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Session 59PD
New Paradigms of Provider and Network Management

Track: Health

Moderator: JAY C. RIPPS
Panel: DENNIS J. HULET
THOMAS D. SNOOK
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Summary: Experts discuss new strategies related to provider contracting and network management. Topics include various reimbursement approaches and risk-sharing arrangements, unique risk arrangements for certain provider specialties, unique risk managements for specific diseases, and the role of care management/care coordinators. At the conclusion of this session, participants know about the newest approaches to network contracting and management.

MR. JAY C. RIPPS:. We have a diverse panel for you including both actuaries and non-actuaries, people from the consulting community and people from the other side of the table representing the provider community in network negotiations. My name is Jay Ripps. I'm a consulting actuary from Milliman U.S.A. in San Francisco. We have three panelists: Tom Snook will deal with network issues and paradigms in general; John Ray will talk about hospital networks; and Dennis Hulet will deal primarily with physician networks.

Our first speaker this morning is Tom Snook. Tom is an FSA and principal and consulting actuary in the Phoenix office of Milliman U.S.A. He's been with Milliman since 1988, and his area of expertise is managed health care and health insurance. He's worked extensively in the projection of financial operations for health insurance risk bearers, including health care providers, individual and group

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insurers, HMOs, and self-funded employers. He's advised clients on the pricing and design of insurance programs, provider reimbursement, valuation of liabilities, financial reporting, and insurance mergers and acquisitions. His clients include hospitals, physician groups, HMOs, PPOs, group health insurers, individual health insurers, employee benefit plan sponsors, and governmental entities. Tom has assisted health care providers analyze and develop capitation rates, reimbursement schedules, and provider incentives and risk pools. He's helped provider clients develop specialist capitation rates and global pricing for carve-out products. He's also advised providers in the development of managed care products, risk assumption, joint ventures, and HMO/PPO development. Tom is a graduate of Rice University, where he received a B.A. in French mathematics.

MR. THOMAS D. SNOOK: I'm going to give a broad overview of things my colleagues and I have observed in the day-to-day work we do in provider contracting. I'm specifically going to talk about the pretty big sea change we've seen in the last two years and speculate about what may be coming down the road in the next year or two. I'm going to start off talking about an overview of trends of where we were, and where we are now, just for background, and specifically talk about hospital inpatient, hospital outpatient, and physician reimbursement. Then, as Jay said, John and Dennis are going to talk about each of those two in more detail.

Where were we four years ago? Managed care organizations (MCOs) had the negotiating leverage and were paying providers at very deeply discounted fee levels or actually probably actuarial equivalents, two fee levels, and were implementing some very aggressive efficiency assumptions into those capitation or other bundled-type payment rates. If you did the math on some of the hospital capitation deals, you were looking at hospital per diems that were running about $800 a day, sometimes less — I saw some proposals that weren't accepted for less than that — and the hospitals would accept these deals because even though they couldn't cover their costs at $800 a day, they could cover their marginal costs and a portion of their fixed costs, so under the philosophy of, "We will attract some patients from our competitors down the street" or "We have to do this to stay in business" (kind of a panic mentality), they agreed to these very low per diem deals.

Similarly, physicians were largely capitated on a deeply discounted basis. For global professional services, we were typically seeing capitation rates on the order of $40 per month per member, sometimes less, sometimes more, depending on the market. For a while there, I was doing a lot of work on specialty capitation, where a group of cardiologists, say, or urologists, were going to take capitation for their services. The actuarial equivalent to these capitation rates, if you did the math and you made some reasonable utilization assumptions, were equivalent to less than 100 percent of Medicare. I saw contracts signed for as little as 90 percent of Medicare and offered for as little as 80 percent of Medicare. Medicare used to be the payer of last choice and for a while it was the most preferred payer, because it was paying the most.

That's where we were. Aggressive contracting and health plans were doing this, of course, because they were in steep price competition, trying to gain market share. Their strategy was, "If we can cut our compensation to our providers, then we can offer lower premium rates and compete in the marketplace." So what happened? Well, first of all, the hopes of efficiency that were built in to allow these capitation deals just didn't materialize. Some of the deals where there may have been very aggressive utilization assumptions on a commercial population — 175-180 days per thousand to a provider that may have been running at 220 or 230 — they just didn't happen. They weren't able or weren't willing to get down to that lower utilization rate.

Secondly, the negotiated rate is just not sustainable over the long term. If all of your members are on an $800 per diem and that covers your marginal cost but not all of your fixed costs, then you're going to be in the red and lose money and that's what started to happen. Also, a few years ago we heard a lot of talk about partnership: Health plans and providers were going to be partners in providing care. It was all a bunch of malarkey. The relationship was antagonistic and because the providers were being beat up on price, you can understand it's going to be antagonistic. You try to take money out of my pocket, I'm not going to like you. So the partnership that was supposed to develop never happened. It became purely a financial contract and so the providers started thinking, "We've got to make this work on a financial basis."

A little bit of influence on the Medicare limits on risk-taking on some providers, and the managed care backlash, the push-back that we all are familiar with, made it so that in the court of public opinion, the providers won and the health plans lost.

Where are we now? I would say that some, most, maybe all providers are negotiating tougher and by that I mean negotiating smarter, so they're not signing contracts that won't sustain them over the long term. In the last two years, there has been less market pressure on premium rates. Up until the recession hit, we had a very tight labor market and employers became willing to pay more for health insurance because it would help them attract employees, and there was a market cycle where everybody started raising their rates, and that's still obviously going on.

The popularity of point-of-service (POS) and PPO plans has also meant that the MCOs have had less leverage in negotiation. I work in Phoenix. I saw some statistics recently that in the Phoenix marketplace in 2001, HMO enrollment actually dropped and PPO enrollment increased by almost the exact same number. People are shifting out of HMO to PPOs and in Phoenix, which has traditionally been a very heavily penetrated managed care market, PPO plans are slightly larger than HMO plans.

Hospitals today are mostly per diem or discounted charges. They've gone up a lot and, in some specific cases, they've gone up a whole lot. Physicians tend not to be

capitated (there still is some physician capitation), but they tend not to be capitated back to fee schedules and their investment level is going way up, and the health plans seem to be worrying less about how much they pay their providers and now their focus is on drug cost, which is the big fire to fight.

HOSPITAL INPATIENT

As I mentioned before, the marginal cost basis for reimbursing hospitals was unworkable. It was not working in the medium term or even the short term, let alone in the long term. And as I touched on a minute ago, hospitals enter these contracts largely out of market share fear or panic. We heard a lot of talk about the number of beds in a market having to come down and are you or is your neighbor down the street going to be in the hospital that closes when we're down to 100 inpatient days per thousand on commercial. So the hospitals were afraid, if we don't participate in this contract with XYZ HMO, we're going to be left out in the cold and we're going to have to shut our doors. What happened is, everybody signed those contracts; everybody kept about their same market share and the hospitals realized, "Now I've got this market share, but I'm not making any money on it so I've got to sign a better contract."

Hospitals became unafraid — sometime in the last two or three years — to say no to health plan contracts, to say, "You need me more than I need you and I will not sign this deal because it does not work for me." In particular, some of the big name tertiary hospitals — the hospitals every market's got, the real prestigious level one trauma, transplants, that sort of thing (in Phoenix there are two of them mainly) — those guys really had marketing leverage because everyone wanted them in their network and it was a badge of quality to say that I have St. Joseph's Hospital in my network in Phoenix. They were able to leverage that into some very large reimbursement increases.

So, what are we seeing? It still varies a lot by region. My focus is in regions Texas and to the west (it just kind of works out that way), but I've talked about this with some of my colleagues in the east and they're seeing the same thing. It varies a lot by region. The relationships are still antagonistic, but the hospitals now have the negotiating leverage. Capitation is out. I have not seen a new capitation or a renewed capitation contract for hospital inpatient services in a couple of years. That doesn't mean they don't exist, I just don't see them — with the exception being there are some provider-sponsored health plans where the hospital actually owns the health plan, there may be some cap deals, but other than that I'm not seeing them. Risk pools, by and large, are out. I'm seeing a lot of per diems: med/surg, intensive care unit (ICU), etc., that type of per diem. Some carriers are doing diagnosis-related groups (DRGs). This is really focusing on HMOs, but on the PPO side, I'm seeing per diems or, more commonly, just discount off of billed charges, which means that the health plans that are writing the PPO business are now exposed again to build charge inflation, whereas before they were not.

What used to be $800 per diems for your normal community primary or secondary hospital are now $1,100 and $1,400 and maybe even $1,500 or $1,600 in some markets. And the tertiary centers are getting just med/surg per diems, not counting ICUs, for $1,600 to $2,000 in the cases I've seen. That's quite an increase.

HOSPITAL OUTPATIENT

Hospital outpatient had traditionally been rolled into hospital capitation or, if it wasn't capitated, it was paid on a discount basis. Again, hospital capitation is out; the discount off billed charges still prevails. While I used to see a lot of 50 percent discounts on hospital outpatient, I'm starting to see a lot more 30 percent discounts off billed charges. But the key thing here is that the billed charge, the charge master for outpatient services, seems to be going way, way up and so the inflation on hospital outpatient services is quite high. There was a very interesting session yesterday on developing hospital outpatient fee schedules like a resource-based relative value schedule (RBRVS) type fee schedule for outpatient facility charges, and a few health plans are starting to do that. That seems to be one area where they're looking at controlling exposures to billed charge master increases, but I don't think it's prevalent enough yet to be called a trend.

PHYSICIAN REIMBURSEMENT

Although capitation is largely gone, it does still exist. Specialty capitation is mostly gone, but I do see some primary care physician capitation still going on. It's been replaced by fee schedules tied to RBRVS almost universally. Eighteen to 24 months ago, as I said, we were seeing physician reimbursement as low as 90 percent of Medicare and almost never higher than 100 percent of Medicare. Today, typical physician reimbursement is 100 to 110 percent of Medicare, depending on the market, the contract, and the type of group. Analogous to what we see in the hospitals, where they exist the big name multi-specialty groups are able to command quite a bit more in terms of reimbursement, and so they may be getting 125 to 150 percent for some providers. Also, in some markets, you'll see monopolies emerging. If there's, say, one group of anesthesiologists in a given city, they can set their own rates and 150 percent and above of Medicare is not at all uncommon.

In response to that then we're starting to see (this is true in the hospitals as well)these tiered networks emerge in some markets where instead of trying to manage care and beat up on price, you just put preferred providers in a tight inter-network and build from that.

What does this mean? I don't know, but I would hold that the reason we've seen both the change and the problem is not capitation or risk-sharing. Those aren't the culprits. It's not the structure of the reimbursement, but rather the levels that have driven the change. The providers may have not been happy with capitation, although if you capitated somebody at double the rate you had been capitating them, they may learn to get happy. There's actually a funny story. Health Net in Arizona, which was at the time called Intergroup, made a change a year and a half

ago where they got rid of all their capitation contracts, and a group of physicians in Tucson sued them because they wanted to keep their capitation contract rather than be paid on a fee-for-service basis. That was one group, at least, that had figured out how to survive and thrive under capitation. But my point here is that I don't know that risk-sharing and capitation necessarily have to be dead; they are dormant right now. I hold that capitation is still doable, as long as the rate is adequate and as long as the providers are appropriately capitated for services that they provide. A lot of the capitation deals we saw had physician groups, for example, on financial risk for services that they didn't provide. That was turning them into an insurance company, and it didn't work too well.

WHAT'S NEXT?

As our former President used to say, "It's the economy, stupid." In commercial health care, the employers are the buyers and the health plans are the middleman and the providers are the providers and so the economy — how much money the employees have to spend — is really what drives the whole market. Obviously, higher provider reimbursement equals higher premiums charged to employers, and, as I said earlier, we've seen two years' worth of high rate increases, double-digit rate increases that are continuing on into 2002.

I gave another presentation about six months ago and I said at some point soon, the employers will say enough is enough and fight back against these high rate increases. Well, six months have passed and I'm still seeing high rate increases being proposed and accepted by employers. I'm not sure where the breaking point is, but at some point the market's got to cycle back the other way, and employers are going to cut down on what they're willing to pay. That's why we're seeing a lot of interest in this defined contribution health, consumer-driven health care, whatever that means, and that's going to have an impact on provider reimbursement. Not that I would think that provider reimbursement would go back down, but I just think the upward trend would probably have to stop.

What impact will the Patient Bill of Rights have on provider contracting, if it ever should get passed, and will HMOs turn around from managing care to getting into the same business they accuse the providers of -- practicing defensive medicine? What will that do to premium and then, in turn, what impact will that have on the money available to pay providers? As I mentioned, what impact will defined contribution health have if it gets here? When you have the consumers being exposed to the price of the product, what will that do to price sensitivity in the marketplace, even in a large employer marketplace, and what will that do to plan design and how will all that filter down? If you look at a pie available to pay providers, you start messing with the size of the pie, that's obviously going to have an impact on what we pay providers.

As I mentioned at the beginning, drug trends are high and have everybody's attention. The question is, "How long are they going to continue with these high rates?" All the projections I'm seeing is that they should taper off in 2002. That

affects the divvying up of the pie and the money available to pay providers. What will managed care look like in the near future? We're already seeing a shift from HMO business to PPO. The HMOs are not aggressively managing care like they used to, and the relationships between the health plans and the providers are strictly financial ones and the contracts are being signed on a financially sound basis. What will that look like in the future? I don't know the answer.

MS. SAMANTHA ENGEL: You were talking about the per diems going to $1,000 to $2,000 depending on hospitals, and I've heard a lot about increased use of stop-loss provisions with the per diem. Can you comment on that and how people are dealing with that?

MR. SNOOK: Thank you for pointing that out because I did fail to mention that. Yes, a provision that's common in those contracts is that we'll pay X-dollars per diem and then when some measure of charges, be it billed or something else, gets to a certain trigger point, we'll revert to a percentage of billed charges. That's like a stop-loss mechanism built in for the hospital. It's a big issue with health plans because they're hitting the trigger point a lot more than they thought they would and they, in turn, are having a hard time getting reinsurance for themselves, so there's exposure to risk there for the health plans, on catastrophic cases. For example, if you have a preemie, and you hit the trigger point, it reverts to the percentage of billed charges, but the reinsurance contract may have a per diem built into it and if the percent of billed charges exceeds what your reinsurance per diem is, then you've got an exposure to risk there. That's a big issue in contracts these days.

MR. RIPPS: John, would you like to comment on that question of stop-loss arrangements coupled with per diems?

MR. JOHN WRAY: Stop-loss provisions, I believe, are essential to have in contracts and they're pretty customary to have in there and they're something that's been of growing concern; I hear it every day when we talk to the plans about it. The plans indicate that they want to have greater predictability in their cost structure and that's the mantra that I keep hearing. My response back is that creates unpredictability for the hospital if we don't have that coverage in there. I remind the plans that the plan's responsibility is to underwrite risk; the hospital's responsibility is to provide service. If there is a catastrophic case with an outlier of some sort, that's the plan's responsibility to absorb that risk and not the hospital's.

MR. ROBERT LYNCH: Most of the comments I've heard on provider reimbursement are focused on contracted network providers, where you can obviously have provisions in your contract to control costs. But in the case of non-network providers where you don't have a contract, the only tool you really have is your policy with the covered members to try to control those costs. I'd like to know what you have seen out there in terms of provisions in policies that are being used to try to help control costs due to runaway reimbursement to non-network

providers? Whatever response you can give, I'd just like to keep in mind that there are two contexts for this. One is the obvious financial performance context, but also for POS plans that are being offered under an HMO contract in many states, you have statutory restrictions on how much of your risk can go out of network, and it becomes a major consideration as well, to try to control that cost.

MR. SNOOK: My answer will be from a PPO's perspective. Your point is right that that is a big issue with exposure to 100 percent of billed charges, say, for non-network at a PPO. Now, you're only covering a percentage of that, but still it's stop-loss and all of a sudden you're covering 100 percent of it. One thing that I'm hearing talked about (I don't know how widely it's being used; I don't even think it's legal in all states) is on the non-network stuff, you will define what your usual, customary & reasonable (UCR) charge is, although that's not the phrase that you use, but essentially what you'll pay as being your network provider rate. So, if you've got a fee schedule on your network providers that's 100 percent Medicare, just for illustration, then that becomes your default. This is how much we will pay and if you want to get more, you have to balance bill the member. I don't know that that's legal in all states, but I'm certainly seeing it being talked about and reviewed. It certainly creates a potential for member relationship issues if you've got a member who goes out of network and not only is he having to pay his 30 percent coinsurance, but he's also being balance billed. You have some potential member relationship issues there, but that's the one policy-type provision that comes to mind to control those costs.

MR. WRAY: I guess my experience is the same as Tom reports. Basically, you've got the two different provisions — one is the usual & customary limitations that are built into policies and then you have to decide how you're going to define that in your organization and hopefully stay out of difficulties on a legal front because of how you administer that. There are some plans that seem to have different definitions for different products and that can get you into trouble once the physicians find out that's what you're doing. There seem to be more and more employer plans that are moving to the old fixed per diems and other things for the coverage. So when you're looking at coverage definitions, you're looking at fixed benefits rather than just a fixed percentage of whatever the charges are. That depends on your contract language and, like Tom says, it's a membership issue when they go to the doctor and find out that you're paying such a small portion of the total bill and that the provider is then coming back after them to get the rest of the money. So if there's not good communication of those products, it becomes a very serious membership problem.

MR. FRANK PARTRIDGE: I have both a comment and a question. First the comment is around the stop-loss provision in the hospitals. What we've seen is that hospitals are marking up their charge master by 10 and 20 percent per year and if we don't move the stop-loss thresholds, we'll get many more claims being paid on the stop-loss provision and at really excessive or very high costs per diem compared to the actual per diem provisions of the contract. My question is how

effective fixed benefit plans are, moving away from a low co-pay into a percentage coinsurance or to a fixed benefit plan, in terms of having the members really seek out those providers which are the lower cost providers?

MR. SNOOK: In my opinion the jury's still out, which is a diplomatic way of saying, "I don't know. I think that the other kind of approach that I'm probably more familiar with is these tiered network-type structures where you may have a network within a network within a network and so far so good on those. Those seem to be doing what they were intended to do. I'm also seeing some good luck on (this isn't really what you're asking), but on drug plans — percentage coinsurance seems to be effective at driving consumer behavior. But on choosing where you're going to go for your coronary artery bypass graft, I don't know that it has an impact.

MR. WRAY: My experience is that those arrangements work pretty well in terms of influencing people to stay in network, but it sort of depends on what the procedure is.

FROM THE FLOOR: Following up on Frank's comment on the stop-loss provisions in hospital contracts, what threshold do you typically see in terms of dollars amounts? Two, have they been moving up over time? And, three, what percent of the charges go over? If you look at the total hospital inpatient revenue, what percent would you say go over the stop-loss provision?

MR. SNOOK: I didn't understand — I thought I understood your last question, but now I don't think I did.

FROM THE FLOOR: Depending what dollar threshold you're setting that stop-loss provision at, what percent of the charges across a market basket of admissions would fall under it and how much would fall over it?

MR. RIPPS: John, do you have a view on that, because you've been in the middle of that recently.

MR. WRAY: There are as many variations as you can imagine out there — first dollar; second dollar; accumulated methodologies; billed charges methodologies; multiples of per diems; percent of charges — there's one of everything out there right now. One of the questions you asked was, "Are we seeing the attachment points rising?" In some cases, yes, but there's an economic effect associated with that. So when we see the attachment point rising, that goes into the overall model for both parties. If the parties decide that they want to have fewer cases go through the stop-loss methodology, that means there are going to be fewer dollars on the hospital's revenue side flowing through this, so it needs to be made up some place else.

MR. RIPPS: Our next speaker is John Wray. John is the senior vice president of managed care with Catholic HealthCare West, which is the largest not-for-profit health system in the western United States and the seventh largest health care system in the country, with revenues in 2001 of approximately $4.6 billion. CHW serves communities in California, Arizona, and Nevada through 42 hospitals, ancillary facilities, home care and affiliated physician organizations, and other enterprises that further its health care ministry. John is responsible for providing executive leadership and direction to the development and implementation of CHW's system-wide and local-managed care strategies, managing relationships with third-party payers and supporting quality and cost-management practices for the system. John's health care experience includes serving as legal counsel for Travelers' Health Network, general counsel of Mullikan Medical Enterprises, and senior vice president of managed care for Med Partners. He is a graduate of Indiana University and Indiana University School of Law, where he graduated cum laude and was editor of the law journal. Mr. Wray is a member of the State Bar of California, American Health Lawyers Association, and Health Care Financial Management Association.

DRIVERS OF CURRENT DYNAMICS

MR. WRAY: I thought I'd spend a few minutes talking about how we got here, what are some of the drivers in our current situation, some of the things the hospitals are doing in response to that, some of the things the health plans are doing, and then some of the challenges and trends that we're seeing, and, to the extent possible, make a projection about what I think might be the future for us. Some of these are going to be consistent with what Tom indicated earlier — some of the reasons that we're seeing what we're seeing right now.

There's a chronic history of underfunding and it's hard for anybody to argue that point, especially in this state. There's a growing and well-respected school of thought that part of the reason that the California economy did so well in the 1990s was because the health cost for employers was held down by the low reimbursement required by the providers, both on the physician and on the hospital side, and there's a lot of catch-up that has to take place now. Coupled with that, there's a growing set of costs that is impacting us every day that we do business on the hospitals, and I'm speaking primarily from the hospital perspective.

Cost of labor is growing at a rate that is unprecedented for us. The biggest cost factor for a hospital is labor, and the biggest labor requirement is nursing staff, and we have a nursing shortage in this country, so we are having difficulties even staffing the beds that we have. Oftentimes we're seeing that we don't have difficulties attracting sufficient inpatient business for surgeries, we're having difficulties staffing the beds and providing the level of personnel needed. That's becoming even more acute in this state because we are going to soon have minimum staffing ratios that will increase the level of staffing required. So at a time when we're having difficulty finding sufficient numbers of licensed professionals to

work in our hospitals and we're having to hire very high-cost registry and traveling nurses, the requirements are going to grow.

Technology is impacting this as well. Some of the new stents that are coming on the market right now, the drug-coated stents, are phenomenally expensive. They're well regarded clinically, but they're very expensive and who has more and more cardiac cases done that require stents? Medicare patients. Medicare doesn't pay us anything extra for that, so that's an additional factor that's hitting us on the cost side. You add all these things together and the cost structure for us just keeps growing beyond anything that we can control.

We've had also a number of impacts in terms of what the Medicare and the Medicaid program pay us. The Balanced Budget Act was a huge hit for hospitals and that was one of the biggest drivers, in my opinion, in some of the changes that have occurred in the managed care industry. Medicare in the past covered up a lot of sins for us in making foolish decisions in managed care and buying physician practices and accepting capitation and accepting rates that are below market, because Medicare paid well enough that we could support that. Well, Medicare cut our reimbursement levels a few years ago and it hurt in a big way. Even with some Medicare reform, the level of growth the hospitals are getting is far below what are the cost increases that we're getting. You couple that with what is happening on the Medicaid side, and California is the 49th worst paying state in the country in Medicaid. If you're a disproportionate share provider, those funds are being challenged further, so the government payers, which constitute a majority of the hospital's revenue, are underperforming for us.

Another factor that obscured reality in the past was investment performance, especially for not-for-profit entities, the hospitals. During the heyday of the stock market growth, investment performance was spectacular. It really covered up a lot of the underlying operational difficulties hospitals had. The stock market, as we all know from our 401(k) accounts, isn't doing quite as well as it used to. So we have to look and behave in a manner that we focus on our core operations for our revenue, because we can't count on the stock market to carry us any longer.

We also have enormous capital demands. In the lean years that we've been going through, we've had to defer more and more capital projects and that has reached the point where it is critical that we move ahead with them. The bond market is difficult in terms of debt offerings and so we have to make it up through cash flow. Again, that puts additional pressure on the revenue side of things, on the commercial payers and the like.

Managed care recently had a lot of criticism in terms of losing its effectiveness. The continuing improvement in days per thousand and admission rates and utilization wasn't being experienced any longer, so it was considered to be a failure and the physician organizations were viewed as less important. More and more medical groups and Individual Practice Associations became insolvent, went out of business.

What was missed in that equation was that even though they were not achieving continuing improvements, they were sustaining some pretty impressive levels of performance. When those medical organizations went away and went back to direct contract networks, in many cases what we've seen is that the utilization has gone up. In a lot of respects, we've had to come to the conclusion that while capitation may have made sense in the past, it no longer makes sense for it, and reimbursement methodologies in some of our fee-for-service contracts need to be changed to reflect the higher utilization.

HOW ARE HOSPITALS IMPROVING PERFORMANCE?

Hospitals are doing some things to improve our performance. One is that, as I said, we have moved out of capitation in many markets entirely. My organization used to have capitation in many markets in California. We were moving toward capitation outside of California. We've put a halt to that. We still have capitation in two markets in the state and we evaluate that year to year. In every other market, we've had to exit those arrangements. Where we've remained in capitation, we've only been able to do it by being able to look at the division of financial responsibility and moving risk that really cannot be effectively managed by the hospital back to the plan, which really is the underwriter of the risk. A lot of the euphoria that took place before about providers taking risk, I was guilty of it myself in those days. I wanted to do as much risk as I could take because I thought I could manage it. Well, you can't manage trauma cases out of network. You can't manage those train wrecks that you're going to get that wind up at your competitors, so what we've done is, we have changed the division of financial responsibility where we've remained in capitation to accept risk for only those things that we have a realistic chance of managing effectively.

We've had to refocus on our core business, which is really running hospitals. We still have ownership interests of two or three medical groups in the greater Sacramento marketplace, but other than that, we've exited our physician group ownerships. Then, as Tom indicated, we've pursued pretty aggressive increases annually — every year, without fail, increases in rates. There's a discipline that we have that on the anniversary date, we need an increase.

We also pay a lot of attention, and this is something that I think the hospital industry is looking at as much these days as the rates themselves, to how well the contract is being managed and are payments taking place at the rates and under the terms they're supposed to take place? There's a growing problem that I'm seeing that the plans are using utilization management activities and other claims activities to deny, to downcode, to underpay claims. So I think one of the dynamics that we're seeing emerge even more is a greater risk of litigation between plans and hospitals. Because if claims aren't paid, and they aggregate large sums of money, and if they can't be resolved through the usual means, then they go to the lawyers. We're seeing some organizations that are taking an extremely aggressive posture on that.

Hospitals are moving more and more to terminate poor performing contracts. There's a greater scrutiny being paid to some of the smaller contracts — some of the smaller PPOs that really are just nothing more than repricing indices. Some of the contracts, when we look at them and we go through our cost accounting systems, aren't even covering variable costs and we can't negotiate them to a reasonable level. We're better off letting them go than continuing them. Also, there's a greater focus on individual service lines. Some of the service lines are more profitable than others; everybody knows that. Cardiac surgery is a great line of business if you can get it, but we're paying more attention to those lines of business that may have been underappreciated in the past: services that we provide to the community like trauma, emergency department, and making sure that those are priced in a manner that really reflects the cost.

HEALTH PLAN ACTIVITIES

The health plans are responding, of course. What happened here is that we went through two or three years where provider pushback came and the health plans really didn't expect it; they didn't know how to react to it and the plans have gotten better at dealing with this. They're more effective at responding to this. I hear a lot of things being said in the public about how the providers are really pushing back on plans, and the plans have lost leverage, and the ball is in the provider's court in terms of leverage. I don't buy that. I think the plans still have enormous leverage over the hospitals and it's reflected by some of the earnings reports I see out of Wall Street. Wellpoint, United Health Care, they're doing just fine. Those plans that are struggling right now, if you look at the underlying reasons, tend to be struggling because of some other business decisions they've made through growth or other strategies that turned out not to be the best approach.

The plans have a greater willingness to let contracts terminate. There was a period of time where a plan would just not blink. Now, the plans are starting to not blink more often and contracts are terminating. My organization has seen contracts terminate and they've stayed terminated for years, and that's going to be another trend that we're going to see more often. The gentleman earlier asked the question about how do you deal with non-contract providers in the network? Well, it's something that's going to be more of an issue because we'll see more of that occurring. We talked a little bit about the UM/Claims activities. This is something where it's been a focus by the plans because the unit pricing has been going up so substantially that the opportunity to control cost has been viewed as taking place on the utilization management side. Their efforts to steer patients more by the plans that I'm seeing, take place to lower cost settings including outpatient surgery centers as opposed to hospital centers. The tier network strategy is being experimented with right now.

Another thing that we're seeing from those who are PPOs is the assignment of benefits issue. That was discussed in one of the earlier questions where if a contract isn't in place, the plan will simply do an assignment of benefits to the member; say to the member, "I'm going to pay you and see how you deal with the

hospital." That has a limited shelf life because usually when that occurs it's through an ER encounter, and there are some very substantial public policy questions that arise when a plan puts the member at that kind of financial exposure.

EMERGING CHALLENGES

I'm going to talk about some of the challenges that we may see. I want to preface this by saying that I've done this for a few years and I made some prognoses a few years ago about where we're going to go, and they were all wrong. My track record is really bad so take this with a grain of salt.

We're seeing, as we all know, the tiered network strategy being rolled out by some, not all, and with varying degrees of interest. People are kind of dancing around it right now. Tom gave a very honest answer earlier. None of us really knows what's going to happen. It's something that has the potential for a near term shift of financial exposure from a plan to a member, but if we're really honest about it, for the most part it's just cost shifting. It also has a very limited impact, because how far can you push the envelope on this? How sustainable can it be over time in terms of continuing improvement?

Also, it's important to focus on the fact that the hospital's underlying cost structure isn't improving, it's getting worse, so simply pushing down the revenues isn't going to address the problem. The hospitals are going to have to adapt to this. If we see more tiered networks come out, we will have to go after the revenue under the contracts through more and more creative ways through our contracts. So if you're not going to give us the ambulatory surgery cases any more, fine, you're going to pay more for trauma cases, you're going to pay more for the ICU days when we don't have enough beds in the community to serve it. We haven't adequately addressed our underlying cost structure. Until we get to that issue, we're not going to be able to solve this underlying problem.

Another challenge that's going to impact all of us on the plan side as well is that the government programs aren't paying enough, and if the government programs aren't paying us enough, then we have to be paid by somebody. Considering that a majority of our revenue comes from those government programs, the only place we can come to is the plans.

The question really arises, "How much, how far can we push the envelope with the employers?" I don't know. Everything I'm seeing for 2003 indicates that the increases are north of 20 percent; they're trending that direction. Caliper, the largest purchaser in this state, had to settle for 25 percent even after cutting out two major HMOs in this state. PacifiCare's best bid to Caliper was around 40 percent and this is the biggest purchaser in the biggest state. What does that tell you about what's going to happen with the smaller purchasers?

We're seeing more and more challenges arising out of the enormous costs of maintaining the hospitals due to the seismic issue in this state. It's a multibillion

dollar issue for hospitals in this state. The government is not going to pay for any of it. It's got to be paid for out of the hospital's operating cash flow. The unfunded mandates that are coming down on hospitals just keep coming. Whether it's the nursing staff ratio, whether it's going to be level of service — whatever — they keep coming, and the revenue that comes from our primary payers, which are the government payers, doesn't make up for that. It sounds gloomy, I realize, but that's where I see it. It's coming down to a matter of public policy, because if we can't sustain the continuing revenue increases that are required on the commercial side, if the government isn't going to pay it, we're going to see more and more hospitals close, we're going to see more hospitals limit service. We're going to see smaller hospitals have to sell to their competitors who will take certain beds out of service and will rationalize services. We're going to see more and more acute shortages of services and greater cost increases on the providers because there will be greater consolidation. That's my cheery news for the morning. Let me open it up for questions.

MR. BRIAN SMALL: In Louisiana, we're seeing a lot of boutique cardiac hospitals, and I guess I have mixed feelings. On one hand, maybe the competition is good, it might make some of the providers give on some cost issues. On the other hand, you have some quality issues and perhaps that's just going to add more cost to the entire system and hurt the hospitals. Do you have any comments on that?

MR. WRAY: Two of the markets that my hospitals serve have those heart hospitals in them already. It appears that the strategy of the main company that operates those is to focus on the Medicare line of business. What we've seen is that it hasn't had a whole lot of impact in terms of competition, because the heart hospital tends to require payment levels from the commercial payers that are at or above Medicare. So it hasn't had that much of an impact in terms of the competitive dynamics. It's had more of an impact in terms of shifting Medicare cardiac cases away from the other hospitals, which, in turn, creates pressure on the sector because if we're losing better paying cardiac business, that just creates greater need on the remaining lines of business that we have.

MR. RIPPS: I have a quick question while Audrey is proceeding to the microphone. I heard Tom say that capitation is not the culprit and I heard John say capitation at whatever price level really doesn't work for a lot of different reasons. Do you fundamentally disagree as to whether capitation is appropriate for hospitals?

MR. WRAY: If you paid a hospital in Los Angeles $200 PMPM for a commercial population with limited risk on some of the outside services, it probably works. It's a matter of dollars. I came from a background of capitation because I was at Mullikan and that's what we lived on. It can work in the right environment, but you have to have a very good medical organization managing along with a hospital that's engaged insufficient levels of pricing. Unless you have all three of those things, it's going to fail and fail badly. In my organization, we experienced

situations where our out of network PMPM cost exceeded our PMPM revenue from the plan. You can't make money that way.

MS. AUDREY HALVORSON: My question is related to partnerships. Obviously, Tom said partnerships weren't working with health plans and the various providers, but some of the things that you talked about, John, were things that we're focusing on: managing contracts, getting out of business that isn't profitable. What do you see as an opportunity now if we're doing the same things for the hospitals to work in partnership with health plans?

MR. SNOOK: I think there are real opportunities for partnerships. I know there's a lot of cynicism because there have been some spectacular failures in terms of provider health plan partnership opportunities. Someone in my organization said, "Every time I've ever tried to do a partnership with a health plan it's cost me money." And historically, in most cases, that's been true, but we have situations that are of common interest to both health plans and hospitals.

For example, independent medical staff, how viable can they remain if the doctors are pulling out of markets because they can't afford to buy houses any more; they're just giving up their practices. That's a common problem that we have. The nursing shortage is a common problem that we have. Going after specific market segments and the uninsured, things like that. Those are episodic opportunities. A partnership is probably the wrong word to use. It's really more in the nature of identification of common opportunities that are of common interest to both, where working together, the hospital and the health plan, can invest resources to attack a common problem. If it's done on an episodic basis, it has a real chance for success.

MR. RIPPS: Our third and final speaker is Dennis Hulet. Dennis is an FSA and a principal in the San Francisco office of Reden and Anders. He has over 25 years of actuarial experience and specializes in the area of finance, risk analysis, and strategic problem solving. Dennis has extensive experience with providers, strategic and financial risk consulting to hospitals, medical groups, managed care organizations, Blue Cross/Blue Shield plans, pharmaceutical companies, and hospital supply companies. He also has experience with insurance product pricing, including HMOs, PPOs, point-of-service and indemnity health and dental plans, and long-term care insurance. His work with health issues includes consulting with plan sponsors such as employers and government. Dennis has a B.S. in Mathematics from Brigham Young University. He's a fellow of the Society of Actuaries and member of the American Academy of Actuaries. Prior to joining Reden and Anders, Dennis was a principal with Milliman U.S.A. in Seattle.

PHYSICIAN REIMBURSEMENT AND MANAGEMENT

MR. HULET: My experience with managed care started over 20 years ago at a Society meeting where I heard a representative from PacifiCare explain what they were doing to manage the cost of care so that they could keep premium rates down. At that point I was working for Pacific Mutual and responsible for the group pricing and knew that that was going to be a competitive disadvantage that we had as an indemnity carrier when dealing with health insurance products. So I spent some time thinking about what are the possible solutions for us as an indemnity carrier and concluded that there were two opportunities that we ought to pursue.

One would be to look at hospitals and see if we could work some special arrangement so that we could help control our cost as an insurance company with delivering inpatient care. The other opportunity would be to work with physician groups and try to negotiate favorable prices with them and to somehow be involved in the issue of medical management with those medical groups. I put this down in a memo, gave it to my boss, and he read it, said it would be an interesting idea, but it will never happen.

A few years later, he came into my office all excited because he had just gotten out of a meeting with senior management. A doctor by the name of Ed Zalta was there presenting the idea of this preferred provided organization that he had put together and wanted Pacific Mutual to be one of the test insurance companies to see if the concept would work. As we know, it worked, it spread around the nation, and there's been a lot of activity in trying to identify what are the best ways to contract between the organization that is trying to deliver the benefits to an employer group or other groups and those that are providing the care, the hospitals and the physicians. As we look over a period of time, I've seen a number of things come and go. So I put together a list of those things that came to mind that I think were fads that really hit the market hard, a lot of people jumped into it, but I think we've seen them fade away.

FADING FADS

Owned Physician Groups — There was a period of time when it seemed everybody wanted to jump into one of these arrangements where the hospital buys out the physician group. It seemed to me like that was doomed to failure from the start unless there was some mechanism to measure the productivity of the physicians. Many of them looked at it as an early retirement program. They get a bunch of cash, and yes, they have some obligation to continue to work, but certainly they wouldn't work at the same level as they would if it were all their money going into it.

Capitation — There were many organizations, not just actuaries but other consulting firms and other disciplines, that were encouraging many in the medical community to go into capitation agreements when, if you looked at the statistical basis of the care that was being delivered, you would conclude that capitation was

not the right form of reimbursement. Indeed, you've seen many of those capitation agreements end in failure both for the health plan and for the providers, because providers weren't set up to take that amount of risk.

Discount from Medicare Allowed — That was how many organizations did their contracting early on, and we found that those discounts are disappearing. Generally now the physician groups will say, "We've got to have Medicare plus some percentage."

Practice Management Groups — That was big. I don't know how many are still out there, but certainly there have been some dramatic failures of those companies.

Risk-Sharing — Although this is decreasing, there are some out there, but it's not the buzz term that it used to be. Everybody wanted to be in risk-sharing so they could get those profits. Physicians soon learned that the profit in risk-sharing was not there for them and that they would be better off in some kind of arrangement that didn't require that they take the risk of loss.

External Utilization and Case Management — We've seen that change over time. The kickback that we've had from the managed care industry by the individual patients has helped us realize that maybe the intrusive nature that we saw for many health care plans in their medical management needed to change. There have been some that have changed that paradigm in their own organizations.

NEW COMPONENTS OF THE PARADIGM

Some of the new components of the paradigm are just continuations of things that have been around for years. But there seems to be an increase in the organization of large medical groups, mainly so they have more power when it comes to the negotiations. Some of those are organizations without walls, others are putting up a physical structure and bringing more physicians together.

Fee-for-service is much more common now than we probably would have thought it would be at this point looking at it five years ago. We have to understand that that is a reaction to the feeling physicians have that they're not being paid sufficiently for their services. As I mentioned, Medicare allowed is now the floor, and most organizations want something in excess of that. There are contractual alliances. I think there's going to be more of that going on where you find common interests in the community and then identify a way to make that an alliance that can be strengthened through non-financial activities, but yet has a bearing on your financial arrangements. Physicians do that in many communities around the country.

Gain-sharing has replaced risk-sharing for many physician groups. They want to have the opportunity to gain if they perform well, but they don't like the idea of taking that insurance risk when things go beyond what is expected.

Mechanisms for case management are changing, and the information technology solutions that are being provided for medical groups allow them to do things they weren't able to do years ago. I was meeting with a health plan here in California a couple of weeks ago. They were demonstrating this system that they had put in place so that the physicians in their community could do online referrals. They had not done any special promotion of the system, just told the physicians it was available. They had had it in place for about four months and it already moved up so that over 30 percent of their referrals were being done directly online real time. They had those in their home office sitting there taking referrals in and making decisions and getting the information back to physicians, so that it was a very timely process and not one that required that they shuffle a lot of paper around.

Those kinds of improvements will help physicians do their job better, but it also allows you to measure what's going on much more quickly so you can get an assessment of what your performance looks like.

FORCES OF CHANGE

Some of the forces of change that are causing disgruntlement among the providers are increases in denials, late payments, and payment errors, to name a few. I have an article here that I pulled off the Internet a couple of weeks ago. The Tennessee Medical Association filed a lawsuit against four health insurers that alleged they downcode and bundle procedures and said it hopes the legal action will level the playing field between the physicians and the insurers. They got so concerned about it in Tennessee that the medical association in Tennessee filed a lawsuit against the big carriers.

Depending on which side of the system you work with, you may see that as a good thing. If you're on the providers' side, you see it as a bad thing. The physicians feel they do as good a job as they can in coding their claims. So it's distressing to them when they get the payment back and there's some reduction in what they have submitted because the health plan says they have bundled things inappropriately, or they have used a code that was more intense than the medical information would say it should have been. Those are issues that help feed this frenzy that we see in the physician market of wanting to change the contractual relationship and have an increase in the reimbursement.

Physician compensation, of course, is another issue that feeds into that. In Table 1, you see that most physician categories have not had their compensation keep up with inflation. There are some other specialties that have done better than inflation, but for many of them they're struggling to keep up with inflation. When they went to medical school, they probably did not view that as a problem that they would have to deal with as a physician in the future. So when they look at what's happening to their compensation compared to the cost of living, many get disappointed and therefore they're going to negotiate much harder when it comes to what health plans pay.

Table 1

Physician Reimbursement & Management

Forces of Change – Compensation/Physician

Median Annual Compensation Per Physician by Specialty							
	Calendar Year						5-Yr Change
	1995	1996	1997	1998	1999	2000	
General Practioner/ Family Practice (w/o OB)	$129,148	$ 132,434	$ 136,002	$ 138,277	$ 141,493	$ 145,121	12.4%
General Internal Medicine	$139,320	$ 140,000	$ 139,879	$ 141,147	$ 145,397	$ 149,104	7.0%
Obstetrics/Gynecology	$215,000	$ 217,549	$ 210,000	$ 216,307	$ 219,022	$ 223,207	3.8%
All Primary Care	$133,329	$ 135,217	$ 135,791	$ 139,244	$ 143,970	$ 147,232	10.4%
Emergency Medicine	$176,439	$ 179,997	$ 177,352	$ 176,217	$ 186,663	$ 198,423	12.5%
Surgery (General)	$216,562	$ 223,388	$ 225,173	$ 225,653	$ 236,572	$ 245,541	13.4%
Neurology	$164,295	$ 161,310	$ 160,000	$ 160,601	$ 178,197	$ 175,143	6.6%
Ophthalmology	$209,736	$ 205,500	$ 213,169	$ 213,422	$ 219,743	$ 236,353	12.7%
Orthopedic Surgery	$301,918	$ 310,475	$ 305,000	$ 312,356	$ 319,315	$ 335,646	11.2%
All Specialists	$215,978	$ 221,544	$ 220,476	$ 231,993	$ 245,910	$ 256,494	18.8%
Increase in CPI	152.4	156.9	160.5	163.0	166.6	172.2	13.0%
Sources: "Physician Compensation and Production Survey" published by the MGMA Bureau of Labor Statistics web site							

Regulation is something that is driving many providers wild these days. John mentioned what's happening on the hospital side, but physicians have a lot to deal with as well. They have to deal with all those medical records that they have traditionally just used in whatever manner they felt appropriate and now there are some regulations that they have to comply with. There will be people who are going in and checking to make sure they're complying with those regulations, and some of them will get in big trouble for not setting up the right procedures. There are states that require that physicians have certain procedures in place to minimize the opportunity for fraud and abuse. There are also regulations in some jurisdictions that tell physicians what they can and can't do with allied health professionals. Medical error reporting disclosure is another issue physicians have to deal with.

For a listing of new paradigms, see Table 2. I've listed several here that have come to mind as I have reflected on my experience with physicians and hearing what health plans are dealing with. I believe that there are probably different issues that are primary in different marketplaces. Since we have a good mix of different marketplaces represented in this group, I would like to hear from you if any of these new things seem to be coming into your marketplace and are being requested when you sit down and negotiate for your health plan.
In this crowd, we've got more of the health plans represented than we do the consulting firms. If you would share that along with your questions, I'd be happy to answer questions, but I would like to get some input from the audience given the depth of experience that is represented here, so thank you for your time.

Table 2

Physician Reimbursement & Management

New Paradigm Includes:

- Patient-centered Care
- Informed Patient
- Pay for Quality
- Tiered Reimbursement
- Report Card
- Renewed Influence
- Risk-adjusted Payment

MR. RIPPS: Are there questions or comments for the panel?

MR. PARTRIDGE: I have a question for Dennis about physician capitation. I know it seems to be a dying breed, but if we were to take away some of the high-risk services from the physician groups, such as chemotherapy and that type of thing, how much does that help the medical group stay with capitation?

MR. HULET: I don't know how much it helps them from an acceptance standpoint, but from a risk standpoint that helps a great deal. If you can deal in your capitation contracts with those services that are high frequency and relatively low cost per service, then the dynamic is much more something that physicians can manage and control than when you build in those things that are infrequent and very high cost. The difficulty with many of the capitation agreements is you put the risk that an insurance company was organized to manage on somebody that didn't know how to manage it and didn't have the financial resources to manage it, and unless they were lucky they had financial failure result from accepting those capitation agreements.

MR. LYNCH: John made the comment that with the increasing terminations of contracts, he sees out-of-network costs as a growing concern in control of those costs. Then Tom commented on possible legal limitations in regards to the policy provisions. I would ask you to either agree or disagree and qualify however you want with the statement: Should managed care organizations and the managed care industry through its trade organizations such as the accountable health plan

going forward pay more attention on the government relations side to keeping those policy provisions options open for controlling those costs than is currently being done?

MR. HULET: There are two issues that we need to think about as we try to deal with that question. The first is that the Medicare and Medicaid programs represent such a large portion of the dollars that are spent on health care, whatever the government decides to do on those two programs will dictate a lot of what happens elsewhere. They have certainly done things to restrict benefits and so forth in those programs and therefore it has an impact on how the marketplace views some of the benefits. If they become comprehensive on Medicare, like including the drugs, then it will open the door for some of the other carriers to look at expansion of benefits, although most benefits are already covered by those programs. The dollars that come from the government to health care providers will impact how the health care providers are willing to negotiate with those outside. As John was saying, the make-up dollars they have to have from the private market are affected by what they're getting from the government market, and as the government cuts back, you've got a problem.

The other issue that we have to think about is that the politicians don't necessarily understand what the cost implications are when they make a decision about a benefit restriction or limitation. So I think the industry has to do a better job of being sure that they understand what the cost is to society when they do something that's politically good for them and their constituency in putting in those limitations or defining such benefits. The impact that Medicare and Medicaid will have on things and the fact that the political environment is not necessarily savvy about the cost of things has to be considered when we look at the future and what will happen, and I can't tell you what will happen. It's just that we have to keep an eye on those things, as they will dictate a lot.

MR. SNOOK: To clarify what I meant when I said there may be some legal issues on that out-of-network reimbursement issue: If you're selling a PPO product and you're marketing it as a comprehensive major medical product, but, in fact, your out-of-network reimbursement is limited to allow charges that are defined as your in-network reimbursement rate, then that could be construed as not a comprehensive major medical product, but instead what we used to call a fixed-income-type product like a hospital income or med/surg fixed benefit. If the policy doesn't appropriately disclose that, you can have some charges of misleading marketing in your policy form or in your marketing materials. Another thing that I'm starting to see, I won't call it a trend, but I've talked about it seriously with one client and another client has talked about it generally, is interest in group med/surg policies and group hospital income policies and things like that. There's the old saying, "Everything old is new again," and in the context of controlling costs and keeping premium rates down, I'm starting to see conversation about those types of plans again.

MR. WRAY: I think some of the tricky questions are going to arise in emergency room encounters and for high-level tertiary coronary level services. When there are coverage questions relating to those, that creates a public policy issue where if a plan decides that it wants to only pay UCR for emergency room encounters that are out of network, people in the state legislature and in the governor's office are going to start paying a whole lot of attention to that.

FROM THE FLOOR: We're an ERISA plan and we focused recently on more of the consumer end of things and informing our patients in regards to what Dennis was trying to find out. We have a coinsurance structure set up for professional and facility services. One of the things, though, that I haven't heard anybody address so much is a corridor-type plan, which is something that we're starting to explore. We'd cover 100 percent for the first $1,000 annually, and then have a corridor where the participant would be responsible for any claims incurred at that point, and then at $5,000 we'd go to 80/20. Is that something that you've seen implemented elsewhere?

MR. HULET: I have heard of that kind of a structure; I have not seen it in the marketplace, so I don't know how successful it's been with the employers or how popular with the covered lives. But certainly anything you can do to help the patient understand what the costs of care are can go a long way to helping them reconsider when and if they go to see the physician or go to the hospital.

MR. SNOOK: Like I said, everything old is new again. Eighteen, 20 years ago when I started my career, corridor plans were just something else we had to price and we were used to doing it. This is the first though that I've heard about them reemerging that makes sense.

MR. WRAY: I'm too young to remember them, but one thing I would encourage all the actuaries in the room to remember, too, is that for any kind of benefit plan where there's going to be more member responsibility, bear in mind that the hospitals, and the physicians to a lesser extent, are going to view those as having a significant impact on their bad-debt exposure. You may value the collectibility of that at 100 percent or something close to it, but the hospitals will use a much bigger bad-debt factor.

FROM THE FLOOR: This question evolved almost like health care did, so I have a bunch of arrows pointing to different premises I want to make before I hit somebody with the question. The first premise is we all know that health care costs have been rising exponentially and that's probably true for the last 30 years, the 30 years that I've been in the game, 20 as an actuary. And we know philosophically that the cost of something that rises exponentially will eventually consume all available resources, so we clearly have a problem with health care. We're talking about PPOs again and frankly it's a 65 or so year cycle because the first group of health plans were essentially PPOs. I guess my question is really to Tom. As an actuary and as an attorney, he would be able to probably answer this best. Would

you share your inner thoughts as best you can about what kind of involvement you'd like to see in terms of — if anything — federal and state government involvement in this, aside from what we all would like to see, which is an increase in Medicare and Medicaid payments? But broader than that, and I think this is a very loaded question, because if it goes in a certain direction, we could see the end of private sector health insurance.

MR. WRAY: Yes, that's really the key question there. The easiest answer is tell the government to pay us more, but with the budgets looking like they are, that's not going to happen any time soon. The risk of single payer is very real and it's interesting, one of the health care associations in California recently had one of those pathfinder, or whatever they call it, one of those computer things where people vote on an anonymous basis, and out of hospital executives, a very significant percentage of them voted in favor of a single payer system. Now, that says volumes to me because I don't think they realized what they were asking for, but if supposedly educated people in this industry are suggesting that as a good idea, then that says a lot. It's something that we need to be prepared for. It's hard to imagine it coming in the Bush administration, but if the crises continue to go as they are, who knows what we might see.

MS. JODIE HANSEN: Two of you mentioned that there is a problem with insurers downcoding claims. Coming from the health plan side, we also see a problem with some providers upcoding and that's why we downcode. I think the purpose of the programs that insurance companies have to go through to make sure that claims are being billed appropriately, which sometimes appears to result in downcoding to the providers, is actually to get people to bill appropriately and not upcode. When you've got two providers in a marketplace, one of whom is upcoding and one of whom is not, it hurts the people who are not just as much as it hurts the insurance company. I'm wondering if you have some suggestions for some reliable kind of unbiased resources other than just the definition of the CPT code or the definition of the coding systems for checking for upcoding to help the insurance plans make sure that they're not inappropriately downcoding.

MR. WRAY: We can spend the next three hours on this subject. In terms of the coding itself, one of the easiest things to do is just use the Medicare guidelines and that's where hospitals already utilize that. There are more denials and in saying from a medical necessity standpoint that patients should have been in retrospect in a med/surg bed instead of an ICU bed, therefore, we're not going to pay the ICU rate. Those are much, much greater issues, I believe, than just the coding itself.

MR. HULET: There are a number of companies out there that make their business to sell people on their upcoding or downcoding capabilities, so I'm not sure that there's a single answer out there. I think that you need to try to strengthen your relationships and try to get along and let them know what you need from them and hopefully they'll provide it. The online capabilities may give us what we need down the road to improve that so that it is more timely and therefore any questions get

resolved at the time of service or before, rather than after the fact when they're counting on a payment.