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## Why Not the Best for the Chronically Ill?

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*Summary: Premium adjusters to neutralize risk selection among health plans are the weakest component in the technology for assuring competitive markets. It will be many years before we have adjusters adequate to free health plans to invest in and market improved managed care to predictably high-cost chronically ill persons. For want of a fair premium, health plans are driven by risk selection to underinvest in and otherwise "demarket" care to these very employees and beneficiaries whose costs and care most need to be managed. To achieve best value for the chronically ill, large employer coalitions, Medicare, and Medicaid should consider radical new approaches, such as establishing separate prices for care to people with specific chronic conditions and purchasing such care both from health plans and directly from provider systems.*

Chronic conditions involve health care needs that seem particularly suited to the kind of improved coordination and capitated payment associated with managed care. Such conditions often require the patient to deal with numerous and varied providers of services over a protracted period of time. In addition, they frequently involve a progression (often downward) over time that requires adjustments in services—to both accommodate to and retard further loss. And they affect patients differently—often requiring very tailored services. In many cases, patients must comply with complex instructions to avoid acute episodes or more rapid deterioration. Health care providers need clinical time to work with such patients—and flexibility to organize care to meet individual needs—beyond that provided under the usual acute medical care fee schedule and coverage categories.

Moreover, the chronically ill incur high costs for employers and public programs. Health care costs for persons with moderate chronic disabilities, for example, may be as much as two to three times higher than those for persons without disabilities.<sup>1</sup> In addition, the morbidity associated with chronic conditions costs employers a great deal in absenteeism and lost productivity.

Given the opportunity managed care seems to offer for the chronically ill, employers, Medicare, and Medicaid by all rights might hope to see health plans competing to develop and market higher-quality and more cost-effective plans for chronically ill employees. Purchasers might hope to see plans advertising aggressively to enroll chronically ill employees and beneficiaries, and they might well want to help channel these employees and beneficiaries to the plans that offer the best value. This hopeful scenario is not justified by the incentives in today's health plan market.

### **ADVERSE RISK SELECTION AND ITS CONSEQUENCES**

In the market of competing health plans, the threat of adverse risk selection encourages health plans to be at best ambivalent about investing in care for the chronically ill. On the one hand, such investments offer great potential for reductions in costs and improvements in value. But on the other hand, if a plan becomes known among employees or beneficiaries as better than its competitors at caring for people with a particular chronic condition, it is likely to attract more such subscribers during open seasons, and its costs and premiums are likely to rise in comparison to its competitors'. This is because, in serving people with chronic conditions, it is hard to be so efficient that the cost of care to a chronically ill enrollee is at or below the average for a plan's enrollees. Ultimately, a plan cannot quote a competitive premium if it enrolls many more than its proportionate share of sicker employees or less than its share of healthier employees.

The importance of risk selection in determining premiums of competing health plans was first documented publicly in the Federal Employees Health Benefits Plan (FEHBP). In 1989, the actuarial values of nine FEHBP plans studied varied by no more than 35%, but the premium of the highest-cost plan was 246% greater than the lowest-cost plan, due primarily to adverse selection. The high-option and standard-option Blue Cross and Blue Shield

plans were virtually identical in benefit value, but the high-option premium was nearly twice the standard option's due to risk selection.<sup>2</sup> Wide variation in benefit value compared to premium among very similar health plans is common where employees or beneficiaries are given the choice of multiple plans. Risk selection therefore can produce much larger variations in premiums than the 15% to 20% estimated savings achievable by the most tightly integrated health maintenance organizations.

The implication of this phenomenon for health plans' competitive strategies is that *health plans can not rely on efficiency alone; they must compete based on risk selection.* If plans were to advertise to enroll the chronically ill, or if Medicare, Medicaid, or employers were to channel beneficiaries or employees who are chronically ill into health plans that offer the best value (price and quality), or if large numbers of the chronically ill were to learn about these plans and seek them out, these plans' competitiveness would be damaged. Because of risk selection, (a) health plans are not motivated to compete to market better value to the group purchasers' most costly and needy employees or beneficiaries, and (b) the group purchasers would harm the best plans if they encouraged their most costly and needy employees to enroll in them.

### "DEMARKETING" TO THE CHRONICALLY ILL

How many health plan advertisements have you seen aimed at recruiting high-cost chronically ill people? With regard to the chronically ill, health plans have a strong incentive to demarket—or at least to "stay in the pack" of competing plans, that is, neither to stand out as a better value nor to appear scandalously behind.

Such a posture argues for investing less, at the margin, in improvements or plan features that increase value to the chronically ill and investing more, at the margins, in improvements or plan features (such as pediatrics) that can be marketed to subscribers who are

healthier on average. It also argues for weighting the plans' marketing and demarketing efforts in the same ways.

A primarily defensive posture requires steps such as the following:

- Investing in ways to contain *costs* of care to chronically ill people already enrolled as a way to keep down overall premiums while avoiding attracting more such enrollees.
- Investing in ways to meet the specific *quality* requirements of accrediting organizations and to gather the data they require on specific performance standards relating to chronically ill people, but avoiding going beyond these requirements.
- Taking care not to overinvest in costly services, new technologies, or benefits that are particularly desirable to a group of chronically ill employees and that are better than those of competing plans.
- Being careful not to outdo competitors in empaneling those types of providers of care (specialty clinics or physicians) widely known for their attractiveness to the chronically ill.
- Avoiding advertising care to chronically ill people unless there are extraordinary extenuating circumstances, such as the ability to keep an asthmatic child's health care costs low enough that they do not outweigh the advantage of enrolling an entire family.

A more aggressive posture regarding risk selection suggests further steps:

- Investing in research based on analysis of claims data and past enrollment and disenrollment patterns, as well as in focus groups and surveys, so as to determine which services, providers, plan features, and marketing and advertising approaches attract (or repel) low-cost subscribers.
- Avoiding specific health care providers favored by the chronically ill or, if it is necessary to contract with these providers for marketing purposes, using referral criteria that minimize their use.

- Discouraging the use of specific referral services favored by the chronically ill or their physicians by using unrefined review protocols that require special approvals or exceptions.
- Using primary care gatekeepers who are paid in ways that discourage referrals of chronically ill persons to specialists.
- Keeping the numbers and availability of specific types of health professionals, clinic facilities, and other resources that attract the chronically ill to a minimum, thus ensuring long waiting times.
- Identifying advertising images and slogans that give an impression the plan is designed for healthier employees rather than for the chronically ill.
- Paying physicians and hospitals in ways that pass on to them increasing amounts of risk (a practice seemingly welcomed by more and more providers across the country), as well as the problems of risk selection.

Depending on their organizational structures, health plans have different options and philosophies for underinvestment and demarketing. For example, a group- or staff-model HMO has more power to control investment in various services through its budgeting process, while a loosely organized PPO will rely on restrictive review protocols. Ironically, the integrated health plan, which has arguably the most potential to improve care to the chronically ill, also has the most options to avoid this population, because it controls the resources for care more directly. And as physicians and other providers assume more and more of the risk, they are likely to have to develop their own set of practices for demarketing to the chronically ill, a frightening thought, given providers' better knowledge of which individuals in their practice are likely to be high-cost.

However it is done, staying in the pack and demarketing produce at best weak competitive

efforts to improve the quality and value of care to the chronically ill. These practices offer weak assurance of long-term improvements in care and can mean higher costs in the short run. As Medicare has documented, purchasers can end up facing higher costs for insurance and care as health plans compete to enroll the low-utilizing employees or beneficiaries and avoid those whose costs are higher.<sup>3</sup>

Chronically ill persons themselves face health plans that are encouraged to underinvest in their care, avoid marketing to them, construct obstacles to their complex referrals, and avoid the providers and services they have searched out as most helpful to them. If they choose to stay with these providers, it is likely to mean staying behind in higher-cost health plans while lower users opt into plans with better risk selection. In FEHBP, this can cost four times the out-of-pocket premium of other employees—thousands of dollars a year.<sup>4</sup>

If the computer industry were motivated to compete the way health plans compete, they would avoid investment in and marketing to the really big users of computing for fear they could not get a fair price.

## PREMIUM ADJUSTORS AND DEMARKETING

Frustrated policymakers and insurance consultants sometimes downplay the importance of risk selection, saying it is not a great problem in "mature markets," where large managed care plans dominate the landscape, or that it is a transitional problem that will balance out over time in any system. The evidence, however, is more discouraging. For example, the variations in benefit value and premiums of Blue Cross's high and low options in the FEHBP mentioned above remain roughly the same today, some 6 years later. The risk selection has not proved to be transitional. As for maturity, the FEHBP has existed for more than 35 years.

Our greatest hope for correcting the risk selection problem that causes plans to demarket

to chronically ill persons has been thought to be a premium adjustor, that is, a formula by which plans receive premium payments adjusted to take account of the extent of the favorable or adverse selection they experience. If a premium adjustor produced a fair premium for people who use a lot of health care, persons with chronic illnesses would become highly desirable subscribers to a health plan—and the providers they favor would likewise become highly desirable participating partners of the plan.

We are, in fact, a long way from having a premium adjustor good enough to facilitate constructive plan competition to invest in and market to the chronically ill. The ultimate test of an adjustor is whether it enables health plans to advertise to this population. Adjustors in use today do very little to correct for risk selection in general. Those being researched hold promise for doing a good bit more, but none promises to meet this ultimate test of allowing advertising to the chronically ill.

As described in recent literature, to neutralize a health plan's incentives to risk select, a premium adjustor must explain predictable variations in costs of potential subscribers at least as well as the health plan can predict them and use the demarketing techniques described above to enroll more of the predictably low users and fewer of the predictably high.<sup>5</sup>

One important effort uses information available in employers' personnel files to divide employees into subgroups whose health care utilization varies, assign a relative future cost to employees based on the subgroup to which they belong, and then adjust the premium of each plan based on how many members of each subgroup it enrolls.<sup>6</sup> Other researchers have used multiple factors (for example, indicators of physiologic health, self-reported general health perceptions and chronic diseases, and prior use of medical services) to divide employees into many subgroups and assign relative premium cost to each employee.<sup>7</sup> Still others have defined subgroups based on diagnostic information.

Some research focuses on predicting future years' costs of the entire insurance group (for example, the employees of one employer enrolled in one of the health plans offered) and claims considerable success in predicting and potentially adjusting premiums to take account of risk selection.<sup>8</sup>

Approaches to predicting and correcting for risk selection are not nearly as successful at predicting the variations in costs at the individual subscriber level. There seems to be some agreement among researchers that it is unusual to be able to explain as much as 10% to 12% of the total variation in costs,<sup>9</sup> or approximately two-thirds of the predictable variation<sup>10</sup> at the level of individual subscribers.

Do health plans have the motivation, opportunity, and resources to predict future costs of individuals or small subgroups better than those who use risk adjustors? Can health plans identify and market (or demarket) to prospectively higher-cost and lower-cost individuals within the subgroups for which research can set premium adjustors?

Plans clearly have the motivation and the opportunity. Limitations in adjustors currently being used in research leave a wide margin for plans to profit by risk selection.<sup>11</sup> Moreover, most of these research adjustors have been developed based on historical data or in situations where the plans have not been strongly motivated to outmaneuver the adjustor. Plans have easily outflanked the Medicare adjustor, and there is every reason to believe their efforts will substantially reduce the predictive power of research adjustors. Indeed, group purchasers will find themselves in something of an arms race with health plans, when and if they attempt to use risk adjustors.

Unfortunately, plans are far more motivated than those who might use risk adjustors to buy from them. In fact, few purchasers today have entered this arms race, since few are using risk adjustors as part of their efforts to manage competing health plans. The Pacific Business Group on Health, the California

Managed Risk Medical Insurance Board, and the Minnesota Buyers Health Care Action Group have interesting plans to use relatively sophisticated risk adjustors for the chronically ill. But most purchasers who do use adjustors have limited themselves to the most elementary, such as age, sex, and geographic location of the subscribers. Medicare is using by far the most sophisticated risk adjustor today, and it is flawed and easily outflanked by health plans.<sup>12</sup> It is not clear why purchasers have been so slow to use adjustors; perhaps it is all just too complicated. But this reluctance does not augur well for the near-term development and use of practical adjustor systems.

When and if the race begins, health plans have formidable resources for attaining favorable risk selection beyond what the adjustor can correct for. Once plans are aware of premium adjustor subgroups and the premium each will carry, they can use the past claims and enrollment files as well as the focus groups and survey techniques described above to characterize their own subscribers over the years within each subgroup or across subgroups so as to identify those to whom they want to market or demarket. The data and financial resources available to the health plans for such research are much greater than those available to the researchers.

Adjustors based on subgroups will also set up a pernicious incentive for plans to identify individual current enrollees whose costs are substantially higher than the premium paid for the subgroup and look for ways to limit their investment in care to the premium amount. This approach would be similar to the common hospital practice of encouraging staff to get patients out within the days covered by a DRG payment, as though the DRG amount were a target or limit for patient stays rather than an average for costs of all patients in the DRG.

A tough-minded assessment of the purchasers' chances of using risk adjustors to win this arms race comes from Joseph P. Newhouse, who argues that "risk adjustment technology has to take major leaps forward to render

these incentives insubstantial," and that "the expectation for further research is for modest improvement."<sup>13</sup>

Since the potential of managed care is so high for the chronically ill, and since the costs and quality problems are so great, it makes sense for employers, Medicare, and Medicaid to look for new approaches to augment whatever premium adjustors they find practical.

### **PURCHASING FOR PEOPLE WITH CHRONIC CONDITIONS: SOME APPROACHES**

Unlike health plans, physicians and other providers of care have no ambivalence about marketing their services to patients with chronic conditions. Moreover, chronically ill persons on the whole are sophisticated consumers of such services and can be counted on to shop carefully for quality and price. If Medicare, Medicaid and very large private purchasers develop fair global prices or capitation rates to provider systems for specific chronic conditions, they facilitate the development of a market in which investing in and marketing to the chronically ill is desirable. Direct contracts between purchasers and providers for care to the chronically ill will force health plans to invest in and market to these subscribers if they are to hold on to them and to the large share of premium revenue they represent. If the system is structured well, chronically ill consumers will be educated to choose based on quality and value—and will use their relatively high level of sophistication about these matters to drive provider systems and health plans to serve them better.

The first key element of this approach is to assure that the price is right. Purchasers such as Medicare might use past claims data to set prices (as is done with DRGs), or they might ask plans and provider systems to bid on the provision of services for people with specific chronic conditions.

The second key element is to define specific chronic conditions as well as clinically and

actuarially manageable service packages for which prices can be set. Ideally, a service package should encompass both comprehensive care and services for the specific condition. However, for some conditions, bidders might be able to set a price for specialty services only and work out agreements and separate prices with primary care providers for the remainder of the patient's care. The prices may be in the form of capitation or mixes of capitation and other forms of payment and risk bearing. Chronic conditions and the range of services and relationships of providers for them vary greatly. The packaging and pricing of services should be clinically driven, taking into account the nature and course of the condition being considered. This is another powerful reason to look to providers directly, rather than only to health plans, to shape the program and bid.

A third key element is choice. The consumer should be offered the choice of these different systems and allowed to discipline the market over time by choice. If the consumer wishes to stay in the traditional arrangement with traditional providers and plans, he or she should be allowed to do so.

Some employers as well as Medicare and Medicaid are already purchasing limited packages of health care from providers on a competitive basis. For example, large employers contract for transplants. Medicare contracts for coronary artery bypass grafts. Employers are purchasing "disease management" approaches to a variety of conditions, such as diabetes, pediatric asthma, coronary artery disease, pregnancy/childbirth, low back pain, breast cancer, stroke, depression, knee care, attention deficit disorder, congestive heart failure, adult asthma, hysterectomy, Alzheimer's dementia, and hypertension.

HealthPartners of Minnesota is considering requesting proposals from provider groups ("caresystems") for capitated payment for comprehensive services to people with specific conditions (for example, insulin-dependent diabetes). This payment would augment an

ambulatory care group (ACG)-based risk adjuster in 1997.<sup>14</sup>

Medicare, Medicaid, and very large employers might take the following types of steps in pursuit of such arrangements:

- Request health plans and provider systems to propose global fees and capitation amounts for providing improved care to people with specific chronic conditions. The purchaser could use diagnostic groupings, such as ACGs, to determine a reasonable price, or it might supply the data to bidding plans and provider systems as a basis for their pricing.
- Request health plans and provider systems to bid on and arrange to offer all covered care to these persons or to demonstrate contractual or other agreements that permit all the covered care of the person to be clinically managed.
- Subtract the projected cost of these new condition-specific payments from the premium rates paid for other employees or beneficiaries.
- Contract with the "best value" provider systems and health plans in the community—or with the sole providers in rural communities.
- Allow chronically ill employees and beneficiaries to choose among health plans and provider systems. The choice might be made at the time of diagnosis as a point of service (POS) option or on a monthly basis as an enrollment shift. Medicare might offer the same choices to its beneficiaries who enroll in alternative health plans, as well as in the traditional Medicare program.

In order to encourage health plans and provider systems to bid on a global fee or capitation basis early in the program, purchasers might offer "risk sharing" arrangements to providers. For example, the employer might:

- Offer to share risks with plans and provider systems for all costs over a maximum for an

individual case or for an individual over a year or longer period of time.<sup>15</sup>

- Pay provider systems and plans a “blended rate” or partial capitation, for example, capitation for half and payment based on current costs for half, with the blend including a higher percentage of current costs for higher-cost patients.<sup>16</sup>
- Allow health plans and provider systems to limit the number of patients they will take in their initial years.

To assure quality, the purchaser's requests for proposals (RFPs) to health plans and provider systems might require management and clinical arrangements that clinicians and consumers consider critical to improved care for the person with the chronic condition. Accreditation by the National Committee on Quality Assurance (NCQA) might be used for this purpose, or Medicare might assemble experts and consumers to specify the best practices that high-value systems for patients with different chronic conditions should have and to develop performance measures for contracting with plans and provider systems. The RFPs might include:

- Possible organizational, risk sharing, and payment arrangements with providers.
- Evidence of investment of capital in improvement of services, treatment protocols, and best practices.
- Collection and submission of performance data, including preventive services, especially measures of preventive services that forestall chronic illnesses for which a capitated rate is paid.
- Evidence that providers have needed expertise and that the ratio of types of providers to planned enrollment is adequate.
- Inclusion of providers with strong local reputations in care of the chronically ill in health plan panels—or justification for not including them.

The employers, Medicare, and Medicaid would also undertake an extraordinary effort

to inform the choices of the chronically ill among health plans and provider systems so plans and provider systems that invest in improved quality could be rewarded with larger market share. This effort might include:

- Developing plan performance data based on best practices for various chronic conditions.
- Informing employees with chronic conditions how to make an objective choice in their own interest and equipping them with materials such as premium-to-benefit value comparisons, quality surveys of health plans and provider systems, and surveys of consumer satisfaction.

## DIFFICULT ISSUES

A number of difficulties must be faced to facilitate competition among provider systems and health plans to manage care to the chronically ill. Three of these—and possible solutions—are listed below:

- *Some chronic conditions affect too few people to support more than one (or even one) provider system in an area, especially if the employees of only one employer are involved. Even the enrollees of one health plan are often too few to contain the critical mass needed to facilitate organization of provider systems. The solution is for Medicare and multi-employer purchasers to take the lead. With Medicare's 37 million beneficiaries and a high incidence of chronic conditions in its population, Medicare in particular has enormous leverage in the market for services to chronically ill persons in most communities. Once a provider system is organized, smaller purchasers might buy from it. In rural areas or for rare conditions, sole provider arrangements might be negotiated with requirements comparable to the above.*
- *There are many different chronic conditions, each requiring a different set of services. Even a very large employer will find it complex to issue RFPs to cover all these possibilities and review competitive bids in each. The solution here is, again, relying on very large group purchasers, such as Medicare and purchasing alliances, to take*

the lead. Large purchasers might work with agents such as the NCQA or the Foundation for Accountability to solicit providers and consumer organizations to develop RFP criteria and provider system performance measures relating to chronic conditions. The effort can begin slowly by selecting the conditions that impact employees or beneficiaries the most or provide the best local market opportunities.

- *Many patients have multiple chronic conditions.* The solution here is for purchasers to solicit proposals from provider systems, such as geriatric centers for elderly patients, that can bridge multiple diagnoses. Although such systems may not be feasible for many complex diagnoses, clinicians should drive the systems' design wherever they can be developed.

Successful purchasing for people with specific chronic conditions will involve a steep learning curve. It will take considerable time and resources. And some chronic conditions may simply not be amenable to this approach. However, every condition for which this approach is perfected will yield that much more value for purchasers' health care dollars.

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Richard Kronick, *University of California, San Diego*; John Ramey, *California Managed Risk Medical Insurance Board*; Michael Von Korff, *Group Health of Puget Sound*; and Cathy Colton, *Harvard Community Health Plan*.

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## ENDNOTES

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6. For example, "a recently hired, single, female clerk, 23 years old, would carry with her an annual contribution of \$563; a single female professional, 60 years old with 10 years on the job would bring a contribution of \$1,277; and a female clerk, married with children, 40 years old with 15 years on the job, would bring a contribution of \$1,529 to whichever plan she chooses." (James C. Robinson et al., "A Method for Risk Adjusting Contributions to Competing Health Insurance Plans," *INQUIRY*, Summer 1991, pp. 107-116.)  
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10. Newhouse et al., "Adjusted Contribution Rates," p. 49.

11. Newhouse et al., "Adjusted Contribution Rates," p. 49.

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