

PHYSICIAN PRACTICE OPTIONS™

IMPROVING PATIENT CARE THROUGH INCREASED PRACTICE EFFICIENCY

September 2004

EDITORIAL

Authors Explain the Language of IT 2

STRATEGY

Fairness of MICRA Is Questioned 3

TECHNOLOGY

Data-Matching Programs Compared 6

INTERVIEW

Four Top Medical Centers
Have Much in Common, Author Says 8

COMMENTARY

Should the Federal Government
Pay for Treating Obesity as a Disease? 11

MANAGED CARE

Aggressive Strategies Are Back 13

Authors Explain the Language of IT

Health care is woefully behind other industries in embracing information technology. Even so, health care organizations of all sizes have achieved success with computer systems, which is what William Bria, MD, and Richard Rydell point out in their book, *The Physician-Computer Conundrum: Get Over It!* In this new book, published by the Healthcare Information and Management Systems Society, the authors explain how physicians can use a structured and phased approach to implement information systems.

Bria, a leader in applied medical informatics, is a clinical associate professor of internal medicine and medical director of clinical information systems at the University of Michigan School of Medicine in Ann Arbor. He is also the medical co-director of the university's medical ICU and asthma airways program. Richard L. Rydell, MBA, is a founder and executive director of the Association of Medical Directors of Information Systems, and senior vice president and chief information officer at Memorial Health Services, in Long Beach, Calif.

Bria and Rydell offer case studies to press their point, and address such topics as which term in industry parlance is more appropriate: "electronic medical record" or "electronic health record." EHR is replacing EMR as the term of choice because it implies health maintenance, prevention, and self-management and conveys a notion of patient engagement, they say. The authors also discuss nagging abbreviation problems, such as whether CPOE means "computerized pharmaceutical order entry" or "computerized provider order entry." They argue that computerized provider order entry is more comprehensive and encompasses all providers (including physicians, nurses, technicians, clerks, and hospitals).

In their book, Bria and Rydell discuss how clinician information systems offer physicians many advantages. Such systems allow physicians to view a wide variety of patient data during a patient visit, to spend more time with patients, to retrieve charts instantly, and to eliminate dictation. They enable physicians to be productive in all aspects of their practices, so that they can see more patients and thus increase income. They also help improve cash flow by speeding claims processing and help physicians get compensated at the highest appropriate code level. By improving computer documentation, they also afford some protection against malpractice suits, the authors say. What's more, clinical information systems allow staff to schedule appointments on the day patients call, reduce waiting times, facilitate scheduling of appointments and refilling of prescriptions, make it easy to get and send laboratory or x-ray reports, and provide timely educational material. In this 90-page book, Bria and Rydell state their message in clear and compelling language: clinical information systems afford a healthy return on investment.



Richard L. Reece, MD

Editor in chief

Phone: 860/395-1501

Fax: 860/395-1512

E-mail: Rreece@premierhealthcare.com

This newsletter is published by Premier Healthcare Resource, Inc., Morristown, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

Publisher

Premier Healthcare Resource, Inc.
150 Washington St.
Morristown, NJ 07960
888/457-8800; Fax: 973/682-9077
publisher@premierhealthcare.com

Editor

Joseph Burns
508/495-0246
editor@premierhealthcare.com

Neil Baum, MD

Urologist
New Orleans

Daniel Beckham

President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD

President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA

Executive Vice President
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD

Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman

President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley, PhD

Executive Director
Vanderbilt Center for
Evidence-based Medicine
Nashville, Tenn.

Peter R. Kongstvedt, MD

Partner
Cap Gemini Ernst & Young
Vienna, Va.

John W. McDaniel

President and CEO
Peak Performance Physicians, LLC
New Orleans

Lee Newcomer, MD

Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD

Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD

Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

James M. Schibanoff, MD

Editor in chief
Milliman Care Guidelines
Milliman USA
San Diego

Jacque Sokolov, MD

Chairman
Sokolov, Sokolov, Burgess
Scottsdale, Ariz.

Fairness of MICRA Is Questioned

The California state legislature enacted a law nearly 30 years ago that limits malpractice awards for pain and suffering to \$250,000. Now, a study by the Rand Institute for Civil Justice, in Santa Monica, Calif., shows that the Medical Injury Compensation Reform Act has in fact reduced jury awards by an average of 30%.

But a recent study by researchers at the Harvard School of Public Health in Boston shows that such limits are distributed inequitably across different types of injuries in the 21 states that have implemented MICRA-like reforms. In fact, the reductions in noneconomic awards are far greater for grave injuries than they are for minor injuries, the Harvard study shows. A third study, also by Harvard researchers, found that in Pennsylvania—where proposed legislation to place MICRA-like caps failed to pass in August—physicians have deep concerns about whether their fears of malpractice litigation result in poorer care.

A National Model

Some politicians (such as President Bush) and some groups (including the AMA) have suggested that MICRA, enacted in 1975, can be a model for national reform of the medical malpractice system and help resolve problems relating to the cost and availability of medical malpractice insurance. Opponents of such caps say they have a negative effect on the economic recovery of patients and their families, and suggest that any problems with malpractice insurance should be addressed in other

ways, by limiting malpractice insurance premium increases, for example.

Although the Rand study did not address whether MICRA or similar legislation has reduced the costs of malpractice insurance, Jack Lewin, MD, the CEO of the California Medical Association in Sacramento, says he thinks the act has had a positive effect on the quality of care patients receive when treated by California's doctors. "The bottom line effect of MICRA has been that many doctors who might have quit practicing are now continuing to practice because rates have been stabilized," Lewin says.

MICRA does not cap economic damage awards for out-of-pocket expenses, such as medical care costs and wage losses. A jury can award whatever amount it believes is appropriate for noneconomic loss, but following the verdict the judge will reduce that portion of the award to \$250,000 (if necessary) prior to entering the final judgment in the case.

A March 2003 report by the Foundation for Taxpayer and Consumer Rights, in Santa Monica, Calif. found that MICRA did not reduce malpractice rates. Premiums actually increased 450% in the 13 years following implementation of the act, FTCR says. Rates did drop in California following the 1988 adoption of Proposition 103, however, which forced insurance companies to roll back their rates by 20%, and created other insurance reforms, including requiring the approval of an elected insurance commissioner for rate increases.

Are Limits Arbitrary?

"What the Rand study shows is that people, regardless of the legitimacy of their claim and the seriousness of their injury, are seeing their recovery arbitrarily reduced, and in some cases, quite dramatically," says FTCR Executive Director Doug Heller.

Before MICRA was enacted, neither trial awards nor the attorneys' fees of plaintiffs in medical malpractice cases were limited under California law. "The framers of MICRA hoped that the law would reduce the overall number of claims brought against health care providers and the costs of resolving those claims, and it was hoped that any savings would be reflected in lower or stabilized premiums, the continuing availability of malpractice insurance coverage, and a robust number of health care providers continuing to offer a variety of routine and specialty services," says Nicholas Pace, the Rand study's lead researcher. "We believe the law has had a direct role in about half of the malpractice cases where there is a verdict for the plaintiffs."

MICRA limits awards in a number of ways, including capping the attorneys' fees of plaintiffs in malpractice cases according to a sliding scale based on the size of the recovery; the fee percentage decreases as the plaintiff's recovery increases. In the cases studied, the attorneys' fees of plaintiffs decreased 60%, from \$140 million based on the average contingency fee of 33% to \$56 million based on the law's sliding scale. The law prohibits attorneys' fees of more than 40% of the first \$50,000 of any amount recovered, 33% of the next

(Continued on page 4)

Some politicians suggest that MICRA can be a market for national reform of the medical malpractice system.

MICRA Results

The July 2004 Rand study, *Capping Non-Economic Awards in Medical Malpractice Trials: California Jury Verdicts Under MICRA*, found the following:

- In 45% of cases, judges had to reduce noneconomic damage awards handed down by juries, which are not required to comply with the \$250,000 cap. The average reduction was \$366,000.
- Noneconomic damage awards for patients with the most severe injuries, were reduced by an average of \$1 million each.
- Overall, 58% of cases involving the death of a patient resulted in total jury awards that had to be reduced by a median 49%, compared with 41% of cases involving injuries, which saw median reductions of 28%.
- In cases in which a patient died of medical abuse or neglect, noneconomic damage awards were reduced by an average 51%.
- Without the caps, the original verdicts handed down by the juries would have produced plaintiff awards totaling \$421 million. Under the law, total awards were reduced by 30% to \$295 million.
- Despite the overall 30% reduction in total awards, injured patients' recoveries fell only 15% because of the cap on attorneys' fees.

—MS

(Continued from page 3)

\$50,000, 25% of the next \$500,000, and 15% of any amount in excess of \$600,000.

This aspect of the law alone could result in a reduction of malpractice cases because such cases are expensive to prepare and in California, plaintiffs lose nearly eight out of every 10 cases taken to trial, Pace says. "Add in the dual effect of the cap on awards and the limits on fees, and the level of scrutiny given to potential clients would go up markedly," he adds.

Emulating MICRA

MICRA-like laws in effect in 20 other states place caps for noneconomic losses in the range of \$250,000 to \$750,000, and most of the laws were adopted in the mid-1970s and mid-1980s. Six states cap total damages, including economic damages. Caps were also the centerpiece of the leading federal tort reform proposal to date: the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act, which passed the

House in 2002. The Patients First Act of 2003, which failed in the Senate last year, included a \$250,000 cap on noneconomic damages.

"Both of those bills sought to emulate California's MICRA," says David Studdert, associate professor of law and public health in the Department of Health Policy and Management at the Harvard School of Public Health. He and his colleagues were authors of an article in the July/August 2004 issue of *Health Affairs*, "Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California."

Inequality Found

Studdert and his colleagues reviewed jury awards in 298 California verdicts between 1985 and 2002, and concluded that "strong evidence that caps' fiscal impact on California verdicts is not distributed equitably across different types of injuries...Caps on damage have emerged as the most controversial legislative response to the new malpractice crisis," said the authors.

"The reductions imposed on grave injury were seven times larger than those for minor injury; the largest proportional reductions were for injuries that centered on pain and disfigurement. Use of sliding scales of damages instead of or in conjunction with caps would mitigate their adverse impacts on fairness."

The Rand study supports the Harvard researchers' conclusions. In the Rand study, researchers found that death-related malpractice cases were capped more often than injury cases were capped (58% versus 41%), had much higher percentage reductions in total award size than injury cases had, and had a median reduction in award of 49% when the award was capped versus a 28% reduction in injury cases. The Rand researchers also found that plaintiffs with the severest nonfatal injuries (such as brain damage) had their noneconomic damage awards capped far more often than plaintiffs with injury claims generally and had median reductions exceeding \$1 million, compared with \$286,000 for all injury cases.

Plaintiffs who lost the highest percentage of their total awards due to the caps were often those with injuries that led to relatively modest economic damage awards (about \$100,000 or less) but that caused a great loss to their quality of life, as suggested by the jury's million-dollar-plus award for pain and suffering, the Rand study shows. These plaintiffs sometimes received final judgments that were cut by two thirds or more from the jury's original decision.

A sliding scale, as described in the *Health Affairs* article, would set award ranges based on the severity of injury suffered and the age of the victim. The Institute of Medicine and some other academic studies have endorsed such a system as more equitable than flat caps, such as the \$250,000 limit set under MICRA. A sliding scale would be feasible to

Rand Study Key Findings

A study by the Rand Institute for Civil Justice published in July found that the Medical Injury Compensation Reform Act in California has reduced jury awards an average of 30%. Other key findings:

- The MICRA cap on noneconomic awards was imposed in 45% of the trials resulting in plaintiff verdicts.
- Awards most likely to be capped involve death cases, cases with the severest nonfatal injuries, and plaintiffs younger than one year.
- Attorneys' fees were reduced by 60%.
- Plaintiffs' net recoveries (final awards less fees) were reduced by 15%.

—MS

develop and implement, the Harvard researchers say, and would likely result in systematically lower awards in cases involving temporary or minor injury than under flat caps, and higher awards for significant and grave injury. "Savings at the low end may not offset more generous compensation at the high end," they add. "But the legitimate societal interest in fairly compensating the severely injured may justify some modest increase in the overall cost of awards."

Studdert argues that a flat dollar cap is unfair: "When you look at the verdicts that are affected by caps, what you see is a really large number of cases that involve major injury."

Physician Dissatisfaction

Addressing such inequities would be of value to patients, but may not affect the negative atmosphere that pervades physician practices regarding malpractice, according to a separate study in *Health Affairs* by other Harvard researchers. In an article, also published in the July/August issue, "Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care," the researchers conducted interviews with 41 leaders of Pennsylvania medical societies and surveyed 824 physician specialists by mail. They concluded that "widespread discontent" existed among physicians in Pennsylvania, where several insurers have left the market

and malpractice premiums have increased dramatically.

The Pennsylvania physicians also believe that their liability concerns could be hurting patient care and limiting patients' ability to be fairly compensated for their pain and suffering. "Physicians are obviously unhappy about the medical malpractice situation, but I think we showed that the current crisis in Pennsylvania is having a palpable impact on the psyche of physicians practicing there," says study co-author Michelle Mello, assistant professor of health policy and law at the Harvard School of Public Health. Physician career dissatisfaction deserves attention if it has damaging consequences for patients, Mello adds.

Mello and her colleagues note that a growing body of research has identified links between physician satisfaction and high-quality care. Studies have shown, for example, that patients of physicians with higher levels of job satisfaction are more likely to adhere to medical treatments, and satisfied physicians tend to be more attentive to patients. Physicians who are dissatisfied are more likely to engage in riskier prescribing practices, disrupt continuity of care, and practice defensive medicine, the studies show.

Most physicians surveyed for the Harvard study denied that malpractice concerns made them less candid with patients, but a sizable minority felt that they did, say the Harvard

authors. Physicians who had been dropped by an insurer, been sued in the past three years, or faced high premiums were much more likely to report being less than candid with patients, and a shockingly high 90% of specialists said that the malpractice system limits their ability to provide the highest quality care.

More MICRA-like reforms are likely, the Harvard authors say, because interest in caps on damages will gain momentum as the malpractice crisis deepens. But they caution that caps should be implemented with an awareness that they are likely to exacerbate existing problems of fairness in compensation. "A decision to limit damage awards represents a social judgment that stabilizing the liability insurance market must be prioritized over allowing juries to determine levels of compensation for medical injuries," the Harvard researchers say. "In the current environment, such a trade-off may well be justified. But from an ethical perspective, care should be taken to choose that policy option that infringes least on the interest of patients and society in fair compensation. Use of a sliding scale of damages represents a more rational balancing of interests."

Mello and her colleagues report in "Caring for Patients" that, overall, reform strategies are being developed in response to physician dissatisfaction. But the efficacy of such strategies as a cure for the tort crisis and a prophylactic against recurrences is questionable, they say. "The core objective of such reforms should not be to restore physicians' job satisfaction, but to improve the malpractice system's performance in compensating patients and promoting high-quality care," they add. "If a byproduct of reform is higher professional satisfaction, however, this may amplify the gains to patients."

—Reported and written by Martin Sippkoff, in Gettysburg, Pa. More information on practice

Data-Matching Programs Compared

A new report by the California HealthCare Foundation, in Oakland, Calif., reviews four commercially available software products that match data to specific patient records. Data matching is a process that electronic medical records are designed to do, but data matching programs can do it for less than it would cost to have an EMR do it.

The data-matching programs reviewed in the CHCF report are aimed at small to medium-size provider organizations of 30 and fewer physicians. But the comprehensive list of criteria used to evaluate these products will be useful to buyers of all sizes, says Walter Sujansky, MD, PhD, one of the authors of the report. "For the price, these tools provide excellent ease of use, configurability of matching weights, the ability to edit, expert results, and user documentation," he notes.

Data matching involves coordinating information about individual patients and collecting those data in a single patient record. It is an important function in the delivery of quality care, and doing it well can help a group practice improve the efficiency of administrative processes, say experts.

"Gathering data, such as hospital encounters and lab reports, and matching those data to specific patient records improves the quality of care," says A. Mark Fendrick, MD. "The technology is available to allow physicians to do that, but some of it is more expensive than others." Fendrick is a professor at the University of Michigan Medical School in Ann Arbor who has studied the use of data to improve outcomes.

The patient data-matching task is an important and challenging step in the disease management and quality improvement processes. And, while many health care and provider organizations have developed software that use simple algorithms to match patient data from disparate sources (hospital and ambulatory encounter data, pharmacy claims, laboratory reports, and so on), the effectiveness of such systems is often less than desired, say experts.

The Right Tools

"Using the right tools to match the right data with the right patient is a critically important step to improving care delivery," says Sam Karp, who leads CHCF's Health Information Technology projects. "With increasing national emphasis on the use of 'real time' clinical information systems, deploying effective patient matching tools is a key component to improving care at the point of patient contact." Sujansky & Associates, consultants in health care informatics and software development in San Carlos, Calif., prepared the report, *Patient Data-Matching Software: A Buyer's Guide for the Budget Conscious*, for the CHCF.

In a survey of about 1,200 group practices of fewer than 20 physicians, researchers found that although only 13% had even rudimentary EMRs in place, more than a third of respondents expressed a strong interest in developing a data-based recordkeeping system such as an EMR. The survey results were published in the March/April issue of *Health Affairs*, in the article, "Physicians' Use of Electronic Medical Records: Barriers and Solutions."

Overcoming Hurdles

"Clearly, data collection and EMRs are of growing importance to many physicians," says Robert Miller, lead researcher for the *Health Affairs* survey. "A significant barrier is cost." Miller is an associate professor of health economics in residence at the Institute for Health and Aging, University of California, San Francisco.

The initial financial costs of implementing an EMR are a primary barrier to adoption, Miller's report says. Such costs range from \$16,000 to \$36,000 per physician, and some practices see revenue decline at least initially because they may see fewer patients while addressing the administrative complexity of converting an office to an EMR-based system.

An alternative to that expense is what the CHCF report calls moderately priced, commercially available software products that can assist organizations in the patient-matching process. "These tools all apply advanced techniques and are easy to use," says Sujansky. "They can serve as useful starting points or even alternatives to EMRs."

Matching data with patient records without having software designed specifically to do such work can be challenging and error-prone, according to the report: "Because no standard patient identifier exists with the private health care system, clinical data must be matched based on multiple, imprecise data elements, such as name, date of birth, health plan identification numbers, and medical record numbers. "These identifying attributes may be shared by multiple patients, represented inconsistently across data sources, and subject to

Matching data with patient records without having a software program designed specifically to do such work can be challenging.

change over time.”

In commissioning the guide, CHCF sought to identify products that met the following criteria: availability on a desktop platform; application of advanced matching techniques; the ability to integrate into existing patient-matching workflows; and a total cost of ownership not exceeding \$50,000. Of the four products that met these criteria, the report provides a qualitative description of the capability of each product, describes 20 features, offers a comparative quantitative score for each product, and provides an inventory of each product’s capabilities with respect to provider organization needs.

Compatibility

An additional important feature the authors looked for in making their recommendations was that all four products had to have the ability to be installed and run on a Windows-based PC. “We found that the task of actually performing the matching functions usually worked independently, using the tools already at their disposal that they are familiar with, and most use Microsoft Windows,” Sujansky says.

The authors consider four products to be comparatively low cost (meaning generally less than \$50,000 for an unlimited number of records) and suggest that budget-conscious health care organizations should consider using these programs for patient data-matching:

1. Dataset V Suite, manufactured by Intercon Systems in Blue Bell, Pa. (at www.ds-dataset.com)
2. Dedupe4Excel, manufactured by DQ Global, Ltd. in Fareham, Hampshire, United Kingdom (U.S. distributor is DQMax in Tucson, Ariz.) (at www.dqglobal.com), and

described by the authors as appropriate only for very small groups of two or three physicians

3. Linkage Wiz, manufactured by LinkageWiz Software in Payneham South, Australia (at www.linkagewiz.com)
4. SureMatch, also manufactured by DQ Global

Although the report says the best products overall are DataSet V and LinkageWiz, all of the programs are similar in terms of cost and the data they process. Wide variation was found in manufacturer support. The four products all follow the same sequence of steps:

- Import the data.
- Massage the data to facilitate a field-by-field comparison of records.
- Specify match weights for the relevant demographic and other fields.
- Run a number of matching algorithms against the data and compute matching scores that indicate the likelihood of a record-pair match.
- Display the actual and possible matches for a manual (clerical) review and editing.
- Export the set of matching records for further processing and data integration.

Prerequisites for Success

The authors found the tools they recommend to be “flexible and easy to use,” but they say there are several prerequisites to adopting these programs successfully in physician groups. First, staff using the software must have a “basic understanding of probabilistic and fuzz-matching techniques.” That’s because most of the tools require “some configuration of matching weights and desired data transformations, which requires familiarity with terms such as ‘exclude lists’ and ‘blocking variables.’”

Second, the data must be available in tabular format. Third, the practice must have a master patient file with unique identifiers. Fourth, the users of the tools must be familiar with the specific values to be matched, meaning “users must know which fields are more and less accurate, which have common synonyms, which are sometimes omitted, and which are more specific to individuals.” Fifth, the practice must have the ability to convert the collected data into a clinical data repository, meaning a database that allows for comparisons, such as an Excel spreadsheet. “All the tools accommodate data in a Microsoft Access database or a Microsoft Excel database,” the authors say.

The amount of documentation and service support varies widely among the three manufacturers of the four products. LinkageWiz provides a 113-page user manual and online support and 10 hours of e-mail support. SureMatch has online manuals only, explanation is minimal, many product features are not described, and e-mail and phone support are not provided, the report says. Dedupe4Excel offers online support only and explanation is minimal, but e-mail and phone support are provided. DataSet V Suite has a large (168-page) comprehensive user manual, and e-mail and phone support are included.

“There’s no doubt that matching claims, lab, and pharmacy data to patient records produces the kinds of data that are invaluable to physicians who want to see how well they are following guidelines and how productive they are being,” says Fendrick. “Software that can do that need not be expensive.”

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

The authors found the tools easy to use, but say there are some prerequisites for successful implementation.

Four Top Medical Centers Have Much in Common, Author Says



Daniel Beckham is president of The Beckham Co., a health care consulting firm in Bluffton, S.C. Most of his engagements involve strategic planning for hospitals, health systems, and multispecialty group practices. His clients include the Mayo Clinic and the Cleveland Clinic. Beckham is writing a book about four major health systems: the Mayo Clinic, the Cleveland Clinic, Johns Hopkins, and Duke University Medical Center. He discussed the book with editor in chief Richard L. Reece, MD.

Q: Let's begin by discussing why you decided to write this book.

A: These four organizations—the Mayo Clinic, the Cleveland Clinic, Johns Hopkins, and Duke University Medical Center—regularly rank in the top five of the annual rankings of hospitals and medical centers by *U.S. News and World Report*. I was interested in looking into the characteristics they share that have allowed them to climb to the top of the list and what differentiates them from other institutions.

Q: How did you go about writing the book?

A: To begin, I went through the *U.S. News and World Report* rankings and did a simple adjustment for heart care and cancer, the two big killers. The magazine's methodology is based on how many specialties from these organizations are ranked in the top. *U.S. News* doesn't give any comparative weighting to the various specialties, so I gave special weighting to heart disease and cancer. Both of those specialties create a strong aura and reputation. When I did my weighting adjustment, those four institutions

popped right to the top of the list.

Q: Two of these institutions (Mayo and Cleveland) are major multispecialty clinics and two (Duke and Hopkins) are major academic medical centers. What do these four organizations have in common?

A: One characteristic is that they are all led by physicians. You have to go pretty far down the *U.S. News* article to find a top hospital that is not physician led. All of the big four have long traditions of being physician-led, dating back 70 to 100 years.

I also suggest they have all benefited from remarkably strong leadership and management. All four are alike in that they operate as employed models, in which all physicians are

A: What struck me most is that each institution has a strong sense of what's important. The people at the Cleveland Clinic, Mayo, Hopkins, and Duke care deeply about what their institutions stand for. They adhere to fundamental principles. They have a clear sense of mission, purpose, and values. They are all good at articulating what they stand for. All of them at every level—from those on the frontlines of care to those in the laboratory doing bench research—know why they are there and what they want to do. They all want to be part of a world-class institution. They are willing to trade off higher incomes and more independence for that goal.

“Inevitably, medicine is going to go in the direction of large physician-led organizations.”

on salary. Each is committed to the medical triangle model of teaching, research, and patient care. What makes each of them unique is the emphasis given to the various legs of the triangle. For example, Mayo has described itself as a tricycle. The big wheel for Mayo is a focus on patient care. The research and teaching wheels are smaller but still fundamental. What's more, all four emphasize pragmatic application. Hopkins can claim two Nobel prizes but it preserves an orientation toward putting scientific discovery to work in an entrepreneurial culture. Each has cultivated a powerful brand identity and very strong consumer preference.

Q: While writing your book, you visited each of these institutions. What struck you most during your visits?

Q: What can you say about the culture at these organizations?

A: As one physician told me, at Mayo you know that if you fall, people will catch you before you hit bottom and help you back up. That is not the case in a lot of other organizations or in struggling independent practices.

Hopkins, which shares a reputation as a hard-driving, competitive organization, insists on this fabric of support. When Hopkins recently hit a rough patch financially, Ed Miller, MD, the dean and CEO, announced a freeze on salaries. After that announcement, he received only three e-mail messages of protest. But when Hopkins lost a physician husband and wife team in an accident, he received thousands of inter-

nal e-mails of condolence and sorrow. Miller thought that was symbolic about what the Hopkins family is all about.

Q: *Often one hears that because academic centers serve the poor and disenfranchised, they are in economic trouble. Do you find that to be true?*

A: Not really. For multiple reasons, these institutions are not as overburdened when it comes to caring for the poor. One characteristic they share is that they are all private institutions, so they may have less pressure from a public standpoint. In Baltimore, a lot of the indigent care is provided at the University of Maryland. Mayo's home base, Rochester, Minn., bears no resemblance to the inner city, so Mayo's exposure to an indigent population is limited. Duke, because of its location, doesn't have a particularly heavy load of poor patients. Cleveland Clinic gets some criticism for not sufficiently serving the poor, but I don't think the criticism is justified. The clinic has done a remarkable job of revitalizing downtown Cleveland, and it has seven affiliated hospitals, some of which are in the most impoverished areas in Cleveland and in the nation.

Q: *Is it true that these institutions are committed to strategic innovation and to improving care?*

A: Yes, and that may be because they are not as consumed by local issues. They aren't distracted from the bigger picture. Each of these organizations has been blessed with great leadership. Look at Fred Loop, MD, the CEO of the Cleveland Clinic. When he took over 15 years

ago, the clinic had revenue of \$675 million. Today, it's a \$3.6 billion organization. That growth reflects Loop's drive, his strategic vision, and, as a world-renowned heart surgeon, his intimate knowledge of the organization and its work.

Q: *How do these organizations treat the outside medical world? Surely they have strategies to cultivate outside collaborators.*

A: All of them will tell you that, as they move into the future, becoming more open is one thing they will spend more time on. They know there is a danger in insular monastic cultures. To remain robust, they'll bring new ideas and new people into their inner circle, while at the same time preserving their founding principles.

Q: *Do independent physicians, many of whom are struggling, have to simulate what these big institutions are doing?*

A: I think so. I have always felt that way. It seems as though the rest of medicine takes a couple of steps in that direction, and then a couple of steps back. We saw that with the proprietary group practice model that PhyCor and MedPartners introduced. That model fell apart. And we saw hospitals acquire practices. That hasn't always worked out well. But, inevitably, medicine is going to go in the direction of large physician-led organizations.

In Cleveland, we see a dramatic example of that. The malpractice situation is so bad there that many physicians feel they're witnessing the accelerated death of private practice. Physicians who three or four years ago wouldn't even think of joining

the Cleveland Clinic are now putting on Cleveland Clinic Foundation lab coats because the malpractice situation is so unbearable.

Q: *So with the decline of private practice, we will have the rise of larger physician-led organizations. Does that logically follow?*

A: Not necessarily. You need leadership. What struck me most when I visited these places is leadership. That's a characteristic that is easy to look past, but leaders are the key to why these organizations have been successful. The physician CEOs provide a powerful role model for organizations inside and outside of health care. These are organizations and leaders that should be emulated. What you see are people who are not only good managers and strategic thinkers, they are also people who are intimately familiar with the value-adding work of their organization.

Loop, for example, is a cardiothoracic surgeon and he knows how the Cleveland Clinic produces value. He knows what it means to be a patient and what it means to be a doctor. He has been to the rodeo. The same is true at Mayo, Duke, and Hopkins. You can't always say that about leaders of many of America's corporations. And you can't always say that about leaders of other hospitals and health systems in America.

It's important that these leaders are all doctors, who have actually put hands on patients and have made scientific and technological contributions as well. Loop's successor, Delos Cosgrove, is a heart surgeon too. Cosgrove has, as I recall, 18 patents

(Continued on page 10)

“The malpractice situation is so bad there that many physicians feel they’re witnessing the accelerated death of private practice... Physicians are now putting on Cleveland Clinic Foundation lab coats because the malpractice situation is so unbearable.”

(Continued from page 9)

stemming from his heart surgery work and has performed more than 22,000 procedures. Mike Wood and Denny Cortese at Mayo are physicians. Ralph Synderman at Duke is a physician. Ed Miller at Hopkins is a physician. All of them know the real work of their institutions.

Q: *Do these institutions train their leaders from within and are therefore trusted by their physician followers?*

A: I think so. These institutions do not necessarily have formal leadership development programs, but they have a process that works very well in developing leaders. For example, they rely on physician leadership councils and committees at Cleveland and at Mayo. These forums have a way of showcasing the abilities of rising physician leaders. They provide a “hot house” in which physicians with innate leadership abilities can develop. They focus on real issues and deal with real challenges. You usually don’t find these hothouses in other organizations.

Q: *Also these organizations seem to have made the necessary accommodations and trade-offs between clinicians and administrators.*

A: That’s an excellent point. Mayo is probably the institution most associated with the notion of being physician-led but at the same time is professionally managed. But all four of them share this dual characteristic, which is significant. They are led by a physician who is technically trained and who understands medicine, but they also have a strong administrative person in a high role. In these organizations, the physician

and administrative leaders have a lot of respect for each other. But it’s also clear who’s in charge: It’s a physician.

Q: *Will the lack of infrastructure among independent physicians lead to the downfall of independent physicians and to the necessity to regroup?*

A: I think so. We’re just on the front-edge of a requirement to have standards for quality, safety, and compliance. The organizations that have the infrastructure and are already working on those kinds of things are going to have a huge lead.

Q: *Is it true that another characteristic of these models is that they have set aside resources and capital to improve infrastructure whereas independent physicians have been lax in that regard.*

A: Even for sizable group practices, not setting aside enough retained earnings is a huge issue. They often simply do not have the money or the will to set aside resources to fund their growth.

Q: *In other words, large institutions have an advantage in developing information technology infrastructure?*

A: Yes. Just look at Mayo’s history and one of its founders, Dr. Henry Plummer. Nearly 100 years ago he set up a conveyor belt system to transport records and charts from one end of the Mayo campus to the other, from the clinics to the hospitals. Mayo understood early the importance of IT. There were no computers then, but it was still information technology.

Q: *Is it true that these four organizations are involved in growth through consolidation?*

A: Mayo bought some competitors in southern Minnesota and Wisconsin. Duke has regional outposts and affiliated hospitals. The Cleveland Clinic has seven affiliated hospitals in Cleveland. Among all four, consolidation is a shared characteristic. In the cases of Mayo and Cleveland Clinic, there’s also a distant outreach strategy in Florida. They tend to emulate each other, although they won’t always admit it. They’ve also pursued the closer-to-home 100-mile circle expansion. In both of those situations, you get a sense of the value of their brands. Cleveland built its regional system, which consists of seven hospitals, for relatively little. It’s not unusual to buy hospitals at about eight times earnings before interest, taxes, and amortization (or EBITA).

Using that formula, seven hospitals would have cost the Cleveland Clinic billions. The reason it was able to buy them for less is that it is the Cleveland Clinic. The other hospitals said, “We need to be part of something that’s world class, so we’ll forgo eight times EBITA just to be part of the Cleveland Clinic. Mayo did the same thing. It was able to pursue a similar strategy with doctors. It doesn’t buy practices; it just says, “Here’s the employment agreement.”

Q: *That strategy certainly simplifies matters, doesn’t it?*

A: Well, it makes things a lot cheaper. It doesn’t have the huge cost of acquisition that a lot of health systems have to shoulder.

—Edited by Deborah J. Neveleff, in *North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

“In these organizations, the physician and administrative leaders have a lot of respect for each other. But it’s also clear who’s in charge: It’s a physician.”

Should the Federal Government Pay for Treating Obesity as a Disease?

By Richard L. Reece, MD, editor in chief

Physicians who treat overweight patients may be bolstered in their efforts by Medicare officials' decision to modify the government's stance on obesity. In July, Tommy G. Thompson, secretary of the U.S. Department of Health and Human Services, said Medicare will remove barriers to covering anti-obesity interventions if scientific and medical evidence demonstrates their effectiveness in improving health outcomes.

This step is encouraging to Medicare beneficiaries who would seek treatment for obesity, but the decision does not mean treatments for patients who want to lose weight will be covered—at least not yet. However, it opens the door for individuals and physicians to submit applications to Medicare for coverage of such obesity therapies as stomach surgery, diet programs, and behavioral and psychological counseling.

Scientific Review

"Obesity is a critical public health problem in our country that causes millions of Americans to suffer unnecessary health problems and to die prematurely," Thompson says. "Treating obesity-related illnesses and complications adds billions of dollars to the nation's health care costs. With this new policy, Medicare will be able to review scientific evidence in order to determine which interventions improve health outcomes for seniors

and disabled Americans who are obese and its many associated medical conditions."

Medicare covers specific medically necessary services for patients who are ill or injured. The previous wording stated that obesity was not an illness, which could thus prevent Medicare from covering treatments for diseases related to obesity, Medicare officials said. The move is one of several by the federal government to fight the nation's rising obesity problem. Many public health experts, anti-obesity advocates, and doctors welcomed the decision. But not everyone agrees that it is correct.

Medicare's decision doesn't yet promise government subsidies or tax deductions for those who attend weight control programs or buy diet books. Most of the government's attention will be focused on gathering evidence to justify payment for surgical procedures to relieve morbid obesity. Federal officials also will seek to determine whether diet programs and behavior therapies are effective in controlling weight. As *The Washington Post* stated in an editorial, "It is a useful regulatory change, because this is precisely the sort of evidence gathering that Medicare, with its financial clout, ought to be doing, and that the diet industry, long a haven for quacks and cranks, desperately needs."

Some critics believe it's absurd for government officials to decide whether obesity is a disease. Clearly,

obesity is a health problem, they argue, since it leads to diabetes, high blood pressure, heart disease, and other health problems. In fact, recent surveys suggest that obesity is more directly associated with illness than are alcohol and cigarettes. Obesity is also a problem that can be addressed early, before it debilitates and kills.

In the past, health plans and Medicare have paid for the consequences of obesity, rather than prevention efforts to slow the disease. But now, some health plans are beginning to experiment with various forms of preventive medicine. Meanwhile, Medicare officials are looking at the success rates of some weight-loss programs, and the Medicare Prescription Drug Improvement and Modernization Act of 2003 calls for Medicare to pay for an initial physical for those entering the program. So, perhaps it is appropriate to begin to pay doctors for counseling patients about obesity.

Many surgeons who perform procedures to reduce the size of the stomach or to bypass the stomach do so on patients who are morbidly obese. People who are considered morbidly obese are more than 100 pounds over their ideal weight as calculated by body mass index, a standard, if flawed measure of weight. These patients have actual health problems that are often life threatening, surgeons say, adding that they consider morbid obesity to be a chronic disease untreatable by diet or exercise alone.

(Continued on page 12)

The government will gather evidence to justify payment for surgical procedures to relieve morbid obesity.

(Continued from page 11)

Personal Responsibility

On the other hand, some experts believe obesity is completely under the control of the individual. These skeptics argue that if people didn't eat so much or sit so long, they wouldn't be fat. Many in the food industry and in conservative organizations contend that obesity is a problem stemming from personal or parental irresponsibility, rather than a problem that requires intervention by the government or advocacy groups.

"This is truly a dumbing-down of the term 'disease,'" says Rick Berman. "This is the only disease that I'm familiar with that you can solve by regularly taking long walks and keeping your mouth shut. It's terrible to start using taxpayer money like this when there are other legitimate diseases that need to be addressed." Berman is executive director of the Center for Consumer Freedom, an advocacy group in Washington, D.C. that is funded by the food industry (at www.consumerfreedom.com).

At least one critic believes the government's decision is based on flawed science. Paul F. Campos, JD, a law professor at the University of Colorado, who wrote the book, *The Obesity Myth*, says that "the decision is irrational, given that being underweight is more of a health problem for the elderly than being overweight. It's not just a bad idea (he says of the change in Medicare policy), it's completely unscientific. We're in the grip of a kind of out-of-control cultural hysteria on this issue that leads to really irrational social decisions, such as making obesity a disease among the elderly."

Perhaps so, but many experts who support the change in Medicare poli-

cy say that it may help to eliminate the social stigma associated with being overweight and may encourage more physicians to treat patients who are overweight as they would treat patients with other medical conditions. The change might also prompt overweight individuals to seek help.

"The lack of recognition of obesity as a disease has cast a pall over the field," says Louis J. Aronne, MD. "Now Medicare is saying obesity deserves treatment like any other disease." Aronne is a clinical associate professor of medicine at Cornell University and president-elect of the North American Association for the Study of Obesity, in Silver Spring, Md. (at www.naaso.org).

Being overweight and obese clearly raises health risks and the risk of death, according to Walter Willett, MD, a professor of epidemiology and nutrition at the Harvard School of Public Health. In a study in 1995 of 115,195 nurses, researchers found the risk of death rose 60% in even slightly overweight women. Other studies show that being overweight causes a five- to tenfold increase in diabetes risk compared with the risk of someone who is very lean, Willett says. "Being obese triples the risk of coronary heart disease and endometrial cancer; it doubles the risk of hypertension and stroke," he adds. Losing even a little weight leads to significant improvements in blood fats, blood pressure, and blood sugar control, he comments.

"Every 10 years someone comes along who thinks he or she has discovered fatal problems in the relationship between body mass index and mortality," Willett says. "But it's always someone who doesn't understand medicine and human disease processes and epidemiology."

Areas of Agreement

The controversy notwithstanding, there is one fundamental issue on which most experts agree: Diets work poorly. Most people can lose only about 10% of their body weight by dieting, and most tend to gain back that weight.

The experts also agree that exercise improves health, regardless of weight. In fact, it's better to be fat and fit than to be lean and unfit, says Steven Blair, president and CEO of the Cooper Institute, a nonprofit research and education foundation in Dallas. He says exercise is by far the most important factor in long-term health. The institute has monitored the fitness levels of thousands of men and women for many decades and has shown that a person's performance on a treadmill test at the study's start was a better predictor of later health than was body weight.

Perhaps Mark McClellan, MD, PhD, administrator of the federal Centers for Medicare & Medicaid, summed up the issue best when he said, "From the standpoint of Medicare coverage and the health of our beneficiaries, the question isn't whether obesity is a disease or a risk factor. What matters is whether there's scientific evidence that an obesity-related medical treatment improves health. This change in Medicare's coverage policy puts the focus on public health. The medical science will now determine whether we provide coverage for the treatments that reduce complications and improve quality of life for the millions of Medicare beneficiaries who are obese."

—More information on physician practice strategies is available on our Web site (see page 16).

**There is one fundamental issue on which most experts agree:
Diets work poorly.**

Aggressive Strategies Are Back

Several aggressive managed care utilization management strategies that were largely abandoned in the 1990s are now making a comeback in response to a continued rise in health care costs, according to a report published in the Aug. 11 issue of the health policy journal, *Health Affairs*.

To some degree, health plans had been backing away from strategies such as requirements for prior authorization, specialist referrals, concurrent and retrospective review, and provider profiling that were unpopular with both physicians and patients. By 2000, consumer dissatisfaction with managed care prompted employers to favor less restrictive insurance products. Double-digit increases in health care premiums and a general economic downturn, however, have prompted some health plans and employers to revisit these strategies in an attempt to manage health care usage more closely.

Shifting Costs

The fact that health plans are revisiting abandoned utilization management strategies is not surprising, says lead author Glen Mays, PhD, MPH, an associate professor at the University of Arkansas for Medical Sciences in Little Rock. "Cost pressures have accelerated," he says. "In response, health plans and employers have moved to benefit designs that shift more costs to consumers. But these strategies can only go so far before undermining the value of health insurance. At some point, health plans have to consider other mechanisms for constraining costs.

Utilization management mechanisms had proven effective in the past, so it is natural to revisit some of these tools."

But these mechanisms are being adapted to make them more palatable to doctors and consumers. "Health plans are being more selective in how they are using these cost controls, in particular by targeting them to services and procedures that are likely to be overutilized or that provide minimal clinical benefit," observes Mays.

Mays and his colleagues also note that while controls may be less stringent than they were during the 1990s, health plans seem to be implementing them in a broader range of insurance products than they did initially.

What's more, health plans are carefully monitoring the effect of these tools on their relationships with providers. "Plans are reluctant to place more administrative burdens on providers, given the provider backlash during the late 1990s and the resulting contracting disputes," he states. "In the interim, plans have taken concrete steps to improve their relationships with physicians and hospitals and they don't want to jeopardize any progress they've made."

Community Tracking

The report is based on an analysis of data collected as part of the Community Tracking Study (CTS), a longitudinal study sponsored by the Center for Studying Health System Change in Washington, D.C. The mission of the CTS is to track changes in health systems and the

effect of those changes on different health care constituencies. For the study, researchers gather data through national surveys of households, physicians, and employers as well as site visits made every two years to 12 metropolitan communities in which local health care leaders are interviewed.

Communities in the CTS were randomly selected to represent health care markets with more than 200,000 residents; they are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; Northern New Jersey; Orange County, Cal.; Phoenix; Seattle; and Syracuse.

As part of the CTS, four rounds of site visits occurred in 1996-97, 1998-99, 2000-01, and 2002-03. Interviews were conducted with providers, hospital executives, health plan executives, employers, insurance brokers, and legislative and regulatory agencies. The analysis of the 2002-03 site visits included data from 56 health plans in 12 communities.

Prior Authorization

The authors found that a considerable number of health plans re-implemented managed care cost containment and utilization management strategies in 2002 and 2003 after eliminating or relaxing them in 2000 and 2001 in response to employer and enrollee dissatisfaction.

For example, in 2002 and 2003, health plans in six of the 12 communities re-implemented requirements for preauthorization of certain services after having eliminated these requirements. Five plans in four communities increased use of preauthorization of

(Continued on page 14)

Some health plans and employers are revisiting old strategies in an attempt to manage health care usage more closely.

(Continued from page 13)

hospitalization. Five plans in four communities increased use of preauthorization of outpatient services or procedures. Four plans in three communities increased use of preauthorization for specialists. Seven plans in four communities increased use of preauthorization for prescription drugs.

Health plan executives interviewed assert that services subject to preauthorization requirements are rarely denied. Still, they believe that the existence of the requirements dissuades requests for services that are not medically necessary, thereby reducing costs.

Furthermore, many plans have reintroduced preauthorization requirements that are less restrictive than those used previously, the authors add. For example, Regence BlueShield in Seattle now requires preauthorization only after certain utilization thresholds (such as three MRIs or 10 chiropractic visits) have been exceeded.

In addition, seven plans in five communities increased their use of concurrent review of inpatient services in an effort to reduce length of stay and in-hospital diagnostic tests and procedures. Strategies to monitor inpatient care include implementing telephone-based review procedures and even placing utilization review nurses in hospitals that are used most frequently.

The authors found that while most plans historically have adopted concurrent review processes only in HMOs, in 2002 and 2003 several plans began employing these strategies in their PPO products as well. Furthermore, some plans have expanded concurrent review processes beyond hospitals to other inpatient facilities, such as skilled nursing and rehabilitation facilities.

Provider Profiling

The analysis also revealed a significant

use of retrospective review and provider profiling. Fifteen plans in nine communities increased their use of retrospective review and provider profiling based on indicators of provider health care utilization and quality of care.

Utilization and quality measures varied widely across plans, the authors note. One health plan developed a claims review system to track inappropriate care and then followed up with providers. Another plan is collecting comparative data on utilization and costs and will use these data during contract negotiations with physicians. Yet another plan is using Health Plan Employer Data and Information Set (HEDIS) measures of quality to profile physicians and will provide feedback to foster quality improvement.

The analysis also revealed that health plans are not only revisiting previously discontinued utilization management activities, but that trends in the development or promotion of numerous cost-containment activities among health plans are continuing.

To manage the costs associated with the care of patients with chronic conditions, for example, 15 health plans in six communities have expanded their investment in disease management programs. Some plans have developed new DM programs. Other health plans have established programs for additional conditions to complement ongoing DM initiatives. Still other plans have expanded participation in existing DM programs, such as by extending offerings for HMO enrollees to PPO enrollees as well, the authors note.

In general, providers may be more amenable to cost-containment activities such as DM programs, Mays says. "These programs can potentially be

quite helpful to physicians who are trying to improve patient compliance," he explains. "While evidence is limited regarding the cost effectiveness of these programs, plans feel they hold promise and so are continuing to expand their program offerings."

A large number of health plans are targeting high-risk, complex patients whose conditions are likely to generate high costs. Since 2001, 18 health plans in nine communities have increased their use of case management programs. These programs offer customized, intensive interventions to help improve outcomes and lower costs. Participants are typically identified through predictive modeling techniques based on data from health care claims and health risk assessments.

The authors state that some plans have developed these case management programs to complement existing DM services. However, other plans envision case management as an alternative to DM, believing that a case management strategy will be more successful in serving patients with complex needs whose health outcomes may not be optimized by standardized DM initiatives and who are often the highest cost users of the health care system.

Provider Networks

In response to consumer backlash against restrictive provider panels, in the late 1990s many plans eased restrictions and developed panels that were more inclusive. But, some plans are again developing restrictive provider networks in an attempt to contain rising health care costs.

Four plans in three communities developed limited network products called exclusive provider organizations. EPOs maintain panels that are smaller than PPO panels, offering this

The analysis also revealed a significant use of retrospective review and provider profiling.

curtailed choice of physicians and hospitals at a lower cost to enrollees. For example, one plan in Orange County, Cal., is developing an EPO that is about half the size of its PPO panel, and is expecting to offer this new product for 10% to 15% less than the PPO.

In addition, nine plans in six communities developed tiered-network products. Tiered-network products group providers into tiers based on their costs to deliver care. Enrollees are given financial incentives (usually reduced cost sharing) to choose providers in the lower-cost tiers. Some plans are including only hospitals in their tiered network products, while other plans are including both hospitals and physicians. However, the authors note that to date, these networks have not been embraced due to objections from providers, challenges in differentiating providers based on cost, and concerns regarding the absence of quality considerations in the tier formation.

Another cost-containment approach gaining popularity involves offering financial incentives to providers. Some plans have created new provider incentive programs designed to encourage efficient, cost-effective, high-quality clinical practice. While such programs were initially implemented in HMOs, the authors note that plans are now adopting these incentives in both HMO and PPO networks.

Fifteen plans in seven communities introduced a financial incentive program, according to CTS data. Several plans are offering financial incentives to physicians who achieve or exceed thresholds of quality performance based on HEDIS standards. One plan is offering higher reimbursements to hospitals that achieve certain patient safety standards, such as reduced medication errors.

Cost-Sharing

Almost all health plans have continued to change benefit designs or increase enrollee cost-sharing in an attempt to manage rising health care costs, the authors found. Cost-containment approaches that employers and health plans have adopted include

- Increasing enrollee copayments and deductibles
- Adding deductibles to HMO plans that previously had offered first-dollar coverage
- Introducing coinsurance to products that previously offered fixed-dollar copayments
- Adding consumer-directed products that incorporate member-directed spending accounts and require out-of-pocket expenditures before a given threshold is reached
- Offering lower cost plans to enrollees who sign up for a limited provider panel or select high-deductible catastrophic coverage.

Since 2001, 35 health plans in 12 communities increased deductible and copayment levels; 30 plans in 11 communities introduced consumer directed health plans; five plans in three communities introduced coinsurance options; and two plans in two communities introduced a deductible with an HMO.

Gatekeeping, Capitation

Interestingly, the authors found that among health plans there was no increase in primary care gatekeeping strategies, a utilization management activity that was popular in the early years of managed care. Rather, the growth in open-access HMO and PPO options reported in 2000-01 continued in 2002-03. However, many plans maintained their existing gatekeeper HMO products as a way

to offer a lower cost option.

Similarly, health plans did not attempt to reintroduce capitated payment arrangements in the communities studied. While some plans, particularly those in Orange County, Cal., continued existing capitated provider payment systems in Medicare and Medicaid HMOs, most plans that had abandoned such systems in 2000 and 2001 did not reintroduce capitation as a method of cost management, likely due to provider resistance, the researchers say.

Many health plan executives and employers interviewed for the study questioned the ability of these cost-containment strategies to reduce health care costs significantly, the authors say. Certainly, short-term effects on costs will be limited as these strategies are only beginning to affect enrollees, the researchers explain.

Furthermore, the success of utilization and cost-containment strategies will depend to a large extent on the cooperation of physicians and other providers, the authors add. Following the managed care backlash, many plans are still reluctant to impose stringent requirements on physicians and hospitals, and in fact lack the leverage to do so in many markets in which providers have consolidated.

Finally, advancements in medical technology represent a potent driver of escalating health care costs, undermining the ability of utilization and cost-containment strategies to have a significant effect on health care costs overall. "These strategies may be helpful, but ultimately costs will grow due to advancements in medical technology," Mays says.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Some plans are offering physicians financial incentives achieving or exceeding thresholds of quality performance based on HEDIS measures.

ALLERGY OPTIONS.com



Our FREE online resource includes:

- ▼ Strategies and tactics to build your practice
- ▼ A complete database searchable by keyword, subject, or issue
- ▼ Interaction with experts on all aspects of the Business of Medicine™
- ▼ Links to business resources, such as practice management, marketing, and CME
- ▼ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let ALLERGYOPTIONS.com come to you! ALLERGYOPTIONS.com can keep you up to date automatically on the latest developments in the **Business of Medicine™**. You can sign up at ALLERGYOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-682-9077**.

Name: _____

E-mail: _____

PHYSICIAN PRACTICE OPTIONS™



Premier Healthcare Resource
150 Washington St.
Morristown, NJ 07960

PSRST STD
U.S. POSTAGE
PAID
Permit No. 664
S.HACKENSACK,NJ