JORDAN'S JOURNAL
1998 Edition

My father once told me. “Son, with your looks, charm and brains, don’t be disappointed if you can’t succeed at a real job. Remember, when you fail, you can always sell insurance. And, to help keep it simple, make it health insurance.” I should have listened to my mother, who fretted over my guitar playing, but said I couldn’t be a doctor if I lost my patience.

Health insurance was simple when I started. Carriers paid percentages instead of playing them. Medical insurance extracted premiums equal to the drilling dental demands now. Medicine wasn’t souped up with its current alphabet (PPO, HMO, MSO, PSO -- O my). You didn’t need a map to figure where to turn for medical care. Medicare was stable, managed care a fable, health care not debatable, and I didn’t have gray hair.

Then again, medical delivery wasn’t much of a right given what was wrong. The only market guarantees were that there weren’t any. As inflation ballooned, premiums were at a premium. Health insurance wasn’t portable and neither were computers. Only Joe Friday asked for the fax, 1954 the last change in tax, job security let you relax, and I didn’t have gray hair.

The problems of access and affordability have remained simple -- it’s the solutions that have grown complex. Navigating the major “Cs” of compliance, coverage and cost was as easy as getting from point A to point B. The rising technological tide, the shifting legislative landscape and receding resources pose greater challenges. Employers must display diligence, consumers increased intelligence and my lot is to be the pilot. No wonder I have gray hair.

Our annual excursion takes us down the road of regulatory incursion and political perversion, as we visit:

Washington, DC	A political district of 30 square miles surrounded by reality
Sacramento	The blessings of living in a blissful state
Markets	A bizarre bazaar where my karma runs over your dogma
The Future	Where “the grass is always greener,” the other sighed.

FEDERAL FOLLIES

Political reality is a strange duality
Philosophical and pragmatic
Passing out tissues with emotional issues
Without appearing too dogmatic

Will Clinton lamely duck so pal Al won't be stuck
With the "bill" he leaves for posterity
As parties move to the middle leaving us with the riddle
Of who to thank for our prosperity

Republicans fight for what they see as right
And then see who is left
Democrats claim they are doing the same
But with less political heft

Party freshmen told Newt they'd give him the boot
So he cast his Lott with Trent
With some alarm he ran from Dick's Armey
Which had assumed a more liberal bent

The Senate stays messy with helmsmen like Jesse
And popular leaders retiring
Unless Teddy gets fit or Tom a Daschle of wit
The roster is not too inspiring

Congress had a scare but they saved Medicare
Though the President took the credit
And laughed Hillaryously as it nefariously
Promotes his health plan (if you read it)

Senator Kennedy had a remedy
And a plot with Orrin hatched
To help families pay for their own way
A subsidy the states matched

Tobacco claims went down in flames
When Clinton nixed the deal
He wants some more facts before he attacks
To smoke out their appeal

Thompson machine gunned methods to raise funds
So the primaries he'd impede
But not before they tried to gore
Poor Al in the reform stampede

So what comes next? Well there's the text
Of Clinton's "Bill" of Rights
And a new snowstorm for health care reform
When "PARCA" begins fights

The number of laws to fix perceived flaws
Of managed care will surely double
During primary preening and some candidate screening
And the unions having new trouble

A lame duck President may get his goose cooked in court. Conservative estimates show a liberal number of party factions, but political posturing prior to primaries panders to moderates. Fundraising could not be held in check, though now we know the room rates at the White House hotel. What made the year interesting for health care, however, is that we saw a lot that did little, yet what we did not see did a great deal.

In January, 1993, President Clinton dropped "The Big One" in the punchbowl of the health care party. His Health Security Act was a 1,342 page manual of social engineering and deconstruction -- it had everything but a chance to succeed. Yet since then, the significant, and continuing theme, of his administration is an inexorable march to "ClintonCare," though by a different route than originally intended. In having his frontal assault repelled, President Clinton, with the help of Congress, is now employing the old political credo "if at first you don't succeed, use small cuts to make them bleed." In September 1997, President Clinton said "it's complicated when you're doing this a piece at a time. We've got to do it right so we can go on to the next step, and the next step and the next step." Same direction, same destination, but with steps rather than leaps. Consider:

1993	Family Medical Leave Act allows 12 weeks of health care continuation
1993	Health Security Act introduced in State of the Union message
1994	Plan fails and the Contract of America is delivered by Republicans
1995	Contract backlash and building for the new version of Clinton Care
1996	Health Insurance Portability and Accountability Act - major changes
1996	Mental Health Parity Act
1996	Newborn and Mothers Protection Act
1997	Families First initiative added to the Social Security Act
1997	Taxpayer Relief Act introduces changes to Medicare and Medicaid
1998	Bill of Rights published by Clinton Committee on Health Care Reform
1998	Proposed changes to managed care, COBRA, tax breaks

Rear View - yesterday's news with today's deadlines

Mental Health Parity Act

Plans may not impose separate lifetime or annual dollar limits on mental health care, except in enough instances to make this more "mental health impairity":

1) Only applies to companies of 50 or more employees
2) Plans are not required to offer any mental health benefits
3) Can put in limits on the number of allowed days or visits
4) Can put in separate deductibles before paying mental health benefits
5) Substance abuse and alcoholism are not subject to the law
6) Cost increase of 1% directly attributable to the plan exempts an employer

Newborn and Mothers Protection Act

Mother and child may not be required to be discharged from the hospital within the first 48 hours following birth (96 if C-Section).

Health Insurance Portability and Accountability Act

Alternately known as the "law of unintended consequences" due to the:

1) Series of interpretations required
2) Coordination between three major governmental agencies
3) Need for each state to pass conforming legislation
4) Federal cleanup legislation to correct, clarify and correct the corrections

Review - Current headlines

The Taxpayer Relief Act of 1997

Probably provided more relief to the politicians who could claim simultaneous solutions to three notably, knotty problems. Look behind what you see to see what you get.

Solution One - Medicare

What you see:

1) Solvency of the Part A Hospital Trust Fund extended from 2001 to 2010

2) Some supplemental policies must be issued on a guaranteed basis

3) Beneficiaries get Medicare + Choice:

   a) Traditional “fee for service” plan; or choice of
   b) Preferred Provider Organization (PPO);
   c) Health Maintenance Organization (HMO);
   d) Preferred Service Organization (PSO - regional independents);
   e) Medical Savings Account (MSA - demonstration project)

4) A series of “open enrollments” allow changes monthly until 2001, every six months in 2002 and annually thereafter

5) Added a series of preventive services as part of the coverage package

What you get:

1) Clinton agenda fulfilled in several areas:

   a) Major investment in fraud and abuse detection
   b) Managed care promoted as a means to stabilize costs
   c) Managed care then subverted by increased choices and the elimination of some of its traditional cost and access controls

2) Further Study:

   After the debate has raged for several years in Congress and Congressional districts, there is now appointed a Bipartisan Panel to consider the problem carefully and make substantial recommendations.

What you don’t get:

1) Solvency not long enough, and with no means of assurance:

   a) The first baby boomers turn 65 in 2012, two years past the new breakpoint
   b) Medicare qualifying age is still 65, though life expectancy higher than 1965
   c) No means test for higher income beneficiaries
   d) Part B outpatient premium is still heavily subsidized

2) Long term savings eroded by cost shifting:

   a) Part B premiums are now scheduled to rise $20 per month in 5 years
   b) Some of the Part A expenses (Trust Fund) have been moved to Part B
   c) The government subsidy will not be raised over current threshold
   d) Medical providers will have fee allowances frozen
   e) Several accounting assumptions used, which may be adjusted

3) Prescription drugs are still not covered, though their cost keeps rising and the utilization among Medicare beneficiaries is exceedingly high

Solution Two - Medicaid (Medi-Cal)

What you see:

Greater solvency and potential savings in a program that is little understood but carefully woven into the fabric of a social democracy.

What you get:

1) States can require beneficiaries to enroll in managed care plans

2) Repeal of Boren rules, which promoted parity and commercial distribution

3) More block grants to the states, giving them more control of the program

4) Clinton agency fulfilled in several areas:

   a) No gag rules on physicians
   b) Plan may not discriminate against a category of health care providers
   c) Grievance procedures must be in place to appeal reduced or denied care
   d) No balance billing for differences in actual vs. mandatory fee allowances
   e) New funding and laws for fraud and abuse prevention

What you don't get:

Families First rules preclude Medicaid from being expanded to enfranchise even more adults and children, given its own funding rules. There are also a number of families who, despite qualifying for Medicaid, are not aware of it or have not yet applied -- they don't get it.

Solution Three - Child Health Assistance Program (CHAP)

What you see:

It is estimated there are 10 million uninsured children in this country. This Act was added to the Social Security regulations to grant a subsidy, administered through the states, to assist families that do not qualify for Medicaid to get health coverage for their children. Total allocation is $24 billion over 5 years, which comes directly from government revenues and an added cigarette tax of 15 cents per pack. States must match some of the funding in order to get funding from the federal government.

What you get:

The original Clinton plan was clearly defined, where this is not, given the latitude permitted the states (by funding through a "block grant" approach). Only the base plan design is outlined.

The amount of money being thrown at the problem is considerable, however, so it sets up the expectation that the administration is following through on its mandate to reduce the size of the uninsured population. It also ultimately gives more control to the federal government which, once it enfranchises participants in a sponsored system, then has the ability to dictate more rules and regulations, and ultimately put those individuals in a bureaucratic system not unlike Medicare and Medicaid.

What you don't get:

1) There are no savings engendered from this program

2) It does not take effect in a state unless they have a program set up and can match some of the funding, and there are no independent resources for the state funding or methods for savings.

3) There is already evidence that many people who are eligible for Medicaid do not sign up, and their qualifications are clearly delineated. With fuzzier guidelines and the ability of 50 states to set up 50 different sets of rules, it is difficult to see how successful this program will be.

4) By dictating plan design and enrollment guidelines, both the state and federal government will have more of a say in how health care is delivered, at the same time they are fighting the managed care industry to allow people more freedom.

See you - what did not pass this session

1) Increasing the health insurance deduction for the self employed to 100%
2) National health insurance - has two traditional sponsors each year
3) Several managed care reform bills - but they are returning for an encore
4) Eliminating the cap on the number of allowed Medical Savings Accounts
5) Malpractice and tort reform
6) Several bills to mandate new forms of coverage in all health plans
7) Adding prescription drug coverage to Medicare

Preview - Advance copy of tomorrow's papers

The battle for the hearts and minds and other body parts of Americans has begun, though the plans are somewhat sketchy. Here is what we expect in 1998:

Clinton:

The President has sent up some trial balloons in some speeches, and his staff has outlined some of the agenda items for the year:

1) COBRA extension for early retirees (55 to 64) until they reach Medicare age
2) Free health care coverage for the temporarily unemployed
3) Consumer protection measures -- more attacks on managed care
4) Mandatory minimum hospital stays for post mastectomy care
5) Rules on privacy and the release of medical information
6) Reducing the Medicare entitlement age from 65 to 62

Clinton's Bill of Rights:

President's Advisory Commission on Consumer Protection and Privacy has already published its recommendations, which President Clinton has suggested should be part of any legislation Congress has to offer. These include:

1) Direct access to specialists without primary care physician referral
2) External appeals allowed to move within the managed care system
3) Detailed consumer information outlining the rules of a managed care plan
4) "Prudent layperson" rule to determine the need for emergency care
5) Medical record confidentiality guarantees

While somewhat innocuous on the surface, the presentation of these principles, and the background to their creation, has created some storm clouds on Capitol Hill. Majority Leader Richard Armey, in a memo to his party members, stated that the Bill of Rights is "intended mostly as a diversion from the President's real project, namely comprehensive legislation giving Washington control of the price, contents and quality of the private health plans covering 150 million Americans."

Patient Access to Responsible Care Act (PARCA) HR 1415, S 644

This joint bill, sponsored by Representative Norwood and Senator D'Amato, already has the health care and insurance industry up in arms, especially when it garnered over 200 co-sponsors in the House. Derisively termed the "Doctor's Lifetime Employment Act" (and that's what we *can* print), it has been estimated by one esteemed actuarial firm that imposition of all its provisions will have the effect of driving up health insurance premiums by 7 to 39%. This does not fully evaluate the internal costs borne by the employer. Shown here are the proposed measures and commentary on their effects:

1) Patient may sue a health plan for malpractice

    a) Additional cost to protect the plan
    b) May violate ERISA and so be thrown out before it is passed
    c) The original language gave the patient the right to sue the employer as well
    d) The “standard of care” interpretation will be a major court headache

2) Self funded employers must establish health care quality improvement programs

    a) Adds cost to the administration of the plan
    b) No guidelines for what these programs should contain
    c) No penalties shown for failure to implement
    d) Will be additional government costs for monitoring and review

3) Employers must evaluate health care professionals in their network annually

    a) No mechanism provided for this measurement
    b) Employer can’t be sued for malpractice (#1) but what suit *would* be filed?
    c) What possible means would an employer have to do a proper evaluation
    d) What legal remedy exists for the employee if they disagree with evaluation

4) Any provider with state licensure must be permitted to be on a panel

    a) This language has been tried and defeated in over 20 state legislatures
    b) Does not tie the provider to quality assurance or discount requirements
    c) Greater access by patient means deterioration of cost controls

5) Plans can’t lower reimbursement rates for services delivered outside network

    a) Eliminates basic cost control of disincentives
    b) Eliminates incentives to stay inside the network, where cost can be controlled

6) Government decides on allowed premium differential

    a) Employer cannot control budget by pricing plans differently
    b) Eliminates incentive for employee to stay within more tightly controlled system
    c) Without disincentives, patient may go outside network more and drive up cost

PARCA Lite - RIMCA (Responsibility in Managed Care Act)

Less odious and comprehensive, is still a vehicle for reduction or elimination of the perceived abuses of the managed care health care delivery system. While more sketchy, it eliminates limits on certain benefits, and prohibits plans from providing financial inducements to doctors to reduce services.

Health Care Bill of Rights and Freedoms:

Senator Phil Gramm is known as an original thinker, but has failed to come up with original or unique health care legislation. He puts his own twists on what others have done, which creates some talking points and can succeed in getting changes made in the final legislative drafts (witness the “Gramm amendment” in the Mental Health Parity Act). This bill will provide for “individual empowerment," negotiations on rates and tax breaks, among other things.

Kennedy Remedy:

Liberal standard bearing, being overbearing, or just plain Teddy bearing, we’ve seen more shifts in his position than the San Andreas fault. Senator Kennedy started the current movement toward comprehensive health care reform, predating the Health Security Act by six years. Just like President Clinton, and unlike their more liberal colleagues, he is more pragmatic, taking smaller steps toward his ultimate destination.

Last year, he promoted family values with a new federal subsidy (any irony here?). This year, he promises comprehensive legislation aimed at reforming the abuses seen with managed care programs.

AFFAIRS OF STATE

What Congress creates is left to the states
For final implementation
They can be more rational and local not national
So seek their own augmentation

Limits may be terminated and House swapping eliminated
But Wilson can't re-Pete
Some pols will push for Quackenbush
To fill the Governor's seat

Senator Di might run since others have begun
But must hold Al in Checchi
And there are shades of Gray without Lungren at bay
The race could be a wrecky

Some bills did conform to health care reform
But not all were to pass
Consumer demand had others expand
But those were vetoed en masse

Wilson's committee is sitting pretty
To beautify managed care
Until they decide he'll let old rules ride
And then launch market repair

Some changes were made but add, I'm afraid
Venomous administration
Cal COBRA amends when coverage ends
On small employer's behalf

And new family rules though passed out in schools
Don't relieve employers
Of the need to enroll kids for those on payroll
Or they will need their lawyers

On the more "domestic" front San Francisco bears the brunt
Without any law "partnership"
Facing litigation over registration
And no state bill bargaining chip

So what's in store? We'll get an encore
Of those bills that did not get out
For once they begin they just get a new spin
Of final passage there is little doubt

Rear View

Individual Guarantees

Part of the national legislation passed last year allowed states to either set up their own mechanism to enfranchise uninsurable individuals, or to default to a prescribed set of rules. California chose the latter course, since no legislation for alternatives could be passed. There is good news and bad news here.

Good news:

Any individual who has group coverage and has either terminated it or any possible extension (e.g. COBRA) may enroll in an individual plan offered by any carrier in the state selling individual coverage.

Bad news:

The only plans the carriers are required to offer are their two most popular plans *by premium volume*. This usually means older plans, which already have high rates and will see a more rapid increase in cost later as more people enroll in or migrate to their newer plans.

Good news:

The plans must be issued on a guaranteed basis, without health review and with no limitation for the coverage of pre-existing conditions.

Bad news:

There is no limit on what the carriers may charge for access to these plans, and the preliminary rates from both Blue Cross and Blue Shield are very high.

Purchasing Pools

Multiple employer trusts that are not state run may be created. Restrictive rules, competition by the state and the use of such programs by carriers already means this legislation arrived drained of any promise.

Other States

California is in the lead in some programs but not in all. Some states are more progressive and others are determinedly retrogressive. Some highlights:

1) Hawaii sets up “reciprocal beneficiary” statute similar to Domestic Partners
2) Relaxed anti trust measures for locally operated plans and networks
3) New mandates on some preventive measures (e.g. PSA test and Pap smears)
4) Launched new comparative data programs to help evaluate health care quality
5) Managed care plan changes, which were not made in California:

    a) 18 states disallowed restrictions on patient advocacy
    b) 17 states require managed care plans to provide better information
    c) 19 states require direct access to OB/GYN without primary referral
    d) 10 states allow “prudent layperson” standard to determine emergency needs

Review

Healthy Families

The Health and Safety Code (101.755) and Insurance Code (Chapter 6.2) were amended to allow the expenditure of state and federal funds for the new CHAP plan. Though Kaiser has launched a campaign to spend $100 million for the subsidized care of 50,000 California children, the Blue Cross charitable trust has a similar program and other carriers are expected to follow, California will now set aside $450 million to qualify for a grant from the federal government of $850 million. Rules:

1) Available to children meeting these qualifications:

    a) Ages 1 to 19
    b) Family income must be 100% to 200% of Federal Poverty level
    c) California resident and citizen

2) Not available to:

    a) Any children who qualify for coverage under Medi-Cal
    b) When parents drop children off group plan just to enroll here
    c) Children who are already covered under group health plan
    d) Those who stay on the plan less than 6 months (must sign agreement)

3) Monthly plan cost:

    a) $7 per child (maximum $14) income 100 to 150% Federal poverty level
    b) $9 or $27 if income is 150 to 200% Federal poverty level
    c) Reduction if enrolled in community health care plan

4) Plan design:

   a) No limitation for pre existing medical conditions
   b) No deductibles, percentages, etc. -- uses series of co-payments
   c) Maximum total of co-payments not to exceed $250 per year
   d) Includes medical, hearing, vision and dental

5) Enrollment:

   May be done through the schools, medical offices or agents

California COBRA

Federal rules have, since 1986, permitted employees and dependents who lose their group coverage the opportunity to continue such coverage, at their own cost, for 18 to 36 months. This only applied to groups of 20 or more employees, however. The new California law will extend these rights to groups of two or more employees.

The rules follow those prescribed by federal legislation and subsequent court and administrative rulings closely, with the following differences or notations:

1) Employer may have premium surcharge of 10% for administration (federal is 2%)
2) Carriers are charged with administration rather than the employer
3) Contracts must show all rules no later than January 1, 1999
4) First premium payment must be by certified mail (not just first class mail)
5) Employer must send notice when changing rates or carriers *30 days in advance*
6) Existing California continuation rules continue:

   a) Extension of Benefits for disabled employees or dependents
   b) Ninety day allowance for those widowed or divorced from employee
   c) Conversion policy
   d) Longer extension for those who terminate at age 60 or beyond after having five years or more of service to the employer

One of the more interesting implications of this new law is that groups may not be able to make fast changes to new carriers, given the 30 day notice requirement. This could delay implementation of a new plan to the following month.

Long Term Care

Federal legislation changed in 1996 to allow the partial tax exemption for both direct and indirect (insurance premium) long term care expenses (nursing home, home health, custodial care). There was already California legislation dictating the coverages and rules that must be in such contracts, but these were not in sync with the new federal standards.

This meant that "California contracts" would not qualify for federal tax exemption. To remedy this, three separate bills were passed to allow consumers a choice between "federally" and "state" qualified contracts. Essential differences are:

1) Federal has 6 qualifying ADLs (Assistance with Daily Living categories) vs. 7
2) Federal needs 90 days of disability/cognitive impairment vs. ADL requirement only
3) Premium may be tax exempt vs. no tax exemption
4) No home health care vs. permitted home health care contract

Maternity Stay

To conform to federal guidelines, the minimum permitted hospital stay for a newborn and their mother must be 48 hours (96 if C-Section) unless both the mother and her physician agree to an earlier discharge.

See You

The bill of most immediate interest to individuals was an attempt by Assemblyman Brewer to limit the premium carriers could charge for use of the newly allowed portable individual plans. Blue Shield was so convinced the bill would pass that they set their rates based on what was prescribed in the law, only to change when it did not get out of the Senate.

There were also several bills which addressed changes in the managed care system, which were systematically vetoed by Governor Wilson pending findings of his own health care commission, due to report in January 1998. Others of interest:

1) Mental health parity for small groups (federal law mandates for large groups)
2) Domestic partner coverage (still present in some municipalities and companies)
3) Minimum stay requirements for post mastectomy hospital treatment
4) Mandates for preventive care, pap smears and PSA testing
5) Medical malpractice and HMO medical certification
6) Replacing Department of Corporations with new board for HMO oversight
7) Ban the use of drug formularies from any health insurance plan

Preview

Governor Wilson's committee will provide recommendations, offering a template for cooperative action on managed care legislation, as old bills return with new numbers. Other bills expected:

1) Questions of plan and employer liability
2) Expanded rights of provider groups and plans to assume risk
3) Expansion of existing small group health insurance rules to larger companies
4) Incremental expansion of employee rights under group and individual plans
5) Mandated benefits to be included in all health plans

MARKET MAYHEM

Our elected never take pause when they are enacting new laws
To foresee what they had not intended
Since the system moves faster there can lurk new disaster
So new rules must be newly amended

Market corrections chart new directions
For carrier profitability
It gives us a chance to see at a glance
If it was just luck or ability

Still they can't quell the urge to find new ways to merge
In the name of health care efficiency
Ignoring the fact that Congress will attack
The resulting service deficiency

US Healthcare met ya by combining with Aetna
MetraHealth became more United
Health netted Foundation a surprise creation
After plans with Blue Cross had ignited

Prudential is rumored for sale Columbia is facing jail
Cignals from the East aren't too strong
PacifiCare's less with their FHP mess
Oxford's systems went terribly wrong

California Advantage needs much more than a bandage
To fix member doctors' woes
Lifeguardedly stays HPR mends its ways
And so it locally goes

Will Brown and Toland overwhelm the partnership Kaiser will helm
As Phycor/MedPartners looms into view
Can Shield end their reliance on protective alliance
Or have to cross swords with the other Blue?

Imminent Inflation

Predictions are that health insurance premiums, after remaining relatively flat for the last two years, will see an increase in 1998 and 1999. Estimates range from 4 to 7% for HMO plans and 8 to 12% for PPOs. Explanations:

1) As usual, competitive bidding caused overcorrection in pricing by carriers
2) Backlash against HMOs in the stock market and their contracting practices
3) Normal increase in pricing
4) Cost of technological improvements, which are usually covered
5) Contract price negotiations for provider networks have hit bottom
6) Prescription drug costs rose twice what HMOs expected (14% in 1997) (higher cost and volume, did not cut other medical services, new successes)

Carrier Consolidation

Predictions are that in California we will see a final “Big Six” among HMOs.

1) Aetna and U.S. Healthcare to form Aetna/US Healthcare
2) Kaiser has signed several deals with local hospitals and is now in 17 states
3) PacifiCare and FHP/TakeCare, which itself was only formed last year
4) United and MetraHealth, itself the product of Travelers and Metropolitan
5) Health Net and Foundation formed Health Systems International
6) Prudential: not for sale or just not making a profit, and who can afford them?
7) CIGNA purchased Health Trust and has had problems with integration
8) Blue Shield has purchased CareAmerica in Southern California
9) Blue Cross/Blue Shield in various states, with each other or outside carriers

Ancillary Aggregation

1) Cardinal to merge with Bergen Brunswig to be the largest pharmacy wholesaler
2) McKesson then launched bid for AmeriSource, to stay the largest wholesaler
3) Apria is purchasing Transworld to become the largest home health care provider
4) Access Health and Informed Access, the largest phone advice systems, merged
5) R.R. Donnelly bought MedAccess, combining their two Internet enrollment systems
6) Quadramed and Healthcare Resource, practice management companies, merged

Provider Penetration

Doctors:

1) MedPartners, which had aggressively grown to become the largest Professional Practice Management company in the country in only four years, merged with the more sedate, internally grown Phycor, which had been second largest. MedPartners had also been on the cutting edge of signing long term agreements with national health carriers (e.g. Aetna) as an exclusive area network provider.

2) In the third and fourth spots, there is another merger between FPA Medical Management and AHI, both of which have expanded aggressively on their own.

3) Locally, Brown and Toland:

    a) Took over California Pacific Medical Service Organization (1,250 MDs)
    b) Will be managing Valley IPA in Modesto (470 MDs)
    c) Has a management contract for 400 doctors in Hawaii
    d) Engaging in aggressive expansion for local management contracts
    e) Is signing affiliation agreements (Healtheon, HiLife, and other vendors)

4) Among independents, the IPA Association of California has expanded and become the National IPA Coalition (Independent Physician Association)

5) Some doctors have taken a new route to affiliation, by doing so with unions:

    a) Doctors at Temple University have petitioned to join Local 56 Food Workers
    b) Oakland UAPD (existing) has joined with Civil Servants AFSCME
    c) AFL-CIO is now pushing to require trusts to only work with union doctors

Hospitals:

1) Tenet acquired OrNda to become the largest hospital corporation in California, surpassing Catholic Health Care West (CHW)

2) CHW took over St. Rose, Sequoia and Sutter-Dameron (Stockton)

3) Sutter Health purchased Eden Hospital, and already works with several in the Bay Area (Marin General, Mills, Peninsula, California Pacific, Alta Bates)

4) Stanford and UCSF got involved in their own "Big Game" and axed each other to merge, forming a new company cleverly called Newco

5) Mt. Diablo Hospital merged with John Muir in the East Bay

Combination:

Columbia/HCA, by far the country's largest hospital corporation in the country, will complete the cycle from vertical integration to virtual disintegration:

1) Medicare billing scandal resulted in federal probe and now a full audit
2) Stock and income has gone down considerably and CEO forced to resign
3) Stopped construction and allowed affiliates to remove Columbia name
4) Doctors may not take equity positions in hospitals, and those that have must sell
5) Bought and now selling Value Health pharmacy benefit management company

Vendor Variation

1) Quotes without agents are offered for term life, disability and auto insurance
2) Hospitals are patterning some wings after hotels with deluxe accommodations
3) Carriers outsourcing their technological capabilities to related health markets
4) HMOs are expanding services to include chiropractic care and acupuncture

Looming Legislation

Domestic partner coverage is either offered or required in several municipalities and with large employers. The problem is that coverage is on a patchwork basis and there is no federally enabling tax code change that makes the cost of such coverage deductible. Notable participants in this trend are:

1) The City of San Francisco, which extends requirement to vendors
2) State of Hawaii, which does not even require that partners be living together
3) UC System just passed extended benefits by a vote of 13-12

While attention has been given to some of the more obvious restrictions imposed by managed care plans (HMOs), modifications to the "binding arbitration" clauses to settle legal disputes have not been brought up as often. This may change with the recent California Superior Court decision against Kaiser which, while upholding their right to require binding arbitration, found that the plan acted "unconscionably" in its application *(Engala vs. The Permanente Medical Group).*

Farewell to Frustration

1) John Alden dropped out of individual and group in California
2) American Western Life filed for bankruptcy
3) CIGNA is concentrating on the large group market (over 50 employees)
4) Principal Mutual sold California individual book of business to Blue Cross
5) California Advantage dropped out of HIPC, undergoing restructuring

Silly Situation

1) NIH calls for more studies to prove the medical value of marijuana
2) Pet insurance is growing to prevent "cat"astrophic health care expenses
3) The American Medical Association agreed to put its logo on Sunbeam products
4) The AMA, responding to membership pressure, withdrew its permission
5) Sunbeam is now suing the AMA for $20 million for its reversal
6) The American Heart Association allowed its logo certifying foods to be low in fat and cholesterol to be put on nutritional products such as:

    a) Cocoa Frosted Flakes
    b) Fruity Marshmallow Crispies
    c) Belgian Creme Cappuccino

FUTURE FORECASTING

What the future portends are new means to old ends
Pitting cost versus costly emotion
There won't be much time to make silly rhyme
It's endless poetry in constant motion

Some will be generic, others more esoteric
Depending on how much greed is involved
The one thing that's clear is things will change by next year
The question is how much will be resolved

The future of health care delivery is debated in the popular, political and professional press, but many of the arguments are on the same side. While they often agree, they differ on degree, and argue future rates as much as the rate of change. The universal answers are affordability, accessibility, accountability and availability. The question is how best to deliver them, and the vehicle used to get there, its power, and the changing shape it must take to remain relevant.

Government intervention is a necessary subset to the debate, since it is usually agreed that the preservation of a "safety net" is a necessary social good. How far to cast that net, and what it should yield, is something that should not be decided in hindsight, however. Rather, legislation should ride the crest of innovation rather than dragging behind the waves of change.

Nobody wants to read a long treatise on the philosophical underpinnings of the health care debate, economic theory or political principles -- and I don't want to write it anyway. A more digestible approach is an outline of some of the trends we are seeing, with reference made to those in their early stages of development. As the spiritual Yogi (Berra) once said, "You can see a lot just by observing."

Current Trends

1) Technology

   Administration:

   a) Prudential, Blue Shield and Kaiser among the carriers going on line
   b) Healtheon, MedAccess, Xybernet among on line service vendors
   c) Will do combined billing, enrollment and termination for all coverage lines
   d) Can include medical Q&A, access to providers, link customers and vendors

Communication:

a) California signed the Telemedicine Act of 1996
b) There is a national Telemedicine association
c) Industry and government developing Electronic Data Interchange protocols

Information:

a) Carriers become greater repository for health care data
b) Providers work with carriers to use data to measure and manage outcomes
c) Governmental entities expand capabilities and data standardization
d) Quality and technological assessment will increase in supply and demand

3) Contracting positions:

a) Providers and carriers signing long term agreements
b) Providers being compensated for achieving customer satisfaction targets
c) Capitation replaced by more risk sharing and use of outcomes targets
d) National carriers using national medical networks not their own
e) Continued development of new provider entities (PHO, PSO, MSO)
f) Shifts in contract and affiliations among Kaiser, Blue Cross and Blue Shield
g) Regional carriers moving to other regions/states ("superregionals")

4) Expanding coalitions:

a) Purchasing groups (PBGH, COSI, PERS, HIPC)
b) Direct provider contracting bypassing the use of carriers (QuadGraphics)
c) Development of comparative health care quality data locally
d) Eight provider owned HMOs have allied for joint product and service development
e) Rise of employee staff leasing (already growing rapidly)

5) General specializations:

a) American Physician Partners is a rollup IPO of seven radiology practices
b) Pediatrix Medical Group is buying many pediatric practices nationwide
c) Mergers with existing general practice groups

6) Legal corrections:

a) Change health care tax exemption from employer to employee
b) Mandate employer sponsorship of coverage
c) Define nature of antitrust as applied to health care more clearly
d) Continue to expand opportunities for the portability of group coverage
e) Incremental reform to improve access, affordability and availability of care
f) Return to a quest for solutions to Medicare financing to extend solvency as baby boomers take an increasingly large share of Gross Domestic Product

7) Market directions:

   a) Increased awareness and sale of long term care coverage
   b) Rising cost of disability coverage as baby boomers take "medical retirement"
   c) Outsourcing of directly manageable areas: mental health, preventive care, etc.
   d) Continuing mergers and acquisitions (less with carriers, more with providers)

Means to Ends

The next generation in health care delivery management uses several methods, gathering clout and dispelling doubt of their ability to meet the primary objectives of both a high quality and efficient quantity of health care. The continuum moves from the original "disease based reimbursement" to "disease state management."

Payment Methodology

1) Capitation payment system is reaching to other medical areas:

   a) Ancillary providers
   b) Specialists on per member or global case rate basis
   c) Hospitals where there is high area HMO concentration and few hospitals

2) Providers are negotiating for reimbursement based on quality measures

   a) Eliminates tendency of capitated providers not to capture outcomes data
   b) Utilizes some of the HEDIS and other quality measures being developed
   c) Permits carrier to point to and prove quality of care when soliciting members
   d) Allows plans to better differentiate themselves from each other

3) Increasing integration of health care systems (hospital, doctor and other medical services such as lab and X-ray) though more selective than before

4) Global contracting and case rates are increasing, but face regulatory (Knox-Keene in California) and potential anti trust problems

5) Another payment trend is for carriers to share premiums with doctors and end "risk withhold" and other fee cutback arrangements

Fee for Benefit

Rewards performance based on the appropriateness of care and the outcomes reached as a form of quality accountability. Under the old system, providers were paid regardless of what happened to the patient in the short or long term. Payment will now be based more on "success rates" rather than the "going rates."

Demand or Episode of Care Management

Recognizing that capitation (fee restrictions) and discounting programs have gone as far as possible, involves the patient in care from the beginning. Case management techniques, care substitution, outcomes data, case rate pricing, and patient education and training are all important components of this type of system. It looks to use a combination of "best practices" and efficiency on a case by case (episode) basis.

Focused Factories

A more formalized structure of efficient care management would utilize what is envisioned by Regina Herzlinger in her recent, popular book. Taking a page from "best practices" of business, the health care industry may look to expand on its current "centers of excellence" approach and use either capital markets or existing resources to create systems devoted to specific diseases, etc.

Provider Partnership

The first generation of Independent Physician Associations (IPA) were put together to combat the inroads being made by managed care and other discount plans. Their marketing clout was insufficient for long term survival, and those that did not also impose cost discipline, mandatory utilization and referral guidelines, outcomes data and improved, integrated systems are failing.

The second generation of IPA is more like an extended group practice, with an integrated network and agreements with ancillary and specialty providers. Some have even signed agreements with local hospitals, either formally (Physician Hospital Organization) or informally (Integrated Service Delivery Network). They have been called managed care networks, integrated delivery systems or virtual medical groups.

It is these networks that should be able to make good on the promise of technology in medical care. Increasing acceptance by doctors, standardization of systems (if for no other reason than resulting from the size of these new networks), improved encryption and other confidentiality measures should all contribute toward its success, which will further enhance the success of the networks themselves.

Growth will come not just by affiliation and general expansion, but by the increasing outreach to capital markets. More than 30 Physician Practice Management (PPM) companies are now publicly traded, and growth is explosive. The Journal of the American Medical Association predicts that "if current trends persist, a majority of physicians will be employees in the very near future."