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Session 30PD
Provider Contracting Issues and Trends

Track: Health

Moderator: Thomas D. Snook

Panelists: Frederick L. Davis
John M. Limm
Susan Elizabeth Pantely

Summary: Panelists discuss current issues impacting health plan contracting with institutional and professional providers. How has negotiating leverage been changing at the hospital and physician level? How can actuaries be engaged in the provider contracting process? Attendees gain an understanding of various market pressures that may be affecting their own companies' situations and how they can add value to the contracting process through proactive analyses.

MR. THOMAS D. SNOOK: We have an esteemed and expert panel for our topic. Susan Pantely is with Milliman. She's a consulting actuary. Her client base includes both health plans and provider groups. John Limm is Director of Health Care Economics with Premera Blue Cross. Premera's coverage area includes Alaska, Washington, Oregon and now Arizona. Frederick Davis is a director with UnitedHealth Group. Prior to joining United in 2002, he spent 10 years in consulting—working with payers, providers, and regulators in provider negotiations, contracting and reimbursement strategies.

The three panelists will take turns talking about certain emerging issues and trends. Having set the stage by talking about these emerging issues, we will discuss the practicality (where the rubber meets the road) first in hospital contracting and then in physician contracting. We will look at it both from the payer's perspective and from the provider's perspective.

At the end, we'll talk about the actuary's role in provider contracting and where we, as a profession, can and do add value. We've identified six emerging issues and trends. Ms. Pantely is going to lead the discussion on hospital charge masters first.

MS. SUSAN ELIZABETH PANTELY: The hospital charge master is something that, until recently, we thought we didn't have to focus on anymore. When we started giving discounts on charges, there was a problem. The hospital could have a 15 percent increase, and our discount would disappear. We started limiting the increases. Eventually, we moved to payment per diem and diagnosis-related groups (DRGs). However, even with these mechanisms in place, there are claims that we pay at the charge master: outlier claims, out-of-network claims, (obviously) the uninsured population and the Medicare outlier. That's come into focus recently because of the way the contracts typically deal with the charge master. When they revert to it, they assume that there's going to be some consistency with cost, in that the charge master is keeping pace at the same rate that costs are going up. However, there has not been a typical increase in the past few years; 25 to 30 percent on the charge master would not have been unusual. This is more than medical care inflation. It's more than costs are going up. It's more than premiums are going up.

In their defense, hospitals cite that labor costs are increasing, equipment costs are increasing and many hospitals are losing money. However, recently there has been resistance to this. About 10 years ago, the cost-to-charge relationship was about 160 percent. Last year, charges-to-costs ratios were over 200 percent. In some of the higher-cost regions (like Florida and California), it could even top 300 percent. So the ratio has been expanding. Even when we revert to these, it's starting to become a problem. There are many states that have started to introduce legislation that would make these charges public, so that people would know exactly what they're charging. The hospitals don't like this. They feel that consumers wouldn't understand this. They also think that nobody pays charges, so why should they publish them? They probably are going to lose both arguments.

Consumers probably are smarter than hospitals give them credit for. Nobody pays sticker price on a car either, but we all realize that when we go shopping for a car. When costs become public, there will be pressure to enforce a rational process in the cost-to-charge ratios. I don't think that it will start a bidding war with the hospitals. That's not the way hospitals work, and that's not the way health care works. But I think that it will drive a more rational process, as consumers see it. A lot of this is going to be forced by the emerging tiered networks. Also, consumers moving to the high-deductible plans are going to be more aware of what hospitals are charging. Hospitals are going to have to justify their costs versus quality to be able to charge higher prices.

MR. FREDERICK L. DAVIS: More than 60 percent of employers now are considering, within the next two years, changing over to some form of a health-care savings account with a high-deductible plan. Employers who decide not to go

that way may significantly change their existing PPO/HMO point-of-service products with higher deductibles, coinsurances and co-pays. These things are going to provide more transparency in costs to the individual consumer. Besides directly impacting utilization, it will end up increasing awareness and pressure to obtain more information.

When you start combining that with the Internet and information regarding quality and outcomes and management, the consumer will be in a position to make choices. If the individual is going to choose between two facilities or two physicians that are providing the same service, he or she will have the ability to look at costs and outcomes in making decisions. Through all of these things, utilization increases will be mitigated a bit down the road. In some services, there actually may be a decline. In some places, supply will outstrip demand. The dynamics regarding all of this portend change in the landscape of contracting between payer and provider.

Other aspects available are to have different deductibles, co-payments or coinsurance, depending on the underlying cost to the health plan. If you have two hospitals, and one costs significantly more than another, then the benefit design will have a higher cost to the individual consumer. Now that the individual consumer is more likely to be aware of the true cost of the care that they're selecting, there may be more price sensitivity. Without having to reduce the network size, there may be a natural process of channeling certain services to certain provider groups.

MR. LIMM: With respect to new technology, most of you are familiar with drug-eluding stents, ceramic hips, artificial spinal disks, etc. Another technology out on the horizon is wafer chemotherapy implants. They are sort of like nicotine patches, but they'll be stuck inside the body. New technology also includes advances in surgical equipment. With that, you see less invasive procedures. We're beginning to see services shifting out of the hospital setting into ambulatory surgical centers (ASCs) and so forth. You're also seeing an increasing number of patients who normally would not have these types of procedures. The procedures are less risky.

We're seeing direct marketing of new medical devices to consumers. With ceramic hips, we saw a lot of direct advertisements to consumers. They're bypassing physicians. It's interesting. It's what drug companies were doing 10 to 15 years ago. Today, you've got the Food and Drug Administration (FDA) regulating pharmacy advertisements, but no one is really regulating these medical device advertisements. At the same time, the manufacturers of these medical devices are developing relationships with surgeons who are in medical school or in their residencies and getting them to use the equipment very early in their career.

MS. PANTELY: I'd like to cover payment-per-performance, which is really starting to gain some momentum. First, I'd like to address the question of why this is coming to the forefront now. There are a few reasons. It started with the Institute of Medicine's two reports. The first one was "To Err Is Human: Building a Safer

Health System," and the second one was "Crossing the Quality Chasm: A New Health System for the 21st Century." I would encourage you to read those. Also, The Leapfrog Group started quality initiatives and solicited the voluntary aid of hospitals to initiate that. Leapfrog focused on safety. Some of the pay-per-performance plans are looking at different outcome levels. Leapfrog was looking for four things, primarily. They wanted items that had an overwhelming evidence base. They wanted things that could be implemented fairly quickly in a feasible schedule. They wanted something that consumers could readily appreciate and something that would be apparent to consumers and health plans.

Leapfrog came up with three indicators. The first one was computer entry for prescriptions. They claimed that this could reduce errors in prescriptions by more than 50 percent. The second one was using evidence-based hospital referrals. They claimed that this could reduce the risk of dying by more than 30 percent. Finally, they considered intensive care unit (ICU) staffing. They claimed that by putting critical-care-credentialed physicians in the ICU, a hospital could reduce death in the ICU by more than 10 percent. There has been controversy over some of these numbers, but that's what they were focusing on. There are several programs out there right now. Most of them focus either on the physicians or the hospitals. Most people feel that you're going to have to combine the two to make the biggest bang for the buck on these initiatives. However, with Stark Law and the anti-kickback laws, a lot of organizations are afraid to combine the two just yet. On the physician side, it does not seem to be that intuitive when you look at the way we've been paying.

In the fee-for-service world, we rewarded time and activity. The system penalized initiatives that would reduce the intensity or length of health care. Then we moved to capitation, which rewarded efficiency but didn't reward for innovation or systems requiring additional revenue. We also had the staff model, which used salary. This really made it stable but did nothing for over- or under-utilization. On a salary, providers became sort of bureaucratic, which discouraged innovation. Current providers don't get rewarded on quality. The report cards typically come from health plans and are not published. The report cards that *are* published are typically on the health plan and not individual providers. That's what consumers see. Usually, health plans issue report cards on physician groups. Even if they are published, it is somewhat confusing to the public when you have two different reports.

One of the pay-per-performance physician groups is in California and includes Aetna, Blue Cross/Blue Shield, Cigna, Heath Net and PacifiCare. They have a common set of performance measures for the physician groups. The financial incentives are based on that. They don't have to have the same financial incentives, but they're going to be based 50 percent on clinical protocols, 40 percent on patient satisfaction and 10 percent on IT infrastructure. One of the bigger hospital initiatives right now is a Center for Medicaid and Medicare Services (CMS) demonstration project. The premier hospital quality incentive demonstration is

going to provide financial rewards to hospitals that show high quality based on 35 measures. They're going to look at pneumonia, hip and knee replacements, coronary artery bypass grafts (CABGs), heart attacks, etc. They will consider outcomes and different evidence-based medicine. The top 10 percent will get a 2 percent bonus. The next 10 percent will get a 1 percent bonus. That's going to total about $7 million a year paid out in bonuses.

This is a three-year demonstration project. The third-year hospitals that don't meet a minimum benchmark actually will be penalized. There is another CMS demonstration project in New Jersey that combines both hospital and physician groups. The physicians actually can make up to a 25 percent bonus in these. CMS has been less enthusiastic about this program than they have been about the premier. Obviously, it's going to be budget-neutral to CMS. They're going to get their bonus from savings from the hospital. There have been some other pay-per-performance initiatives that are nonfinancial. I'm not sure how well those are going to work. Usually, you need to combine financial rewards. Perhaps physicians that provide high quality standards will have less preoperative administration, so they'll be given more latitude in their decision-making. However, the effect on that has yet to be seen.

MR. LIMM: Earlier, I talked about new technology. It is one of the primary drivers of shifting services out of hospitals. Another driver is that it's easier and cheaper either to buy the equipment or lease it. What's interesting is that there are several Web sites that you can go to as a physician. If you want to lease a cardiac catheterization laboratory, you plug in your parameters. It will tell you how much revenue you can generate by leasing the catheterization laboratory. They are marketing this to physicians.

Aside from outpatient surgeries moving to ASCs, we're also seeing a lot of cancer-treatment centers starting up. We're seeing pain management centers (which is a bit unusual) and sleep studies. These three things are starting up in Washington and Arizona. What's disturbing is that they come to us and ask for the same level of reimbursement that we pay hospitals. Obviously, there's a different cost structure, so that's a bit of a problem.

There are other issues regarding services shifting out of hospitals. One is that there is increased utilization. Particularly with ASCs, we're seeing a lot more outpatient surgeries than in the past. In some markets, hospitals are telling us that their outpatient revenue has dropped. They need to increase their inpatient revenue.

MR. DAVIS: There have been recent publications regarding a large consortium of employers, representing about 4 million uninsured members. They are large employers that have employees who might not work full-time. They're looking for a way to provide affordable access to health care for these individuals. One doesn't know exactly in what direction they're going to end up going. However, if you have consortiums like this that are interested in gaining access to health care on behalf

of their employees, there's a lot of potential for increased health-care usage. If these organizations go directly to the market to contract with the providers, their constraints are different than the payers' constraints. If they happen to be in a particular geographic region, they can examine data that's particular to their market. They might not care about the national hospital systems. They might not have to worry about a backlash in contracting in other parts of the country if they're located in only a couple of different geographic regions. Their constraints in contracting may be significantly different than the payers. Once something of that nature becomes evident, the payers might take advantage of that opportunity to take the best of whatever gets negotiated in terms or conditions. Right now, you have a possibility of a third entrant into this marketplace that could influence how an organization would go about negotiating with providers.

MR. SNOOK: Before we move on to the specifics of hospital contracting, I had a point of clarification on something that Ms. Pantely said. In the California model, for which the various health plans had gotten together, can you talk about what their motivation was for doing that and if they think they've been successful? In particular, are the bonuses large enough to change hospital behavior?

MS. PANTELY: Since each health plan can decide what the bonus is and how it's contributed, at this point it's hard to tell if the bonuses have been successful because there's so much variation. The Integrated Health Care Association was the impetus behind this. It is a leadership group of California health plans. It has physician groups, health-care systems, academics, pharmaceutical representatives, purchasers and consumers. They were committed to public dialogue on what was going on in the market. It was one of their key initiatives to tie performance to financial incentives. That's where the idea came from.

That is one of the big unknowns that you have to think about when you're implementing this project. How much of a financial incentive is going to be necessary to drive behavior, particularly when physicians don't contract with only one health plan? That bonus may be only a part of his income, because he works with other health plans that aren't paying this bonus. So it gets diluted. In the California program, there were several health plans that were of larger magnitude. Those represented a bigger percentage of physician income.

MR. SNOOK: We want to look at hospital contracting from both the health plan's perspective and the hospital's perspective. Mr. Davis will start by talking about the payers.

MR. DAVIS: Before anybody contracts, you have to know what your philosophy is, from a company perspective. You have to have a guiding set of rules or terms so that you have consistency, especially if you're in multiple markets. What is your company's philosophy regarding provider risk sharing or capitation? What about the potential of having more than one size of network? How do you cope if you have a difficult negotiation session with a major, well-known facility? Is it your philosophy

that you're going to contract with them in any circumstance? Would you consider not having that entity as part of the network? Your objectives and standards must be clearly stated.

When you move to the next level in contracting strategy, what do you need to know? What are the cost targets that you have to hit in a particular market? You need to know where you are currently. You need to know your target. You need to know the exposures on a market basis and at an individual-facility level. Starting with a significant amount of information regarding each of your negotiations is important. You probably have to tie the negotiations across many facilities within a marketplace.

Another aspect that's going to develop is consumerism. If more information is going to be made available to consumers regarding cost and outcomes, it's going to be more difficult. I think that the onus is going to be on the provider. They will have to explain why they should get more money than alternatives in their market if their outcomes are not materially different. Another aspect that one has to consider is the contracting type. You have niche facilities. You have capitations or centers of excellence. You have per diems, DRG case rates and fee-for-service.

How do you go about handling outliers? You have to have a strategy. Obviously, you have to have a total-cost perspective. Depending on the program or options that you get with respect to your negotiation strategy, you may have more or less leniency. You can't necessarily go in with just one model. You may have to come up with three or four different options.

You're going to have to take into consideration a lot of extraneous issues in your negotiations. Administration is one. A second one is employer relations and marketing. Perhaps you've made guarantees regarding discounts to employers. Employers may want certain metrics measured in terms of medical management. There are going to be many other considerations that must go into how you design and what you end up doing in provider contracting. The market needs for stop-loss, on top of that, are interesting with this phenomenon of reverting back to first dollar on a fee-for-service basis for large outlier claims.

The traditional thoughts about leveraged trend for stop-loss may not be appropriate in this middle-cost arena—perhaps from $75,000 to $150,000, depending on the marketplace—to the extent that you have a lot of previously per-diem payment arrangements that now go to fee-for-service. Your stop-loss experience might have accelerated trends in that marketplace. To the extent that you have a large ASO population to which you provide some sort of stop-loss product, you have to consider those needs in the terms that you negotiate in a contract.

MS. PANTELY: Additionally, there are two things from the payer's perspective. Even if you're not going to use a pay-per-performance model, quality issues have to come into play in any conversation with hospitals in today's environment. Any of

us who have been to a hospital realize that there are inefficiencies, as simple as getting test results on time. It has to be discussed. Some payers are trying to limit new technology or procedures that are getting a lot of attention (like gastric bypass for obesity, which has been getting a lot of prominence, press and requests). Some payers are trying to limit this to develop a center of excellence. If a patient wants these procedures, he or she can only go to one hospital, because it can give better control on utilization. You can't have everybody's doctors saying that their patients need this procedure. You have tighter controls on that.

MR. LIMM: With respect to the charge master, as a company, we have tried to add charge master control language into a percentage of charge contracts. It has been successful at getting hospitals to tell us what their increases have been. However, from a monitoring perspective, it's a bit difficult, because most claim systems do not keep charge master service line items. That's another struggle we're facing.

MR. DAVIS: Certainly, information these days is the key to collecting data both at a market level and at an individual-hospital level. Going into any negotiations, you have to be able to figure out what the break points are and how you go about dealing with situations in which the negotiations are not necessarily going well. There might be a wider range of alternatives to the traditional outlier approach. For example, do you measure outliers in dollars or do you measure them in terms of inpatient days, which can't be upcoded? Do you somehow come back to higher per-diem payments in exchange for not having outliers? Do you move to centers of excellence that reduce the potential exposure that you have to outliers? Do you provide a flat dollar amount in lieu of an outlier provision?

You could have a reinsurance provision that says that you'll pay "x" dollars on top of your normal charge, in exchange for not having any exposure. You would have a flat per-diem rate up to a certain point. After that, you might increase the per diem, which would take care of that large tail. There are a lot of different ways that one can come up with to offer alternatives that get to your cost targets. I want to emphasize that the employee, the individual having the opportunity to make choices going forward, is going to provide a significant leverage for the payer in negotiations. If cost and outcomes are provided or made available in one form or another to the consumer, the consumer is naturally going to decide if it is worth extra money to go to one particular facility over another, because he or she will get better care. That will make the variation between facilities significantly less in the future than we observe now.

MR. SNOOK: Mr. Limm, in your day-to-day routine, you work with physician groups and hospitals quite a bit. You've got a unique perspective of what the hospital systems are thinking and what their perspective is on contracting. Why don't you tell us about that?

MR. LIMM: In the last six months or so, hospitals have been asking us for 10 to 20 percent increases. Typically, the reasons are malpractice premium, labor and nurse

shortage, and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance. In Oregon and Washington, we have minimum nurse-to-patient ratios. IT structures are also cited. For some of these hospitals, their billing systems are somewhat old and they need to be replaced. We're hearing about the increase in cost from their side. In addition to cost, they always emphasize the need for reimbursement methodology that they can monitor. Right away, they want a percentage of charge, even for the big hospitals. Some of these bigger hospitals are reasonable. They are willing to use DRG-based or ambulatory patient classification (APC)-based methods, a fixed-rate basis.

The other thing that's important to hospitals is cash flow. They want prompt pay. It's that simple. From a payer's perspective, in some areas where we don't have much leverage, if we're not contracted with the provider, with the hospital, we make sure that the check is cut to the member. In many cases, that's the only leverage that we have. With respect to rural hospitals, it's interesting. We actually have some small 25-to-50-bed hospitals on fixed rates, case rates and per diems. We're changing that today. We're looking at rural hospitals from a different perspective. We want to move these hospitals to a percentage-of-charge form of payment. It's better for both parties.

MR. SNOOK: I did a study a year or so ago on Medicaid that is not directly applicable to commercial insurance. We were looking at how the state of Arizona pays hospitals for inpatient services on Medicaid. We examined a bunch of different cuts. On average, Arizona Medicaid reimbursement runs about 90 percent of cost. Hospitals aren't covering their full costs. They're certainly covering more than their variable cost, but they're not covering their full cost. That varies a lot from hospital to hospital. When you start looking at rural hospitals, you see numbers like 65 and 70 percent of costs being covered by fixed per-diem Medicaid reimbursement. The study found that the reason for that isn't that they're being paid less, it's that their costs are more on a per-day basis because they're smaller. You've got a bigger proportion of fixed overhead. It's hard to hire people, especially in rural Arizona. As a result, the legislature is making changes in how that reimbursement mechanism works. Rural hospitals do have a different perspective and a different need in contracting. From the other side, if you're going into a rural area and you've got a contract with that hospital, you don't have much negotiating leverage as a health plan. In Flagstaff, Arizona, there's one hospital. It can dictate what it wants to charge.

MS. PANTELY: Just to follow up on the rural issue, we were setting up a provider-owned HMO. They were changing their payment plan from a per-diem basis to a DRG basis. They wanted a single DRG schedule. The rural hospitals were fighting back, saying that they needed a higher schedule. They finally did accept the same fee schedule. We got around that by offering them access to certain types of physicians that they were lacking. One day a week, we would send somebody out there. They actually appreciated some of these little extras more than the fee.

MR. SNOOK: When do hospitals say "no" in contracting? Five or 10 years ago, there were some very aggressive health-plan contracting strategies in place. Hospital agreed to deals that, in retrospect, maybe they shouldn't have agreed to. Many of the hospitals are in the process of undoing those contracts. I know of one major hospital system in the Phoenix area that says "no" to contracts that they don't like, and they are gaining a reputation. It was actually a radical idea to say "no" to a bad deal.

How does this all shake out? Mr. Limm mentioned that hospitals are asking for 10 to 20 percent increases. Obviously, hospital capitation was common five or 10 years ago and is now unusual. It exists, but it's unusual. In the markets with which I'm familiar, per diem is king. You talked about DRGs. How have the structures changed, as well as the levels?

MR. LIMM: We have some homegrown service categories. We are eliminating those. We're moving to either case rates (APC- or DRG-based) or per diems. We have had numerous standoffs with hospitals. We've examined hospital income statements and operating margins. There are some hospitals that have an operating margin of 10 to 15 percent. In our eyes, it's not quite reasonable to ask us for a 20 percent increase if you have a 15 percent operating margin. We're fighting back in different ways.

MR. DAVIS: I think that there's more information shared now between payer and provider. That's a healthy thing. It helps strengthen the relationship, because this is a relationship at the end of the day. If one side or the other gets too much of a perceived advantage, then I don't think that's good in the long run. There has to be a healthy balance. I've seen a lot more cost information shared. I've seen scenarios in which you enter negotiations with three different approaches that come out to about the same cost—like revenue neutral to the hospital. You start working with any of those three or four options with which the hospital feels most comfortable. You're disclosing more up front, but there still is a bit of a shell game.

MS. PANTELY: One of the other things that's driving the pressure on hospitals in negotiation is their reduced ability to get capital. Right now, the funding is not there. They're feeling a lot of pressure from that. Instead of getting funds from increased revenue, they're going to have to get more of it from increased efficiency. That is driving their negotiations.

I would also like to comment on outliers. One of the things that I've seen small health plans do is loosen up the language around outliers regarding controls on the charge master. They examined the outliers to find what happened and why there were outliers. They found that the hospital was submitting fewer outliers to them. We believe that this was because, in some cases, the outliers formed due to something that the hospital did wrong. The hospital decided, rather than try to get extra money for the outliers, they would just keep the money in-house, because they don't want to tell anybody about it. That was an interesting by-product.

MR. DAVIS: We've started looking at medical management. If you have a good understanding of the distribution of your outliers and your exposures—medical management, nurses in the hospitals, whatever else—that might help to change the continuum of care and set up care to prevent outliers. It is, perhaps, an alternative strategy to address the outlier issue.

MR. SNOOK: How do health plans pay hospitals for different lines of business—HMOs versus PPOs, Medicare versus commercial? One could make the argument that if you're using an all patient refined (APR)-DRG, that's already case-mixed and risk-adjusted. You could say that this is the fee schedule for all lines of business. Intensity services will take care of itself. In practice, how's that working out?

MR. LIMM: The negotiation typically centers on the conversion factor. We only have commercial products, and we really don't distinguish for hospital.

MR. DAVIS: We still find a difference in the traditional HMO product, for which there's a lot less administration and submission necessary on the hospital's part and a lot less credit risk in terms of collecting money from the individual. The HMO cost to the company would be slightly less than alternatives, recognizing the fact that a point-of-service or PPO plan could have a delay in getting money. You have some credit risk, and you have more administration. We still see that as a common difference.

MR. SNOOK: Let's move on to physician contracting. Five or 10 years ago, this was a hot topic. This was interesting. We were talking about specialty capitations and risk pools, etc. It seems to be a much tamer topic now. Mr. Davis, why don't you explain the payer's perspective?

MR. DAVIS: There has been a movement away from transferring risk to the physician or physician group. There are several reasons behind that. Part of it, for us, is a corporate philosophy. Certainly, I've seen a lot less volume. Perhaps the places where it might be appropriate are in a primary-care setting. Our approach has changed there in terms of wanting to ensure that there is a certain quality of care. Incentive programs, quality initiatives and the like are becoming more prevalent. I'll call it one-way risk sharing with only an upside. Some of the earlier initiatives might include expanding office hours or setting standards regarding asthma and other conditions. Further items could be associated with the total continuum of care for a population in an area. They could go to educational seminars or somebody from the company could inform them of their utilization pattern compared to their peers. There's a lot more education taking place. The focus is moving toward quality outcomes. The compensation structure is trying to reward risk—meaning the underlying costs of individuals—so that higher-cost people get the care that they need. Secondly, if you can provide good quality and outcomes, that'll be rewarded.

MR. LIMM: From the physician's perspective, what's reasonable reimbursement typically is what the highest payer is paying. That's what we're hearing. They're not shy about telling us that as a commercial payer, we have to help subsidize Medicaid and Medicare patients. I guess that you have to respect the honesty.

What we're hearing from hospitals is similar to what we're hearing from physicians. When you look at the relative value units (RVUs), the malpractice RVU is typically about 3 percent of total RVUs. When a physician group tells us that their malpractice premium went up by 10 or 20 percent, we start asking further questions regarding cost structure. How much is their malpractice premium as a percentage of their total cost? How is that split among the commercial payers? As you ask these physician groups more questions, they understand that they can't get us to cover all of their increases.

From the physician's perspective, aside from nursing shortages, they're having difficulty recruiting certain specialty doctors in some markets. We've got a couple of multi-specialty clinics that claim that they may drop obstetrics out of their program because of malpractice premiums. I'm not sure if that's posturing or if it's true. We'll find out.

One of the things that we've noticed is that emergency room physicians are getting bold and asking us to pay 100 percent of charge. In Washington, there are regulations saying that if we are not contracted with an emergency room physician, we have to pay 100 percent of charge. We are handcuffed in that respect. It's not only the emergency room physicians that are coming out. Other hospital-based physicians are becoming more bold in asking us for bigger increases, particularly anesthesiologists and radiologists.

MR. SNOOK: Why is that?

MR. LIMM: It's hostage service. I don't think that anyone can choose which anesthesiologist they want to see. That's a problem. Typically, the surgeon, hospital or medical group chooses them.

MS. PANTELY: From the physician's perspective, one of our issues is unobtrusive care management. I find that to be an oxymoron. Care management is, by definition, obtrusive. I don't think that we can get away from that. Risk sharing is more from a quality perspective than true risk sharing. Many of these programs can be set up in different terms. I find that they like the first two out of these three better. You can set up an absolute term. If you perform foot exams on 70 percent of diabetics, you qualify. You can set it up on an improvement basis. If you increase your foot exams on diabetic patients by 10 percent, you qualify. They tend to like those a lot better than risk sharing, for which, if you get in the top 10 percent, you qualify. They feel more in control of the first two. It's tangible to them. It's hard for them to know what everybody else is doing and how much they have to do to get in that top 10 percent.

MR. DAVIS: I'd say that this transfer of information about how a provider is performing relative to its peers is extremely important in terms of reducing the variability of performance. It is also important in terms of improving the quality of care. It's not necessarily one doctor against his peers. Everybody can win. The payers now are more receptive to that because the employers want guarantees or maybe the payers are putting at risk ASO fees toward guaranteeing a certain level of discount, quality outcomes, disease management or certain metrics. I think that's going to become more prevalent as there's more agreement on quality metrics. As the government is becoming more involved, and the National Committee for Quality Assurance (NCQA) and other organizations become stronger, you're going to find that employers are going to be pushing for better quality. That, in turn, is going to change the structure of compensation to align the providers with employer demands.

MR. SNOOK: Is resource-based relative value schedule (RBRVS) the standard? Is everybody using a percentage of RBRVS? In my experience, that's the standard. I won't put you on the spot and ask you percentages, unless you want to volunteer that information.

MR. LIMM: I can tell you that up in Alaska, it's about 250. Some doctors don't want a contract with us, just because of the whole insurance principle. It's a completely different market up there.

MR. SNOOK: They don't believe in insurance?

MR. LIMM: They don't like insurance companies. Many of them are physicians who moved from the lower 48 states to Alaska to get away from society.

MR. SNOOK: Let's move on now to what the actuary's role is or can be in provider reimbursement within a health plan or within a provider. Where do we add value to our clients or our employers? What are some examples?

MS. PANTELY: Obviously, one of the main roles that we have is reviewing experience and trend analysis. When I say "trend analysis," it's more than just what the trend has been in the past. What can we do to control them, and why are they going up? I recently was involved in a negotiation with a carrier that was complaining that their drug costs in one region were going up 25 percent. In the other regions, they actually were not too bad. My first question for them was, "Why?" They didn't know. This was their business, and they hadn't looked at why. They said that it had to do with utilization. Just knowing utilization isn't enough. When *we* looked into it, the cost per claim was driven by just a couple of providers. We may find fraudulent activity there. It's very compelling when you analyze the data.

We were looking at the behavior of health carriers in Puerto Rico. They have eight regions there. In one of the regions, the drug cost per person for mental health

services was five times any of the other regions. I analyzed the data by physician, but it was really physician practices in that region that were driving it. We could come up with no other explanation as to why costs in that part of the island should be five times that per person. This is the type of thing we need to uncover. When we negotiated with them, we said that they had to get the situation under control. It's just unreasonable. Not only were they five times higher than anywhere else, but they also were increasing at a faster pace. It was truly a problem. You just can't accept it. You need to examine some of these things.

MR. SNOOK: How did that situation resolve itself, or has it?

MS. PANTELY: We reached an agreement with which they are not very happy. We actually projected a per-month per-member (PMPM) payment for the drug costs in that particular region to decrease over the next year. It's not going to be easy. They have sort of a Medicaid Plus program there. They call it Health Care Reform. It's Medicaid plus indigent, and it's a government-run program. With constraints on the budget right now, they had to get this under control. We just implemented a new data system there that is going to give better reporting. We said that we would work with them and examine this throughout the year, but they need to get this under control.

MR. SNOOK: Mr. Limm, Premera has an interesting setup. The company has an actuarial department, and it has a Health Care Economics (HCE) department that also has actuaries in it. The two departments have different responsibilities. Why don't you tell us what goes on there?

MR. LIMM: My department is called Health Care Economics, and our primary responsibility is to support the financial analysis of negotiations with a provider or hospital. Under Health Care Economics, there is an actuarial team that develops tools for non-actuarial people to use to analyze the contracts.

One of the skill sets that actuarial students have, above anybody else, is their PC-skill set. You need those skills to develop models. For example, in negotiations with one provider in certain markets, you're going to have a ripple effect. You have to understand that what you do with one hospital impacts another hospital. Does it impact the medical group that's affiliated with the hospital? Does it impact the ASCs, and so forth?

The actuarial students develop complicated, actuarial Excel spreadsheets. I think that the actuarial students know the claims data the best out of anybody else in a company. On the premium side, you are looking at claims. From the reserving side, you are looking at claims. I try to encourage actuarial students in my area to go through a claims-processing class, just to see what it looks like.

MR. DAVIS: I think that the actuary is uniquely qualified to address the complex issues associated with the risk management aspects of contracting. That could be

working for a payer, provider or a regulator. The spectrum of what an actuary can accomplish is not limited in any manner. I had the privilege of working with a physician, when I was consulting. He and I represented numerous provider organizations. In this particular case, the combination of a doctor (somebody who understood the practice of medicine and business) talking to other doctors, and myself (who understood the data and the analysis) was effective. You're not trying to hide or gain, but educate. You're able to address the concerns of the other party. That endeavor was very successful.

Can you synthesize the data and communicate that in an effective way to enable two different parties to come to an agreement about what's fair and reasonable? I know that there are places for actuaries in the actual negotiation, not just in preparing data or strategies. Certainly there's a role for actuaries after the contract is signed, in terms of examining all of the information collected regarding contracts that have been negotiated. We try to turn that into predictive modeling of what that means for trend in the pricing cycle. This is an area that an actuary can impact from start to finish. The only limit is their interest level.

MR. SNOOK: Is having actuaries present at the negotiating table common?

MS. PANTELY: I don't think it's that common. I've done quite a bit of it, but I don't know that it's that common. It brings a certain rationale to the process. In fact, I was working for the government, negotiating with carriers, and one of the carriers asked me if I would still be there the following year, pending a change in management. They said that they would encourage the new management to hire me. I said that I didn't know if a recommendation from them was such a good idea. But they said that at least negotiations became a rational process when I was involved. They didn't always agree with me, and we did argue, but it brought some rationale to the process.

MR. DAVIS: I worked as an actuary serving almost as an in-house chief financial officer (CFO) for 700-, 1,000-, 1,500-doctor groups. I sat with the lawyer and with the respective CEOs of each physician group. I went through all of the negotiations. Much of my role is to educate my client, just as the lawyer is there to educate with respect to the law. That brings me to one point that I don't want to underemphasize. There are many negotiations. Perhaps the business aspects are lost if the contract goes to lawyers and is not reviewed by somebody who really understands what was intended and the operation of the arrangement. In some respects, you can do your company or your client a lot of good by reviewing that document before it gets signed because in many instances, things that you're dealing with are very complex. A lawyer is good at making sure that a contract complies with the law but may not necessarily write it up so that it's interpreted in the way that it was meant to be when it was negotiated.

MR. LIMM: In my company, no contract goes out without HCE signing off on it. That was established a couple of years ago, after there were some mishaps. The

other point to make regarding sitting on the negotiation table is that my primary role has been to explain technical issues. If we were using episode-treatment groupers (ETGs) to justify our position, I would show up to explain that. If we're using the hospital RVU conversion factors to justify our position, I'm at the table explaining the details behind the calculation.

MR. DAVIS: A consulting actuary also could provide the third independent leg. On many occasions, I was hired by both payer and provider to give an independent actuarial assessment of a financial arrangement. Both parties agreed to whatever the outcomes were. In other instances, even though I represented a provider organization, the payer organization that they were dealing with actually wanted me to participate because they wanted to change a reimbursement schedule completely. They wanted to change everything. They felt that the actuary has the credibility to convey to the physicians how something could be revenue-neutral—even at a specialty-specific level—so that they could make a change in the way that they contracted. They felt that the actuary was uniquely qualified to do an independent assessment and to communicate that, while being viewed as the expert in that arena. There are a lot of different roles that an actuary can play in this arena.

MR. SNOOK: Now we'll open the floor up to questions.

MR. JOSEPH BOJMAN: What kind of reaction are you seeing on discounts that hospitals are getting as more membership moves to PPO and HMO organizations? Are you seeing a lot of negative reaction? People are moving to these plans. Why are we still giving a discount to the plans?

MR. LIMM: We don't distinguish our payment between products. Hospitals are asking us what our average deductible is and what our average coinsurance is. They're having problems collecting member liability.

MR. DAVIS: I would say that our strategy would be to simplify as much as possible. The ideal situation is to have the same compensation for the two. Maybe you do something from an administrative perspective. However, that migration of product mix was not a leading force in the negotiations. That just may be how the current distribution of existing membership is, in terms of how it's written between pure HMO and a PPO point of service. Based on where our contract mix is currently, I don't think that we've seen that big of a change in the mix between product written on insurance-company paper versus an HMO license.

FROM THE FLOOR: What opportunities do you see in restructuring contract incentives to motivate management of supply-sensitive services, as well as to improve longitudinal efficiency—as opposed to just overall utilization—given that the incentives are that more money is received for more services?

MS. PANTELY: When you're giving better services and having better outcomes, it doesn't necessarily mean that you're always going to have under-utilization or reduced utilization. The contracts structured that way will focus on quality. Before, they focused on controlling utilization. There's a big difference between the two.

MR. LIMM: One may be a contracting strategy, and the other is a compensation strategy. You might develop centers of excellence. With a limited number of providers, you're able to control quality, per se, and set specific rules for that smaller group. In exchange, they're getting more volume. I see episode-of-care analysis used directly or indirectly measured against outcomes. If you're looking at an individual physician perspective, it's also very difficult to draw too many inferences, unless you have a significant database of information on the physician, relative to his or her peers. Again, you only represent maybe 20 to 50 percent of the physician's population. How much experience data do you really have for an individual provider? As data becomes easier to obtain and compare, there will be additional changes in contracting. At this point in time, the limits are the credibility of the data in the assessment.

MR. LIMM: We are looking into bringing ETGs into the physician contract. But it's a difficult issue because of the time lag from when you have credible ETG data to your contracting period.

MR. ROBERT F. WARREN: In the days of low deductibles or first-dollar coverage, hospital contracting was simple with per diems or DRGs, because there was a whole book of business that developed. With the high-deductible plans now, don't we have to think more about cost-based reimbursement because of equity issues? Each member going in is a little different. He's going to be liable for a lot of that cost. I can predict that a member will complain if he's charged a deductible that's based on a per diem, or even a DRG, instead of what really was incurred by him in the hospital. Will the contracting have to move toward cost-based initiatives and be unbundled in more cases?

MR. LIMM: Payment is shifting to a more cost-based system, but not because of the issues that you laid out. We want to pay an appropriate margin to the hospital.

MR. SCOTT GUILLEMETTE: Do you think that physician groups would be willing to reveal information about their cost structure if they knew that the health plans would potentially restructure the way they reimburse physicians? If you walked into a physician group and the physicians revealed to you what proportion of their expenses was fixed and what was variable, you could reimburse them on a capitated basis for their fixed expenses, but then use a fee schedule to pay them for variable- and productivity-driven services. There are conflicting tendencies in over-utilization or under-utilization issues, because it's not a fully fee-for-service setup. Do you think that they'd reveal that information?

MR. LIMM: We have asked numerous multi-specialty groups for their financial statements. No one wants to share them with us. For those questions regarding malpractice premium, they give us their financial statement piecemeal.

MS. PANTELY: I've also found it very difficult to get information from provider groups when we've asked during negotiations. It's something that they're not comfortable revealing.

MR. DAVIS: Even if you were successful, I think that the other challenge is to develop financial reporting with system limitations that you could actually implement and monitor. What you're talking about is complex. On the provider side, how do they get comfortable with whatever is developed?

MR. SNOOK: The issue that I've always had with cost accounting for a physician's practice is, how do you define that cost? In particular, how is the physician's compensation measured as cost? It seems to me that if you got into that type of structure, you have to make an explicit decision—rather than an implicit decision—as to the right compensation level for that physician. As opposed to market forces and percentage of RBRVS, you're letting other people make that decision for you.

MR. DAVIS: Going back many years, one of the clients that this physician consultant and I worked for was a multi-specialty group. The group worked with him to come up with a consolidated measurement of units worked for each specialty group. They put all of the services into some sort of function. All costs were related back to the units worked and productivity. It was very difficult. It's a great idea, but I think that it is too complex to be successful in the current business world.

MR. THOMAS JACOB LEIBOWITZ: I used to work at a firm where, when it came to hospital contracting, contractors would go out with their laptops and create a tentative new contract. They'd be able to enter information based on hospital-specific data to find what the impact was going to be on that particular hospital. After the contract was signed, they'd come back to the home office. They'd look at what the impact was going to be on the market as a whole. One of the biggest issues was that the models weren't very sophisticated. When it came to carve-outs, they weren't able to handle it. That was seven or eight years ago. I'm wondering what is state-of-the-art now in terms of on-site contracting. How are carve-outs handled at the point of contract?

MR. LIMM: From my company's perspective, we do give the contractors several options, and the options are, essentially, rate sheets. Along with it, we provide the expected unit cost increase, and so forth. To be frank, we don't trust the contractors with spreadsheets.

MR. DAVIS: From a payer's perspective, what is your strategy? Once you have a strategy, tools and objectives, the individual representing the company goes out

with parameters. In advance, the individual representing the company has an idea of the limitations on the types of structures that could be acceptable. With the use of technology and an integrated approach, I think that we're in a better position to have controls on the negotiation process. Many of our carve-outs are handled on a national scale, so that, again, has been determined prior to the negotiations.

FROM THE FLOOR: My contractor experience is only with dental care, which is a similar world in terms of the actuarial math. There are fewer issues. Our main issue is that they have a very poor impression of insurance companies to start with. The worst problem is that they have no mental capacity for understanding how fees are set. It's a real issue. There's a communication barrier. How were you able to resolve your issues with health-care providers in Alaska who were more difficult to deal with?

MR. LIMM: In general, we usually try to educate the provider on how a claim is paid. If we are talking to a physician group, we show the common procedural technology (CPT) code that they bill. We show them what they will get today. We show them what they will get with the new contract. We try to simplify. In the Alaska situation, some of these providers don't even want to take 100 percent of charges.

MR. LEIBOWITZ: RBRVS actually has gone down over the past few years. But many contracts out there are based on 2001 RBRVS. Is that going to continue, now that we're in 2004 looking toward the 2005 schedule? Are we going to start updating those? Or do you think that we're going to be stuck with what's actually a nice benchmark, 2001 RBRVS, for the rest of the decade?

MS. PANTELY: Several of my clients still are using an older schedule, like the 2001. They have no plans to change it in the near future. Eventually, we're going to have to change it, but I think it's going to be out there for at least another couple of years.

MR. SNOOK: It's nice to have a fixed benchmark that's not changing every year. However, codes are added and dropped every year, so as a few years go by, reality diverges from the code set that was used in the fee schedule.

FROM THE FLOOR: Given that lots of contracts are based on conversion factors when there's an analysis of a fee schedule relative to RBRVS, is it relative to the current RBRVS or is it relative to some benchmark from a few years ago?

MR. LIMM: It's relative to how that particular provider is paid.

MR. SNOOK: It would depend on the situation. I know that if my client didn't care, I would use the most recent RBRVS. If the client specified something else, I would use something else. As long as you compare apples to apples, you're fine.

FROM THE FLOOR: Short of saying that we're not going to contract with a hospital, what's the next best weapon in our arsenal to keep costs down? What is effective at getting our way at the negotiating table?

MR. DAVIS: Part of that is going to be based upon the existing relationship that you have with that provider. You have to think of the dynamics of the situation. What is the need, and what's the relationship? When I consulted, there was a physician organization that required 170 percent of RBRVS. The payer had to meet the terms, because they had two national accounts that demanded it. The senior executives of those accounts demanded that this group be included. In that case, you don't have much of a choice. At the other extreme, if you develop benefit designs that relate back to the underlying costs, you might be able to transfer cost to the individual choosing care. If you show the difference in costs and no difference in outcomes, perhaps the consumer will choose the lower-cost plan. You may be stuck with a very large cost, but hopefully you will have very little utilization because consumers will choose different care.

You have to find out the sensitivities of that organization. What is it that they're afraid of? Are you trying to eliminate an outlier provision? Are you trying to examine why they have a 35 percent higher cost across the board? You have to take a look at what the underlying issue is, take a look at your claim history and come up with some alternatives. I don't think that there's a silver bullet.

MR. SNOOK: That's kind of what this tiered-network benefit structure is all about. If you put a hospital in a tier that is less attractive to the member, you have not gone to the extreme of dropping the hospital, but you've put them on probation.

FROM THE FLOOR: We had a lot of trouble pursuing that particular approach. If nothing else, the unions said that the low-paid people will get the worst care. That was one of the big problems with that approach.