# Physician Response to the Formal Referral Policy of a Blue Shield Capitation Plan

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As health plan administrators search for ways to curb unnecessary utilization and at the same time ensure the provision of high-quality care, they experiment with various forms of prior authorization. One such strategy, especially useful for open panel plans in areas with many physicians, is the lock-in or formal referral or primary physician policy. In general outline this policy requires each subscriber to designate as a primary provider one name from a list of plan approved or participating physicians. This physician is expected to serve as the manager or gatekeeper for all the medical care needs of his patients. The primary physician is to be the sole source for most routine primary care and to be the authorizer and approver of nonemergency medical services provided by specialists to the patients on his panel. Authorization by the primary provider for a referral may be made a condition for plan payment of specialists' fees (or plan reimbursement to the patient for payment of specialists' fees).

This policy is aimed at deterring wasteful doctor shopping, the practice by some patients of seeing one doctor after another without referral in order to obtain repeated diagnostic workups for the same illness or set of symptoms. Such patients are engaged in a search for a second opinion on an unwelcome diagnosis, for a preferred or more satisfying therapy, or for any of a number of economic, social, or psychological reasons.[1] The policy is also aimed at more rational use of medical manpower by discouraging self-initiated visits directly to specialists for services which primary care physicians can provide more economically or appropriately.

A well-enforced lock-in is a necessary administrative component of any third party payment plan that relies on another cost saving approach: reimbursement of participating providers in whole or in part on a capitation basis. A serious financial drain may be created for capitation systems when patients seek covered services from providers other than those being prepaid to offer those services. When a patient wants to begin visiting a primary provider other than the one currently designated, the third party payer needs ample advance notice

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of the intended switch in order to rechannel the capitation payments.

Although a directive to play a role as gatekeeper may be communicated to primary providers, and although they may agree to such a role in a contract, it cannot be assumed that they will understand and support such a role or uniformly and consistently comply.[2] The actual behavioral responses of physicians in lock-in situations deserve careful investigation.

A unique experiment in formal referral and in direct capitation of primary care physicians within an open panel framework is underway in Wisconsin. This is the Health Maintenance Program (HMP) administered by Wisconsin Physicians Service (WPS), one of the state's two competing Blue Shield plans. The WPS Health Maintenance Program is marked by a number of innovative features, but this study focuses on physicians' attitudes and approaches toward the formal referral policy, as revealed by interviews held with a sample of the program's physicians and other sources.

## The Health Maintenance Program of Wisconsin

The WPS Health Maintenance Program policy, with its very generous array of in- and outpatient benefits, is offered to employee groups as an alternative to the highest level of coverage under the Wisconsin Physicians Service Blue Shield base contract. The WPS Health Maintenance Program offers broader coverage than the Blue Shield standard plan, as well as exemption from certain deductibles and copayments imposed by the standard plan, but at no additional out-of-pocket premium cost to the employee.

Varieties of the WPS Health Maintenance Program are offered in over 40 Wisconsin counties, with certain key features implemented only by election of each county medical society. Because the vast bulk of the subscribers, participating physicians, and claims volume is concentrated in Dane County (Madison), and because the severest test of the program's lock-in policy is occurring in this community with its numerous physicians and clinics, the performance of the plan there merits special attention. In 1978, the Dane County WPS Health Maintenance Program had some 67,000 subscribers and 650 participating physicians.

### *Capitation*

Dane County is one of 11 county medical society areas having a capitation arrangement for primary care services that is tailored for each provider group. Any physician, regardless of specialty, may agree to serve as a "primary provider." Each primary provider receives a flat payment at the beginning of each month for each WPS Health Maintenance Program subscriber who signs up with him or his group, regardless of whether the subscriber obtains services.

Primary providers sign a contract by which they agree to be prepaid for a specified minimum range of primary care services. With some exceptions, this includes hospital inpatient visits and office and hospital outpatient care (surgical, medical, accident, and well-baby care; injections, immunizations, and preventive care; and ancillary materials and supplies provided by the physician). In addition, if the primary provider or his or her group does laboratory work, performs in-hospital surgery, or delivers babies, he or his group are expected, with few exceptions, to have these services included in the prepaid range.

Services provided on a referral basis by specialists not choosing to be listed as primary providers are paid for on the basis of "usual, customary, or reasonable" fee for service.

### *The Health Maintenance Account*

Basic to the operation of the WPS Health Maintenance Program is a bookkeeping device called the health maintenance account (HMA). Each primary provider site (solo or group practice) will have its own health maintenance account provided that at least 500 subscribers sign up with that site. The remaining physicians, each with fewer than 500 subscribers, are combined in separate pools.

A health maintenance account is credited with the monthly premiums paid to the Wisconsin Physician Service for each Health Maintenance Pro-

gram subscriber who selected the physician or clinic as primary provider, minus amounts to cover the Wisconsin Physicians Service administrative costs and emergency services rendered by nonparticipating and out-of-area physicians. A separate allocation is also made for a shock loss, or catastrophic, expense fund to cover fees in excess of certain maximum levels per illness or injury sustained by an individual subscriber. Thus, primary providers have limited financial liability per patient under the plan.

Out of the health maintenance account come the amounts to cover health care expenses presumed to be within the primary provider's influence. These include the following expenses:

1. The capitation payments, which cover the small bill services included in the prepaid range.
2. Payment for other services rendered by the primary provider that are reimbursed on a fee-for-service basis.
3. Payments for other plan benefits that are rendered and billed for separately by other than the primary provider. These benefits include the fees for service of the referral specialists as well as hospital charges, prescription drugs, and ancillary services, supplies, and appliances.
4. Possible surplus.

The WPS Health Maintenance Program payments cover only the provider's actual costs, that is, his charges less a deduction said to cover the savings to the provider in overhead expenses made possible by the system. These savings are said to result from the elimination of billing expenses and collection losses.

## Risk Assumption and Surplus Sharing

Primary providers on capitation have both a positive and a negative financial incentive to strive for economy. Under the current contract, if capitations fall short of the costs of care rendered for any service year, the Wisconsin Physicians Service pays each primary provider no more than roughly 87.5 percent of the difference between his actual costs and his total capitation payments. If, on the other hand, the capitations exceed actual costs, primary providers may retain an amount equal to their actual costs plus up to ten percent of the total capitation payments to the provider.

If a surplus remains in the health maintenance account after an accounting period, it is to be distributed among the physicians sharing that health maintenance account and the persons paying the premiums for WPS Health Maintenance Program subscribers. But experience thus far shows there have been very few and minor instances of health maintenance accounts emerging with unused funds that have been distributed.

The Blue Shield plan guarantees payment of a large percentage of costs, and the primary providers agree to accept a limited degree of risk. Health service expenses of individual subscribers beyond certain maximums are covered by funds that are not debited to any health maintenance account. And when total capitation payments fall behind costs, the Wisconsin Physicians Service makes periodic lump sum supplementary payments to cover most of the difference. In its promotion of Health Maintenance Programs to physicians, the Wisconsin Physicians Service made emphatic assurances that participating providers would not suffer any appreciable financial losses under the plan.

## Formal Referral

Receipt by the Wisconsin Physicians Service of a referral authorization form signed by a primary provider is a condition for payment by the Wisconsin Physicians Service of claims submitted by nonprimary providers in Dane County for covered services to most WPS Health Maintenance Program subscribers. After joining the program, a subscriber must select a physician from a list of primary providers. Each covered member of a family may have a different primary provider. If a physician in a group practice is designated, all the physicians in that group are considered to be the primary providers for that subscriber. A subscriber can change to another primary provider on the first of a month after giving written 45-day advance notice to the Wisconsin Physicians Service. WPS Health Maintenance Program newsletters to subscribers strongly discourage self-referrals and doctor shopping and point out the wastefulness of seeking medical attention without the advice of one's primary provider. If a subscriber for any reason other than accident or emergency seeks

care without the written authorization of his or her primary provider, the subscriber risks being dropped from the program and placed under standard coverage, thus incurring the penalty of reduction in the benefit package. (This sanction is to apply, however, only to those subscribers covered by group contracts that include provision for enforcement of a lock-in. The scope of enforcement will also vary with other understandings that the Wisconsin Physicians Service has with the various group buyers.)

A primary provider fills out special referral authorization forms in triplicate in order to authorize payment for specialists' services out of his health maintenance account. The authorization is not for a single visit but for a treatment that may entail a series of visits: the form includes a space for specifying duration. The Wisconsin Physicians Service is sent a copy of the form, and the patient is given a copy that the patient is expected to mail or hand deliver to the referral physician and that the referral physician is expected to attach to the claim when it is sent to the Wisconsin Physicians Service. But because patients may lose their copies, the administration of the lock-in has not relied on the specialists having anything in hand from either the primary provider or the patient. But if the Wisconsin Physicians Service does not receive a proper authorization slip from a primary provider, the referral physician must bill the patient directly.

The Dane County Medical Society approved the WPS Health Maintenance Program in late 1971 by the slimmest of margins, and only on condition that self-referral be allowed. At the end of the first year, when the program was breaking even financially, the medical society voted overwhelmingly to continue the experiment for two more years. But in 1975, in response to heavy financial losses as utilization outstripped expectations, the medical society voted in favor of "strict adherence to principles of formal referral as a prerequisite to payment of physician's services."

This policy generated a negative reaction from some physicians and group buyers, which resulted in the medical society adopting, only about six months later, a significant relaxation of its position. According to the new rule, which currently prevails, ". . . the primary physician's responsibility is to make a determination as to whether a service is needed. The subscriber shall have free choice of physician in determining who should perform that service." What this has been interpreted to mean is that patients who have established relationships with specialists are to be allowed to continue seeing those specialists for necessary services. It also means that when a primary provider determines that a patient is in need of a service, and when the patient expresses a preference to obtain that service from an outside specialist, the primary provider is expected to honor that preference by means of a referral authorization, even if the needed service is available in the primary provider's clinic. The rule also permits approval of the referral request even when the service in question is one which the primary provider ordinarily performs.

Under the capitation systems of some European national health insurance plans, the general practitioners have monetary incentives to make high rates of referrals.[3] Under the WPS Health Maintenance Program, however, the financial incentive appears to be reversed: Primary providers stand to lose money by making referrals because the payments for authorized specialists' services come out of the health maintenance accounts and reduce the chances for a surplus that the primary providers would have a share in. In theory the WPS Health Maintenance Program arrangement should reinforce already strong disincentives to referral existing in the conventional open market. When a referral must be made, moreover, there exists an incentive to send the patient (in a choice situation, with all other things being equal) to affiliated physicians who charge lower fees or are viewed as otherwise imbued with some cost consciousness.

In actual practice, lock-in violators are not being dropped from the WPS Health Maintenance Program as threatened. According to one Wisconsin Physicians Service source, the approach to both subscribers and physicians is "low key and nonpunitive" and based on persuasion and education rather than expulsion or other penalties.

## Methods

Observations about the WPS Health Maintenance Program were obtained by means of open

ended interviews conducted in the summer of 1976 with 17 primary providers and one specialist, all practicing in Madison. The sample was not chosen randomly but with an effort to represent a cross-section of the medical community. The sample consisted of 8 internists practicing in seven different groups ranging in size from 2 to 55 physicians, 3 family practice physicians in group settings, 3 general practitioners in solo practice, 2 pediatricians, 1 obstetrician-gynecologist, and 1 proctologist. These physicians ran the gamut in terms of awareness of the mechanics of the program, interest in its performance, satisfaction with its administration, and admitted behavioral response to its incentives.

Interviews were also conducted with Wisconsin Physicians Service staff, with the risk managers for four major groups covered by the Health Maintenance Program, and with the business managers and office secretaries for several medical clinics.

Because of the small physician sample and the exploratory nature of the interviews, the range in the themes and trends in the responses are broadly reported here without precise tabulations of frequencies.

## Results

### *Views on the Formal Referral Policy*

The physicians' responses to questions about the lock-in showed spirited variation in awareness, support, and behavioral response. Only one respondent acknowledged that he did not know that payments for the fees of referral physicians were charged to his health maintenance account. Almost none of the physicians, however, admitted to making any change in their referral rates or patterns as a result of this financial disincentive, and this response was found among strong supporters of the principle as well as opponents.

Three categories of reasons were given by those who agreed that formal referral was a good idea:

1. The family practice physicians value the opportunity to monitor and control patient access to specialists' services. This expansion of the primary provider's authority is viewed as a means of contributing to the continuity and coordination of care as well as cost control. One of these supporters defended the lock-in in terms of rational allocation of tasks:

> We do not train obstetricians to do routine pelvic exams, neurosurgeons should not be doing college checkups, and surgeons have better things to do than treat ingrown toenails. These fall within the primary services I have contracted to perform, and I do not want the traditional services I have been performing to leave me.

An example of the ways that the lock-in could strengthen the position of the primary provider was offered by a family physician after he complained about the insufficiency of the communications he received from psychiatrists on the goals and outcomes of their treatment for shared patients. He said he authorizes only a certain number of psychiatric visits for some patients, then demands from the psychiatrist a report on the progress of each patient. He observed that the majority of psychiatrists he deals with accept this condition, but on two occasions psychiatrists made vehement complaints to his secretary.

2. Another group of physicians support the lock-in principally on the grounds that its success is critical to the financial solvency of the WPS Health Maintenance Program and thus its survival as a business enterprise. The market success of the program is viewed as an important bulwark against the intrusion of competing health insurance plans potentially more adverse to the interests of physicians.

3. One general practitioner gave strictly a self-serving argument in favor of the lock-in. He brushed aside the suggestion that the system gave him a welcome opportunity to advise patients on referrals. For him, the value of the policy lies in its deterrent effect: "My patients will not ask for a referral in the first place if they need to ask me—they would have a guilty conscience. They will stay with me and I will not lose them" to other primary providers, which, he explained, happens especially when his patients seek help elsewhere when he is on vacation.

Some respondents expressed misgivings about the potential of the lock-in for interfering with traditional help seeking patterns. Even staunch supporters of the lock-in favored a grandfather

clause, exceptions in the case of patients who have established relationships with outside providers.

Those who did not like the formal referral policy generally gave one or more of the following responses:

1. Some minimized the extent of the problem of doctor shopping, saying that they did not believe it occurred very much in the community or that it was a negligible source of financial loss for the program.

2. Some invoked the principle of free choice of physicians and described their distaste for the role of rationer of services. They said they lacked the time, the right, or the inclination to monitor the outside help seeking of their patients. Some of these physicians said they try to convince their patients that inappropriate self-referral will hurt HMP, but they added that they do not see their role as including enforcement of the lock-in or, as one respondent put it, being a "policeman for my patients." Many said they routinely refer the WPS Health Maintenance Program administrative matters to their business managers; several said they even delegated to office secretaries the authority to fill out referral authorization slips for patients.

3. A small but intense minority of physicians objected to the personal inconvenience of filling out referral slips, saying this burden offsets the reduction in paperwork resulting from the capitation system. (A majority of the respondents agreed without qualification that the HMP system, by eliminating the necessity for filing individual claims for primary care services, has resulted in a big reduction in their paperwork burden.) Most of the physicians were just as emphatic, however, in dismissing any suggestion that there was any bother involved in filling out the authorization forms, and indeed, a glance at a few slips filled out by an internist revealed how minimal the data supplied could be. A referral to an orthopedist, for example, gave as the reason, "leg problem," and most of the duration blanks were filled with "as needed," which shifted the discretion to the specialist. No sign was found that the Wisconsin Physicians Service challenged anyone about the information supplied on the forms.

4. Many references were made to the inadequacies in the education of HMP subscribers as to the merits of the formal referral policy and the requirement of primary provider authorization. Some respondents blamed not only the carrier but the group buyers as well for failures in patient indoctrination. The Wisconsin Physicians Service staff admit that this has been a major shortcoming of the plan and the service has increased its mailings to its Health Maintenance Program subscribers. It was the observation of office secretaries, however, that many patients who did receive mailed explanations simply did not understand them, and the task of patient education fell to the receptionists.

Subscriber ignorance about the requirement for a written authorization is given the blame for the bulk of the self-referrals that occurred after inauguration of the lock-in. The result was a huge number of after-the-fact, or postdated, approvals: Patients would see a specialist on their own initiative, learn about the need for a referral slip, then go to their primary provider and obtain a retroactive authorization. Another common response to lock-in violators was to handle single unauthorized visits to specialists as emergency visits. In many cases, subscribers who continued to see different physicians, but who failed to provide the Wisconsin Physicians Service with timely notification of their wish to designate a new primary provider, would be processed as emergency cases or given referral authorizations until they complied with the program's instructions for switches.

Specialists, rather than refusing services to patients lacking referral slips, typically delayed filing claims to the Wisconsin Physicians Service in order to give these patients a chance to obtain authorizations.

All sources who referred to the problem of lock-in violations said the frequency tapered off as more and more subscribers arrived at an understanding of the requirements.

Despite universal denial that the lock-in was having a heavy impact on their behavior, some physicians described salient instances of refusals of requests to sign a referral slip.

One of the major effects of the lock-in is one that officials of the program consider a key thrust of the plan. This is to make the large medical group practices in Madison, which serve a large majority of WPS Health Maintenance Program subscribers in the area, become more self-contained and more interested in seeing their patients obtain services from in-house specialists rather than outside sources. The feeling is that specialists on the staff can be subjected to rules and peer pressures aimed

at achieving efficiencies. It has been primarily certain big multispecialty clinics that have been the target of the few efforts by the Wisconsin Physicians Service at "focused" utilization review, instruction on cost containment, and negotiation regarding payment levels. If nothing else, the lock-in gives physicians at the larger clinics more opportunity to inform patients about the services available within the clinic, and some respondents said that they found themselves making extra efforts to make patients aware that needed services could be obtained from staff colleagues.

### Problem Areas

The problem set that divides primary providers into liberals and hardliners on the issue of enforcement of the lock-in involves subscribers seeking valid primary care services and preferring, but not needing, such services to be provided by either (a) a specialist, or (b) another primary provider outside the subscriber's designated primary provider site. Several troublesome situations were identified.

Some self-referrals reflect no explicit judgment by the patient of the efforts or abilities of his primary provider; a visit to an ophthalmologist for an eye problem, for example, may simply be considered the most efficient and appropriate thing to do. On the other hand, other self-referrals for second opinions are rooted in a lack of confidence in the primary provider's judgment, and the physicians in the sample, while saying that challenges to their opinion or competence were rare, varied in their likely response to patient doubt. At one extreme is the pediatrician who said that he always encourages his patients to get a second opinion. A middle ground is occupied by the internist who, when confronted by a patient who doubts a diagnosis he is sure about, would "stall" the patient, then eventually accede to the patient's request for a referral "if he raised a fuss." At another extreme is the allergist, so confident in his abilities that he would refuse to approve a referral request for a second opinion on an allergy problem.

The Wisconsin Physicians Service does not intend for its Health Maintenance Program formal referral to be an obstacle for patient pursuit of second opinions when elective surgery has been recommended. The service established a second opinion program for its Medicare business and encouraged its use by standard business policyholders.

At risk when a physician refuses to accede to a patient's request for a referral authorization may be the patient's peace of mind, which must be recognized as an important dimension of the patient's health status, one having interactive effects with physical condition. Also at risk is the rapport of a patient with his primary provider, which can be so critical in obtaining patient compliance with other prescribed regimens. The ultimate danger is loss of the patient altogether as he or she switches designations to either the preferred source of services or another primary provider more lenient with referral requests. However, when supporters of the lock-in are posed with the problem of patients seeing outside physicians for primary care, their most typical response is to allow it once or twice and then suggest to the patients that they designate the other physician as their primary provider if they wish to continue seeing him.

Another problem set includes patient demands to continue prior relationships with certain providers for particular conditions or services. Already noted was the sympathy that prevails for referral requests in the case of established physician-patient relationships. This type of request was found to have two most common expressions: (1) females wanting to see an obstetrician-gynecologist for routine pelvic examinations, and (2) patients wanting to see a proctologist for anal-rectal examinations and services. At work here are the strong loyalties that women develop to the physicians who delivered their babies and the special sensitivities associated with pelvic and proctological examinations. Some women might have gone through the formal switching process, with 45-day notice to the Wisconsin Physicians Service, to temporarily designate an obstetrician-gynecologist as a primary provider for the sole purpose of getting a pelvic examination, and then switching back to the original physician. Group buyers said the most frequent complaints they heard from employees about the lock-in concerned difficulties they were having in getting referrals to obstetrician-gynecologists, a particularly popular proctologist, and psychiatrists. The view that the hardships created by the lock-in outweigh its benefits led the city, county, and school employee groups to drop

formal referral when they each renewed their respective WPS Health Maintenance Program contracts.

## Psychiatric Services

One of the most glaring financial drains in the WPS Health Maintenance Program experience, and one that is generating much concern among its leaders and group buyers, results from the high rate of utilization of psychiatric services. The high use can be attributed in part to the heavy concentration of psychiatrists and of a myriad of other kinds of counseling services in Madison. It can also be attributed in part to the fact that the program enrollment reflects the demographic composition of Madison: both are largely white collar and middle class, and this stratum has repeatedly been shown in utilization studies to be much greater consumers of psychiatric services than blue-collar workers.[4] The financial impact of this benefit is lessened by policy limitations on the number of covered sessions of psychiatric therapy per enrollee per year.

Most of the physicians in this study indicated they would be inclined to grant referral requests to psychiatrists. A few respondents, however, said they denied patients' requests to see nonpsychiatric counselors, such as psychologists, when the reasons for the requests were deemed to be frivolous. Other respondents were concerned about patients seeking psychiatric care when it was felt they could be managed just as well by less expensive student counselors or other nonmedical personnel. Still other physicians, as noted earlier, may insist on progress reports from psychiatrists as a condition for authorizing additional visits.

## Views on the Specialists' Service Reports

An abortive administrative corollary to the WPS Health Maintenance Program lock-in was the distribution to each primary provider location of computer printouts listing all the services of specialists received by the program subscribers signed up with that location and billed to its health maintenance account. Since the primary provider authorizes payment of specialists' bills, this information was made available, according to the program promoters, to help the primary provider follow through on referrals, determine if specialists services are appropriate and if their charges are warranted, and thus be more in command of his patients' care. The Wisconsin Physicians Service, however, never adhered to a consistent policy in disseminating these reports and has dropped the service on the grounds that the reports were not being studied enough to justify their expense.

Support for this conclusion can be found in the interview responses. The sample ranged widely in their opinions on the usefulness of the information on specialists' services, with again only a minority admitting to making changes in their routines as a result of something they learned from these reports. One drawback was that the data were aggregated by clinic, and this made it difficult for individual physicians in large groups to track the service use of their own patients.

Some medical groups assigned one member or their business manager to study Wisconsin Physicians Service reports and summarize the trends, sometimes at staff meetings called for this purpose; or a Wisconsin Physicians Service staffperson came around to apprise the staff on the trends.

The most enthusiastic response came from a member of a large group who said the reports were exposing the wide variations in fees being charged for comparable services by practitioners of particular specialties throughout the community. He also considered the reports an eye-opener as to the high fees that certain specialists on his own staff were charging patients he had referred to them.

A few respondents said that they were surprised, after reading the service reports, to learn how much money was going out for specialists' care, especially for psychiatric services. Some merely found it mildly interesting to find out which of their patients were seeing psychiatrists. Some had a low opinion of the reports because they said they learn where their self-referring patients go through letters or other communications from the specialists.

Two respondents, however, said they studied their reports carefully and were determined to "plug the leaks" they discovered, ie, tell subscribers seeing other physicians without authorization to either obtain clearances or designate the other physicians as their primary providers.

One respondent raised a possible ethical issue. He observed that the availability of information on specialists' charges might create problems with a "reverse kind of fee splitting." Instead of the traditional form, where the referring physician ignores expertise considerations and looks for a kickback from high charging specialists, under the WPS Health Maintenance Program he has financial incentives to refer patients to low charging specialists. But the lukewarm responses of the physicians in the survey suggest that such a pattern is hardly likely to become widespread.

## Key Lessons

A patient lock-in in an open panel format, along with a unique capitation reimbursement arrangement for primary care physicians, has been a feature of certain Blue Shield contracts offered in Dane County (Madison), Wisconsin. After several years of experience, the WPS Health Maintenance Program has been found to be operating in this metropolitan area without creating either the physician disaffection or the widespread disruption of patient help seeking patterns that had been predicted by some early opponents. Among the major reasons for this smooth transition are (1) the rarity with which the Blue Shield plan imposes threatened penalities on lock-in violators, (2) the relaxations of the policy formally adopted by the county medical society in order to accommodate established patient-physician relationships and patient preferences for sources of needed services, and (3) the leniency of some physicians in granting patient requests for referral authorizations. Much remains to be learned about the impacts of the program's formal referral policy, but interviews with a sample of physicians serving as primary providers suggest that key lessons of the WPS Health Maintenance Program experience are as follows:

1. The early years of implementation were marked by numerous instances of retroactive authorizations of patients' self-initiated visits to specialists. But the frequency of this evasion diminished as the formal referral requirement became better understood as the result of communications from physicians, physicians' office personnel, group buyers, and the carrier. Subscriber education about the merits and mechanics of the lock-in must be made a high priority in a capitation system.

2. The primary providers exhibited considerable diversity in their evaluations of the lock-in, their expressed willingness to enforce it, and their claimed routines of enforcement. A common response to patient requests for referrals for services falling within the prepaid range is to accede to such requests once or twice, then suggest to the patient that the primary provider designation be shifted to the other source.

3. The need for referral authorizations has expanded the primary physicians' opportunities for counseling patients on specialists' services. This in turn has made possible more patient awareness about the in-house availability of needed services at the large multispecialty clinics in Madison. The formal referral process appears to be combining with the financial incentives of the program to produce the intended effect of making the large clinics seek ways to be the source of more of the medical services needed by their patients.

4. Some program physicians are making marginal changes in their practice patterns, in response either to the financial incentives of the WPS Health Maintenance Program or to the exhortations of its promoters. Among these changes are occasional refusals of questionable requests for referral authorizations. Consideration should continue to be given to the possible advantages for cost containment and quality of care in increasing the gatekeeping role of primary physicians by means of a capitation *cum* lock-in system.

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