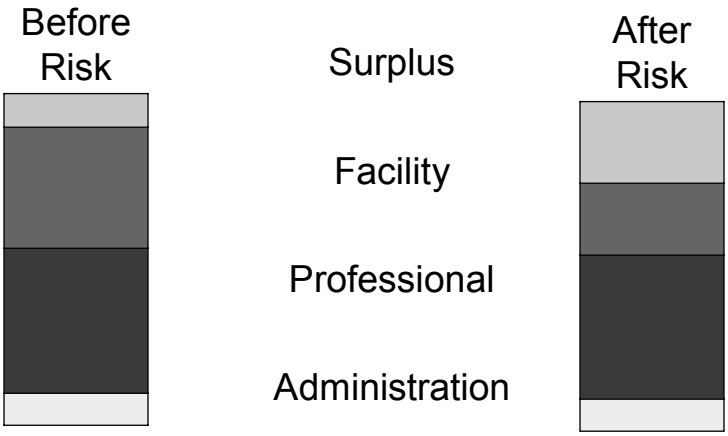
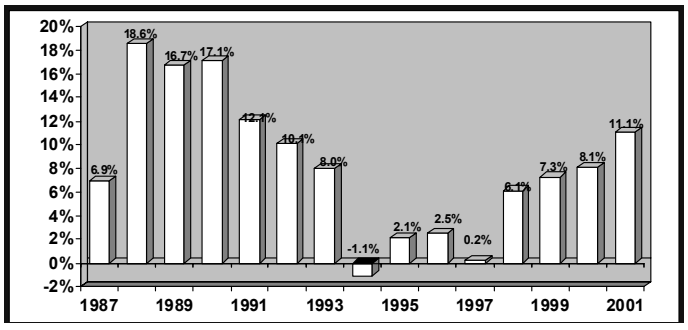


Chart 2

U.S. Employer Health Benefit Cost Increases



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