Global Reach

MR. LESLIE MICHELSON AND DR. JACQUELINE KOSECOFF

Physicians and Managed Care

Worldwide Education Seminar • April 20

At the April Worldwide Education Seminar, Mr. Leslie Michelson and Dr. Jacqueline Kosecoff described the complexities of motivating and compensating physicians in a managed care setting. The two speakers—introduced by Peter Brandt, Vice President of Planning and Business Development—brought their unique perspective to a lively discussion of the managed care environment.

Michelson and Kosecoff, who spoke last year on Disease Management, are co-founders of Value Health Sciences (VHS), a premier health care research science company that specializes in consulting and software development. Located in Santa Monica, CA, VHS is well known in the industry for the development of science-based tools used to support medical management decision making. Their products include the Medical Review System (MRS), an interactive expert system that assesses the appropriateness of selected medical and surgical procedures; and the Practice Review System (PRS), an automated system designed to enhance the quality of care and contain costs by applying sophisticated clinical logic to profile physician practices.

Pfizer is working with VHS to develop the next generation PRS program, which will include pharmaceutical utilization and its profiling capabilities, and VHS has dedicated a unit to help Pfizer develop its disease management offerings.

What Prompted the Health Care Revolution?

Says Michelson, "About two and a half years ago, an extraordinary thing happened in the United States. For the first time in the history of this country, the organization of an industry became the focal point of a presidential election. That had happened in the late '20s and early '30s in the banking industry, and with the railroad industry, but the focus there was in defining the role of government in regulating abuses within that industry."

"Why did the organization of the health care industry become such a critical issue?" Michelson continues. "How did that happen? It's true that the promised legal reforms didn't occur. But in some ways that's irrelevant, because reform is actually happening today through the rapid growth and development of managed care. What were the driving forces behind this issue?"

The first such force is cost—which is skyrocketing. A safe prediction is that more than 20 percent of our

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gross domestic product will soon be spent on health care. The U.S. spends more per capita on health care than the industrialized countries in Europe, and the gap in spending levels has been increasing over the last 14 years.

Yet in urging health care reform, the question becomes, "Who is going to pay for it?" The government became involved in the debate because government expenses for health care are squeezing out all other programs. Says Michelson, "If you didn't launch an initiative to reform the health care delivery system, you would have no domestic program. That's why there was a crusade in Washington to reform the system."

Michelson believes that businesses supported health care reform because it's their after-tax dollars that are spent on health care. And their health care expenses have steadily climbed.

At the same time, the percentage of disposable income that individuals spend out-of-pocket for health care has actually dropped. About 3 percent of individual disposable income is spent on health care today, versus about 3.25 percent in 1960. Michelson stresses that the middle class has been insulated to a large degree from the growth in health care costs by insurance, and by government programs such as Medicare and Medicaid.

The present health care delivery system has failed to persuade the public that the value they're getting is worth the incremental cost, Michelson claims. "We've made tremendous progress in reducing the age-adjusted mortality from a variety of diseases, and the pharmaceutical industry in particular has had unbelievable success in helping eradicate and diminish disease. I think the whole industry needs to do a better job of getting the message of the value of its research out to the public."

"But," he cautions, "there are some areas where we have been unsuccessful, and people have a sense about that. For example, the increment in life expectancy has not increased greatly over the past 30 years. Although the U.S. spends much more than its trading partners, it cannot show that life expectancy here is any higher."

Quality is also an issue. Says Michelson, "There is no question in anyone's mind that we have the best health care delivery system in the world. But there are still significant problems. We have done analyses of 16 major academic medical centers—some of the most distinguished health care names in the world. We worked with them to develop criteria for things like instruction in breast self-exams, flu vaccines, and diabetes control." Applying their data to the criteria they developed, VHS studied the medical centers and—by their own standards—they came up short. Explains Michelson, "We found that they provided instruction in breast self-exam, on average, only 50 percent of the time. The best performing player did it only 63 percent of the time, and the worst did it in one third of the cases. In the worst hospital, only 4 percent of the patients who—by their criteria—should have had flu vaccines, actually got them."

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Michelson cites a study of 182 consecutive deaths at 12 hospitals. "Should these people have gone out through the front door or the back door?" he asks. "What we found was that between 18 and 37 percent of those deaths—by the judgment of our expert panel—were preventable as a result of specific, identifiable process errors that should never have happened. Again, people don't know the data, but they have a sense about it. And we, as an industry, need to do a much better job of improving quality."

"All of this is why we've got managed care. There are very powerful forces in the economy and society driving it."

Integrating Health Care Financing and Delivery

Michelson defines managed care as a system that integrates both the financing and delivery of health care to a defined population. It typically has a variety of components. "You select providers, and you have explicit standards for their selection," he says. "You put in place formal programs to control and monitor what's going

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on in terms of utilization and quality. And then you construct financial incentives for members to use the providers that you have carefully selected, and financial incentives for those providers to offer high quality, cost-effective care."

The most popular form of managed care is the HMO. An HMO combines the insurance and provider functions typically paid on a fixed PMPM—per member, per month—basis. Providers are usually placed at risk for the cost of particular services that they are responsible either for providing or influencing.

An important structural component of many HMOs is a primary care provider who acts as a triage agent or "gatekeeper," preventing patients from unnecessary access to specialists and other services.

Michelson lists five factors for HMO success. "You need to get physicians to accept financial risk," he says. "You need to change their incentives. You need to shift services from an in-patient to an out-patient arena. You need physicians to share in the risk for over-utilization. And you need to have some centralized resource for facility and financial planning."

There are four HMO models: staff, group, network, and independent practice association (IPA). The HMO movement started with staff models; over the years, it has evolved to group, network, and the most common form, IPA.

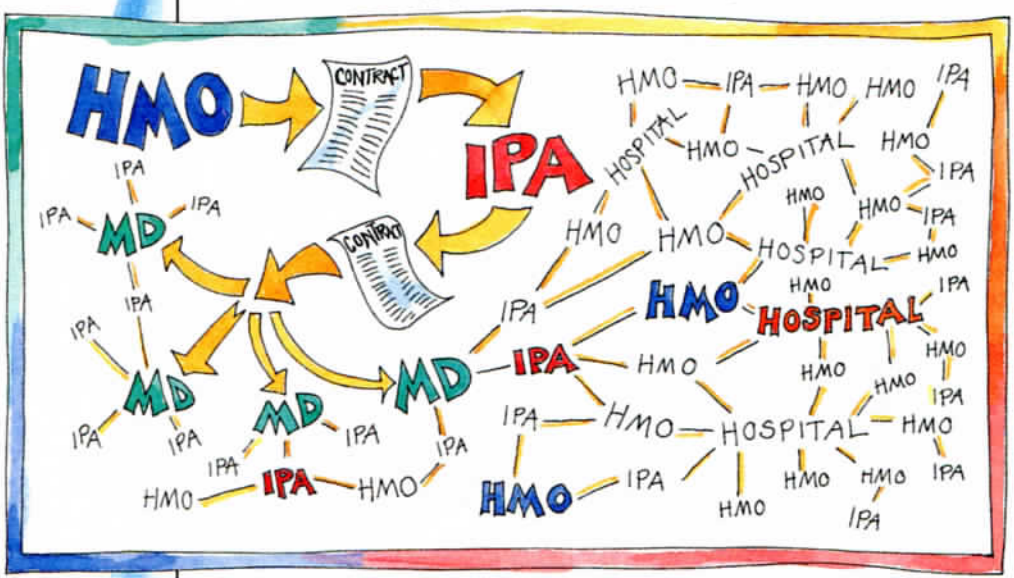
A staff model HMO is one that receives money from an employer to provide a full set of health care services for a defined population; has direct employment relationships with physicians on staff; has nurses on staff who provide care; and either owns a hospital or has contracts with other hospitals. Kaiser Permanente is an example of a staff model HMO.

A group practice HMO model is one in which a medical group has a contract with an HMO, and is fully utilized by that HMO.

Network model HMOs have contracts with several group practices. Those practices also have contracts with other HMOs, which have contracts with hospitals that have contracts with other HMOs as well.

The IPA model HMO is the most complex. In this model, an HMO contracts with an IPA, which in turn has contracts with multiple physicians, each of whom continues to practice in his or her office and has similar relationships with—on average—3 to 10 different IPAs. Each IPA, in turn, has contracts with multiple HMOs, and each HMO has contracts with multiple hospitals and other provider organizations, who in turn have contracts with multiple HMOs.

Says Michelson, "This is a very complicated—in some senses quite chaotic—organizational structure. If you go out into the marketplace as we have, what you'll hear from physicians and hospitals are robust complaints about the administrative difficulty of functioning in a context with that many different connections and linkages. My own view is that simplification must take place."



How HMOs Affect the Industry

Asks Kosecoff, "Did HMOs actually take off? Do they work? I don't know if they're working, but I can tell you that they're growing in number and they're growing daily."

In 1986, only 26 million Americans were covered by HMOs. In 1995, an estimated 50 million Americans will be covered by HMOs. This extraordinary level of growth is projected to continue for the foreseeable future.

Most of this growth is coming in the IPA model HMOs. Asks Kosecoff, "What does that mean for those of us who are trying to effect disease management, or sell pharmaceuticals within the managed care industry? It means that, when we finally get down to the level of a physician, that person is talking to between 30 and 40 different HMOs every day through his or her IPA relationships. They're very distracted. No one group controls enough of their business, or patients, to warrant their undivided attention. And, last but not least, physicians are both disturbed and inconvenienced by the fact that IPAs have competing rules and regulations. As a result," Kosecoff says, "physicians not only have to worry about what's wrong with the patient, but also about what the particular benefit plan for this program will permit the doctor to do for this patient. This is often based on seemingly weak clinical considerations."

"On the other hand, if you were the CEO of a large corporation in America today, you'd say, 'While I'm truly sorry for my friends the doctors, they're still earning a whole lot of money'," Kosecoff continues. "'Meanwhile, HMOs are saving me money.' The fact is, if you look at the rate of increase in all health plans from one year to the other, the HMOs are finally beginning to show actual decreases in premiums. So, yes, they seem to be achieving some of their financial goals, which continues to make them very popular with corporate America. Are they satisfying physicians in terms of providing a happy and meaningful clinical vehicle for them? Probably not."

How do HMOs make money? First, they attempt to lower hospital costs by either owning the hospital resources or coming into a town with sufficient patient volume so as to develop deep discounts for hospital bed days.

They also attempt to control specialists in several ways. For example, HMOs don't pay specialists as much. A specialist who works for Kaiser, for example, typically earns less than a specialist in fee-for-service medicine. More importantly, however, HMOs reduce the number of visits to—and services from—specialists.

In the average community, the mix of specialists to primary care doctors ranges from about 20 to 30 percent primary care doctors, and 70 to 80 percent specialists. In the average HMO, it's about a 50-50 split. Stresses Kosecoff, "That's a very fundamental change. To effect that change, they're driving patient care away from specialists and back toward primary care physicians. That's important for those of us who are working with family physicians. It's even more important for those of us who are developing disease management programs, because primary care and family physicians and internists become a very important focal point for directing care."

HMOs save money by attracting younger, healthier patients. A patient with a serious chronic illness such as diabetes might be frightened to join an HMO, where he or she is locked into a particular set of providers. On the other hand, a healthy 22-year-old—who doesn't expect to visit a doctor in the near future—wants to spend as little as possible on health care.

HMOs use their concentrated buying power to get discounts. They also reward physicians in a fundamentally different way than fee-for-service managed care. Points out Kosecoff, "In the world of fee-for-service managed care, doctors get paid for doing more. And in managed care, it's the exact opposite. The incentive is to do less."

HMOs have many utilization management controls. Says Kosecoff, "Among the most effective is reorganizing clinical practice. If, 20 years ago, it would take a geriatric patient half an hour for a brand new consultation, nowadays that patient may get 10 minutes. And if you don't complete the consultation in 10 minutes, you'll find yourself working 24 hours a day to get through the number of patients that have been booked for you."

Finally, HMOs save money through the use of gatekeepers. Kosecoff defines a gatekeeper as a primary care physician pre-authorization to specialty care. Illustrating this point with an anecdote, she says, "One of our VHS co-workers broke her ankle this week, and because we're a managed care company, the emergency room doctor said, 'Bad news: your ankle's broken, call tomorrow and

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get casted.' She called the next day, and they said, 'Oh, you can't see an orthopaedist. You must see your primary care doctor for a referral.' She said, 'You don't understand. I have a problem. My ankle's broken, I can't move. How am I going to get first to the primary care doctor and then to the orthopaedist?' They said, 'You don't understand. You haven't seen a primary care doctor. Until the primary care doctor sees it, until he or she reads the X ray and believes that the ankle is broken, you're not going to see an orthopaedist.' This is a new world."

Exploring Other Forms of Managed Care

Managed care takes other forms besides that of the HMO. For example, a PPO, or preferred provider organization, is an alternative to a tightly managed HMO. In a PPO, doctors get together and form a network. The most important aspect of this network in the first generation PPO is that there are no restrictions on it. Virtually anybody can join. Patients can see doctors inside or outside the network; there is no gatekeeper, and doctors get paid a discounted fee-for-service. Thus, in return for discounting their normal rates about 10 to 20 percent, they can stay in fee-for-service medicine.

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Says Kosecoff, "PPOs, on behalf of their physician members, go to the purchasers and offer large contracts. If company 'XYZ' gave me a large contract and said, 'Here's 100,000 lives, please go into metropolitan Los Angeles and arrange for health care,' one fast way to get started would be to talk to a PPO that had many doctors and offer them a discounted fee-for-service in return for access to the company's patients."

Second-generation PPOs are called EPOs, or exclusive provider organizations. An EPO is an extreme form of PPO. In EPOs, members must get care from the doctors in that network. EPOs are more exclusive about who can join the network. They're also more concerned about the provider mix within the network; they have to make sure to have one psychiatrist, one cardiologist, one nephrologist, and so on.

Says Kosecoff, "EPOs have now introduced the concept of gatekeepers, so patients can't go directly to the nephrologist; they have to first go to the internist. This is a bit self-serving, since the basic mechanism is still fee-for-service. If I'm an internist, and you can go see Peter the nephrologist without me, I don't get any revenue. Whereas if I at least have this arrangement with Peter that you have to see me first, and I control it, then we're each sharing a little. On the other hand, the economic theory says that if we all share a little bit in the incentives for making the health care system go, I'll only send to Peter people who have serious headaches, not a person who has had one headache in the last 14 years."

The last, and newest, form of managed care organization is the point-of-service plan. Point-of-service plans try to combine the best aspects of HMOs and PPOs. They enable patients to stay within the group or go outside if desired. If patients choose to go outside, they may have to pick up 20 percent of the total cost that the doctor bills the insurance company. Explains Kosecoff, "This is a very new model; it's catching on very quickly since most people fear HMOs because they're closed. In this model, they can take advantage of the cost savings of an HMO but choose to go outside for particularly serious problems."

Managed care is growing very quickly. In the year 1980, only 8 percent of people in commercial insurance plans were in an HMO. By the year 2000, 85 percent are projected to be in some kind of managed care arena.

HMOs are expected to represent about 35 percent of all commercially insured patients by the year 2000. Point-of-service plans are growing rapidly as well. Says Kosecoff, "Since you can look at HMOs and point-of-service as just open and closed model HMOs, then the fact is that

65 percent of us are going to be in one of those plans. We're going to have gatekeepers, strict utilization, providers who are being 'incented' to do less, not more. That's the driving force moving physicians in the year 1995, and will continue to be in the year 2000."

Reimbursing Health Care Providers

How do physicians, facilities, and other health care providers get reimbursed in the managed care world? The most typical way of reimbursing physicians in managed care organizations is discounted fee-for-service. "Withholds" also play a role. Kosecoff defines withholds as a mechanism by which, "if I pay you as an internist a PMPM or a discounted fee-for-service, I take away some of that each month. I don't pay you the full amount. Typically, I take away about 20 percent of that, and return it to you if—and only if—you keep utilization down throughout the system."

In some plans, withholds are so small that they would not influence physician behavior, while in others they are larger than the physician's salary. Thus, withholds can be a powerful physician incentive.

Hospital and specialty risk pools may play a role as well. Such pools enable primary care providers to be paid an additional dividend, depending on how well they control use of the hospital and specialists.

HMOs can offer hospitals discounted fee-for-service. Explains Kosecoff, "I'm an enormous HMO. When I come to town, I tell the hospital, 'If you want to be part of my network, I expect to spend 50 percent of what everyone else is spending on a hospital bed.' Another model I can use is per diems, which are very complicated formulas. I can figure out that an ICU bed costs $1,200 per day, a low intensity bed costs $600 a day, and a normal bed is $800 a day. Based on a typical population mix and 100,000 patients, we would expect to pay $852, on average, per hospital bed per day. The HMO takes a discount, pays $800 a day, and says, 'We don't care where you put them, but don't charge us more than $800 a day.'"

Finally, hospitals can be paid case rates. The most famous example of case rates is Diagnostic-Related Groups (DRGs), which were introduced by the Medicare system. With DRGs, the reasons for hospital admission are distilled into one of several hundred-odd groups. A set fee is paid, regardless of how little or how much is done for the patient.

How Capitation Affects Managed Care

Kosecoff believes that capitation has changed the face of managed care. The basic concept behind full capitation is that a risk-bearing HMO utilizes a primary care group to provide care to a population of patients. If the HMO is receiving $120 per month, $20 per month is kept by that HMO for administrative overhead and profit. The other $100 per month is passed on to the primary care group, which has full responsibility for providing all services to patients.

There are variations on this theme. A group can be sub-capitated for their professional services. Explains Kosecoff, "I can go to a group of primary care doctors, and say, 'If you don't want to take full capitation, we'll offer you capitation only for the primary care services you offer and your professional fees. You get $2 per patient per month.' Or, I can capitate their full professional fees and take charge of only the hospital costs."

Incentives vary depending on the type of capitation arrangement doctors take. Moreover, the amount of money that can be earned varies dramatically, because in a true capitated environment, tremendous amounts can be saved by avoiding the use of hospitals.

Incentives play out in a number of ways. Says Kosecoff, "If I have capitation responsibility just for my primary care professional fees, then I'm totally 'incented' to send every single patient to a specialist. On the other hand, if I have capitation responsibility for all professional services, I don't want to send anybody to a specialist because I'm going to have to pay that specialist's fee. Furthermore, if I take responsibility for hospital care as well, I'm going to think three times before I hospitalize a patient who can be managed in an outpatient facility."

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These incentives work in reverse with specialty care capitation. Explains Kosecoff, "If I'm a specialist taking capitation for cardiology care, all of a sudden my attitude changes. I no longer think that every single case of angina needs to be managed by an invasive cardiologist, such as myself. In fact, I don't understand why the primary care doctors aren't taking care of some of these simpler problems."

Capitation has changed the health care world by helping drive down costs. However, because capitation typically motivates primary care doctors to keep patients in the group, it has hit specialists very hard.

Managed Care Restrictions & Growth

In spite of savings, state legislation is slowing the development of managed care. According to Michelson, these factors fall into three categories. The first is "any willing provider" legislation, which is state legislation that forces a health plan to accept any provider who is willing to meet the health plan's terms, fees, and conditions as a participating provider.

The second factor is "freedom of choice" legislation, which compels an HMO to permit members to seek care from any non-participating provider. In some extreme cases, this legislation may also prohibit financial incentives designed to promote the use of managed care.

The last factor is "due process" legislation, which imposes on the HMO business significant constraints on the process by which provider applications are accepted and considered, and the process by which providers who aren't performing in an acceptable way are removed from participation in the panel.

Managed care companies thinking about how to do business must be acutely sensitive to such state-by-state restrictions. And pharmaceutical companies hoping to do business with them must be sensitive to these restrictions as well.

What happens when managed care comes to town? Michelson defines four stages. The first stage—0 to 10 percent managed care penetration—doesn't change the status quo significantly. Hospitals operate independently, physicians continue to thrive, and fee-for service clearly remains the dominant form of reimbursement.

The situation begins to change in Stage Two, with 10 to 30 percent managed care penetration. In this stage, physicians begin to identify the need to form networks so they can have a coherent structure.

Employers begin to form employer coalitions to put pressure back on the system and consolidate their otherwise diffuse power. Hospitals begin to consolidate into systems because everyone is looking for scale and protection. And specialists begin to feel the economic chill.

In Stage Three—30 to 50 percent managed care penetration—things really begin to change. Very large networks of multi-specialty groups begin to dominate the market. Hospitals align themselves to sometimes as few as three or four systems. Prices become intensely competitive, and specialists become "very, very much in surplus." The payor base begins to consolidate, with HMOs acquiring one another. Emphasizes Michelson, "The game in managed care is going to be highest relative local market penetration. That's what it's going to be, and everybody is vying for it."

In the final stage—50 percent or more managed care penetration—virtually all the providers are in networks. There is a very highly concentrated payor base, and intimate linkages between physicians and hospitals. The trend toward Stage Four is continuing throughout the country.

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The most important changes occurring as a result are integration and disease management. Says Michelson, "Integration is when you have a payor who collects 100 cents of premium to provide health care for a defined population, and then sends 82 cents of every dollar to an integrated delivery system in a particular geographic area that has primary care, specialty care, and hospitals integrated within the same economic entity."

"We've also had a new animal introduced into this environment over the past couple of years: the commercial practice acquisition companies—publicly traded companies that do nothing but acquire and manage physician practices," Michelson continues. "The profession of being a physician is being turned into a commercial enterprise, not unlike Pfizer or Value Health. This is going on everywhere. There are literally hundreds of millions of dollars that have been committed to the acquisition of physician practices as part of the development of integrated systems."

Analyzing Disease Management Programs

The other important change in the restructuring of our delivery system and the evolution of managed care is disease management. Asks Kosecoff, "What are the things we need to worry about when we think about disease management and the whole managed care environment? First, the control of providers. Second, the approach to the disease. And third, which provider groups are we actually addressing?"

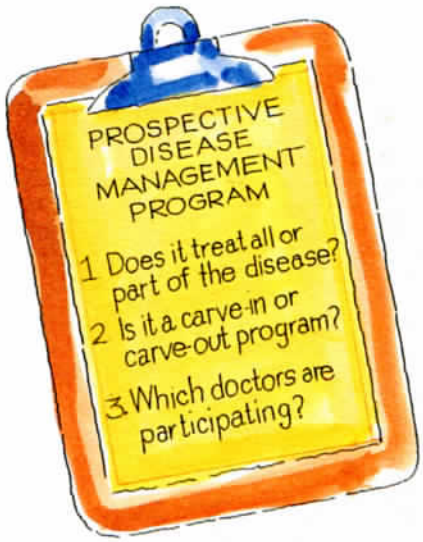
There are two ways to control providers: carve-ins and carve-outs. Michelson illustrates a carve-out with the following example. "Value Health, Inc., owns a mental health company called Value Behavioral Health. We go to employers and managed care companies and say, 'You guys are doing a less than perfect job of managing mental health. We'll do a much better job. The price of admission is not your doctors, but ours'."

"The advantage of carve-outs is that, because you control the provider network, you can control the whole health care dollar, or, in the above example, the whole mental health dollar. And when you're thinking about capitation, it's easier to take risks because you're controlling all the resources yourself."

The disadvantage of carve-outs is that they are primarily limited to the worlds of mental health, dentistry, and ophthalmology, since most managed care networks are unwilling to give up the management of diseases for which they have long provided treatment.

Michelson illustrates carve-ins as follows: "We, as a disease management company, go to the managed care organization and say, 'We're going to improve the quality and reduce the cost of care, and we're going to do it using your provider network, your hospitals, your infrastructure.' They like that much better. The problem is it's a greater challenge, because you now have to find and work with those doctors."

Disease management programs may be focused or comprehensive.



A focused program consists of targeting a particular problem, such as asthmatics not using their peak flow monitors well enough, and working to correct it. A comprehensive program targets the entire management of asthma, from diagnosis through therapy and complications. Both focused and comprehensive disease management can occur in the carve-out or carve-in environment.

Says Kosecoff, "I would advise you, whenever you look at some of these new disease management programs, to ask, 'Just what is this? Is it comprehensive care for the whole disease, or focused care for just part of it? Is it being offered within the network as a carve-in, or outside the network as a carve-out? And which doctors are using that program, primary care physicians or specialists?' If you can't get a good answer to these questions, my guess is that the program won't succeed in today's very structured managed care market."

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