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Research Report

Provider Reimbursement

by Catherine M. Murphy-Barron, FSA
peer reviewed by Patrick A. Gallagher, PhD

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PROVIDER REIMBURSEMENT

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Introduction

Provider reimbursement is a fundamental area of managed care. It is imperative that providers receive payment in a manner that offers appropriate incentives to provide quality and efficient healthcare. There have been a number of recent reports about physician organizations that have failed in their effort to take on the risks associated with providing care in a tightly managed care environment. Why have they failed? Managed care provider incentives are reported to work in some locations but not in others. Why does this happen?

The purpose of this research report is to attempt to answer these questions. We will do this by first looking at the methods of provider reimbursement popular in the current healthcare environment and see how well these methods fit with the objectives of managed care. We will also examine some new provider reimbursement methods.

We will examine some real life examples of successes and failures of different methods of reimbursement in an attempt to understand why they succeeded or failed. Finally, we will look to the future of the healthcare industry itself and of provider reimbursement methods.

Although the title of this paper is *Provider Reimbursement,* its focus is almost exclusively on physician reimbursement. Health plans spend a large portion of every healthcare dollar on physician reimbursement, and it is the area receiving the most attention in today's healthcare environment. Therefore it deserves the most attention.

The objective of managed care is to provide necessary, quality healthcare in the most efficient and cost-effective manner. The aim of managed care reimbursement methods is to reward physicians for the appropriate use of scarce healthcare resources. Health plans, especially health maintenance organizations (HMOs), often attempt to do this by sharing the risk of providing healthcare with the physicians actually performing the services. As a result, physicians have an incentive to provide quality care in the most efficient manner and possibly share in any savings.

The local regulatory environment is extremely important when choosing a reimbursement method. Several states have enacted laws that disallow certain types of incentive arrangements. Medicare also has strict rules about the types of incentive arrangements it allows. In recent years, we have seen the development of managed care backlash where physicians and patients are rebelling against the restrictions imposed by HMO plans. With this backlash comes an increasing number of lawsuits blaming the physician reimbursement method for adverse outcomes in healthcare. All of this will affect the choice of reimbursement.

The current two extremes of provider reimbursement are "fee-for-service", the traditional method of compensating healthcare providers, and "capitation", the method most commonly associated with managed care. Various other methods lie between these two extremes. We will examine the most common.

Traditional Methods of Provider Reimbursement

This section briefly describes the more traditional reimbursement methods.[1]

Fee-For-Service

Under fee-for-service (FFS) reimbursement, every time a doctor or other healthcare provider performs a service, the provider receives a payment. This has long been the traditional method of provider reimbursement. Some variations on FFS have developed in an attempt to provide more cost-effective and efficient care. These are discussed below.

Discount from Billed Charges

This method operates in a manner similar to FFS, however the health plan only pays a percentage of the billed charge, such as 90%. The physician and the health plan agree on the percentage discount before the performance of the services.

Fee Schedules

The fee schedule method continues to pay physicians on a FFS basis, but instead of the physician determining the amount due for each service (i.e., billed charges), the health plan develops a fixed fee schedule. The physician accepts this schedule as payment in full or, if the contract permits, he bills the patient for the difference.

Relative Value Scale

The relative value scale (RVS) method involves the development of a relative value unit for each procedure. A procedure is defined by its Current Procedural Terminology, 4th edition (CPT-4) code. The relative value unit reflects the amount of effort put forth by the provider to do the procedure. The fee for a particular procedure is the procedure's relative value unit multiplied by a monetary multiplier. The RVS method most widely recognized and most often used is, the Resource Based Relative Value Scale (RBRVS), developed by the Centers for Medicare and Medicaid Services' (CMS), formerly HCFA. CMS pays physicians for Medicare covered services using this method. As most physicians already use RBRVS for their Medicare patients, a large number of health plans have adopted RBRVS for use with their non-Medicare members.

Mandatory Reduction in All Fees

Under this method the physicians are paid FFS, usually according to a fee schedule equivalent to some discount off their usual charges. If total medical expenses exceed the budget agreed upon between the health plan and the physicians for a particular population, the health plan will reduce all fees again by an agreed upon percentage.

Budgeted Fee-For-Service

This method is similar to the mandatory reduction in all fees except that each physician specialty has its own budget. If costs for a particular specialty exceed the specialty budget, the health plan will reduce that specialty's fees by the agreed upon additional discount.

Sliding Scale Individual Fee Allowances

This method is also similar to mandatory reduction in all fees except that the performance of each individual physician is compared with an agreed upon benchmark and the percentage paid varies depending on that individual's performance.

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1 Peter R. Kongstvedt. *The Managed Care Handbook.* Third Edition

Capitation

Capitation is at the opposite end of the spectrum from FFS. This method of reimbursement moves the financial risk associated with providing healthcare to the doctors themselves. The physician receives a fixed monthly fee for every member—(per member per month (PMPM))—in the health plan (or their assigned member population), regardless of whether or not the member receives services. For those members who do visit the doctor, the physician must provide all the necessary services regardless of the cost.

Full Risk Capitation

This capitation method moves all of the risk of providing professional services to the physician. The physician receives a fixed PMPM for each member to cover both primary and specialty care. If the physician refers a member to a specialist, he must pay the specialist's bill out of the capitated amount.

Only the larger physician groups contract for this method, because they are in a position to negotiate favorable rates with specialty physicians, whereas individual physicians are not. These larger groups are also better able to financially bear the downside risk associated with this method.

Global Capitation

Global capitation takes full risk capitation one step further. The capitation payment covers all medical expenses, including professional and institutional expenses. Integrated delivery systems (IDS), where the IDS provides all professional and institutional services to the members, often use global capitation.

Incentives

Incentives are programs used in addition to the underlying method of provider reimbursement to provide additional inducement to the physician to practice in a particular manner. The health plan keeps the money allocated for these incentive arrangements in a separate account called a "pool", so that the physician knows what money is available and how the health plan distributes it.

Withholds

The health plan withholds a percentage of the physician's income to cover any excess medical expenses. The physician receives any money leftover at year-end, after payment of all the claim expenses. The idea is to induce the physician to be aware of medical expenses and to practice more cost effectively.

Bonuses

The physician receives a bonus at year-end for satisfying some performance criteria. The issue becomes what performance criteria to use. Traditional bonus arrangements use utilization or medical expenses to allocate bonuses. The newer bonus arrangements use a benchmark not related to utilization. There is a discussion on possible non-utilization benchmarks in the section on New Methods of Provider Reimbursement.

Case Rate, Flat Rate, or Global Fee for Procedures

Case rates, flat rates, or global fees are different names for the same method of reimbursement. A single fee is determined for certain services. The fee is the same regardless of how much or how little time and effort is spent. For example, a health plan may use a flat rate or case rate for maternity delivery. This rate is the same whether it is a vaginal delivery or cesarean section, and covers all prenatal visits, the delivery itself, and at least one postnatal visit.

Bundled Case Rate or Package Pricing

This is a variation on the case rate described above. Bundled case rate or package pricing combines the institutional and professional components into one case rate. For example, a bundled case rate for cardiac bypass surgery includes hospital charges, surgeon and anesthesiologists fees, and pre- and post-operative care.

Salary

The physicians are employees of the health plan and receive a salary. This is typically the method of choice of staff model HMOs.

Retainer

Health plans will sometimes use a retainer for payments to specialty physicians. The physician receives a fixed amount every month. The retainer amount is then reconciled periodically against actual utilization according to some agreed upon fee schedule. This method assures the health plan that the specialist will be available for the plan's members if necessary. This method is useful if there is a shortage of a particular specialty in the health plan's area.

New Methods of Provider Reimbursement

As the healthcare industry has changed, some of the established managed care reimbursement methods have fallen out of favor or been disallowed by laws and regulations. The results are new and creative methods of compensating providers.

Episode-Based Global Fees

In the past, global fees were used to reimburse physicians for surgical procedures and maternity. However, global fees now focus on episodes of care as well as surgical procedures.[2,3] The episode-based global fee bundles together all services related to a particular disease across the entire continuum of care. There are several ways to define an episode of care. It may be a chronic episode over a designated period, such as diabetes followed through the course of a year. It may also be an acute self-limited condition, such as myocardial infarction involving six months of follow-up care. Or it may be a single procedure with the associated follow-up, such as non-surgical coronary revascularization with one year of follow-up care.

Contact Capitation

Capitation in its true form does not work well with specialty physicians because of the low dollars associated with capitation contracts for specialists. Consequently, reimbursement for most specialists is on a discounted FFS basis. Contact capitation[4,5] modifies traditional capitation to better suit the circumstances of specialty physicians.

Contact capitation pays the specialist physician a lump sum upon the physician's first contact with a new patient. The payment basis is the average cost of care and covers a set period (e.g., 6 or 12 months) called the contact period. The specialist is responsible for all the specialty care within that contact period. A primary care physician (PCP) referral is still required for the initial visit. This referral covers all visits until the contact period is over. If the patient leaves the network before the specified period is over or switches to a different specialist of the same specialty in the panel, the patient is no longer counted as a contact, and the physician's payments for managing that patient stop.

The contact capitation payment incorporates risk adjustment to ensure that physicians receive fair compensation for variations in patient severity of illness. There are several ways to accomplish risk adjustment:

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2 Douglas W. Emery, MS, and Michael Pine, MD. For Surgeons, Global Payments Align Incentives. *Surgery Practice Options.* October 15, 1999.

3 Douglas W. Emery, MS. Finding Middle Ground with Global Fees. *Gastroenterology Practice Options.* March 15, 2000.

4 Cliff Frank and Jon Brunsbert. Using Contact Capitation to Align Payment Incentives among Specialists. *Healthcare Financial Management.* October 1999.

5 Judith L. Horowitz, MA, MBA. Contact Capitation: An Alternative for Specialist Capitation. *Healthcare Financial Management.* November 1997.

- Certain diagnoses or procedures may carry higher contact weights.
- Selected subspecialties and/or procedures may be covered separately.
- Separate capitation rates may be developed for different age segments.
- The sickest patients or patients with particularly difficult diagnoses may be carved out and paid on a fee-for-service basis.

Contact capitation fits with the objectives of managed care because it creates incentives for physicians to manage patient care as efficiently and effectively as possible. It is easy to understand and may be more marketable to physicians, because the payment amount is associated with specific patients, just like FFS. In a physician group situation, only physicians who actually treat patients receive payment. Contact capitation also shares the financial risk of over-utilization with the specialists. Therefore, physicians become more interested in disease management and patient treatment compliance, because keeping patients healthy reduces the need for additional visits that may not result in additional revenue.

Physician DRGs

A reimbursement method whereby the physician is paid based on Diagnosis Related Groups (DRGs) in the same way that hospitals receive payment by DRG is currently under development. Physicians receive a set payment, adjusted for the severity of illness, for each DRG. If the physician provides care in a more efficient manner, the physician keeps the savings, in the same way that a hospital keeps the savings if it can reduce the length of stay. This is effectively a case rate methodology. It expands the usual services that are paid by case rate (e.g., maternity) to include all physician services, even those not usually regarded as being conducive to case rate type methodologies. This method is still in development and is difficult because of the problems with developing appropriate DRGs and adjusting for severity.

Market Share Capitation

At first glance, market share capitation looks like contact capitation—counting patients as opposed to services. However, the difference arises in the allocation of the capitation payment. Market share capitation uses market share to allocate the capitation among specialty physician groups.[6] If a specialty group sees 20% of the patients who require that type of specialist in a year, that specialty group will receive 20% of the monthly capitation budget for that specialty.

This method relies on historical referral patterns on which to base payments. New physician groups that do not have this history usually receive fee-for-service payments until they establish a referral history.

Market share capitation is less difficult to administer than contact capitation because there are fewer items to track. However, this method is only appropriate for single specialty groups. Individual doctors in multi-specialty groups do not have enough share of the market for the method to work.

Direct Contracting between Physicians and Employers

The idea behind this system of reimbursement is to cut out the middle man, or in this case, the health plan. Groups of physicians organize to provide the necessary healthcare services, which they market directly to self-insured employers.

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6 Market-Share Capitation: A New Twist for Specialists. *Capitation Management Report.* Vol. 6, No. 8, August 1999.

A group of large employers contract directly with networks of providers to provide necessary care to their employees. Each network or care system consists of PCP physicians with affiliated specialty physicians and a hospital. The care system must be able to provide the continuum of medically necessary services to the enrolled population. The employer group contracts with as many care systems as fit their requirements and are willing, but a physician cannot belong to more than one care system.

The physician reimbursement is FFS, but the care systems propose annually a prospective risk-adjusted claim target PMPM for the entire year. The care system's fee schedules are adjusted, prospectively, up or down during the year based on actual claims experience to ensure that fees do not exceed the annual risk-adjusted budgets. The employers have stop-loss thresholds so they, not the care systems, are solely responsible for claims greater than these thresholds. The claim costs above these thresholds do not count against the care system's claim target budget.

The employer group distributes quality of care information to its employees so the employees can make informed decisions on which care system to use based on price and quality of care.

The Minneapolis/St. Paul market has had some success with direct contracting.[7,8]

Gainsharing

Gainsharing is an incentive arrangement between the hospital and its physicians.[9] Receiving a share of any hospital savings gives the physicians an incentive to develop new systems and protocols for more effective care management. However, due to the restrictions on its use in federal programs, its use in non-federal programs has also been dampened. Gainsharing is best suited to situations where the physician reimbursement is by fee schedule and the hospitals receive payment on a DRG basis. However, the underlying method of physician reimbursement has no real effect on the gainsharing arrangement-gainsharing is strictly an incentive bonus arrangement.

The focus of gainsharing must be on quality. The new systems and protocols must meet the predetermined quality and patient satisfaction outcomes for the hospital to share any savings. If they do not meet the appropriate outcomes, the physicians must review the initiative and make the necessary changes. The program design emphasizes the improvement of quality and outcomes by insisting that certain quality and patient satisfaction measures be met. It also reduces variability of care by the use of clinical pathways and other evidence-based clinical tools. The reduced cost is a by-product. A hospital will usually implement gainsharing in a particular area (e.g., cardiology) and then expand into other areas. Gainsharing requires the physician to consider the entire healthcare delivery system (rather than just the physician's piece of the system), and it provides incentives for quality, cost-effective care.

The main drawback to gainsharing is that it is prohibited under federal programs. The Social Security Act "prohibits any hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care".[10] Gainsharing is a violation of the Act, even if there is no reduction in the quality of care. Consequently, hospitals must be extremely careful in the use of gainsharing and, as such, most tend to stay away from it, even for their non-Medicare/non-Medicaid business.

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7 Jon Christianson, Roger Feldman, Jonathan P. Weiner, and Patricia Drury. Early Experience with a New Model of Employer Group Purchasing in Minnesota. *Health Affairs.* Vol. 18, No. 6, November/December 1999.

8 Steven N. Burrows, MBA, MPH, and Robert C. Moravec, MD, FACEP. Direct Contracting: A Minnesota Case Study. *Healthcare Financial Management.* August 1997.

9 Gainsharing Model Helps Align Physicians, Hospitals. *Capitation Management Report.* Vol. 5, No. 7, July 1998.

10 Office of Inspector General of the Department of Health and Human Services Special Advisory Bulletin. Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries. July 1999.

Reimbursement for Internet Consultations

This program pays physicians a fixed dollar amount for online communications with patients. It allows physicians to keep updated on the health status of their chronic patients. These patients often wait too long to contact their physician when their health starts to deteriorate. This results in an increased number of chronic episodes. The doctor can help prevent these episodes by monitoring the patient. Via email, patients can describe their current conditions (e.g., blood sugar levels in the case of diabetics), and they can ask questions. The physician responds via email. The physician does not have to prescribe any medication or action to receive payment-no action may be necessary.

Quality-Based Incentive Arrangements

Most of the reimbursement programs using information on the quality of care are bonus programs. The basis for the bonuses is benchmarks related to the quality of care provided. Some examples of quality of care bonus criteria are:

- Preventive care measures, such as pediatric immunizations, mammograms, etc.
- Appointment access, number of patient complaints, turnover rates
- Use of practice guidelines
- Health Plan Employer Data Information Set (HEDIS) measures
- Member satisfaction surveys

These incentive arrangements have proven to work well in the workers' compensation field. A bonus program offered by a San Diego PPO, to their workers' compensation network provides bonuses based on employee satisfaction, reduction in litigation, lower medical costs, and timely, sustained return to work.[11] The medical cost and duration is set for each diagnosis, taking into account the patient's age, sex and occupation. To avoid charges that this program induces a physician to withhold medically necessary care, the company has taken steps to ensure this does not happen. If a case results in litigation, the physician's bonus drops by 25% and a provider loses the chance of receiving a bonus at all if a patient chooses another physician because he or she is unhappy with the care received.

Bonus arrangements related to the quality of care provided are usually more acceptable to physicians than other types of bonus arrangements. The problem is how to measure the quality of care.

Fee Incentive Methodology

Some health plans are using a flat fee methodology to change physician behavior. This methodology does not affect the underlying physician reimbursement, but it induces the physician to work in a manner that fits with the needs of the patient and the health plan. The following are some examples:

- If the health plan wanted to increase the use of disease management, it could pay a flat fee for each referral to a disease management program.
- To increase preventive care, a health plan could monitor HEDIS preventive care measures and pay a physician a higher fee schedule, if the physician has high performance-based HEDIS scores.
- To induce primary care physicians to follow appropriate referral patterns, a health plan could pay a flat fee for appropriate documentation of the steps taken prior to referral. Alternatively, the health plan could pay a flat

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11 PPO Goes National with Performance-Based Bonuses. *Managed Care Outlook.* Vol. 11, No. 36, September 18, 1998.

fee to the PCP for tracking a patient, once referral takes place. This would help pay for the physician's time to communicate back and forth with the specialist.

- In a capitation situation where it is hard for a health plan to get good claims information, the health plan could offer a flat fee for timely reporting of encounters with a small fee per record reported.

Successes And Failures

There have been successes and failures under both the managed care and non-managed care methods of provider reimbursement. Success can be defined as providing quality care while still meeting all financial obligations. In the current environment of managed care backlash, it appears to be only the failures that are remembered. There have, however, been several reports in the health insurance press of managed care successes as well as the failures. This section will review some of the success and failures recently reported.

Successes

Ob/Gyn Management (OGM) is a specialty physician group in Dayton Ohio that receives capitation from its contracting health plans and then subcapitates its physicians.[12] OGM found that 95% of its network physicians earned more under capitation than they would have under FFS, with no drop in patient satisfaction. OGM cites the following reasons for its success:

- OGM realigned the physicians' financial incentives. The doctors no longer receive payment for doing more procedures. Those specialists doing the best job with the most number of patients get the most money.

- The physicians have other physicians whom they respect advising them on the appropriate way to care for their patients. OGM feels it is more effective than health plans in getting physicians to improve their methods. The network physicians see OGM as OB/Gyn physicians with similar concerns, rather than a health plan telling them how to practice medicine.

- OGM makes sure its physicians are aware of the risks involved in operating under capitation and how to deal with them. This is an important step, as capitation is still new to most of its physicians. It is also important that physicians are aware of the procedures or services the capitation payment covers.

- OGM implemented an extensive information system to provide regular feedback to the physicians on their practice patterns on a timely basis.

In Atlanta, Georgia Urology, PA, is using capitation successfully in its specialist group.[13] It receives capitation from the health plans with which it contracts, and then subcapitates its network physicians. In six years, Georgia Urology has grown from four physicians based in two southern Atlanta offices to 34 physicians in 22 locations throughout the Atlanta area. Georgia Urology cites the following reasons for its success:

- It developed good relationships with the health plans.

- It developed clinical pathways for the diagnosis and treatment of common conditions. This worked especially well because this specialty lends itself to clinical pathways.

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12 Martin Sipkoff. Some Specialists Find More Income, Less Stress Under Capitated Payment Plans. *Physician Practice Options.* May 15, 1999.

13 David L. Coleman. Urology Group Embraces Managed Care. *Physician Practice Options.* August 15, 1998.

- It measures clinical outcomes and reports them to the physicians. (Georgia Urology implemented a new information system to accomplish this.)

- It nurtures good relationships with PCPs, the primary referral sources.

Raleigh Orthopedic Clinic, also a single specialty group in a managed care environment, is another reported success with capitation.[14] The clinic has managed care penetration of approximately 50% in its practice's payer mix. Raleigh Orthopedic cites the following reasons for its success:

- Strategically plans with the physicians involved in the decision-making process.

- Thoroughly tracks and documents quality measures. These outcomes are shared with physicians on a group basis and individually.

- Offers payers a critical mass of providers who can provide care over a geographic area with good service, access, and quality.

- Negotiates good contracts and declines the bad ones. (It does the group, the health plan, and the patients no good, if the group goes bankrupt because of bad contracts that do not cover costs.)

- Nurtures good relationships with PCPs and other key players.

- Uses clinical care guidelines.

A common belief is that capitation is not appropriate for specialists or that it does not fit with the specialist mentality. Yet, these three specialist groups have succeeded. How has this happened?

Table 1 indicates some key elements for success and which of these were pursued by OGM, Georgia Urology, and Raleigh Orthopedic.

TABLE 1

Key Strategies Used or Not Used by Successful Specialty Groups That Used Capitation

	OGM	Georgia Urology	Raleigh Orthopedic
Data Collection	Yes	Yes	Yes
Investment in Data Collection Infrastructure	Yes	Yes	Yes
Alignment of Financial Incentives	Yes	Yes	Yes
Use of Clinical Pathways	Unknown	Yes	Yes
Good Relationships with Key Players	Unknown	Yes	Yes

14 Deborah J. Neveleff. Surgery Group Thrives Under Managed Care. *Surgery Practice Options.* February 15, 2000.

There are some common threads among these three organizations for their success. First, all three are collecting data on practice patterns, outcomes, quality of care, and other performance measures. They share this information with their physicians on a group basis and individually. They give their physicians regular and timely feedback on how they are performing in general and in comparison with their peers in the network. This has proven to be a most effective way to promote positive change among physicians.

The collection of outcomes data is also important for contract negotiations. The more information brought to the negotiating table, the better able the organization will be to negotiate fair contracts.

Having recognized the need to collect this outcomes data, all three organizations invested in the tools necessary to do so. Data needs to be collected from several sources, assimilated, and then reported back to the physicians in a manner they can understand. This involves a large initial investment, but it is imperative to an organization's success.

The second common thread involves the financial incentives provided to the physicians in the group. Both OGM and Georgia Urology subcapitate their physicians. While Raleigh Orthopedic did not reveal exactly how it reimburses its physicians, it did emphasize the importance of a fair and equitable compensation system that provides the correct types of incentives. To succeed, it is imperative to have financial incentives that induce behavior consistent with the goals of the group (i.e., quality care with little waste).

Another common thread is the use of care guidelines or pathways. Both Georgia Urology and Raleigh Orthopedic use care guidelines or pathways. The physicians in the network sign off on the guidelines and agree that they provide the most appropriate care. These guidelines allow the group to provide improved quality of care at reduced cost because the "fat", or unnecessary steps, is removed from the process.

Finally, building close relationships with key players in the market is also critical. This includes health plans, insurance companies, and PCPs. Specialists rely on PCPs for referrals, so good relationships are vital.

One item not mentioned by any of the three organizations is the amount of risk the physicians can handle. Risk and responsibility must be balanced between the health plan and the provider. The physician should only take on risk for that over which he has control. The health plan should not push all the risk onto the physicians simply because it has the power to do so. The secret to success is to accept only as much risk as can be handled by the practice and to make sure you have the right people advising you on how to handle the risk.

Failures

Burns Clinic in Petoskey, Michigan was a multi-specialty group that attempted to embrace capitation and failed.[15,16,17] The reported reasons for the failure were:

- Lack of success by the clinic in getting doctors to join its network. Because of the lack of managed care in the area, physicians did not feel it necessary to give up their independence.

- Inequities in compensation. The clinic failed to adjust compensation for productivity. This provided a disincentive for physicians to work harder or be more productive.

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15 Thomas M. Gorey, JD. Anatomy of a Group Practice Dissolution. *Surgery Practice Options.* February 15, 2000.
16 Thomas M. Gorey, JD. Lessons Learned from a Group's Demise. *Urology Practice Options.* March 30, 2000.
17 Thomas M. Goery, JD. Eleven Lessons Learned the Hard Way. *Surgery Practice Options.* April 15, 2000.

- Conflict with the hospital. The clinic traditionally had a close relationship with the hospital, but when conflicts arose between the two, the hospital set up its own network to compete directly with the clinic.

- Conflict with Blue Cross Blue Shield. The clinic choose to discontinue its participation with Blue Cross Blue Shield, which turned into a public relations nightmare.

- Failure of governance and leadership. The culture at Burns Clinic supported non-involvement by physicians in the governance of the group. Therefore, when the leadership failed, there was no one able, or willing, to take over.

- Failure of communication. Decisions made by the board of directors were not communicated to the rank and file, or the physicians choose not to attend the meetings at which these decisions were communicated.

- Problems with capital acquisition. In 1994, the group entered into a long-term agreement with PhyCor to acquire some much-needed capital. However, Burns clinic reportedly used the money to increase physician payments rather than to address critical underlying operational problems within the group. In 1998, PhyCor pressured Burns Clinic into reducing physician compensation, and a PhyCor-appointed administrator replaced the executive director. By this time, PhyCor was having its own problems and had no more money to give to Burns Clinic.

The failures of physician practice management companies (PPMs) have received a lot of press. A PPM is an organization that manages physicians' practices and in most cases either owns the practices outright or has rights to purchase them in the future. Many PPMs are publicly traded. Some well-known PPM failures are MedPartners Provider Network Inc., PhyCor, and FPA Medical Management Inc. Many opinions were put forward on why these and other PPMs failed.[18,19,20,21] Some of the reported reasons are:

- Health plan rates were too low. Health plans were keeping up to 25% of premium for overhead and profit, even though they were delegating more of the administration to the PPM. Capitation contracts negotiated by the PPMs were too low and did not cover medical costs.

- PPMs overpaid for the physician practices and then found the physicians' productivity dropped markedly once the physicians were no longer owners.

- Many PPMs focused on acquisitions rather than improving the physician efficiency or clinical performance of those they already owned.

- PPMs put little investment into critical areas, such as information systems or medical equipment, to foster internal growth.

- PPMs took on too much debt from acquisitions.

- Physician groups often held partial risk for prescription drugs and drug spending was increasing at double-digit rates.

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18 R. Rhundle and A. Sharpe. Physician-Management First Have Landed in Sick Bay. *Wall Street Journal.* July 21, 1998.

19 R. Lowes. The Rise and Fall of FPA: Few Heeded the Warning Signals. *Medical Economics.* January 25, 1999.

20 Do Financial Woes Stem from Mismanagement or Inadequate Rates? *Managed Care Outlook.* Vol. 12, No. 42, October 22, 1999.

21 M. Parrish. The California Nightmare: Is this where Managed Care is Taking Us? *Medical Economics.* January 24, 2000.

- Mismanagement of funds and poor business decisions.

- Many severely underestimated service delivery costs, largely because they did not have the necessary information to project costs accurately.

A reason for failure common to both Burns Clinic and the failure of the PPMs is the misalignment of financial incentives. The compensation systems were working against the goals of these organizations. They were not inducing physicians to operate more efficiently. In fact, they were doing just the opposite. The alignment of financial incentives is one of the reasons for success common to all three of the organizations described in the section *Successes.*

If we compare the reasons for failure put forward by Burns Clinic with the reasons for success identified in the section *Successes*, a couple of indicators emerge, aside from the misalignment of incentives described above.

First, Burns was not providing proper feedback to its physicians with respect to their performance or the operating decisions of the board of directors. The board decisions were either not communicated to the physicians, or the physicians choose not to attend those meetings where decisions were communicated. This led to misunderstanding and distrust. With regard to the physicians' actual performance, they were not given feedback on how they were doing either individually or compared with the whole group. Moreover, they were being rewarded for continuing to do what they were already doing.

Secondly, Burns was unable to maintain good relationships with key players. For example, Burns apparently needed a good relationship with the hospital and Blue Cross Blue Shield to succeed. Once these relationships soured, Burns was unable to recover.

Looking at the PPMs' reasons for failure compared with the reasons for success described in the *Successes* section, it seems the decision of the PPMs not to invest in the infrastructure needed to provide necessary feedback to the physicians was a key element in their failure. This was identified by the successful organizations as a key requirement for success.

Table 2 shows some of the critical elements for success and which of these elements were not addressed by Burns Clinic or the failed PPMs.

TABLE 2

Key Strategies Used or Not Used by Failed Specialty Groups That Used Capitation

	Burns Clinic	PPMs
Data Collection	No	No
Investment in Data Collection Infrastructure	No	No
Alignment of Financial Incentives	No	No
Use of Clinical Pathways	Unknown	Unknown
Good Relationships with Key Players	No	Unknown

Just as physicians are struggling with capitation, so too are hospitals. Many hospitals are now battling with health plans to renegotiate their capitation contracts. Some are even threatening to cancel their contracts because they feel they are not receiving enough payment.[22] Why are hospitals struggling under capitation?[23]

- Hospitals often rush into capitation unprepared, because they fear their competitors are doing the same and they might gain an edge in market share.

- Hospitals' capitated patients sometimes check into a competing facility, causing the hospital to pay costlier charges to the competing hospital.

- Hospitals pay regular charges instead of subcapitating outsourced tertiary services, ambulance, SNF, etc. Some hospitals also give away as much as 65% to their medical group partner.

For capitation to work for a physician group or hospital, the providers must know what they are getting into. They must also understand the risks, and know how to deal with them.

One of the developments resulting from managed care backlash is a move towards tying physician incentive arrangements to quality measures. An employer group in California attempted to tie their physician compensation to quality measures. The results were surprising.[24]

The Pacific Business Group on Health (PBGH), a group of employers in California, attempted to tie part of the reimbursement of 13 HMOs to quality. With the goal of improving health plan performance, a percentage of each HMO's income was placed at risk in the event that certain quality, member satisfaction and customer service targets were not met. The HMOs and PBGH collaborated on selecting and defining the measures to ensure that all measures were consequential and reportable. The measures selected were ones the HMOs were already collecting for the National Commissioner on Quality Assurance (NCQA) HEDIS reporting. This ensured that the measures would be comparable across all the plans. The result was not what PBGH had expected: the HMOs forfeited 23% of the income at risk because they did not meet PBGH's quality goals. PBGH realigned the financial incentives to meet their goals. And while most of their goals were achieved, some were not.

It apparently takes more than one employer group to create a change. If more employers attempted to tie reimbursement to quality, the methods of providing the care would change to meet the needs of all the employers.

We have said a great deal in this section about aligning the financial incentives of the physicians in the group. It must also be noted, however, that a group may find that its financial incentives are not totally aligned and yet it is still quite successful, and changing its incentives has little impact. This group may be just fortuitous in that it has good people who communicate well, and who already understand and are working toward the goals of the group. Nevertheless, it is unlikely that this situation can be sustained indefinitely. Without the proper environment, even the best people can get discouraged. It is therefore better to improve the environment before it is too late.

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22 Mary Ann Costello. Hospitals Battle HMO in Pennyslvania, New Jersey. *AHA News.* Vol. 36, No. 10, March 13, 2000.

23 Providers' Global Cap Dissatisfaction Leading to Next-Generation Risk. *Managed Care Outlook.* Vol.12, No. 14, April 2, 1999.

24 Do Health Plan Performance Targets Improve Quality and Member Satisfaction? *Capitation Rates & Data.* Vol. 4, No. 12, December 1999.

As evidenced in the cases examined in this section, one must recognize the importance of the proper alignment of incentives and goals, and that knowledge is crucial. That is:

- *Know what you are getting into.* For example, if you are planning on taking on capitation, make sure you know how it works, you understand the risks involved, and only take on as much risk as you can afford.

- *Know how you are performing.* Tracking outcomes is important for negotiations and for providing feedback to the doctors on how they are doing.

- *Know the key players in the market.* These can be insurance companies, health plans, or PCPs.

The choice of reimbursement method is not the sole reason for success or failure, however, it is a major contributing factor. If a group is financially strong, the choice of reimbursement method may not have a great impact. The same can also be said for a group that is not well funded, no one reimbursement method will solve that problem. However, for a group somewhere in the middle, the choice of reimbursement method may be what tips them towards success or failure.

The Future

The Healthcare Industry

To talk about the future of provider reimbursement we must first look at the future of the healthcare industry. The recent managed care backlash has pushed the market into a state of flux. Managed care in its original form will not continue. A move toward more Preferred Provider Organization (PPO) and Point of Service (POS) plans, which allow members more choice and less restriction, is already underway.

A PPO is a plan that contracts with independent providers at a discount for services. A POS plan is a plan where members do not have to choose how to receive services (in-network or out-of-network) until they need them. There are different benefits, depending on whether the member chooses to use the plan (in-network) or to go outside the plan (out-of-network) for services.

We also know that we cannot afford to return to a fully FFS environment. Employers cannot afford a return to the high levels of healthcare trend they were experiencing prior to the advent of managed care. So managed care will evolve into something new—not quite FFS and not quite managed care as we currently know it. There are many opinions as to what the future will hold for the healthcare market in the United States.

J.D. Kleinke puts forward in his book, *Bleeding Edge: The Business of Health Care in the New Century,* his opinion of the future.[25] He sees vertical integration as the new healthcare market. This means combining physicians and facilities, all levels of healthcare, into entities able and willing to cut out HMOs and contract directly with employers and the government. Recent attempts at vertical integration have not been successful, mainly because the wants of both parties were misaligned, and therefore, the hospital and the physician group found themselves being pulled in opposite directions. However, Mr. Kleinke is optimistic that, as the market continues to emerge, it will become obvious that this is the future of healthcare in the US. Hospitals will recognize that they cannot exist without physicians, and physicians will recognize that they cannot exist without the infrastructure of the hospital. For vertical integration to operate in the manner described by Mr. Kleinke, there must also be some changes to

25 J.D. Kleinke. Bleeding Edge: The Business of Health Care in the New Century.

the current healthcare legislation. For example, current healthcare legislation prohibits doctors from referring patients to entities in which they have a financial interest. It will require the amendment of this type of legislation, for vertical integration to be successful.

At the opposite end of the spectrum, Regina Herzlinger, in her book, *Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry,*[26] sees the future as more horizontal integration. She sees the market restructuring itself into what she calls "focused factories". These factories will focus on a particular disease (e.g., cancer), and the patients will receive all the care needed for their particular disease from these factories including such things as nutrition counseling not normally considered part of covered healthcare. These focused factories, would provide one-stop-shopping and make it easier for consumers to compare prices and determine if they are getting value for their money. This will be necessary in the healthcare environment she sees for the future. In Ms. Herzlinger's view of the new healthcare market, the consumers will be the buyers of healthcare not employers. She sees employers moving to defined contribution plans.

Defined contribution (DC) plans have received a lot of attention from the trade press recently. Under DC arrangements, the employer puts aside a certain amount each month into an account for each employee, and the employee then uses this money to purchase health insurance that best suits the employee's needs. Some employers are already experimenting with DC plans.[27,28,29] The movement to these types of plans in their true form would mean a major change in the design of the health insurance market in the US. For this to work, there must be health plans from which employees can choose. The entire healthcare market would change from a large group market to a small group/individual type market. This may not be a good thing, considering the uncertain state of the current small group market. However, some feel that, as the economy makes its downturn and employers find money again becoming tight, a large number of employers will resort to this method to control their healthcare costs. We saw a similar situation in the pension area some years ago, when employers moved from defined benefit pension plans to defined contribution plans, such as 401(k)s.

Employer group purchasing (direct contracting between physicians and employers) is also appealing to many employers seeking to reduce costs by cutting out the health plans. As described in the section on new methods of provider reimbursement, Minnesota is already doing this. If this were to become widespread, it would lead to a fundamental change in the US healthcare system.

For the healthcare system to evolve into an effective and efficient system, the healthcare market must align the needs of the three major players in the market—the consumer, the providers, and the payers, with the consumers becoming the dominant force in the market.

The consumers' role in the healthcare market has changed dramatically in recent times. The managed care backlash erupted because consumers found they no longer had a choice as to which doctor they could visit, and they disliked the number of restrictions imposed by their HMOs. This resulted in people looking at their healthcare benefits and asking questions about the delivery of their healthcare. Ultimately consumers began demanding more control.

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26 Regina Herzlinger. Market Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry.

27 Thomas C. Buchmueller. Does A Fixed-Dollar Premium Contribution Lower Spending? *Health Affairs.* Vol. 17, No. 6, November/December 1998.

28 Highmark's Internet Strategy Reflects Anticipation of "Defined Contribution". *Managed Care Outlook.* Vol. 13, No. 14, April 7, 2000.

29 New Health Plan Puts Consumer in Driver's Seat. *Managed Care Outlook.* Vol. 13, No. 17, April 28, 2000.

Another major force that has changed the consumers' role in the market, is the increased use of the Internet. The advent of the Internet may change both the way healthcare is sold and consumed. The obvious result of the growth of the Internet is the ability for health plans (the sellers of healthcare services) to reach the consumers of these services directly. Some health plans are already selling insurance over the Internet, and the technology already exists to allow members to enroll via the Internet. All this should make the process of buying healthcare insurance more efficient.

The other result of the growth of the Internet, which is not addressed as often, is how it has changed the way patients interact with their physicians, as well as the entity providing their healthcare coverage. Many consumers are now more informed. They are not willing to just sit back and accept what they are told without question. They want all the information, they want choices, and they want to be able to make informed choices about their healthcare. We are also seeing consumers of healthcare banding together into support groups (e.g., a support group for women with breast cancer), and they are meeting these other people through the Internet. These support groups provide a forum for these people to share their stories, the information they have discovered about the disease, and advice. The sheer force of numbers gives these patients the confidence to question their physicians and demand that the physicians and the health plans take notice of their opinions and demands.

Physicians must also adapt to the new market. Physicians are already consolidating into groups to gain leverage in their negotiations with health plans. Some doctors are also attempting to form unions so that they can collectively bargain. Physicians must also change the way they deal with their patients. Patients are now better informed and will no longer simply accept what the doctor says. They will question everything, and if they do not like the service they are getting, they will go elsewhere. Physicians must service their customers' needs in the same way other service industries have to, or risk losing them to physicians that do.

What will be the role of the health plans and insurance companies in this new healthcare market? The public wants more choice and less restriction on their care, and managed care organizations are already moving towards providing this. The PPO model is experiencing an increase in popularity, as are POS plans. HMOs are also cutting back on some of the restrictions that were fundamental to their operation in the past. Does this mean that HMOs are doomed? Probably not. HMOs will adapt to serve the market in a way that fits with the new market. Health plans and insurance companies provide necessary services much more efficiently than most providers can, and this may well be their role in the future.[30]

Provider Reimbursement

What does all this change mean for provider reimbursement methods? No matter which direction the future of the healthcare industry takes, all of the methods described in this paper will continue to be used, capitation will not disappear. Neither will FFS. The reimbursement method used will be the one that best fits into the particular environment. There will also be some blending of methods as well as some new methods. Some possible directions for provider reimbursement are described below.

Vertical integration as described by Mr. Kleinke lends itself to the capitation method of provider reimbursement, especially global capitation. The organization receives a global capitation payment to cover the provision of all the services provided by the new organization-institutional and professional.

30 Douglas W. Emery. What Will Become of the HMO? *Urology Practice Options.* April 30, 2000.

Horizontal integration, on the other hand, lends itself more to global fees or case rates. The aim of Ms. Herzlinger's focused factories is to provide all the care necessary for a particular disease; therefore, case rates, or episode-based global fees, would seem to be the ideal way to reimburse these providers. Global fees will also aid in comparison-shopping, which Ms. Herzlinger sees as an important part of focused factories.

The reimbursement for Internet consultations described in the new methods section is an example of using FFS, a traditional reimbursement method, to encourage a type of physician behavior necessary in the new managed care environment. We will see a lot more of this in the future, no matter which direction the industry heads. Email communication is now a major part of many people's daily life. Most will find it more convenient than sitting waiting for the doctor to return their phone call.

We will also see the blending of reimbursement methods to fit the situations at hand. Some physician practices, especially in California, are already putting these types of reimbursement methods into operation.[31] An example is paying PCPs on a capitation basis and carving out certain procedures and visits from the capitation payment and paying these on a FFS basis. The types of services that are carved out are preventive services, such a mammograms and vaccinations, to encourage their use.

We will also see a move away from purely financial incentives for physicians and a move towards incentives based on quality of care and patient satisfaction. These types of incentives are taking on more importance as a direct result of the recent managed care backlash and increased consumer involvement in the delivery of healthcare. Employers and their employees are demanding it. Currently, the biggest hindrance to these types of reimbursement methods is how to measure quality. However, these measures are being developed (e.g., HEDIS measures), and better measures will continue to be developed, as these types of methods grow in popularity.

There will also be more risk adjustment in the provider reimbursement methods used. A physician will no longer be penalized for having sicker patients. This will help prevent the situation where physicians have an incentive to refuse very sick patients or to refer them to another doctor. These methods will become more sophisticated and more accurate in the future, as risk adjustment is performed more often and health plans and providers get more sophisticated in tracking their data.

No matter where the future takes us, one thing is certain: We can never return to a purely FFS environment. Even those health plans that choose to continue to pay on a FFS basis will incorporate some managed care components into their FFS methodology, such as care management, disease management, and centers of excellence. Some plans are already doing this.[32] Employers will not allow healthcare expenditures to return to the level of annual increases seen in the FFS world. The new managed care plans will still demand efficiencies, but they will involve the providers more in the process, and they will be more consumer friendly.

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31 James C. Robinson, PhD, MPH. Blended Payment Methods in Physician Organizations Under Managed Care. *Journal of the American Medical Association (JAMA).* Vol. 282, No. 13, October 6, 1999.

32 GM Adds Case Management Tools to Indemnity Plan. *Managed Care Outlook.* Vol. 12, No. 11, March 12, 1999.

Conclusion

Managed care provider reimbursement methods can succeed in any of the markets in the country. However, there is much work to be done before implementation for them to succeed, such as:

- Examine the market. In tightly managed care markets, physicians are already practicing in a manner that fits with the objectives of managed care, while in less managed markets, the physicians are not. They must be educated and given the opportunity to adapt.
- Gain the support of the physicians. If the physicians understand the system and are involved in the development and implementation, there is a greater chance of success.
- Ensure that the reimbursement method chosen properly aligns the incentives. It may not be possible to align all the incentives, but it is imperative that the incentives not work against each other.
- Invest in data collection infrastructure. Good managed care contracts cannot be negotiated or physicians induced to change their practice behavior without good data.
- Providers need to understand the risks they are taking on. They also need stop-loss insurance to limit their exposure to catastrophic risk.
- Risk must be balanced between the health plan and the provider.

If all these items are addressed, before the reimbursement method is implemented, the physician and the health plan have every opportunity to succeed.

Milliman *Offices*

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6, Jongro 2-Ga
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Seoul, Korea 110-789
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Tampa (813) 282-9262
500 North Westshore Blvd.
Suite 800
Tampa, FL 33609-3524
Fax: (813) 282-8276

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Kioicho Hills
3-32 Kioicho
Chiyoda-ku
Tokyo, Japan 102
Fax: (03) 5211-7033

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