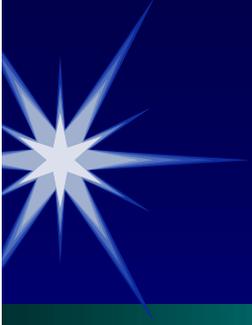




**CHALLENGES AND OPPORTUNITIES
FACING CALIFORNIA'S PHYSICIAN
ORGANIZATIONS**

**California Health Care Symposium
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University of California, Berkeley**



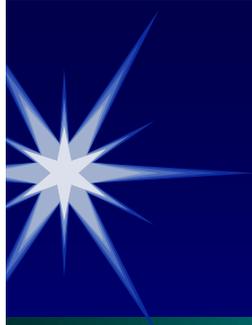
Overview

- ⑩ Network promiscuity
- ⑩ Financial standards and solvency
- ⑩ Capitation payment methods
- ⑩ Data and information technology
- ⑩ The only future with a future



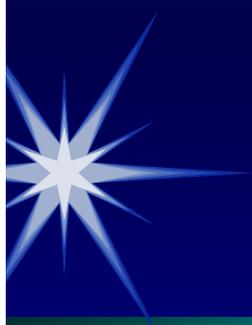
The Original Concept of the Delegated and Capitated Network

- ⑩ HMOs would contract with small number of large physician organizations
 - ⑩ Who are committed to managed care
 - ⑩ Have financial and organizational capabilities
 - ⑩ Joint planning, marketing, lobbying
- ⑩ Success of Kaiser-Permanente proves this can work well



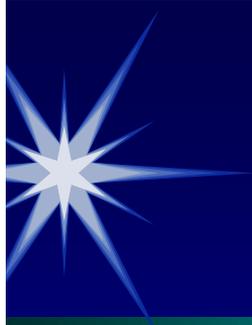
Current State of HMO Networks (outside Kaiser-Permanente)

- ⑩ Approximately 250 medical groups/IPAs
- ⑩ Largest 50 groups serve 2/3 of enrollees
- ⑩ Wide variation in solvency, competency
- ⑩ All HMOs contract with (almost) all groups
- ⑩ No network differentiation, investment



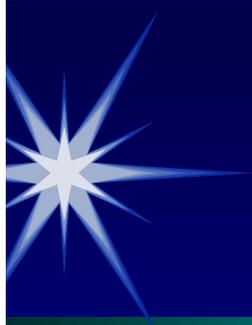
Effect of Network Promiscuity

- ⑩ No mutual investment by plans and groups
 - ⑩ IT, medical mgmt, claims processing
 - ⑩ Marketing, lobbying, public relations
- ⑩ No product differentiation among HMOs
- ⑩ Neither broad choice nor true efficiency
- ⑩ Continued turbulence among groups/IPAs



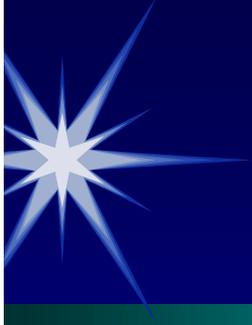
Why Do HMOs Maintain Dysfunctional Networks?

- ⑩ 1. It's the fault of the health plans
- ⑩ 2. It's the fault of the physician groups
- ⑩ 3. It's the fault of the purchasers



It's the Fault of the Health Plans

- ⑩ Network of large, sophisticated groups and IPAs would improve efficiency, quality, consumer service, political image
- ⑩ But health plans fear monopoly power
- ⑩ They retain weak groups (large and small) to undermine payment rates and power of physician organizations



It's the Fault of the Physician Organizations

- ⑩ Most physician organizations are poorly managed (large, small, clinic, IPA)
 - ⑩ No financial reserves, weak governance
 - ⑩ No IT investment, organizational infrastructure
 - ⑩ Refusal to consolidate successfully
- ⑩ Difficult for plans to predict who will do well and hence must contract with all



It's the Fault of the Purchasers

- ⑩ Large purchasers choose plans mostly on network (physician, hospital) coverage
- ⑩ Want non-differentiated networks to threaten plan termination unless reduce premiums
- ⑩ Do not fix contributions to pass full benefit of lower premium to employee



Financial Solvency

- ⑩ Leading groups have thin operating surplus but weak balance sheets due to years of underfunding and underpricing
- ⑩ Unfunded liabilities to rank and file MDs
- ⑩ Traditional cost control strategies are no longer effective (reducing days/1000, specialist fees)



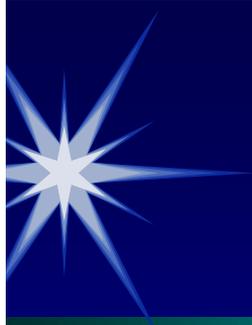
Looming Regulatory “Solution”

- ⑩ Capitation rates are rising
- ⑩ But groups are unable to fund reserves
- ⑩ If solvency board interprets capitated groups/IPAs as risk-bearing insurance entities, capitation will go away
- ⑩ HMOs need to resolve fears of “paying twice” and develop regulatory strategy



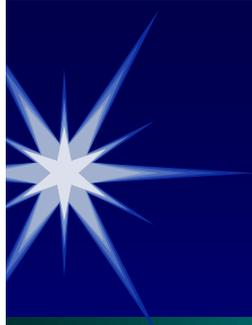
Capitation Payment Methods: Basic Principles

- ⑩ Physician groups should be responsible for those services that they control
- ⑩ Insurers should be responsible for epidemiology, insurance risk
- ⑩ Purchasers/consumers should be responsible for cost of new drugs and devices, standards of care, mandated benefits



The Current Capitation Contract is Far out of Line with Principles

- ⑩ Physician organizations for many services that they do not control
- ⑩ This has weakened them financially and disenchanted them with delegated model
- ⑩ Pullback of capitation is accelerating
- ⑩ Cheshire cat: nothing left but the smile?



Injectible Medications and New Devices

- ⑩ HMOs must pay on a FFS basis (“insured services”) for new drugs/devices until actuarial experience is gained and capitation contracts are re-negotiated
- ⑩ Otherwise physicians will support legislation/regulation to mandate FFS payment



Outpatient Pharmaceuticals

- ⑩ Most groups have renounced pharmacy capitation due to DTC advertising, pipeline of new products, FDA unpredictability
- ⑩ Gainsharing (upside risk with reasonable targets) is better than no risk, for both plans and providers
- ⑩ Uncontrolled costs hurt everyone



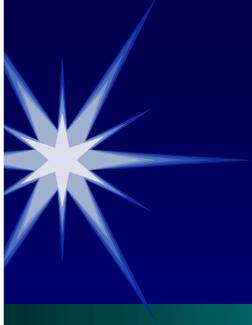
Hospital Services

- ⑩ Hospitals are raising per diem rates and resisting concurrent review
- ⑩ HMOs must increase risk pools commensurately or MDs will abandon UM
- ⑩ Variety of group/IPA views on dual risk versus shared risk versus gainsharing



Data and Information Technology

- ⑩ Delegated model is woefully behind
 - ⑩ Connectivity between plans and groups
 - ⑩ Connectivity between groups and MD practices
 - ⑩ Connectivity with hospitals, pharmacies, etc.
- ⑩ Groups lack capital and management to invest in IT: hardware, software, staffing, training



Information Technology Standards

- ⑩ Any IT initiative that does not fit all major health plans and providers is useless
- ⑩ Standards are essential
- ⑩ Plans need to cooperate with each other and with major groups/IPAs
- ⑩ MedUnite is interesting but may seek to disintermediate the groups/IPAs



Eligibility Data

- ⑩ Some problems stem from data, not IT
- ⑩ Eligibility versus capitation reports
 - ⑩ Always late, error-filled, biased
 - ⑩ Why cannot these be combined?
- ⑩ This issue is symptomatic of incompetence and/or bad faith



Benefit Design

- ⑩ HMO marketing staff push for infinite permutations of copays, coverage
- ⑩ Extremely costly for groups to administer
- ⑩ Often unclear which patient has which benefit coverage; need daily data refresh
- ⑩ Joint planning (plan/provider) on benefit design would be valuable



Conclusion: Avoiding Mutually Assured Destruction

- ⑩ The HMO product suffers from years of financial and intellectual underinvestment
- ⑩ Relations between plans and providers are terrible, consumers have bad image of HMO, regulators/litigators are energized
- ⑩ It is last call for the medical group model



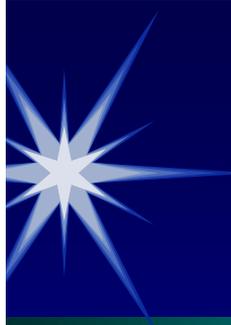
The Only Future that has a Future

- ⑩ The delegated model rests on cooperation between leading plans and providers
 - ⑩ Product design, pricing, and marketing
 - ⑩ Administrative and clinical operations
 - ⑩ Transparency and trust for rank and file MDs
 - ⑩ Politics and public opinion



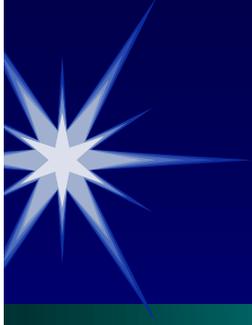
Health Plans must Reach out to Physician Organizations

- ⑩ Sustainable capitation payments
 - ⑩ No more surprises
- ⑩ Timely, accurate, and honest data
 - ⑩ No more surprises
- ⑩ Standards and investment in IT
 - ⑩ No more surprises



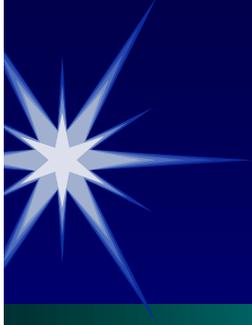
Physician Organizations Must Reach out to Health Plans

- ⑩ Audited financials, tangible net equity
 - ⑩ Act like a real business
- ⑩ Governance, management, leadership
 - ⑩ Act like a real business
- ⑩ Stop the termination letters
 - ⑩ Act like a real business



Memorable and Quotable

- ⑩ “Successful firms outside the health sector listen carefully to their customers and then build partnerships with their key suppliers and distributors to build the product the customer wants.”



Memorable and Quotable

- ⑩ “Health plans and physician organizations have fired on each other until everyone ran out of ammunition. Now we all are drawing bayonets.”