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Testimony before Texas Department of Insurance
Proposed Financial Incentive Guidelines
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My name is James L. Holly. I am a family physician and the managing partner of a multi-specialty provider group in Southeast Texas. Southeast Texas Medical Associates, LLP was founded in August, 1995 and will soon have twenty-five providers. I am also the Medical Director of Golden Triangle Physicians Alliance, a 400 physician IPA.

I want to thank the Commissioner of the Texas Department of Insurance, Mr. Elton Bomer, and his staff for the opportunity to comment publicly on the Department's proposed financial incentive guidelines. As I have read the proposed guidelines, it appears that the Department's chief concern is that the integrity of the healthcare delivery system in Texas be protected. And, the Department wants to prevent an inordinate "liability" from being placed on physicians by managed care companies that may affect treatment decisions because of the impact of this risk on a physician's income.

I appreciate the Department's concern about the correlation between risk arrangements and treatment decisions, but let me suggest a slightly different perspective. "Risk" means freedom of choice for physicians to honor their oath to provide the best quality care that we can, while at the same time allowing us to make the most of a finite amount of healthcare resources. In short, to provide cost-effective, quality healthcare.

"Risk" is nothing new to human society. In his book, *Against the Gods: The Remarkable Story of Risk*, Mr. Peter L. Bernstein traces man's dealing with uncertainty in financial matters. He states:

> "The word 'risk' derives from the early Italian *risicare*, which means 'to dare.' In this sense, risk is a choice rather than a fate. The actions we dare to take, which depend on how free we are to make choices, are what the story of risk is all about." (p. 8)

Mr. Commissioner, every physician who makes his or her services available to the public takes risk that no one will respond. And, society, whether as an agency of the government or as an agency of a private business, assumes the risk of paying for healthcare services for a defined population. The only way to eliminate risk – and indeed the only way to significantly reduce risk – is with a concomitant reduction in freedom. As physicians who have embraced the managed-care model of healthcare, we want to be able to accept risk. And, we would ask you and your Department not to limit our ability to choose to take that risk.

In the old healthcare system, where physicians were rewarded on the basis of how many units of work they produced, rather than how much health they created, and in a system where others had the responsibility for paying for that care, there were no checks or balances on utilization. In the old system:

- For the provider, more utilization meant more income.
- For the patient, more utilization meant a sense – often misplaced – of better care.
- And, those who had no leverage in the system – the government and industry -- picked up the bill.

It is possible, I believe, under the old indemnity insurance model for healthcare to produce ruinous cost overruns in our national economy. But, there is an alternative --

managed care. There was a time when I was an opponent of managed care, but I have been converted. I have found a system:

- In which my patients get excellent care;
- In which, the best of the old system – the strong physician-patient relationship -- is preserved,
- In which, the best of the new system – high quality care in a cost-effective delivery system is created,
- In which, my practice remains my practice, and
- In which, because the system is based on a physician-driven IPA, I have no interference with sound medical decisions making.

The reality is:

- There are excessive costs in the present healthcare delivery system.
- It is possible to control those costs without compromising care.
- "Excellence" and "expensive" are not synonyms.
- Cost savings and excellence are not mutually exclusive terms.

And, healthcare providers who are willing to engage in the management of healthcare resources can achieve significant savings while enhancing the quality of care. Let me illustrate.

1. Due to my personal philosophy, our group participates in the State of Texas' Star Medicaid managed care plan. Recently, I received the financial review of my panel of patients. The result: it costs the state of Texas 50% less to take care of this group of patients than they expected. Why? Because, we apply managed-care principles to their care, and we treat them the same as all our patients, with quality and compassion in an environment where every person is treated with dignity and respect. That is why Medicaid patients are lining up trying to get into our practice. These Texans are benefiting from a new method of providing healthcare. It is high quality, service-oriented and cost effect, which simply means that it provides a high value for the money spent.

2. As a physician, several weeks ago, I was called by the emergency room about one of our HMO patients. By the way, the emergency room is required to call us before the treatment of ANY and ALL of our patients, but failed to do so this time. When I arrived, the ER provider had ordered a CAT scan, a chest x-ray, an EKG, a complete abdominal series, and multiple laboratory tests, at a total potential cost of $2700. I did a history and physical exam on the patient, and cancelled the unnecessary tests. The result: the patient was given 500 cc of $D_5$1/2NS, and went home.

She was seen fourteen hours later in the clinic and was completely well, at one-tenth the cost. **Cost of testing?** Nothing! **Quality of service?** Excellent! **Patient satisfaction?** Overwhelmed! These savings can now be used for appropriate care for someone else who needs the tests and/or treatments ordered by a physician.

3. As a medical director, I was asked to approve a referral of a patient to a tertiary medical center for removal of her gallbladder. When I asked why, I was told, "Because she has gallbladder carcinoma." The evidence of this was a CAT scan report, which said: "Thickened, irregular gallbladder wall consistent with chronic cholecystitis. Differential diagnosis would include the possibility of gallbladder carcinoma." I refused the referral and recommend that an in-network surgeon remove the gallbladder. After a lengthy discussion over several days, this was finally done. **The result? A patient who had been virtually convinced that she had gallbladder cancer had a simple cholecystectomy, and at least**

$25,000 was saved. Again, these resources are now available to provide care for patients who really need highly specialized care.

I could go on with these illustrations, but the point is, when physicians and other healthcare providers – we have six nurse practitioners in our group – embrace cost-effective, quality healthcare in a managed-care environment, costs go down, quality often goes up and everyone wins. But, one of the keys to achieving these successes is to allow physicians to take risk and then to be rewarded for the hard work required to achieve these results. Mr. Commissioner, if you adopt TDI guidelines, which prevent these rewards from being offered, you will prevent Texans from benefiting from this new emerging healthcare delivery system. Many of the concerns which you have about managed care risk are eliminated when physicians are engaged, when physicians have chosen to accept "risk," and when the physicians' values and commitment to their neighbors are allowed to operate.

Mr. Commissioner, I would ask you that whatever guidelines you adopt that they not interfere with the legitimate dynamics of managed care, which allow:

1. For effective, quality healthcare that produces cost savings from utilization management, concurrent review of care, utilization of cost effective facilities and adherence to quality performance indicators.
2. For HMOs to transfer global risk to physicians who choose to engage in managed care – who "dare" accept the risk and who achieve outstanding results.
3. For patients and payers to benefit from the redistribution of healthcare resources and to reward those healthcare providers who strive for and can demonstrate healthy outcomes as opposed to compensation based strictly on productivity.

Mr. Commissioner, over the past three years in Southeast Texas, we have experienced the emergence of a unique and remarkable healthcare delivery system. A system where an HMO – HMO Texas – an IPA – Golden Triangle Physicians Alliance –

a management company – Heritage Health Systems – and private physicians – Southeast Texas Medical Associates and others – have learned how to work together to:

- To create our own Patient Bill of Rights.
- To protect the healthcare interests of the most vulnerable of our citizens.
- To work collaboratively together to provide excellence in healthcare and to be able to demonstrate that excellence.
- And, to do all of this in a cost-effective system.

Mr. Commissioner, before you adopt new TDI Financial Incentives Guidelines, I would invite you and/or your staff to visit SETMA and GTPA. I would invite you to observe and to experience what I believe is the most exciting and excellent healthcare delivery system I have ever seen, and then to develop TDI guidelines that would foster and support the development of similar systems all over the state of Texas.

In the old healthcare system, physicians provided a service, sent a bill and received their money. Unfortunately, there were no limitations on how many services they could provide, where those services could be provided or how much they could charge. The result, coupled with many other important factors, was runaway healthcare cost.

A growing number of Texas physicians are finding that if they redesign their approach to healthcare deliver; if they have the information systems in place; if they have case-management nurses; if they follow treatment pathways, and if they are engaged in the total healthcare of their patients, they can achieve the three things most physicians seek, which are to:

- Practice quality medicine
- Have a responsible input to the direction of their future, and
- Make a reasonable income based on their education, experience, and investment in an infrastructure of healthcare delivery.

We believe the managed-care model, which we have developed in Southeast Texas:

- Meets all of the legitimate public responsibility issues of the TDI.
- Allows physicians to accept "risk" and to manage that "risk" within the context of their moral and ethical responsibility to their friends and patients, and
- To do this within a budget which is reasonable and practical.
- Provides the needed resources to maintain the fiscal sounds of the physician's practice and to put the systems and infrastructure in place for maintaining outstanding, quality healthcare, which is, at the same time, cost effective.

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