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Creative Provider Reimbursement Approaches

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As plans complete to win the best deals from providers, the need for creative provider reimbursement approaches becomes more evident. We explore several such approaches, where a single capitation rate and fee schedule just wasn't the right solution.

Ms. Susan Elizabeth Pantely: This is supposed to be an open forum, so we're hoping to have a lot of participation. We have three panelists. We have Scott Guillemette from Towers Perrin in Minneapolis, Sunit Patel with Milliman & Robertson in New York, and Steve Wander with Deloitte & Touche in Minneapolis. Steve is filling in at the last minute and we really appreciate it.

Each one of the three panelists is going to give a presentation on some provider incentive structures that they've worked with. I'm going to start out by giving us a few things to think about, to hopefully get some conversation started.

The managed care industry started to combine risk management with healthcare management, and they focused on discounts, utilization, and management incentives.

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Note: The charts for this session, and Tables 11 and 12, are not available online. Please contact Linda Blatchford at lblatchford@soa.org or call 847/706-3564 for a hard copy.

Any successful reimbursement structure is going to address at least two issues and we should think about these as we talk about the different structures.

First, it's going to address risks of equity disputes. You're not going to want to have any perceived, unfair division of income between the specialist, hospitals and primary care physicians (PCPs). You may not be able to make everybody happy, but if they think somebody else is getting the better end of the deal, it's not going to work. We always call it the quality of sacrifice. While everybody might be unhappy, at least, they're all at the same level of unhappiness.

Second, and this is pretty intuitive, you don't want to have counterproductive incentives. You don't want to have any reimbursement that encourages over-utilization. One of managed care's objectives is to produce the same or better outcomes as an unmanaged environment, but we want to use fewer resources and less intensive services. It basically rearranges the basic four elements that you have in insurance.

The first one is risk, which is the uncertainty of the group's healthcare needs or costs. The second is the financing, which has typically been a large premium paid by either the government or the employer. Third, you have the production, which has typically come from fragmented and variable sources: physicians, hospitals, and others. Fourth, you have the market, which is a high-demand, high-cost market, and has historically been controlled by the producer, with little direct cost to consumers. Managed care has tried to shift the risk and shift some of these four influences. With that in the back of our minds, Scott is going to go first.

Mr. Scott E. Guillemette: I'm going to talk a little bit about more of a focus, not necessarily on a global perspective, but this particular approach may be applied to a global entity such as a physician hospital organization (PHO) or PSO. However, in this particular presentation, I'm going to walk through its application to a primary care group.

I'm not sure if this focus or this presentation that I'm giving, and the approach that I'm going to talk about, has been introduced into the market yet or not. It takes two known methods and kind of combines them. It's called, for lack of another term, compound capitation. Again, I don't know if this has been applied in the market or not, however, this method probably works more to incent human behavior, and not through an explicit risk-sharing mechanism. However, we'll see as we go along that it certainly presents certain incentives in each approach.

First, I want to plow through some of the traditional methods quickly so that everyone can position themselves with what's out there in the market right now. As

I see it, there are primarily two modes of reimbursement, a fee-for-service reimbursement and a capitated environment. What I’m going to do here is present three traditional modes, and give the advantages and disadvantages of each from two different perspectives: the provider’s and the health plan’s perspective.

Now I want you to know that these lists are not exhaustive, so what I’ve listed here are what I consider the more important issues or advantages (Table 1).

TABLE 1
TRADITIONAL REIMBURSEMENT APPROACHES—FEE FOR SERVICE (FFS)

Provider’s Perspective		Health Plan’s Perspective	
Advantages	Disadvantages	Advantages	Disadvantages
No utilization risk	Most health plans don’t pay FFS anymore	Happy providers	Costly
Little severity or price risk	Bad debt, delays		Overutilization
			Probably not competitive products

First, looking at the advantages from the provider’s perspective, is utilization risk as I have called it, and I’ll give you an example of a utilization risk, from a provider’s perspective. If the patients decide to come into the practice twice as often, then the provider wouldn’t necessarily negatively be impacted under a fee-for-service arrangement, because for each service that they deliver, obviously, they get paid some amount from the health plan. There’s little severity risk. Now let’s define severity risk. It’s when the cost to treat a patient exceeds the reimbursement for the services provided. So in the fee-for-service arrangement, the doctor bills out whatever the cost of that service was to the health plan and the health plan generally pays it. That’s really where I’d say, 15 years ago, the traditional indemnity products were.

The disadvantage is that most health plans obviously don’t do that anymore, as we all know. And there is bad debt and delays, and that’s a characteristic that filters through most fee-for-service arrangements. From the health plans’ perspective, it has incredibly happy providers, because they’re getting everything that they want. But the disadvantage is that they really don’t have a good competitive product to sell, because it’s priced too high, and because the physicians probably maximize their income.

Another form of fee-for-service reimbursement is what I’m calling modified, which is one that uses a fee schedule (Table 2). There are a lot of the same advantages and disadvantages. However, from the provider’s perspective, there’s a greater exposure

to severity risk for any one service. And then, on the health plan side, things are getting a little bit better.

TABLE 2
TRADITIONAL REIMBURSEMENT APPROACHES—MODIFIED FEE FOR SERVICE (FFS)

Provider's Perspective		Health Plan's Perspective	
Advantages	Disadvantages	Advantages	Disadvantages
No utilization risk	Exposed to price risk Bad debt, delays	Can partially control costs Partially limits variability	Still at risk for utilization May encourage over-utilization if scheduled rates are too low

And lastly, we have capitation, which is shifting a lot of the risk to the provider. (Table 3). It's prepaid. The provider likes the aspect of it having the income up front and being able to take advantage of the float. And it somewhat stabilizes their income as well. But they are now exposed to utilization and severity risk to the greatest degree. The health plan obviously enjoys the limited risk and the stability in their cash flow and their statements. However, one of the disadvantages is that there is the chance that the physician or the provider receives this chunk of money, and that they don't do anything.

TABLE 3
TRADITIONAL REIMBURSEMENT APPROACHES—CAPITATION

Provider's Perspective		Health Plan's Perspective	
Advantages	Disadvantages	Advantages	Disadvantages
Prepaid based on members Stabilizes income	Exposed to utilization and price risk Exposed if membership is too low	Limits risk Encourages managed utilization	May be selective utilization Generates lost profits if priced inappropriately

Here are some of the incentives tied to each of these approaches.

Fee For Service

- Maximize utilization
- Not as concerned with catastrophic cases
- Not concerned with the expense of the service delivered
- Not affected by referrals
- Can generally refuse patients
- Less concerned about operating costs (passed on to payer)

Primarily from the provider's perspective, maximizing utilization to maximize income is pretty straightforward. They are not as concerned with catastrophics. I

put “not concerned,” but they’re not as concerned with the expense of the service delivered. Most health plans today, even PPOs on an out-of-network basis, have some form of fee schedule that is tied to MDR or high or something so there is some limit to the billed charges that the provider can charge.

Fee-for-service approaches are not affected by referrals and generally in a physician group, the provider can refuse a patient, which is not a characteristic say of an HMO, where they must accept a certain level of patients, unless they’re full to capacity. And this last item here is somewhat important. They’re less concerned about the operating costs, as we’ll see as we go along. In the context that these are passed on through their fees.

Fee Schedules

- Maximize utilization
- More concerned with catastrophic cases
- Partially at risk (limited to scheduled amounts)
- Not affected by referrals
- Can generally refuse patients
- Less concerned about operating costs (partially passed on to payer)

Essentially the same thing, maximized utilization, applies here. But many of the same issues or incentives as in the base fee-for-service approach apply. And capitation, as theoretically designed, had the philosophy that the physician would manage utilization. There is a concern, obviously, from the physician’s perspective about catastrophic cases. But it’s a complete transference of risk to the provider. Also, with capitation, we’re talking about a reversing of the incentives from the fee-for-service arrangement. In the fee-for-service case, it was maximized services, which essentially increased expenses and revenues. On the capitated side, it’s exactly the opposite. It has reduced the number of services you provide. It becomes a cost center, not a revenue center. This has all been in the market for quite some time, and capitation is a growing form of reimbursement.

Thus this new approach, which I’m calling compound capitation, essentially is two of the known methods administered simultaneously.

It’s a capitation in a fee schedule and, in a nutshell, the capitation is based on provider’s fixed expenses, which we’ll talk a little bit about in a minute and the fee schedule is based on the service delivery of what the provider is actually delivering. So, there are two forms. They’re getting a piece of income prepaid, and then a piece of income that will be timed a little bit differently.

Provider Reimbursement = Capitation + Fee Schedule

- Capitation is based on a provider's fixed expenses
- Fee schedule is based on provider's variable expenses
- Two forms of payment—1 prepaid, 1 FFS

Now from the provider's perspective, compound capitation better immunizes the income and the expense streams. That may become obvious. If I'm a provider group, I have to pay people's salaries and pay bills to operate my practice, and those come due at certain dates. The capitation meets that payment as it comes in. I can turn around and pay my staff and so forth. However, the provider still has the ability to go out and maximize their income by providing more service. And it somewhat allays the fear of the catastrophic patient as well, because they still can have some form of fee-for-service reimbursement. The fee-for-service portion could be a fee schedule, which we'll later see. That's how I've actually built this.

Now from the health plan's perspective, by paying that fixed capitation, it somewhat encourages the provider to manage their operating cost and staff somewhat efficiently. They just can't go out and hire 15 PAs to help them do their job and help them bring on more patients, simply because the health plan is only paying them a certain amount each month.

Health Plan's Perspective

- Capitation for fixed expenses encourages efficient management of staff and capital
- Risk of overutilization tempered by
 - Lower fee schedule
 - Cap on fixed expenses
- Risk of underutilization avoided by FFS component
- Presumably creates a natural balance of utilization
- Approach encourages the addition of more members
- Encourages correct coding

Now the health plan presumably would take the time and energy to do some type of a strong due diligence to figure out what true fixed expenses are and build some form of a contract with a definition of what those are. The capitation is limited to those items, much like the primary care capitation.

Now the risk of utilization from the fee-for-service component is somewhat tempered by the lower fee schedule. We'll see that it's not a fee schedule that we're accustomed to seeing, where, say an office visit may range from \$50 to \$70. In this particular instance, the fee schedule is only reduced down to the work component of say the resource based relative value schedule (RBRVS) fee schedule. So it's a much smaller piece. It somewhat allays some of the fears of paying for over utilization, because those would be reduced. The fees are actually lower and the

cap on the fixed expenses reduces the physician’s incentive to continue to just do more and more and more and maximize.

And because the capitation is only paying the fixed expenses, the physicians have to do something. I mean, they have to provide some services if they want to get paid themselves. That’s what this item essentially means. They’re paying everybody else their support costs, except their own salary. They have to deliver services to pay their own salary. Now I suspect, and this is just a presumption on my part, that utilization would be balanced by this mechanism. They can’t really utilize too much because of the fixed cap. They can’t underutilize, because, if they do decide to leave for the golf course early, they’re going to get paid commensurate because they’ll just be doing less services. And those last two items are fairly straightforward.

Now these are the disadvantages.

Disadvantages of Compound Capitation

- Requires an ample number of members
- Requires more administration
- More complex

I’ve only listed three of them here. However, there are a lot more of what I’m calling complicating issues that are tied to this. But these are the ones that are prevalent in my mind. Compound capitation just requires more members to do this because of the capitation piece, which presumably, if they’re already accepting capitation, this approach should carry over just as well. But I contend that because the capitation is based on the fixed expenses, which are less variable, you probably need fewer members to actually do this. That’s just because the fixed expenses are less a variable within a particular practice. But because we are doing two forms of reimbursement, it’s going to take a little bit more time and energy to administrate it. And it’s just more complex right now.

I’m going to walk through the process of what I consider the construction of the compound capitation. I’m going to look at the capitation component first—the fixed expenses, divided by the assigned membership. It’s no different than it would be done today. However, the capitation requires a defined exposure base. So this can’t be done unless you can count the members just like you would in the standard capitation today.

Constructing a Compound Capitation—Capitation Component

$$\text{Fixed Expense PMPM} = \frac{\text{Providers Annual Fixed Expenses (Overhead)}}{\text{Member Months}}$$

Fixed Expenses = Costs the provider would have to pay to stay open even if no patients were seen for the entire year

Member Months = Members assigned to the provider (voluntarily or by default)

Now these are some of the fixed expenses that are within a practice (Table 4). I've listed the primary ones that are in the MGMA booklet, which is from the *Medical Group Management Association*. These sum to 100, just to give you an idea of the distribution. However, in total, the fixed expenses generally comprise 45–75% of the provider's total practice. And that really does vary based on whether it's a hospital or whether it's a cardiology group. It just depends what type of animal we're talking about.

TABLE 4
TYPICAL FIXED EXPENSES

Support Staff Costs	44.3%
Insurance	2.6
Taxes	3.6
Building and Occupancy	11.5
Operating Costs	32.7
Retirement and Benefits	5.3

Fixed expenses can comprise 45% to 75% of the provider's total expenses
Fixed expenses vary by provider type/specialty

Now let's move on to the fee schedule component. The fee schedule is essentially based on the work component, RVUs. RVU stands for relative value units of the RBRVS fee schedule. Now the objective here is to determine a conversion factor, such that on a fee-for-service equivalent basis, the fee schedule, when combined with the utilization of the practice, and then adding the actual capitation PMPM, creates something that is a competitive PMPM that's acceptable to the health plan and to the provider. So in building an actuarial model of this sort, you will need to obtain the provider's utilization levels, or some form of representation of those, which are going to vary again, based on whether it's a hospital, a cardiology group, or a PCP group. But in essence the formula down at the bottom is how the annual variable expenses would be determined. That first component there, the summation, is the sum of the service counts by Common (Current) Procedural Technology code (CPT). If anyone has had exposure to actually developing fee schedules before, or capitations for that matter, you'd probably be looking a lot at that type of data.

Constructing a Compound Capitation—Fee Schedule Component

- Fixed schedule established using RBRVS Work RVUs as the basis.
- Objective is to determine a fixed conversion factor and fee schedule that produces competitive rates when combined with the capitation

$$\text{Target Variable Expense PMPM} = \frac{\text{Providers Anticipated Annual Variable Expenses}}{\text{Member Months}}$$

$$\begin{aligned} \text{Annual Variable Expenses} &= \sum_{\text{CPT}} \left(\text{Annual Service Count}_{\text{CPT}} \right) \times \left(\text{Conversion Factor} \right) \times \left(\text{Work RVU}_{\text{CPT}} \right) \\ &= \sum_{\text{CPT}} \left(\text{Total Work RVU}_{\text{CPT}} \right) \times \left(\text{Conversion Factor} \right) \end{aligned}$$

I’m going to walk into a case study, just to illustrate how this works (Table 5). In this particular instance a five-physician, primary-care group is examined. The physicians are family practitioners, and the panel is composed of 25% Medicare patients, and 75% non-Medicare. The reason that I’ve done this is it’s based on some information that we have. I’ve adjusted the numbers, but it is based on a real life experience. I’ve combined the Medicare versus non-Medicare because it’s difficult to allocate what your expenses are for the Medicare population versus the non-Medicare. So when you take an HMO’s administrative component, and you try to split that out into pieces, it’s very difficult to do, unless there is some type of allocation algorithm that people are using. A lot of them are using RVUs to do that.

TABLE 5
CASE STUDY—FIVE-PHYSICIAN PRACTICE

Incurred Month in 1998	Members	Fixed Expenses	Variable Expenses	Total Expenses	Total RBRVS Work RVUs
January	14,025	\$114,025	\$108,497	\$222,522	3,477.0
February	14,053	114,474	91,604	206,078	3,193.4
March	14,087	114,293	90,279	204,572	3,134.7
April	14,129	116,010	103,427	219,437	3,577.0
May	14,169	113,725	90,934	204,659	3,132.6
June	14,216	115,000	96,609	211,609	3,315.0
July	14,287	114,752	109,250	224,002	3,734.1
August	14,350	113,892	94,577	208,469	3,220.0
September	14,410	114,732	111,452	226,184	3,779.9
October	14,482	113,279	109,946	223,225	3,714.4
November	14,552	115,937	96,917	212,854	3,261.6
December	14,609	116,421	106,179	222,600	3,559.6
Total	171,369	1,376,540	1,209,671	2,586,211	41,099.3

However, this is just an annual layout of the group's fixed and variable expenses, and I've also illustrated over there the total work RVUs, which will become important in a moment.

Case Study—Compound Capitation Calculations

$$\text{Fixed Expense PMPM} = \frac{\text{Annual Fixed Expenses}}{\text{Assigned Member Months}} = \frac{\$1,376,540}{171,369} = \$8.03 \text{ PMPM}$$

$$\text{Variable Expense PMPM} = \frac{\text{Annual Fixed Expenses}}{\text{Assigned Member Months}} = \frac{\$1,209,671}{171,369} = \$7.06 \text{ PMPM}$$

$$\text{Work Based RBRVS Conversion Factor} = \frac{\text{Annual Fixed Expenses}}{\text{Total Work RVUs}} = \frac{\$1,209,671}{41,099.3} = \$29.43$$

$$\text{FFS-Equivalent Compound Capitation} = \$8.03 + \$7.06 = 15.09 \text{ PMPM}$$

In determining a fixed expense PMPM and a variable expense PMPM, bear in mind that the variable piece will be affected by this approach in theory. So if I implement this, the utilization numbers may change, because they are getting a fixed capitation for a piece. The reason I've done this is to illustrate how this particular approach immunizes the cash-flow streams of the provider practice.

I've also calculated the work-based conversion factor, which you see is a little bit lower than what we're used to seeing. And then this is the fee-for-service equivalent capitation for this particular primary care group. See, it's just the sum of the two pieces. In theory though, this piece may be varied up and down until we get a competitive number. And we'll see how that works in a moment.

I can take that \$15.09 and assume that it's the primary care capitation for that group. This is how the actual experience would pan out (Table 6). When I apply that \$15.09 PMPM to the membership each month, and compare the actual payments to the expenses, you see on the far right there is the surplus or deficits in each month. And you'll see in each scenario, the sum is zero, because I'm using a zero sum game here to illustrate a point.

TABLE 6
CASE STUDY—CAPITATION ONLY

Incurring Month in 1998	Members	Fixed Expenses	Variable Expenses	Total Expenses	Total Capitation Payments	Surplus/ (Deficit)
January	14,025	\$114,025	\$108,497	\$222,522	\$211,658	\$(10,864)
February	14,053	114,474	91,604	206,078	212,080	6,003
March	14,087	114,293	90,279	204,572	212,594	8,022
April	14,129	116,010	103,427	219,437	213,227	(6,209)
May	14,169	113,725	90,934	204,659	213,831	9,172
June	14,216	115,000	96,609	211,609	214,540	2,932
July	14,287	114,752	109,250	224,002	215,612	(8,391)
August	14,350	113,892	94,577	208,469	216,563	8,093
September	14,410	114,732	111,452	226,184	217,468	(8,716)
October	14,482	113,279	109,946	223,225	218,555	(4,670)
November	14,552	115,937	96,917	212,854	219,611	6,757
December	14,609	116,421	106,179	222,600	220,417	(2,129)
Total	171,369	1,376,540	1,209,671	2,586,211	2,586,211	(0)

Capitation Payment = FFS – Equivalent Compound Capitation X Members
 FFS – Equivalent Compound Capitation = \$15.09 PMPM

Table 7 shows the fee schedule and a couple of additional items here. We've also determined what the total RVUs are. When I say total, that includes the work practice expense in malpractice, under the traditional RBRVS basis. I then determine what the convergent factor was for this particular group, and it was \$44.05. If I were to take that conversion factor and apply it each month to the total RVUs, and carry out the same algorithm that we did on the capitation basis, I'd see the surplus and deficits again, and they still sum to zero.

TABLE 7
CASE STUDY—FEE SCHEDULE ONLY

Incurring Month in 1998	Members	Fixed Expenses	Variable Expenses	Total Expenses	Total Procedure RVUs	Total Fee Schedule	Surplus/ (Deficit)
January	14,025	\$114,025	\$108,497	\$222,522	4,967.2	\$218,795	\$(3,727)
February	14,053	114,474	91,604	206,078	4,562.0	200,947	(5,130)
March	14,087	114,293	90,279	204,572	4,478.1	197,254	(7,318)
April	14,129	116,010	103,427	219,437	5,110.1	225,086	5,649
May	14,169	113,725	90,934	204,659	4,475.1	197,211	(7,538)
June	14,216	115,000	96,609	211,609	4,735.7	208,599	3,009
July	14,287	114,752	109,250	224,002	5,334.4	234,971	10,969
August	14,350	113,892	94,577	208,469	4,600.0	202,621	(5,848)
September	14,410	114,732	111,452	226,184	5,399.9	237,853	11,669
October	14,482	113,279	109,946	223,225	5,306.3	233,732	10,507
November	14,552	115,937	96,917	212,854	4,659.4	205,239	(7,615)
December	14,609	116,421	106,179	222,600	5,085.1	223,991	1,391
Total	171,369	1,376,540	1,209,671	2,586,211	58,713.3	2,586,211	(0)

Total Procedure RVUs include work, practice expense, and malpractice components.
Fee schedule assumes a total conversion factor of \$44.05.

Now we move into compound capitation (Table 8). Instead of \$15.09 capitation, we're taking an \$8.03 capitation and applying it to the membership to generate the fixed capitation. The fee schedule is based on the \$29 and some odd cent conversion factor to generate the fee schedule portion of that table. Summing those two with the fixed capitation and the fee schedule generates the total compound capitation payment. In comparing that to the total expenses generates a fee surplus and deficit.

TABLE 8
CASE STUDY—COMPOUND CAPITATION

Incurring Month in 1998	Members	Fixed Expenses	Variable Expenses	Total Expenses	Fixed Capitation	Fee Schedule	Total Compound Capitation	Surplus/ (Deficit)
January	14,025	\$114,025	\$108,497	\$222,522	\$112,657	\$102,339	\$214,996	(\$7,526)
February	14,053	114,474	91,604	206,078	112,882	93,991	206,873	795
March	14,087	114,293	90,279	204,572	113,155	92,263	205,419	847
April	14,129	116,010	103,427	219,437	113,493	105,281	218,774	(662)
May	14,169	113,725	90,934	204,659	113,816	92,201	206,015	1,356
June	14,216	115,000	96,609	211,609	114,192	97,570	211,761	153
July	14,287	114,752	109,250	224,002	114,762	109,905	224,667	665
August	14,350	113,892	94,577	208,469	115,268	94,774	210,042	1,572
September	14,410	114,732	111,452	226,184	115,750	111,253	227,003	819
October	14,482	113,279	109,946	223,225	116,328	109,325	225,654	2,429
November	14,552	115,937	96,917	212,854	116,891	95,998	212,889	35
December	14,609	116,421	106,179	222,600	117,348	104,769	222,118	(842)
Total	171,369	1,376,540	1,209,671	2,586,211	1,376,540	1,209,671	2,586,211	(0)

Fixed Capitation = Fixed Expense PMPM X Members

Fee Schedule = Total RBRVS Work RVUs X Work-Based RBRVS Conversion Factor

The whole point to this exercise is to illustrate how this particular approach better immunizes the provider's cash-flow streams. They are the amounts on the far right

under the compound capitation approach, and they vary little, around zero (Table 9). So the cash flows in theory are meeting the expense stream of the provider practice versus straight capitation or straight fee schedule. Bearing in mind, it's important to note that implementing this particular approach changes the variables, utilization and so forth. However, I contend that by continuing to implement this type of approach with the incentives that I've illustrated thus far, that it will better immunize the provider's practice and in theory, they'll be able to practice medicine the way they may want to, as opposed to the way the health plan is dictating that they should practice medicine.

TABLE 9
CASE STUDY—A COMPARISON OF METHODS

Incurring Month in 1998	Capitation Surplus/ (Deficits)	Fee Schedule Surplus/(Deficits)	Compound Capitation Surplus/ (Deficits)
January	\$(10,864)	\$(3,727)	(\$7,526)
February	6,003	(5,130)	795
March	8,022	(7,318)	847
April	(6,209)	5,649	(662)
May	9,172	(7,538)	1,356
June	2,932	3,009	153
July	(8,391)	10,969	665
August	8,093	(5,848)	1,572
September	(8,716)	11,669	819
October	(4,670)	10,507	2,429
November	6,757	(7,615)	35
December	(2,129)	1,391	(482)
Total	(0)	(0)	(0)

Compound capitation better aligns the provider's income and expense streams.

There are complicating issues associated with the particular compound capitation. These can be very large things. A lot of practices as you know, affiliate with several HMOs. This may become an issue. However, with a little extra work, you can certainly still do this approach, and apply it to HMO A, B, and C for my particular practice. It's certainly a doable thing. There are service scope issues. We certainly can define what the scope issues are, however this obviously works a lot easier if you're talking about the whole scope of the services that that particular practice would provide.

Population diversities are the Medicare versus non-Medicare issue or Medicaid and how our expense is different when treating a Medicare patient. Also, there are fixed expenses. It doesn't cost more to have the receptionist register a Medicare patient versus a non-Medicare patient. Some of those fixed expenses will be different based

on the patient type. In a lot of practices, especially if it's multispecialty, there may be some sharing of facilities, meaning the three particular multispecialty groups may combine to use one MRI machine in that particular community. How do you take that fixed expense and allocate it to the three? Now again, I've indicated before that fixed expenses vary. Right now the information systems and their ability to handle this approach theoretically should be able to do that, because they already handle fee-for-service, and capitation, administering this simultaneously, and this may just be another complicating factor for that. I haven't really built in any of the things that Steve and Sunit are going to talk about in terms of explicit risk-sharing arrangements.

In conclusion, as with anything, when you're doing rating, you must abide by *Actuarial Standard of Practice No. 31*. It takes two known methods and simultaneously combines them. The approach develops a deeper understanding for the actuary as to the expense structure of the provider because you're actually going in and looking at its fixed expenses. And what are their variable expenses? I think that this ties in nicely with the PSO regulation, solvency regulations, which are primarily tied to all this stuff, and what kind of volatility you are going to experience if you see what proportion of the hospital's expenses are fixed versus variable. It gives you a better idea of how their cash flow streams fluctuate. And this requires the skill of an actuary.

Mr. Sunit R. Patel: Currently, most of the clients that I work with are PHOs on the East Coast; in particular, they're located in the New York-New Jersey area and also in Massachusetts. So my perspective is going to be mainly from the provider side.

PHOs are simply organizations where physicians and hospitals have gotten together, formed a joint venture, and the primary purpose of the joint venture is to negotiate contracts collectively with HMOs. These contracts in broad terms are often global risk contracts. Global because they normally cover a comprehensive set of services and risks, obviously, because the providers are put at risk.

Just a real quick example is HMO. If they receive \$150 from a member, they might decide to keep say \$30 and then pass on \$120 to PHOs, and the PHOs would be responsible for delivering medical services to patients in return for the \$120. The providers, of course, would be subject and be responsible for any deficits. For example, if experience came in at \$150, the providers would have to accept the deficit of \$30.

Let's talk about the current trends and again, this is from an East Coast perspective. I'm sure there are some areas of the country that are a bit more advanced than this. On the other hand, there are other parts that are not at this point, but this is what we

currently see in the marketplace. One is that payers are transferring risks to providers. This obviously started with PCP capitation payments, but now it's spread to a greater number of services and it's not just PCPs that are being put at risk anymore.

The PHOs are assuming global risk as I've termed it there. And the impact of it on providers is that they are struggling to establish journal payments, and incentive methodologies. Now what that means is that the PHOs are receiving, for example, \$120 per member per month but they're having a hard time figuring out how to pay the hospitals and how to pay the physicians. If you can imagine, each one thinks that the other one is getting too much. And that's creating many problems.

Initially, when PHOs were formed, and they were assuming global risk, a lot of the providers were actually very excited at the opportunity. They thought that they could get the HMOs off their back, and it would go back to being business as usual. But what's happened is a lot of them experience large financial losses and with those losses, they've come to understand they've got to start acting like HMOs if they want to be profitable. And that's actually one of the things that we tell all our clients initially: this is not a tool where everyone is going to be happy. You're going to have to make sacrifices. You're going to have to pay certain providers more money than others, especially those that will be able to control costs for you.

The selling point now, once the physicians and other providers understand this, is that if they're able to become a bit more efficient, they'll be able to keep the savings as opposed to the innermost keeping the savings. So again, the main thesis of my talk is going to be how to analyze the contracts that PHOs are being offered by HMOs.

Next we'll talk about developing a framework for global reimbursement. The first point is that we need to develop a comprehensive reimbursement strategy where all the pieces fit together. As I go through this, you'll see that it's very important to look at all the different components of reimbursement. You can't just look at how PCPs are getting paid or how hospitals are getting paid. You'll have to look at the whole picture in order to understand and to make things work.

The second one is that the framework that we're going to look at can be used to analyze many different reimbursement approaches, and last is that the funds flow model is the basis of the framework. The funds flow model is basically an outline of the financial terms that have been negotiated between the providers and the HMO. It'll only take five minutes to go through, but the fastest we've gone through this whole process with physicians has been nine months. So, a lot of this has to do with physician education. It also has a lot to do with helping the parties resolve

their differences and making them understand what the impact of such an arrangement is going to be.

Here we have a generic fund flow model (Chart 1). It doesn't have to look like this. This is just an example. But we have a premium and it's \$120. It's the \$115 plus the \$5 and that's how much the HMO is giving to the PHO. We've taken off \$5 for administration and that leaves \$115 for medical services.

Now as actuaries, we're used to analyzing the \$115. I'm sure most, if not everyone, here has done basic pricing. So we could give an estimate of whether we think the \$115 is okay for the PHO to accept. Now the harder part comes with how we're going to pay each of the different parties or each of the different providers. And none of the components below the \$115 can be viewed independently. We need to make assumptions about each of the pieces and then at the end do an analysis to see how everything fits.

So for example, the pure premium is \$115, and it's being split into three different funds. It's a \$45, \$55, and \$15. And we really can't analyze whether the \$45 is a good deal for the hospital fund, per se, unless we look at everything below that. So again, let's start with the hospitals. We have \$45 which is the budget that we've allocated to the hospital fund, and you can think of that as a bank account basically where we're depositing that much money per member per month, and against that account, we're going to charge for services that are performed. So for example, in a hospital fund, we're going to charge for inpatient services at \$1,200 per diem. For the hospital it's going to get \$1,200 out of this bank account for each day a patient is in the hospital. In any of these arrangements, for example, the per diem rate could be a case rate, it really doesn't matter what the arrangement is. This is just an example. The outpatient services are at a 10% discount. The physicians are going to have a pool of \$55, and they're going to be getting paid on a fee-for-service basis at 100% of Medicare. And we'll get to the carve-out last.

And below the charges against the fund, you see that there are surpluses and deficits. So of the hospital fund we have a 50/50 sharing of the hospital surplus or deficit between the hospital and the physicians. So for example, if the fund is \$45, and we end up charging \$40 to the fund, and we have a surplus of \$5 left over, half of that is going to stay with the hospital fund and the other half is going to go to the physicians. Now the physicians, on the other hand, get to keep 100% of their surplus or deficit. Lastly, are the carve-outs. And in this example, I've just assumed that the plan or the HMO assumes responsibility for the carve-out. There're different reasons why you might want to carve things out. We'll get into more detail about that in each of the components later on. But just as an example, prescription drugs might be capitated out to a vendor for \$8 per member per month, so there's

no reason for it to be put in any of the pools. For example, the physicians might not want ambulance charges in their pool because they might argue that they don't have any control about how often their patients call an ambulance for service. So that's the basic funds flow model. This usually takes place like I said, after a lot of negotiating between the providers and the HMOs.

All this is great; but it's really hard for providers to figure out what they're going to get paid. Physicians know they're getting paid 100% of Medicare up-front, but what's going to be the effective payment? So if they make the system more efficient, it's really hard for them, without a concrete analysis, to figure out what they're going to get paid.

Chart 2 basically shows how we began the funds flow model, which is done by determining what the basic structure is going to be. So here we see that the premium is coming in and usually PHOs do need to take off some for administration. There will be some sort of internal administration. Normally, we see three funds: the hospital fund, the physician fund, and a carve-out fund. There can be more funds. We've seen the physician fund broken down into PCPs and specialists. But this is the basic structure that we see.

The structure should be aligned with the corporate goals. We need to clearly define what the covered services are, so you'll have to look at the plan benefits to see what's covered and what's not. And you'll also need to develop a service responsibility matrix, so that the physicians know that for the capitation amount they're getting they will know exactly what they are going to be responsible for.

Chart 3 is premium assumptions and allocation of funds. As I had mentioned, the \$115 is something that we're used to looking at and determining whether it's a reasonable rate or not. Those numbers below the \$45, \$55, and \$15 are not necessarily based on what we expect costs to be. And as I had mentioned before, those are just initial assumptions. The other assumptions, like the surplus deficit sharing, and the charges against the fund, will impact the effect of reimbursement to the providers.

We often feel the PCP reimbursement should produce an efficient system and prevent inappropriate outcomes. It should be simple to administer. That's very important. We've seen a lot of fund flow models, which are much more complicated than what I showed you. But if you can't administer it, then what's the point? So we really tried to keep it very simple. And it should allow for growth.

The PCP is responsible for all medical costs, all professional costs, and PCP services only.

And here is an example of how I showed you the big picture, but there are really small details that we haven't touched here yet. And one is PCP reimbursement. One of the first things that we need to determine when we're performing such an analysis or looking at a system is what the role of the PCP should be. Should they be responsible for all medical costs, all professional costs, or just for PCP services? And the decision you make here will impact the rest of the fund flow models.

Here are some conclusions. One is that providers are assuming more risk, and as they are assuming more risk, it's becoming very important for them to assess exactly what they're getting themselves into and, in order to assess what the risks are, we've developed these fund flow models and outcomes that hopefully will help physicians and hospitals get a better handle on the risks they're taking and the potential rewards.

Mr. Steven N. Wander: Angela Liang was originally supposed to be doing this presentation. She had a family emergency last weekend and couldn't make the trip, so she asked me to volunteer. The projects that were a basis for this presentation were a couple of large projects we did developing integrated delivery systems and some current ones we're working on right now, developing PSOs. I was pretty heavily involved in those projects, so I think I should be able to add some value to the presentation.

We're going to cover types of risks, whether this arrangement can be successful, and risk-sharing arrangement options.

The American Heritage Dictionary, 2nd College Edition, defines risk as, "probability of loss to an insurer," and uncertain as, "condition of being in doubt." In an insurance situation, when you have uncertainty that will lead to risk.

Here are some of the different types of risks that you're going to encounter in an insurance situation:

- Pricing Risk: Can we accurately estimate utilization and cost?
- Statistical Risk: Do we understand how volatile this business is?
- Business Risk: Do we know what we are getting into?
- Partner Risk: Are the other providers/insurers/purchasers involved in this plan doing their part?

There's pricing risk, which I'm sure everyone is familiar with. It is the risk that you haven't priced things appropriately. This is one risk I think that providers often overlook. They assume that their capitation rates have been developed by actuaries

who know what they're doing, and they basically look at the statistical risk and they know there's going to be some variance, but they seem to think that if they have enough people, they'll be fine. Because they'll get rid of that statistical risk, but I think in reality, a lot of times, the pricing risk might actually be a bigger risk to providers than statistical risk.

Business risk is pretty much a catch-all category for everything—it comprises other kinds of risks that don't fit in any other category. It includes economic risk and inflation being higher than expected, and things like that. Partner risk could deal with maybe having a partner that goes insolvent and can't fulfill his or her obligations, causing more risk on your organization.

Next are some success factors for a successful risk-sharing arrangement:

- Trust among participating parties
- Aligned incentives
- Minimize impact of adverse results—proper use of reinsurance
- Equity among participants
- Rewards based on measurable criteria
- Gains based on relative influence of participant
- Administrative simplicity
- Results tracked and reported
- Align with Medical Management Budget
- Realistic reimbursement rates
- Education and communication
- Do the providers have adequate capital for the risk?

From my experience, the most important ones are at the top of the last: trust among participants, aligning incentives, and equity among participants. I've been in a lot of rooms with an organization where they want to have a common goal, but when you've got hospitals, physicians, and all the different providers, and they all have their own goals and they're not common at all. They all have different incentives that they want to see, and I think a good risk-sharing arrangement can bring people together. If you can align the incentives and get everyone to buy into the incentives that you're setting up and you get them to buy into the theory that this is going to help to make a successful venture, that's real important. It will bring people together and set up an integrated delivery system where everyone is on board with a common goal. Some of the other big ones would be using measurable criteria. It's hard to have a risk-sharing arrangement if you can't really measure the criteria you're using. You want to have the gains based on the relative influence of the participants. An example would be primary care physicians have a lot of control over specialists because they're the ones doing the referrals, but specialists don't have nearly as much control over primary care. So you don't want to have a

specialist sharing as much in the primary care pool as you'd have primary care physicians sharing in specialist pool.

Other than that, I think the other ones are pretty similar to what's already been discussed. So we'll move on.

These are some issues that we came across in dealing with integrated delivery systems and PSOs in how we want to set up this risk sharing arrangement. First of all, do you want to use capitations? Do you want to capitate the medical group and hospitals directly? Do you want to have the HMO sharing and risk? If you have an integrated delivery system that's big enough, they may want all the risk themselves and the HMO would just be more of an administrative vehicle. With reimbursement, you could use capitation or fee-for-service. In the use of reserve pools, do you want to have pools set up where you have the different pool sharing in gains and losses from the other pools? And then it's very important to define who is going to be at risk for the different services. There're a lot of categories, like out of area, ambulance fee, and DME, that don't really fit anywhere, so it's important to get those in the appropriate place.

Next, let's discuss a few more issues. Again, definition of services. Getting those into the right pools. Making sure everything is clear, so that at the end of the year, when you're reconciling everything, you know where a certain CPT code belongs, or what a certain service pool it should be charged against. One that is often overlooked is the amount of capital that physicians have. Do they have enough capital to accept the kind of risks that the risk-sharing arrangement is going to entail for them?

One thing that we've used a lot is the new risk-based capital formula that the NAIC has recently adopted. That's one means of trying to determine how much capital a group should have before they're taking on this kind of risk. I think it's very important.

And then, the regulatory complexities, when you're dealing for instance with Medicare. If you're putting physicians at substantial financial risk, you need to provide stop-loss coverage to them, and sometimes it's at very low stop-loss thresholds, so that can really affect how you set up your insuring arrangements.

The products you need to tailor to the market when dealing with Medicare and Medicaid. You're probably going to need different risk-sharing arrangements from Medicare, given this as the regulatory environment and then also the percentages. You'll have a different distribution between hospital and physician costs on the Medicare side than you would on the commercial or Medicaid side.

One comment here about providers participating in underwriting. I don't know if I've ever seen that before, but I guess if they're taking risks, that's something they might want to do. I don't know if that would actually happen though.

With regard to reinsurance, you can get some pretty big complexities if you've got some smaller groups. They might want a different attachment point than a larger group and it just adds complexity to the whole system.

Chart 4 is an example of a risk-sharing arrangement that we implemented with a new integrated delivery system. It's similar to the prior model, but maybe a little more complex. Basically, the funds come in, and it's separated between the physician pool and the hospital pool. But within the hospital pool, there's a separation among inpatient, outpatient, and ancillary. And on the physician side, there's a primary care and a specialist pool. And then within each of these pools, 15% of the target gets put into a reserve pool. And then claims are paid out of these pools at 85% of the target fee schedule, or the target capitation. And then at the end of the year, there's a sort of reconciliation, and depending on if there is a surplus or deficit, the reserve pool could be returned to the provider to be shared. Chart 5 gets into how those surplus and deficits would be shared.

I'm not going to go into all the percentages here. They're pretty complicated. But basically, what you would have here is the gains in the different pools. First of all, if there are any deficits in any pools, gains in other pools would be used to offset those deficits. And then the remaining gains would be shared among the different pools, depending on the percentages here. And those percentages have been aligned to put incentives on the providers that can control different provider's costs, and they would have more risk on those pools.

The next series of charts is a little more detailed blow-up of that last diagram that gets into the specific pools. On Chart 6, you have the percentage of premium coming into the primary care pool from the physician organization. Claims are paid out at 85% of budget, either 85% of fee schedule or 85% of the budget at capitation rate. The rest goes into the reserve pool. And if there are any delivery system deficits, money would be taken out of that pool to cover deficits. Any surplus that's left at the end would then go back to the different pools, based on these percentages. Basically, 10% would go to each of the other pools and the primary care would keep the rest.

Chart 7 is a similar diagram for the specialist. Again, you have the premium coming in from the physician organization, claims paid out at 85% of target, the rest goes into the reserve pool. The one difference here with the specialist is they're not

going to be held accountable for the deficits in other pools. They're basically sharing in the gains, but they're not going to have as much of the deficits since they don't have as much control over the other pools.

Chart 8 illustrates the same thing for inpatient hospital. It is similar again, but uses different percentages based on their control over the different pools. Again, they're not going to be offsetting deficits in other pools.

Now we're going to get into some other options of how this could be set up, different ways to do this (Chart 9). The first one is called the total medical capitation, and basically you've got the HMO paying capitation to the integrated delivery system after they take out their percentage for administration. And then we have two pools, a medical pool and "other" pool, and then within those, you have sub pools. And basically, if there are any losses on the "other" services pool, the medical side will transfer money over to help cover those, but then again, if there are gains on those pools, money will come back in the other direction.

Chart 10 shows an all entity risk-sharing model. Here the HMO is also sharing in some of the gains and losses. So you've got your hospital pool and physician pool, but the HMO is also getting involved here, and there's some more complicated percentages used to share risk between the different funds.

Chart 11 is the integrated delivery system incentive pool risk-sharing model. And we've got a few different options here that we'll go through. In the first one, you have the HMO, and it's fairly similar to the more detailed example at the beginning of the presentation. There may be some different percentages used to share risk but I guess for the most part, there is a similar type concept.

Chart 12 is a combined referral and hospital fund model, which is a little different concept because we've shifted the specialist over with the hospital flow. So, instead of having a physician pool with the primary care, and specialist on the same side, they've been moved over into the other pool I guess this again puts a little more risk on the primary care group, since they do tend to have a little more control over what happens in the other pools.

Chart 13 illustrates another type of arrangement with an incentive pool. Here you have money going to the hospital side, money going to the physician side, also some going into an incentive pool, and then depending on sort of the algorithm defined here of where the surpluses are and where the deficits are, they will work into how that incentive pool gets allocated.

Chart 14 is the risk corridor model. Here the premium goes from the HMO to the integrated delivery system, and then how much of the risk is going to be taken by the delivery system will depend on where the expenses come out. If expenses are above 115% of the target, the HMO pays 25% of those. The delivery system takes 75% of the losses. If they're between 105% and 115%, the loss is split 50/50. Within 5% of the mean, there's no risk sharing and then, when it goes below 95%, you're actually into a gain situation. Then there is a 50/50 split. And below 85%, the HMO is only getting 25% of the gain and the delivery system is getting 85%. And these percentages can vary and the corridors can really be designed any way you want to do it.

The next topic I'm going to get into is something that I don't think has been covered yet. Once you've done all your risk sharing, and you've got your surpluses and deficits and find out how much goes to this pool or that pool, now you actually have to pay the individual physicians within those pools. And so, I'm going to get into some of the methodology views for the primary care pool. How do they allocate that money to the individual physicians or with the specialists? How do they give it to the individual physicians? And even in the hospital pool, you might have multiple hospitals in your delivery system. And basically, there are four ways to distribute the money within the physician pool. You've got a production base system. Basically, you're paying based on the level of production, so it's a fee-for-service type thing. If someone is doing more, they're billing more charges, more CBT codes, and they get paid more money. Next we're going to get into some of the advantages and disadvantages.

Under equal shares, basically everybody gets an equal share as long as they meet minimum requirements. If you don't qualify, then you might not get any of the bonus or the surplus in the pool. Performance improvement is basically looking at improvement from last year to this year. So if you're continually improving, you're going to maximize your bonus payment. And then we get down to performance versus the target. There you would set utilization targets and if you beat the targets, you would get additional bonus. If you don't beat the targets, then you wouldn't.

Table 10 lists some advantages and disadvantages. Obviously, on the production side, if you're strictly using productions, then you're going to give incentives to do things that might be unnecessary, so you probably don't want to have a system that's completely production based. There are some advantages. It's pretty simple to do. You're giving incentive for physicians to work harder, maybe to stay longer and to see more patients, and so I think you want to have some production based incentives in there. You probably don't want to use that as your only method.

TABLE 10
DISTRIBUTION OF SURPLUS POOLS

Methodology	Advantages	Disadvantages
Production	Production or amount of business reflects relative opportunity to contribute to improvements Relatively simple administratively	Does not reflect actual contributions to improvements Creates an incentive at the individual level to increase services provided
Equal Shares	Does not create incentive to increase services provided at the individual level Easiest administratively	Does not reflect actual contributions to improvements Does not reflect relative opportunity to contribute to improvements
Performance Improvement	Provides an incentive for all physicians to improve performance Easier administratively than measuring performance versus a standard or target	May reward historically low-performing physicians and penalize historically high-performing physicians
Performance versus Standard or Target	Rewards high-performing physicians for their contribution	May not provide as direct an incentive to low-performing physicians to improve Most difficult administratively to set targets or standards

On the equal shares, it's also very easy to administer. It doesn't give any incentive to work hard. If you can get the same share regardless of what type of effort you put in, you're going to get physicians who probably won't be trying so hard. And with performance improvement, you're incenting people to improve, but the disadvantage would be if you have a physician who is already doing well, there might not be a lot of room for improvement. So, it would be real hard for a high-performing physician to consistently get a bonus. With the performance targets, you're holding someone to some theoretical targets that you would consider optimal. The tough part is it's often hard to determine what should be optimal

The best thing to do is use some sort of a combination of the methods. You have maybe some percentage based on production and some equal shares, some kind of combination to give the appropriate incentive.

When you're implementing this type of a payment system there are certain things you want to look at. You want to be sure of the criteria that you use to determine who gets the high score and who gets the low score. Make sure that everything is

measurable, and that the things you're going to look at are going to be quantitative. Those are easy to evaluate and other things will be qualitative, like surveys and things like that. You need to establish target levels for each behavior. So if you've identified a behavior, as we think it's important, then you might have some ranges of excellent, good, and different sort of point scales that you can assign to these. So you can determine where a certain physician sits within the scale. Also, you have to make sure that everything fits in with provider contracts, and that you also have the bonus calculation coordinated.

Tables 11 and 12 show examples of this type of a scoring system. There are several measures along the side, under appropriate use; there's things like days per 1,000, non-compliant with M&R guidelines, and c-section rates. There are all kinds of different measures, and depending on the type of physician you're looking at, some of those might have an NA in there. For example, when you're talking about family practice, the C-section rate is out of the control of the family practice physicians, so that wouldn't be looked at. Some of them are going to be more qualitatively based. Under Quality, you've got the member and patient satisfaction, so there would be different surveys that would be done. And then for each one, you would have a best, favorable target, unfavorable, outlier, and depending on where they fall within those ranges, you would assign them a number of points.

Table 13 is an example of how the bonus can then be allocated to the physicians, depending on this type of a system. Here there are a certain number of physicians: we have five physicians, and these are the number of points that each of the physicians had based on our system. We also have the number of members that each physician had, and then you multiply the points times the members to get a distribution of how you will distribute your bonus. So then if you got a \$150,000 bonus, that's how it would be allocated to the different physicians.

TABLE 13
PROVIDER BONUS POOL ALLOCATION

Physician	Points	Members	Points x Members	Percentage of Total Points	Bonus Allocation
One	97	1,000	97,000	24.4%	\$36,530
Two	77	1,200	92,400	23.2	34,798
Three	69	1,500	103,500	26.0	38,978
Four	87	700	60,900	15.3	22,935
Five	89	500	44,500	11.2	16,759
Total		4,900	398,300	100.0	150,000

From the Floor: A couple of questions. One is each of you have described models that have a lot of similarities to them, but I notice, Sunit, your presumption was

fixed dollar capitation, and, Steve, yours was model illustrated percentage of premium. I know you can do it either way, but I was wondering what the prevailing trend is, and whether you have strong preferences about fixed dollar versus percentage of premium type risk-sharing arrangements?

Mr. Patel: If it's a global risk-sharing arrangement, I think a percentage of premium would make more sense. It would automatically adjust for age and sex. It would also automatically adjust for trends.

From the Floor Assuming you're not community rated?

Mr. Patel: That's correct. So I guess my answer is that a percentage of premium would make more sense.

From the Floor: Also, one other question for you, Steve. In your bonus calculations, how do providers feel about credibility? And when you talk about a five-physician group, and you're measuring days per 1,000 physician-by-physician, it seems to me that that subject has pretty wild fluctuations.

Mr. Wander: Yeah, I guess it probably doesn't depend as much on the number of physicians as it does on the number of patients that each physician has. I would say that in the example those are pretty illustrative numbers, but you probably need somewhere between maybe 2,000 and 5,000 to start to be credible. I also think that in a good risk-sharing arrangement, there probably would be some risk adjustment going on. So you know, if someone is getting a higher days per 1,000, because they're getting a selected sicker population, I think that would also be important.

I think the physicians are pretty accepting of it, just because there's probably not a better way to do it. There needs to be a way and they want to have a way that adjusts and is fair. And there's always going to be problems with any measures that you use and so you try to pick the ones that are best.

Mr. John F. Fritz: The question is directed at Sunit, but any of you can answer. The \$120 that you used in your funds flow example, I assume, is some percentage of the total health plan premium, like maybe 80% of it or something like that. Somehow the provider side is going to distribute these funds, and with all of the things we've been reading in the paper about some of the physician management companies having some problems, and great big losses in terms of what's happening on their side, I'm assuming a lot of it is happening because of these capitations, especially global capitations. And when you deal with these global capitations, these provider groups start acting and are really insurance entities. In terms of regulations, what for

example is New York doing in terms of regulating global capitation? Is there a minimum capital requirement or something similar? That's the first part of the question.

Mr. Patel: To be honest with you, I don't know in New York what the legal requirements are. I know that working in New Jersey we have not run into any problems. There are the personal equity plans (PEP) laws and other laws that I guess restrict the risk sharing that you can pass on to providers. So I guess when you look at the whole funds flow model, you should look at what the minimum and maximum level of reimbursement was. I think if it falls within the 25% range, so that not more than 25% of the fees are subject to risk, I think that meets some of the federal laws.

Mr. Wander: I would add to that. With all the risk-based capital stuff that we're seeing now with the NAIC, they're basically only applying that to licensed entities, and licensed health insurers, so it applies to HMOs, but it does not apply to providers. So for the most part, I don't know of any states that really have capital requirements for providers that are accepting risk. Some regulators I've talked to have said, we'll get to the providers through the HMO. So we're going to have the HMO hold the capital, and if the provider did go insolvent, it would all come back up through the HMO. But I think ultimately it would make sense to have any organization that has risk have to have a certain amount of capital, but I don't think there is any mechanism to do that right now. Just because of the fact that the NAIC has no authority to do that.

Mr. Fritz: I think that's right.

Mr. Scott E. Guillemette: Real quick, in my experience with New York, generally with the PHOs or any of those types of organizations, the physician piece is established or organized under some form of an Individual Practice Association (IPA) licensure, and the state does have requirements with respect to that. However, I agree with Steve in the context that from an insurer standpoint, there certainly hasn't been anything that I've seen that's out on the market now.

Mr. Fritz: The reason I asked the question is I think my numbers may be a little bit off, but my recollection is, that a company like Med Partners has something like an \$800 million loss the last quarter of 1997, FPA is having some major problems in terms of losses, as well. Those organizations are moving toward global capitations, and it seems like we don't have the regulations in place and the capital requirements in place for those organizations to take on such huge risks. They're not just taking on the risk of the services that they themselves can deliver. Basically, on a global cap, they're taking the hospital risk. Second part of the question, if you

could maybe address, in the examples you used, what happens if there is a positive surplus in these funds. How do they distribute and how do they pay for the deficits when those deficits occur?

Mr. Patel: One example I've seen is a percentage of the premium (1% or 2%) is allocated initially to build reserves. Hopefully, in the first year there are not significant losses. The hospitals often times will fund that too, initially. And it'll be viewed as a loan to the PHO.

Mr. Wander: In the integrated delivery system example there we are taking 85% of what gets allocated to the delivery system and putting that into the pool to pay claims. Everything is paid at 85% of the target fee schedule. The other 15% is put into a reserve fund that is used to handle the deficit. And I think with the delivery system, if you have a big network, a bunch of hospitals, and all the physician specialties covered, it's pretty hard to have a real large amount of services go outside of your network. So if it's something within your network, within your delivery system, it's really not like a hard dollar loss. You know, if you've got patients with higher utilization, you just have to work harder and see more people. There are certain things that will be hard dollar losses. Generally, they wouldn't be above 15%, so that would be used to cover that. After that, it's just losses to the delivery system, and there really isn't anything to cover it.

Mr. Guillemette: Ultimately, because they're contracting with the HMO, I believe the HMO is responsible if the PHO or the provider becomes insolvent. I believe that's the way it has been throughout the years, and I think it would be treated as such if that ever did happen. I have seen reserves established as Sunit has said; however, aggregate stop loss is another measure to protect against that type of situation. My experience has been that it's a fairly difficult thing; the reinsurers may not sell stop loss until they have a comfortable understanding that the PHO or the delivery system understands the risks that they're getting into.

Mr. Patel: Or on a specific stop loss, it is easier to purchase an aggregate, which would also help a lot.

Mr. Richard G. Rush: A follow-up to John's question. We have seen in the same city, some provider management groups get it and some provider management groups in the same city, with the same plan design and the same employer base, not get it. Some run surpluses, and some run significant deficits. Can the panel address your experience on what distinguishes one type of group within that city from the different group that does get it?

Mr. Patel: I can start off with a short answer, maybe something longer later. But I think a lot of it has to do with physician education and getting the physician buy-in into the marketplace. Also, the level of competition within a marketplace and how much clout the providers have would also play a role in that.

Mr. Wander: I guess from my experience I've tended to see it a little more. Some markets get it and other markets don't get it as much. I haven't seen it too much where you've got two groups in the same market. It seems to me that when you're in an area that has a real high managed care penetration, like Minneapolis or California, the physicians get used to a certain way of practicing medicine and things seem to work out better. They don't realize whether the patient they're seeing is either fee-for-service or managed care, so they tend to get into a style of practicing medicine. And in other areas, it's still fee-for-service and totally different.

Mr. Rush: Within some of the Pacific Care markets there has been success in getting it in the hospital funds and getting it in the physician funds, but almost universally, the area where they aren't accomplishing the targets and running large deficits is on the pharmacy funds. Would the panel address any of the creative things that have been going on in managing those pharmacy costs?

Mr. Guillemette: Personally, I've seen that they've tried to incorporate that risk into the various pools and having performance targets much like Steve had indicated for some of the specialties. However, my personal opinion is that many of the HMOs haven't figured out which of the HMOs primarily comprise providers. I don't think that there has been a good regimen or guideline that has been adhered to by any particular integrated delivery system or HMO. It's one of those risks that's typically been left alone and just assumed to be x percent. I've not really seen anything that's truly effective. We've seen something like formularies and in the institution of generic versus brand, any of those sorts of things. However, I think it really does need to be tied to the physician and how they're practicing medicine in some form. In terms of what types of drugs, the provider is going to argue, I don't want to be put at risk for drug x, especially for example, in the HIV AIDS area. That's changing every day. And you know, the question that they pose is a valid one. Would you like to be put at risk for something like that? So that's why I think there has been a little bit of hesitance to really dig into that and aggressively manage it, but it certainly is the next area I believe.

Mr. Wander: The one thing I want to add to is on the drug side. I think one of the biggest problems is just the unit cost, maybe a little more than the utilization. It's going out of control. There are so many new drugs coming out, like the Viagras and things like that. There was some decision or legislation several years ago that allowed drug companies to advertise on TV and go right to the consumers and

you've got people asking for drugs. They don't even know if they need it, but they want this drug. So I think, on the drug side, it's going out of control more maybe on the unit cost side. In these risk-sharing arrangements, you may have a physician group put at risk for prescription drugs, and they can have some control over the utilization by maybe not writing so many prescriptions or not writing unnecessary prescriptions. But, there are going to be some that are necessary, and if the unit cost keeps going up and up, it's going to keep trash in the pools I guess.

Mr. Wander: And I think another thing I remember from Ms. Wear's (from the pharmaceutical card system (PCS)) presentation was that PCS does not like to take risk on the drugs.

Mr. Bruce R. Sobus: I have a question with respect to point-of-service claims, where the member can opt out or self-refer outside the IDS network or PHO network. How is that accepted? Or how is that dealt with generally?

Mr. Wander: Point of service obviously is a different product, so I think you'd need a different risk-sharing arrangement to handle that. That's sort of a tough one there. I guess I've seen things where they've done capitations, and maybe the capitation on a point-of-service member might be 80% of what the capitation would be on a regular commercial member. I've also seen point-of-service capitations where it's the same as it would be for a regular commercial HMO member.

Mr. Sobus: But generally, does the PHO take the risk for self-referral outside the network?

Mr. Wander: I've seen it, but they probably would prefer not to.

Mr. Sobus: It seems like in the other way it wouldn't work for the carrier.

Mr. Wander: Right.

Mr. Guillemette: In all my experiences of working with PHOs, they've just accepted the risk. However, we've very loudly communicated to them to be careful with what they're doing. A book called *Actuarial Aspects of Fee-For-Service and Prepaid Environment*, generated by the Community Reinvestment Act (CRA), and written by Alan Sorbo and Harry Sutton, illustrates very well some of the issues with respect to point-of-service plans and how they're addressed in capitation, which is essentially something that is tied heavily to these global arrangements. But I'd be very wary of a point-of-service product just being thrown over the top of one of these arrangements. It's strictly a function of the network and how dispersed it is and what types of providers there are. Does it include the primary tertiary facilities

and a lot of those things? I think that's something that needs to be looked at very thoroughly.

From the Floor: I'll add a couple of comments. We've seen in our risk-sharing arrangements, some provider groups that are interested in taking only the in-network risk for point of service and others where the providers were actually interested and anxious to take both in-network and out-of-network. The providers actually set up parallel funds, in-network funds, and out-of-network funds. Some of that, I think, has to do with the sophistication of the provider. Maybe inversely proportional to the sophistication of the provider, because I think that some of the providers just see the out-of-network piece as an additional source of income, without fully understanding the claim costs risk associated with it.