IAAHS 2004 Colloquium
Dresden April 27 – 29 2004

Bailey, Daniel

"The role of a physician-initiated managed care organization in the US"

Unabbreviated Abstract: This paper is intended for presentation at the International Health Colloquium in Dresden, Germany in April 2004. This 30-minute presentation will cover various aspects of the US system for the finance and delivery of healthcare, particularly as it pertains to the Capital District Physicians' Health Plan of Albany, NY, USA. The scope of the paper will include discussion of private employer-based coverage as well as various state, federal, and mixed US programs of social insurance. It will embrace both fully insured healthcare financing and self-funding. It will touch on aspects of actuarial theory pertaining to managed healthcare, health policy, and health insurance products—public, private, and mixed. A brief overview will be presented of the current status of managed care and managed competition. It will look more specifically at New York state and generally at the US, at the beginning of the 21st century, and will focus on managed healthcare—cost, access, and quality—where we are, where we were, and more importantly, where we have to go…

The paper will be predicated on the actual experience of CDPHP (Capital District Physicians' Health Plan), a non-profit, health insurer and managed care organization initiated by physicians 20 years ago in Albany, New York, and for which I serve as vice president. CDPHP will provide an empirical context and platform for many of the products, programs, and issues to be discussed. CDPHP is licensed to operate in 24 counties in NY. It has over 300,000 fully insured members enrolled in its commercial coverage (240,000+) and various government programs (75,000+ members); and it has approximately 50,000 additional members on an ASO (administrative services only) basis through 10 large, well informed, self-funded employers. The constituent segments of the employer-based commercial pool will be examined—small group and large (more than 50 employees), chamber and association business, the Federal Employees Health Benefit Program, the state employees health program, and community-rated versus experience-rated business. The many government programs are various forms of social insurance and include managed *Medicaid, Child Health Plus, Family Health Plus*, and *Medicare + Choice*. Furthermore, the different types and levels of medical service covered by the various benefit plans and programs will be explained. Additionally, *Healthy New York*, mandated sole proprietor, and mandated individual coverage will be discussed in the context of how these stopgap plans help the state to mend tears in the government's healthcare safety net, which is a complex patchwork of state and federal programs. Several NY State mechanisms to promote equity will be explained:

1) mandatory community-rating of all HMO groups and all small groups in health insurance products,
2) compensation of indigent care,
3) financing of graduate medical education, and
4) the small group pooling mechanism used to prevent health carriers from "cherry-picking" healthier groups and avoiding higher risk employer groups. The grassroots role of the community HMO will be expanded upon and compared with that of the national for-profit carriers.

This paper will remark on the effect of federal and state insurance regulation on the cost, quality, and availability of commercial, employment-based coverage while underlining the variance of health policy across individual states. The balance of state versus federal regulation will be pondered, and the potential consequences of interstate uniformity, achievable through federal regulation, will be considered.

The paper will examine the lines of demarcation separating eligibility for or access to the various programs and products, both employment-based and government. In so doing, it will expose the occasionally overlapping roles of public and private systems, and identify situations in which the private sector's business mission may be at cross-purposes with the government's desire to see that adequate and comprehensive healthcare is available for all citizens.

Another factor to be considered will be the underlying reasons for healthcare cost increases, such as the rapid advancement in medical technology, and the reasons why healthcare cost increases faster than the cost of consumer goods. A paradigm of medical necessity versus medical wants will be explored from the standpoints of cost, access, and quality, as it pertains to the populations served by

CDPHP. A brief comparison will be drawn with the German and Canadian systems, where the government may designate which hospitals will be allocated new medical technology. This will be juxtaposed to the US competitive market approach, in which the prevalence of new technological equipment is the norm, but the cost of care is consequently higher, particularly in mid-size to large communities, where closely situated competing hospitals can duplicate each other's infrastructure and services. Other local examples of redundancy and scarcity will be noted where relevant.

A description of the provider network will be set forth, with mention of the capitated specialty services. The expenditures of the MCO for different types of service—hospital, medical, ancillary, and RX—will be examined from an actuarial perspective. This will involve comparison of costs across different products, programs, regions, and population segments, by type of service, shown in graphical and tabular format. A claim probability distribution will be presented to demonstrate the pooling of cost amongst members; this includes the budgetable cost of preventive care, as well as catastrophic and individual expenses that are spread across all the members within the pool. Another factor to be considered is the administrative cost of health carriers, not only in the US, but also in single-payer or publicly managed systems. The variance of administrative costs across different health carriers and systems will be discussed. The intent is 1) to establish an appropriate range in a multiple payer system and 2) to identify what the member obtains for that portion of health premium corresponding to the cost of the network, risk assumption, and ongoing operations and administration of the health carrier itself. Customer satisfaction, quality assurance, and accreditation will be discussed. It will be noted that the US health system is as diverse as the US itself, and that these manifold approaches to healthcare comprise an enormous body of experimental data for scientific study.

Finally, the paper will end with a recommendation to help depoliticize US health policy by objectively establishing clarified roles for the private and public sector—roles that better align with each party's incentives to attain their goals and objectives. This will include a proposed model for the integration and interface of public and private US systems for the financing and delivery of healthcare.