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Strategies: Three Clinics Form a Physician Practice Management Company

Physicians seeking to remain independent while building market strength may find that consolidating several smaller physician groups or clinics into one company offers many advantages.

By combining several groups, the participating physicians form, in effect, their own physician practice management company (PPMC). By owning and operating the new entity, the physicians retain control of the physician-patient relationship. In markets dominated by HMOs, the PPMC has more size and thus more strength when negotiating with managed care organizations. Moreover, the new entity may qualify for capital from investors, physicians can hold an equity stake in the company, and the new venture may have the potential to go public, creating yet another opportunity for profit. Wall Street has been interested in such companies when the merging clinics have compatible cultures, strong and experienced management, a well-crafted business plan, solid physician leadership, broad geographic scope, managed care experience, and combined revenue of more than \$100 million.

Three Become One
Physician Partners, Inc. (PPI), a PPMC formed last July in Portland, Ore., offers an example. The company resulted from the merger of three of Oregon's largest clinics: the HealthFirst Medical Group, the Corvallis Clinic, and the Medford Clinic. With annual revenue of \$146 million, the new company has the size needed to gain capital through the public market and the potential to consider an initial public offering this year.

"This is a merger of three substantial, dominant medical groups with more than 50 years of history in each of their respective communities," said David Goldberg, CEO of the new venture. Formerly a consultant to physicians, Goldberg had advised two of the groups on strategic planning and merger activities. "Simultaneously, they asked me if I would help them evaluate their strategic and capital options," he said. "We knew physicians could no longer compete effectively by funding growth out of next year's income, and we were competing with health plans, publicly traded physician practice management companies, and local hospitals with deep pockets."

Facing Competition

In a competitive market, the physicians in the three clinics realized they needed substantially more market clout. But their options were unattractive. They could have sold out to an area hospital, but chose not to

(Continued on page 5)

PPI at a Glance

No. of employees:	1,600
Annual patient visits:	1 million
Net revenue (1996):	\$146 million

Clinic location	Physicians
HealthFirst	
Medical Group, Portland	128
Corvallis Clinic, Corvallis	85
Medford Clinic, Medford	75
Total	288

Multiple Clinics Show Promise of Teamwork

Working together, individual physicians can assume many of the functions currently managed by large HMOs and other managed care organizations. When physicians pool their resources, they can establish their own management systems, improve referral procedures, tighten up protocols for disease management, decide when to hospitalize, and monitor colleagues for signs of under treatment or over treatment.

"Physician-initiated managed care has considerable promise," said George Anders, a reporter for *The Wall Street Journal* and author of *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (Houghton Mifflin Co., New York, 1996). "In contrast to a remote HMO, key decisions can be made by people who treat patients every day and who can keep a close eye on one another. Managed-care decisions needn't be based solely on statistical data that can fit onto a computer spreadsheet; there's more room for human judgment and attention to the complexity of patients' needs."

Examples of physicians working together are not uncommon. One such group is Physician Partners, Inc. (PPI), a physician-owned and physician-governed practice management company in Portland, Ore. The group was formed when three clinics in Portland merged last summer. (See "Strategies: Three Clinics Form a Physician Practice Management Company," page 1.)

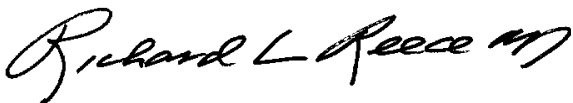
Increasingly, conditions are favorable for multiclinic consolidations. These conditions include:

- The growing number of clinics of 25 or more physicians, now numbering more than 1,000;
- Well-managed systems in these clinics to handle capitated contracts; and
- The emergence of physicians schooled and seasoned in managed care markets to lead these organizations.

Moreover, these clinics have capital available to help them develop and integrate the management structure of these organizations. This capital comes from Wall Street and other investors who recognize that these multiclinic consolidations produce economies of scale that make them desirable as investment opportunities. Investors correctly reason that a multiclinic consolidation creates a parent company that is likely to have much more market clout than small groups and may dominate a region. In addition, such clinics can achieve diversification across markets, generate income from ancillary services, attract top management, and establish systems to handle capitated managed care contracts. What's more, they have the potential for growth by expanding existing clinics and acquiring other groups.

By consolidating clinics into statewide and national organizations, physicians are signaling that they have accepted the fact that managed care is becoming a *de facto* health care policy. This policy has been adopted by the market and came about even though there was no White House declaration that managed care is the national policy, no congressional vote to sanctify its presence, and no national referendum to endorse it. Nevertheless, managed care has proved that it is effectively controlling costs.

It only makes sense, therefore, that physicians should develop the systems, the market clout, the expertise, and the experience to manage care efficiently.



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Lessons Learned in Starting a Physician-sponsored Health Plan

By John G. Gray

Second of two parts

Breaking away from typical managed care organizations, many physicians are starting or joining physician-owned and physician-managed health plans. This movement began in state medical societies such as those in California, Florida, and Washington. But now, in New Jersey, New York, Pennsylvania, and other states, physicians are raising the capital needed to start health plans independent of state physician associations.

Frustrated by large managed care organizations that may dictate how medicine is practiced, these physicians are seeking to regain autonomy in medical decision-making. They do not want fees that stress profit over quality medical care, and they believe that large insurers waste too much money on overhead. Instead, physicians want health plans that put patients first and that direct health care funds toward patient care.

Many states prohibit physicians from contracting directly with self-insured employers or with insurers. Under these restrictions, physicians can contract only with health plans, which retain the ability to dictate fee schedules, capitation rates, and other operational policies to the physician-owned groups.

California had such restrictions until October 1995, when the Federal Trade Commission rescinded a 14-year-old order that, in effect, barred organized provider groups from developing or publishing physician reimbursement schedules or relative value scales, and from contracting directly with insurers. The repeal of the order allowed for the creation of physician-sponsored managed care organizations, such as California Advantage.

A New Kind of Health Plan

Given an opening, the California Medical Association (CMA) introduced California Advantage, a physician-sponsored managed care organization (MCO), on July 1, 1996. The CMA owns 51% of the entity,

and individual physicians who have purchased stock in the company own the remaining 49%.

To participate in California Advantage, more than 6,500 physicians throughout the state have invested \$1,000 each for a single share of stock. Owning a share entitles a doctor to vote on the ownership and control of the company and medical management issues. Participating physicians do not earn money from their stock or individually profit from the equity investment. Instead, any profits are reinvested back into delivering health care to uninsured or underinsured patients.

Initially, California Advantage is offering three products: an exclusive provider organization (EPO), a preferred provider organization (PPO), and an EPO with a point-of-service (POS) option. The plans are offered through the Health Insurance Plan of California (HIPC), a state-sponsored insurance pool in Sacramento that allows small employers to enjoy the benefits that large companies can command from health insurers and providers. California Advantage plans to offer an HMO product this year. Of 22 health plans in California, including such plans as those offered by Aetna and Kaiser, California Advantage placed second during open enrollment for California employees obtaining their health insurance through HIPC in July 1996.

While there are a number of innovations in the structure of California Advantage, four major points distinguish it from others in the California marketplace:

1. Local management;
2. Access to information;
3. Comprehensive geographic coverage; and
4. Choice of specialists as care managers.

Local management. California Advantage organizes its network physicians into more than 200 local operations called shared performance groups that work together to provide coordinated medical care in a particular community. Physician steering committees assume governance and policy responsibilities for the local groups and coordinate peer review, information sharing, patient outcomes data gathering, and quality improvement. Each group's performance is measured in three areas:

1. Customer satisfaction, as determined by patient surveys;
2. Compliance with the physician-established utilization review processes; and
3. Fiscal management of the patient load, as determined by a detailed analysis of actual expenditures compared with a budget and adjusted for each group's individual patient population.

Access to information. Physician-managers with California Advantage believe that using such information as clinical guidelines, outcomes measures, patient medical records, and rankings of physician performance is essential to improving the quality and cost-effectiveness of care. Using a fee-for-service structure allows California Advantage to collect and provide more information to physicians, payers, employers, and patients than health plans that use a capitated system. One employer may be interested, for example, in certain kinds of illnesses common to employ-



John G. Gray is CEO of California Advantage, in San Francisco, a managed care organization sponsored by the California Medical Association. Prior to assuming this position in 1995, Gray served as president of the managed care division for Admar Corp., a managed care organization in Santa Ana, Calif. At Admar, Gray developed and operated the company's physician hospital organization (PHO) and exclusive provider organization (EPO). Part one of this series, "California Physicians Form a New Health Plan," was published in January.

ees in its particular industry. Another employer may want data on the utilization of care, such as how many employees visited an obstetrician in the last year. California

primary care gatekeeper model. Because all California Advantage physicians are paid on the same fee-for-service basis, patients can seek care from any California Advantage

business successfully.

Establish business relationships with other health care service providers. Starting a statewide health plan requires a substantial investment in infrastructure. Rather than delay the start while it raised capital, California Advantage established strategic alliances with a utilization review company, a claims management firm, a pharmacy distribution system, and a data collection company to handle specific functions. California Advantage did not establish these relationships as equity alliances. Each association was formed as a business relationship in which the two sides would work together in joint-marketing or product-development endeavors. In most cases, California Advantage pays each of these providers a nominal fee initially and then compensates each one based on utilization.

Before launching California Advantage, CMA engaged external business consultants to conduct research and create a business plan for delivering these services. The consultants concluded that the new health plan would require \$23 million to start and would need 36 months to come to market if all services were provided internally. By partnering with established providers, California Advantage spent \$6

Most health plans use primary care gatekeeper physicians, but enrollees in California Advantage can choose specialists, such as cardiologists, oncologists, or neurologists, as their physician care manager.

Advantage also can provide employers with health risk data to develop workplace health promotion programs, such as those aimed at smoking cessation.

Comprehensive geographic coverage. Many commercial health plans limit the use of their networks by restricting members' access to providers in a local area. California Advantage members can seek care from any of the organization's 35,000 primary care and specialist physicians without paying an out-of-network fee. They also can seek care at more than 320 hospitals in 55 of California's 58 counties.

Specialists manage care. A California Advantage physician whom a patient selects to manage his or her overall care is called a physician care manager (PCM). Like a PCP, the PCM coordinates care for a patient. However, unlike health plans that require participants to select a general or family practice physician, an internist, or a pediatrician, California Advantage allows enrollees to choose specialists, such as cardiologists, oncologists, or neurologists, as their PCM. This freedom of choice can be advantageous for a patient with chronic heart disease, for example, who sees a cardiologist frequently. If the patient complains of headaches, the cardiologist-PCM can determine whether the headaches are related to the patient's heart condition or to prescribed medication. If not, the PCM can refer the patient to another physician, if appropriate. In this way, patients who have a comprehensive illness can have direct, continuous access to an appropriate specialist without interference from a gatekeeper or an insurer.

As PCMs, specialists can provide a full range of health care services for their plan members, which they might not be able to do in a more traditional health plan using a

physician without any variation in cost.

Three Lessons

For physicians seeking to start a health plan, the experience of California Advantage offers three lessons:

- Assess the market,
- Seek experienced management, and
- Establish relationships with other providers.

Assess the market. After conducting research into what consumers prefer from a health plan, California Advantage concluded that consumers want choice in the type of health insurance coverage they can purchase. In response, California Advantage designed a variety of products,

By partnering with established providers, California Advantage spent \$6 million in start-up costs and offered its first product within nine months, saving \$17 million in initial capitalization and 27 months.

including an EPO, a PPO, and an EPO with a POS option, that offer consumers choices beyond a traditional HMO capitated plan. California Advantage reasoned that to succeed, a health plan must do what businesses do: Determine what its customers want and then design innovative products or services to meet those needs.

Recruit experienced senior executives to manage the business. Although a physician may be an excellent clinician, he or she may not necessarily be suited to managing a large health plan. California Advantage discovered that it needed a seasoned business executive with experience in managing health care organizations to run the

million in start-up costs and offered its first product within nine months, saving \$17 million in initial capitalization and 27 months.

California Advantage, and other similar physician-sponsored plans, are giving physicians reason to be optimistic about regaining authority and autonomy in health care decision-making. The goal of these organizations is to preserve the cost efficiencies of managed care while improving the quality of health care. Designing a health plan focused on the needs of the patient—choice of benefits, access to care, and a full range of services—can be a successful model for improving managed care. ■

(Continued from page 1)

because they did not want to relinquish control to hospital administrators. They also chose not to sell out to one of the large PPMCs. They reasoned that selling for cash would require each participating physician to pay a substantial sum in taxes. They also were unsure if selling to a PPMC would add much value to their practices. Given that their operations are in Oregon, where managed care dominates, they saw comparatively little managed care experience in these companies. Moreover, the PPMCs were not run by doctors, but by business professionals, many of whom are former hospital administrators.

While considering their options they decided to merge the three physician groups. The merger went smoothly partly because Goldberg had established two requirements for each participating clinic. First, each clinic was required to get support for the merger

Top 5 States in HMO Enrollment
(As a percentage of population on Jan. 1, 1996)

	HMO enrollment (in millions)	Percentage of population	Annual growth (%)
Oregon	1.4	44.8	14.1
California	13.0	40.3	11.4
Massachusetts	2.4	39.0	1.5
Maryland	1.6	30.9	5.4
Utah	0.6	30.1	23.7

Source: The InterStudy Competitive Edge: HMO Industry Report 6.2, InterStudy Publications, Minneapolis, 1996.

from all of its physicians. Second, each clinic was to supply the capital and time needed to make the merger succeed. A straw vote taken among the 288 physicians in the three groups showed overwhelming support.

"I can't emphasize too strongly the feeling all of us had when we sat down together," said Michael Bonazzola, MD, senior vice president and chief medical officer of PPI, and formerly medical director at the Medford Clinic. "These three group practices were facing basically the same opportunities and had gone through a variety of options to access capital, and yet when we sat down and talked to each other, we finished each other's sentences.

"We had all been thinking along the same track," Bonazzola continued. "And we realized that we have the experience, we have the track record, and we have the knowledge to do this together. We needed some advice, and we were able to get that fairly easily. After that, it just came together nicely."

Market Forces

While the physicians were well suited to each other, market conditions also played a role, said Bonazzola. In particular, two hospitals in Medford had recently been buying physician practices. "When hospitals started recruiting primary care doctors who were not members of the Medford Clinic and began buying their practices and their office buildings, paying them above-market salaries and guaranteeing their incomes, it was very difficult for us. Our clinic brought in 25% of the hospitals' business, and they were using the money to compete

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The Oregon Factor

Another galvanizing factor was the maturity of the Oregon market. As of Jan. 1, 1996, some 44.8% of Oregon residents were enrolled in HMOs, the highest penetration rate among the 50 states, according to The InterStudy Competitive Edge: HMO Industry Report 6.2, from InterStudy Publications, in Minneapolis, which tracks HMO enrollment (see table). The national average is 22.3%. What’s more, Oregon had a high proportion of Medicare patients in HMOs, and an activist state government pushing Medicaid patients into HMOs.

When commercial, Medicare, and Medicaid populations are all moving into HMOs, physicians must be in groups to handle large prepaid populations. Another factor forcing physicians into groups was the relatively low Medicare rates in Oregon. The average adjusted per capita cost (AAPCC), the rate the federal Health Care Financing Administration pays for prepaid care, was \$304 in Medford and \$380 in Portland. The national average is \$460.

“We may be in only one state, but it’s an incredibly tough state,” said Bonazzola. “If we can do this successfully in Oregon with the combination of low AAPCCs and incredibly low commercial rates, we can export it anywhere.”

Looking Ahead

In considering their options for the future, the physicians invited investment bankers to make presentations to them regarding their financial and professional options, said Goldberg. “We studied the major institutional investors and found out what the financial analysts who specialize in health care thought of each one.” In addition, the physicians sought advice from the PPMCs about which investment bankers would be best to work with. “We invited six investment bankers to a meeting with our board, which had a dominant number of physicians, and we asked them to make their presentation to us about why we should use them as our financial advisor. Everyone plus several others accepted the invitation.” As a result, the board preliminarily chose to work with Morgan Stanley.

PPI is attractive to investment bankers

The Importance of Retaining Control

Many physicians today believe they need to develop strategies that will allow them to retain control of the physician-patient relationship. In an interview, David Goldberg, CEO of Physician Partners, Inc., in Portland, Ore., discussed that issue, saying, “A number of us believe that the profession is at a crossroads. Managed care and other market forces have left us with a limited ability right now to maintain control of the patient-doctor relationship. If this situation doesn’t improve, then we are not doing our job.

“There are several ways for physicians to retain or to retake control, and this strategy of merging three clinics is one of them,” Goldberg continued. “Another vehicle, frankly, may be labor unions for physicians, which are developing elsewhere.

“But I believe the only way physicians can take control is to be willing to take on some level of risk, and that means taking on an entrepreneurial spirit rather than an employee spirit. Employees—even physician employees—go to work, do the job, and go home. When doctors do that, they are not assuming the fundamental role of the physician, and that means having a deep abiding concern for improving the quality of care for each and every patient.”

Michael Bonazzola, MD, senior vice president and chief medical officer of PPI, concurred, “From a physician’s standpoint, as you get further into managed care, it is absolutely imperative that physicians be the ones who make decisions about patient care on a day-to-day basis. The only way that can happen is if physicians retain more control or get more control of the process.

“We’re creating our own brand of managed care,” Bonazzola continued. “We think it’s managed care in its best form, which is physician-driven managed care. When you’re talking to a clerk in an HMO who’s working from a protocol book, that’s the worst case. The best case is when you’re a primary-care doctor discussing with the specialist how best and most efficiently to deliver care to a particular patient. That’s an example of physician-driven managed care, not HMO-driven managed care. Our group is run by physicians who want to invest in their own future.”

because the physicians have extensive experience working under capitated contracts, an existing managed care infrastructure, and a cohesive group culture—and they are making money. “We certainly are not what they are used to seeing: We are not losing money and we’re not a start-up.”

Second, they would have or want to have experience in managed care because we think that’s the arena in which the future will be directed. Third, they need to be fairly dominant in their market. The target groups also would need to share PPI’s vision of high-quality care in which physicians

“Our clinic brought in 25% of the hospitals’ business, and they were using the money to recruit primary care doctors to compete with us. We were ready for an alternative.”

Acknowledging a weakness, Goldberg said the group currently operates in only one state. “My sense is that would have to change before we go forward,” he said. If PPI were to acquire other groups, it would look for practices that meet several conditions. “First, they must be willing to be physician owned and physician governed.

manage physicians.

“If we have the right partners—that is, the right physicians in other states who are motivated by high-quality care, concern for efficiency and productivity, and a desire to be both in control and at risk—then I think we can make this model work everywhere,” Goldberg commented. ■

Understanding the Struggle Between Doctors and Hospitals



Daniel Beckham is president of the Beckham Co., physician and hospital consultants, in Whitefish Bay, Wis. A health care business strategist, Beckham has consulted widely on integrated delivery systems, physician

hospital organizations, and group practice development. As a consultant, he has helped providers nationwide to build new organizations oriented toward the demands of managed care and health care market reform. A former chairman of the board of the American Marketing Association, Beckham focuses on strategic planning and physician integration for medical groups, hospitals, and health systems. He is also a member of the advisory board of Physician Practice Options. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: *The relationship between physician practices and hospitals seems to be in an uneasy, even unstable, state today. Vertical integration, or the purchase of physician practices by hospital groups, no longer seems as attractive as it once was for physicians or hospitals. In addition, physician practice management companies appear to be increasing in number and influence. Do you see a power struggle occurring between physicians and hospitals?*

A: Yes, I do. Physicians and hospitals need each other but are engaged in a battle for control of health care dollars. They could both end up in difficult financial straits and yet, often through stubbornness, they refuse to help each other. Certainly, there is much more mutual self-interest between them than there is between either physicians or hospitals and insurers.

But it is a difficult and complex situation. The kind of financial pressure managed care has imposed on physicians and hospitals is pitting them against each other. It is also pitting physicians against

one another. Yet, I don't think there has ever been a time when a strong relationship between physicians and hospitals has been more important to the survival of both.

Q: *How would you define a constructive relationship between physicians and hospitals, one that is responsive to the market?*

A: Both sides need to think about what the word "partnership" means. From the hospitals' standpoint it too often means employing a doctor and creating some sort of subsidiary box on their organization chart. Hospital CEOs too often feel they can't manage someone without exercising a high degree of control. Yet by doing that they destroy the spirit of entrepreneurship and commitment that has always set the practice of medicine apart. On the other hand, physicians have to be willing to give up some of the independence and autonomy that they appear to view as a birthright if they are going to work in a partnership.

The truth is that most of the employment models that have been developed by hospital systems have some major problems. For example, there are problems related to productivity. Once physicians

Studies of hospital systems we have conducted demonstrate that for every 100 primary care physicians the system employs, it is probably losing \$1 million a month, and we've seen that hold up in market after market.

Q: *How do you explain that hospitals have lost that amount of money consistently when they own physician practices? Is it strictly a loss of productivity of physicians once they are employed by a hospital system?*

A: There is a direct loss of productivity. The physicians entering the practice of medicine today have different motivations than the physicians had in the past; they also have different expectations of what they want out of life. One factor is the increase in the number of women who have entered medicine, some of whom find themselves not only committed to a career but also to raising a family. That has an impact on the amount of time they want to spend in practicing medicine and that has some implications for productivity. I am not saying that these doctors aren't working as hard, but they are working fewer hours and committing themselves to other things, like starting families and being at home with the family.

"I don't think there has ever been a time when a strong relationship between physicians and hospitals has been more important to the survival of both."

are employed by a hospital, productivity drops. We have had physicians tell us, "I am an employee now. I have four weeks of vacation, two or three weeks for education, and I am going to take that time." When they were in independent practice, they may have taken a one-week vacation annually, and that was a lot. Hospital systems are losing millions of dollars on the primary practices they have acquired.

The same is true for many men. The younger male physicians we talk to today have a much stronger interest in having a family life than some of the older physicians we talk to. If these younger physicians are the ones the hospitals and health systems are hiring, then that affects productivity.

Another important factor is that many hospitals and health systems got into bid-

ding wars when purchasing primary care practices. In doing so, they purchased the practices at costs that the underlying economics of the practices couldn't support. In other words, they paid too much money for these practices, and then, to get the physicians on board, they often committed to paying them too much in salary.

Another factor having an effect on practice profitability for hospitals and health systems is the quality of management available for these new groups and the quality of management that they need, particularly as they come together as new organizations. There is a real shortage of capable group practice expertise, and a shortage of physicians interested in assuming management and leadership responsibilities within these new groups. That translates into a lack of effective management, which, in turn, translates into shortfalls in financial performance.

Q: *Is it possible that running a hospital and running a group practice require different competencies, and that's one reason the relationship between hospitals and doctors doesn't always work?*

A: Yes, absolutely. Hospitals tend to be managed under control-and-command models, where somebody at the top can tell somebody at any level below what to do and have some reasonable expectation that it will get done. On the other hand, most group practices, both new and well-established groups, as well as large and small groups, are more democratic in their approach. Physicians who practice within these groups expect that they will have a vote when major questions arise, such as those related to compensation or to acquisitions. It is a difficult model to make work in a turbulent, quick-changing environment like a hospital system.

So these are different kinds of organizations. Within a hospital system, physicians obviously are much more limited in their independence and autonomy.

Q: *It used to be that the only health care organization in town was the hospital. Today, physicians can choose between a hospital and a physician practice management company as a source of capital. What issues are involved in that choice for physicians?*

A: There has been a major change in opportunities for physicians, particularly within the last two or three years, as

physician-led organizations have developed as alternatives to hospital-based systems. In many instances the reason physicians have aligned with hospitals, or sold their practices to hospitals, is that they were concerned about the future. Their level of anxiety was high. They viewed hospitals as big organizations with deep pockets. But I think that in large measure the choice was often made because there weren't a lot of alternatives available.

Today, physician practice management organizations are addressing concerns about the depth of financial resources. For example, PhyCor, a physician practice

changed physicians' options and the dynamics of local markets. When physicians are weighing alternatives, they say, "I'll do this deal with the hospital, but that doesn't mean I have to stay in this deal forever." They may not say that publicly or directly to hospital administrators, but they say it to us in interviews. I think something that hospitals have greatly overestimated is their ability to keep these physicians once they've acquired them. Slavery was outlawed in this country a long time ago and so was indentureship. Owning a group practice doesn't mean you own its doctors. We're already seeing a lot

"Some people are entering medicine today with different motivations than people have had in the past and with different expectations about what they want out of life. That has an impact on the amount of time that they want to spend practicing medicine, which in turn has some implications for productivity."

management company in Nashville, Tenn., is a darling of Wall Street and has almost infinite access to capital as long as it continues to meet earnings expectations. It is bigger and more focused on group practice than a local hospital could be. Now, for the same reasons that physicians might have chosen the hospital, they are choosing companies like PhyCor. In addition, these practice management companies are physician-oriented and bring a lot of management experience. Practice management is their only business.

Here in Milwaukee we have spent a fair amount of time working with the three largest clinics in Southeastern Wisconsin to put together a physician-driven delivery system. It wasn't that the doctors in those clinics were opposed to their local hospitals, or that they wanted to jeopardize their relationships with their hospitals, but the physicians within these groups were interested in a physician-led alternative. Not surprisingly, other physicians in the area were excited about what these clinics were doing.

Such alternatives have dramatically

of physicians walk out of relationships after hospitals have spent millions to build new organizations. One day, the hospitals look up to see the most precious assets in their system walking out the door.

Q: *You have commented that it is very expensive to create a vertically integrated system, much more expensive than proponents first believed. There is now a spirited argument on the relative virtues of a vertically integrated system versus a virtually integrated system. What do you see evolving?*

A: The reason new physician organizations are losing money relates directly to productivity and the cost of acquisition, but I believe strongly that they don't need to continue to lose money. They are losing money because the people who acquired them have failed to fully answer the question of why the practice was purchased to begin with. In most instances, the initial reason for the acquisitions was to keep somebody else from acquiring these physicians and to protect their current referral patterns. They were trying to protect current admissions.

So all they did was buy their own market

share, and they bought it at a much higher price than it was costing them before. What they ought to be doing now is using the primary care practice to create market influence. If they own 30% or 40% of the primary care practices in a market, they have a lot of market influence.

They then need to use that influence to say to the health plans, “The amount of money you are taking out of the profits being earned by the health plans and the insurers is too high.” They need to say, “You can’t do business in this market without us and unless you agree to our terms, you’re not going to do business in this market. We are no longer going to let you keep as much of the premium dollar because we have market influence. We have influence because we have 40% of the area’s primary care physicians and we have two or three of the critical hospitals. As a middleman you provide some value in the market, and as long as you do we are going to allow you to earn X% of the premium dollar. But more than that is too much, and we’re going to back you down.” Notice that I emphasize the word “we.” That kind of partnership will create more revenue for hospitals and for primary care physicians, as well as at least the same level of revenue, if not potentially more revenue, for the specialists.

They just haven’t had the courage to do it. You have hospital CEOs, and I think to some extent physicians, wringing their

hands, has told one of the major health plans in town to go to hell. Aurora’s flagship hospital, St. Lukes, is one of the pre-

ferred hospitals in Wisconsin. It has a lot of market influence. It owns about 200 to 300 physician practices now, and its response to the health plan was to “take a walk” when it demanded a 60% discount. Aurora dropped out of that particular health plan, and the health plan is having a difficult time competing now.

Q: So, together, you think hospitals and physicians have the potential power to compete effectively against HMOs?

A: Yes, I do.

Q: It has been said that Minneapolis and St. Paul are now in what is called the post-HMO era and, apparently, the critical force there was a business coalition. Is that an example of what you’re saying?

A: It is a different scenario in that the Twin Cities has always had a high

“Hospitals tend to be managed under control-and-command models, where somebody at the top can tell somebody at any level below them what to do. On the other hand, most group practices are very democratic in their approach.”

level of employer activism. That activism is uncharacteristic for the rest of the country. I’m not saying that it’s not possible that you could see the same level of employer activism in other cities, but I think, generally, you haven’t. In the Twin Cities, the managed care plans all into one organization. In response, the employer coalition basically said, “We’re not so sure we like that. It strips competition out of the marketplace.” So they pushed choice back to the consumer. The movement of choice back to the consumer, whether or not it’s employer-driven, is a phenomenon that will manifest itself throughout the country. Consumers will not allow themselves to continue being herded like sheep from one managed care corral into another, from one physician to another. That’s not going to hold up in this country.

Q: You mentioned earlier that these big systems are losing \$1 million a month on each 100 primary care physicians they employ. That cannot continue indefinitely. Can you see a scenario where the hospitals have so much red ink that, in desperation, they sell these collective practices to physician practice management companies?

A: I could see that happening. The hospitals could say, “Politically and financially, we can’t handle this anymore. Here I am a hospital CEO or chairman of a hospital board, and at every board meeting discussion is dominated by the loss associated with our physician group.” Board members continue to see red ink at the bottom of the page every month. These board members say, “Get in there and cut costs.” What costs are they going to cut? The largest cost will always be physician and other staffing compensation. Cut that and you’ll have disaffected doctors. Can they tell physicians that they need to take a cut in compensation even though their practices were acquired at higher-than-market cost because of a bidding war? That’s not going to make them

“Slavery was outlawed in this country a long time ago and so was indentureship. Owning a group practice doesn’t mean you own its doctors. A lot of physicians are walking away from relationships after hospitals have spent millions to build these organizations. The hospitals then look up to see their most precious assets walking out the door.”

hands saying, “Oh my God, these health plans are so powerful. They control, X% of our patients and if we try to stand up to them, they’re going to beat us up.”

But that isn’t the case. Here in Milwaukee, the Aurora Health System, to

level of employer activism. That activism is uncharacteristic for the rest of the country. I’m not saying that it’s not possible that you could see the same level of employer activism in other cities, but I think, generally, you haven’t. In the Twin Cities, the

very happy. In that scenario, all the hospitals have done is invested millions of dollars to anger their most precious asset.

A primary care practice is basically a break-even business. Unless they can fig-

initial public offering (IPO). As time goes by there will be more of these IPOs, and as they become more widespread, physicians will become more aware of these opportunities and more responsive to them.

“The movement of choice back to the consumer, whether or not it’s employer-driven, is a phenomenon that will manifest itself throughout the country. Consumers will refuse to continue being herded like sheep from one managed care corral into another, from one physician to another.”

ure out a way to create the market influence that allows you to demand a better deal from the health plans, the primary care practices the hospitals own will continue to lose money on their direct operations.

So, if somebody comes in and makes the hospital an offer to take these “problem practices” off their hands, I think some hospitals will welcome the opportunity. But whoever acquires these groups from the hospital will have to make a commitment to the hospital that those physicians will continue to use that hospital and the specialists aligned with it, or I don’t think the hospitals will give them up.

Q: *How important is equity to physicians? How much does ownership drive physicians in the formation of practice groups?*

A: In advising physicians, we expected they were going to insist on equity, but that hasn’t been the case. I think physicians generally don’t understand the concept of equity and the importance of maintaining ownership. They seem to understand “equity” primarily in terms of maintaining autonomy and independence, and those tend to be greater forces for many physicians in the pursuit of particular kinds of deals.

One problem is that there still aren’t a lot of physician equity models out there for physicians to learn from. There have not been many instances where somebody put together a company and took it public, with physicians benefiting financially from an

Q: *Do you think physician groups will eventually evolve into large professional corporations like giant law firms?*

A: There will continue to be strong local and regional influences, but I do foresee consolidation into bigger groups. One major influence is going to be the need for physicians to create information links and consistent practice standards so that they can demonstrate cost and quality effectiveness. Creating information links and consistent practice standards requires infrastructure and commitment on the part of physicians.

“American medicine still has its center of gravity around the patient. Therefore, physicians must remain in the best possible position to represent the best interests of their patients.”

Independent physicians may have a difficult time demonstrating cost and quality effectiveness, especially compared with physicians who are linked together electronically and who are applying consistent practice standards. Physicians who are linked and who are applying consistent practice standards can collect the information they need to demonstrate a cost and quality advantage. As a result, small groups and independent solo physicians are at a decided disadvantage.

Q: *There appears to be a new breed of physicians with credibility in both clinical practice and business. These are physicians with business degrees, an MD with an MBA. Do you think they will be a powerful influence?*

A: Yes, I do. The MD-MBA is the wave of the future. There was a point in the evolution of health care in America where a line was drawn between medicine and management. Because physicians are so strongly oriented to clinical care, they often were willing to surrender the management side of health care. But that was in an era of explosive growth in the demand for medical services. There was more than enough work and money to go around, so management didn’t impinge on the clinical side. As a result, a class of non-physician managers rose up to run hospitals and other health systems. But you should not separate management from medicine completely. That is an artificial delineation.

The issue that is causing physicians so much frustration today is the encroachment of management on medicine. The people running HMOs, who are financially oriented, now have their fingers in the clinical side, even though they are not physicians. The way for physicians to deal with that is to learn management strategies and techniques themselves.

For all its shortcomings, I think American medicine still does have its center of gravity around the patient. And physicians must remain in a position to represent the best interest of their patients, even if it means they must broaden their involvement to include management issues. Management training and experience will equip them to dissolve the line between management and medicine to the benefit of both physicians and their patients. ■

Selecting Managed Care Software

By Mark Wallis



Mark Wallis is a marketing manager for Rothenberg Health Systems, Inc., in Woodland Hills, Calif. A pioneer in software and information systems for health care providers, Rothenberg Health Systems markets EZ-

CAP, a managed care information system for physicians and other providers. Introduced in 1985, EZ-CAP was among the first software products developed for managed care providers. EZ-CAP is used today by more than 300 provider groups nationwide.

High levels of managed care penetration mean physicians and group managers need sophisticated information systems to manage the myriad details required to run a practice efficiently and profitably. Traditional billing systems rely heavily on manpower and paperwork and thus may be inefficient for managing sophisticated contracts. In particular, capitation, electronic data transmission, eligibility information, referral control, risk pool calculations, and payments to specialists mean physician groups need effective systems that can do more than process claims and generate bills.

In response to the need for advanced information systems, vendors have developed a number of computer programs to help physicians manage their managed care contracts. Just as one would do before making any major purchase, physicians and those managing physician practices should follow three basic steps before spending any money on such systems:

1. Determine the specific needs of your practice,
2. Review the specifications of the systems available, and
3. Consider which vendors offer products and services that best meet your needs.

Assessing the Need

The first step is to determine if, indeed, a software system is even necessary for your practice. If your group is small or has a limited number of patients under managed care, you may not need a system. Otherwise, a system might be necessary. Are you a member of an independent practice association (IPA), multispecialty group, or other large integrated practice? Has your practice decided to seek HMO contracts actively? Do you have more than 1,000 enrollees currently? Are you anticipating any enrollment increases? If the answer to any of these questions is yes—meaning managed care is or will represent a significant portion of your business—managed care software likely would be a good investment.

If a system is appropriate for your practice, it should:

- Reduce labor costs. While a manual operation requires two or three people to handle the necessary paperwork for every 2,000 enrollees, an automated system needs one person for the same caseload.

If managed care is or will represent a significant portion of your business, an information system is likely to be a good investment.

- Generate reports. The system should produce reports that let you assess whether existing managed care contracts are profitable. Once you have this information, you will know whether to seek additional agreements at similar or higher rates.
- Help manage patient benefits. A system can quickly and accurately manage all of the activities associated with the wide variety and complex nature of your patients' health care benefit plans and related compensation structures for providers.
- Save you money over time. As the sophistication and features of managed

care software grow to automate and streamline processes, the cost of the software may increase. Therefore, investing in managed care software now may be less expensive than waiting. Some vendors offer upgrades or enhancements to customers who have already purchased systems at a lower cost than new customers spend on the same system.

Reviewing Specifications

Once you've determined that your practice needs a system, identify which current and future activities you will manage with a computer. Many systems have features, such as custom programming or color monitors, that may not be necessary or cost effective. Since managed care software systems range in price from less than \$50,000 to over \$1million, review product specifications before you meet with a sales representative. Doing so will help you to select only the features you need and may help you to stay within your budget.

It is likely that you will be inclined to

seek a system that will accommodate your office practices. But if doing so means you will need a customized system, you would be well served to consider carefully how an off-the-shelf system may accomplish these same tasks. Change is difficult for most businesses, and as a result, many companies opt for computerization only if the program will mirror their current methods of entering and retrieving data. But a customized system can be expensive both initially and when upgrades and enhancements are needed. Also, with a one-of-a-kind customized program, standard user guides and customer support services may be unable to help you when

problems arise. A customized system may be unnecessary if you alter your current office practice slightly to accommodate an off-the-shelf product.

In the next step, consider how any system would handle specific practice management chores, such as updating patient records, processing claims, tracking authorizations, paying providers, and creating reports.

Patient records. A system should maintain detailed data about each patient's benefits and required copayments and an extensive history of any changes in health plan coverage or physician assignments.

Given the complexity of patient data, a system that allows you to download patient eligibility data electronically can save considerable time. Also, be sure to determine how many health plan systems would be compatible with any system you would buy. The wide diversity of health plan data formats means that if your system is incompatible, it won't be as useful as one that works with many health plan systems.

Processing claims. A system that allows your staff to enter and file claims data electronically can reduce receivables turnaround time. Ensure that the software can accommodate the number of line items required by your patients' health plans. For claims processing, some systems allow only four lines for procedure codes, but some specialists require many times that number. Also, determine how many claims the system can process daily. This number can range from 70 claims per operator to more than 200. Does the system process each claim immediately, or is it batch-oriented, requiring overnight processing?

You'll also want to know if the system can adjudicate benefits based on a variety of variables. The system should determine whether a procedure is covered by a plan and whether the procedure would be reimbursable for a particular patient. By reviewing the patient's gender and age, and the number of allowable treatments for the condition in question, for example, the system should determine whether reimbursement is appropriate.

Tracking authorizations. Another key feature is the ability to track the financial liability created for authorized services. If

you approve a coronary bypass, for example, and your contract with a cardiac surgeon states that he or she will be paid \$25,000, can the system determine covered benefits and the dollar amount to be paid if specific data, such as procedure codes, are entered?

Paying providers. Another important feature of a managed care system is the ability to pay providers automatically based on a variety of contractual terms. The system should have enough flexibility to manage several reimbursement

customer service and evaluate response time and the quality of the answer to a hypothetical problem. What are each vendor's hours of operation, and what is the average time it takes each one to resolve customers' problems? Do telephone support services cost extra? Many vendors charge an average of 20% of the system's cost for technical support services.

Looking Forward

Find out how a purchase of a particular product will affect future purchases. Is the

System-generated reports can help track monthly member activity and how well your practice fares financially under various health plan contracts.

designs, including flat fees, a percentage of charges, resource-based relative value scales, and capitation. The software also should be able to differentiate between capitated and fee-for-service providers. In addition, of course, it should generate checks to pay providers.

Creating reports. System-generated reports can help you to track monthly member activity and how well your practice fares financially under various health plan contracts. Some systems create reports that detail this information by health plan, primary care provider, medical specialty, or other category. Determine if producing reports will be easy or will require the vendor or a consultant to produce them for you.

Choosing a Vendor

Selecting a vendor is as important as assessing system requirements. One place to start is with the vendor's other clients. Make a list of questions to ask each user and then analyze the answers to see if a trend emerges. Ask other physicians or group managers about their experiences with upgrades or enhancements, for example, and if they are satisfied with their vendors' ability to meet their needs and to adapt to market changes.

Next, inquire about the nature and quality of technical support. Place a test call to

hardware proprietary, for example, or can you add other equipment from other manufacturers later? Does the system require computer terminals, personal computers, or mid-range computers? The cost of a computer terminal may be lower initially than that of a PC, but a system that uses PCs may be more cost effective over time if you need to add word processing, spreadsheet, or other common software.

Finally, determine how long it will take the vendor to install the system, train your staff, and have both fully functional. How long will the system be unavailable for use while data and operations are installed or converted from another system? An installation involves building support files, such as terms of health plan contracts and payment schedules, and training staff to process claims and produce reports. Installation may take from 60 days up to a year.

Purchasing a managed care information system is more than simply adding hardware and software. The purchase should be a business investment that allows you to support your current operations more efficiently and to build for the future. As such, the proper system should pay for itself in increased efficiency and the ability to respond quickly as your practice grows and the market changes. ■

Capital Investment in Physician Groups Grew Sharply in 1996

Significant growth opportunities associated with the rapid consolidation and organization of physician groups have attracted record levels of investment by public and private investors. Both the amount of capital invested and the pace at which such capital was deployed to fund acquisitions and build infrastructure increased dramatically last year.

Publicly traded physician practice management companies (PPMCs) raised almost \$2 billion from investors in 1996, over twice the amount of capital raised in 1995 (Table 1). At the same time, initial and secondary offerings slowed during the second half of 1996 as a result of a softening in prices for health care stocks. Based on an index of 20 companies, PPMC stock prices declined an average of 33% since hitting a peak in May 1996.

The health care industry also was a major area of investment for venture capitalists. According to a survey by Coopers & Lybrand, CPAs and health care consultants in New York, an estimated \$1 billion was invested in health care by venture capital firms in 1996, an increase of 95% over the level of the previous year (Table 2). Health care ranks as the third largest industry in terms of capital committed, behind software and communications.

Much of the capital being raised by PPMC's has funded acquisitions and the development of physician practice networks. As a result, physician group practices experienced unprecedented consolidation activity last year. Through Dec. 19, 1996, 229 transactions involving physician practices were announced, an increase of 55% over 1995's announced transactions (Table 3). Selected recent PPMC acquisitions are shown in Table 4.

Table 2: Venture Capital Activity

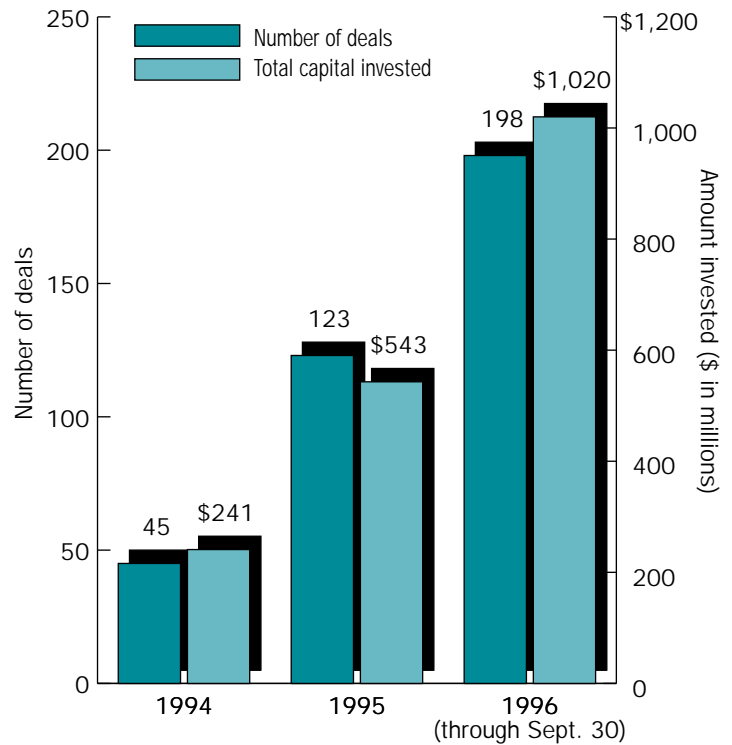


Table 1: Capital Raised by Public PPMC's

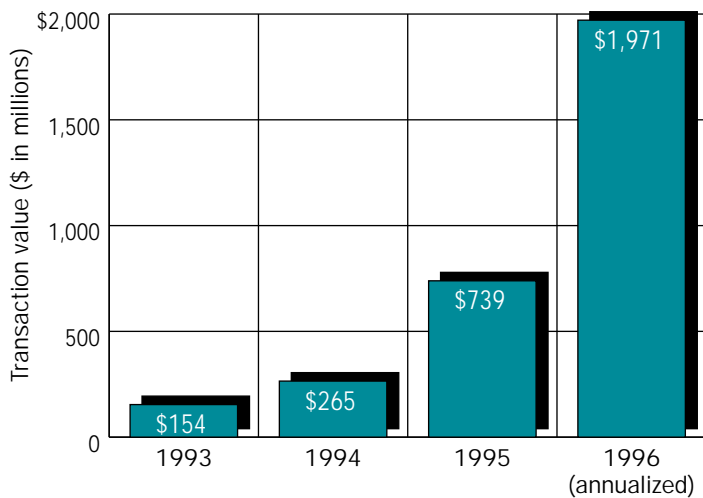
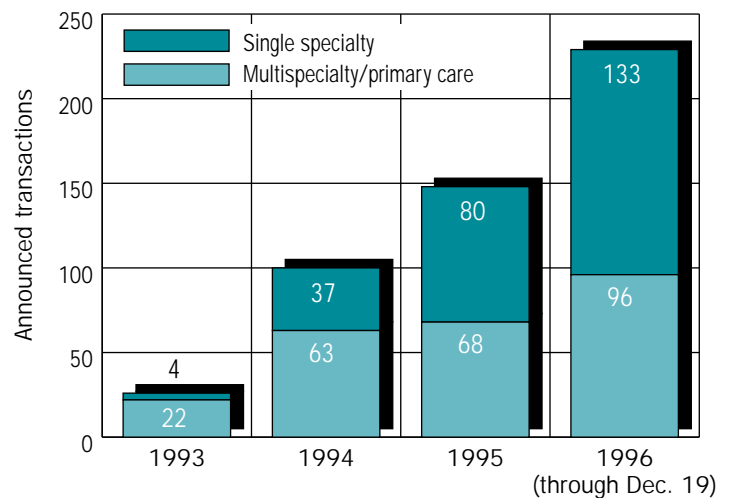


Table 3: Physician Practice Acquisitions



Source: Townsend Frew & Co., investment bankers specializing in health care, Durham, N.C., 1996, and Coopers & Lybrand, CPAs and health care consultants, New York, 1996.

Table 4: Selected Recent PPMC Acquisitions

Date Anncd.	Target Company	Location	Acquirer	Transaction Value (\$000)	# of MDs	Deal Terms / Notes	Transaction Value Per Physician Revenue (\$000) (x)
12/03/96	Sheer, Ahern & Associates	Tampa, FL	MedPartners, Inc.	\$49,000	43	Accounted for as a pooling-of-interests transaction; target acquired by TEAM HEALTH, MedPartners hospital-based contracting subsidiary; target is the largest provider of radiology services in the Tampa market	\$1,140
12/02/96	San Luis Medical Clinic	San Luis, CA	Tenet Healthcare Corp.	ND	35	The acquisition links Tenet's two area hospitals with the clinic and its physicians	—
11/01/96	Family Physicians Group	Vancouver, WA	MedPartners, Inc.	ND	20	Target is a multispecialty clinic with four sites	—
10/30/96	HealthNet Medical Group	Ridgewood, NJ	Valley Care Corp.	ND	32	Target was a subsidiary of Coastal Physician Group	—
10/08/96	STAT Healthcare, Inc.	Houston, TX	American Medical Response, Inc.	\$140,385	200	Accounted for as a pooling-of-interests transaction; STAT valued at \$9,375 per share in a 100% stock transaction; American Medical Response is a provider of emergency ambulatory services	3.9
10/07/96	EquiMed, Inc. eye care division	Tucker, GA	Physicians Resource Group	\$68,863	73	Consideration consisted of cash plus assumed liabilities	\$943
10/07/96	American Ophthalmic, Inc.	Winter Park, FL	Physicians Resource Group	\$70,000	102	50% cash and 50% stock, with \$10 million in contingent consideration	\$686
10/03/96	Hattiesburg Clinic, P.A.	Hattiesburg, MI	PhyCor, Inc.	ND	100	Target provides 19 specialties with a mix 50% primary care and 50% specialty in 12 sites	—
10/02/96	Straub Clinic & Hospital, Inc.	Honolulu, HI	PhyCor, Inc.	\$39,750	150	\$7.7 mm stock and \$32.1 mm cash; the acquisition includes clinic plus 157-bed hospital and management of 40-physician multispecialty group in Guam	\$265
09/11/96	Readicare, Inc.	Sunnyvale, CA	Healthsouth Corp.	\$70,548	117	Accounted for as a pooling-of-interests transaction; Readicare shareholders receive 0.2425 Healthsouth shares for each Readicare share held	\$603
08/12/96	Gulf Coast Medical Group	Galveston, TX	PhyCor, Inc.	ND	38	Target mix 86% primary care	—
08/01/96	Wilmington Health Associates	Wilmington, NC	PhyCor, Inc.	ND	43	PhyCor's second affiliation in North Carolina	—
08/01/96	Medical Arts Clinic	Minot, ND	PhyCor, Inc.	ND	42	PhyCor's first clinic affiliation in North Dakota	—
07/12/96	Doctor's Walk-In Clinics	Tampa, FL	First Physician Care	\$10,000	28	Seven sites with 75% urgent care, 25% occupational medicine mix	\$357

ND = Not Disclosed

New Rules Seek to Improve HMO Care

The federal Health Care Financing Administration (HCFA) has issued rules to ensure that managed care plans do not limit necessary care for Medicaid and Medicare patients. Effective Jan. 1, the rules restrict health plans from providing physicians with financial incentives for curtailing medical care. The new rules limit the amount of financial penalties a health plan can levy to discourage physicians, especially those in capitated plans, from providing care or referring patients to specialists for services. "We want to ensure that patients are not hurt in the process of curtailing costs," said a HCFA spokesman.

Earlier, HCFA had issued a rule barring doctors who treat Medicare and Medicaid patients from withholding information on treatment options and medical procedures. Physicians had complained that the so-called gag rules had prevented them from providing unencumbered advice.

The American Association of Health Plans (AAHP) also issued rules regarding managed care quality. The AAHP, in Washington, D.C., said all managed health plans should provide patients with information on how physicians are paid, how plans review and decide whether

treatments are necessary, which treatments and drugs are covered, and how plans decide whether treatments are experimental. The group also said physicians should give patients information about their medical needs and options and the best treatment plans, even if an option is not covered by a plan. Physicians were instructed not to disparage any treatment simply because the plan does not cover it.

Comment: *The AAHP issued the rules and has taken other steps to forestall the passage of legislation in Congress and in the states that would regulate managed care plans.*

Auto Makers Treating Providers as They Do Any Other Suppliers

The Big 3 auto makers have begun treating health care as if it were any other commodity, according to *The Wall Street Journal*. Ford, Chrysler, and GM are demanding from doctors, hospitals, and health plans the highest quality at the lowest price by giving them precise specifications for the services they buy. In other words, providers are being treated as if they were supplying auto parts.

To enforce quality standards, auto makers encourage workers to join managed care plans. To cut expenditures, the manufacturers have been finding and eliminating disparities in costs and the use of services from one location to another. In Flint, Mich., GM supports a move to consolidate care into one medical center and to close four hospitals. In this eastern Michigan city, GM buys health care for 210,000 residents, 60% of the population.

For its workers, Ford pays \$510 per car for health care and Chrysler \$700. GM spends \$1,200 per car for health care, more than \$700 over what it spends for steel, *The Journal* reported. For health care, foreign auto makers pay as little as \$100 per car.

Comment: *Hamstrung by union contracts that require provider choice, the Big 3 have won concessions during union negotiations to control health care quality and utilization by managing providers more closely.*

HMO Offers Direct Access to Ob-Gyns

Under a program started last month, women members of the Prudential HealthCare HMO of Woodland Hills, Calif., can get well-woman and pregnancy care from their ob-gyn without a referral. The program is available as long as the ob-gyns participate in the same medical group as the member's primary care physician and if the member's medical group elects to participate in the HMO's direct obstetrician program.

Since female plan members had asked for direct access to pregnancy and well-woman care without a referral, the new plan should increase member satisfaction and expedite access to prenatal care, said Elaine Batchlor, MD, the HMO's chief medical officer.

Comment: *Growing more sophisticated, consumers are demanding the right to bypass primary care gatekeepers to go directly to specialists. This trend is particularly powerful in the case of gynecologists because many women consider them their primary care physician.*

Nine States Draft New Rules to Regulate Managed Care Plans

Legislators in nine states have drafted new rules to regulate managed health plans and to improve safeguards for patients. In January, the new rules were introduced in New Jersey and Texas. They are scheduled to be introduced in Colorado, Georgia, Delaware, Kansas, Ohio, Oregon, and Tennessee.

Under the rules, managed care plans would be required to provide a sufficient number of facilities and doctors. Managed care plans also would need to allow patients to pay more to see a physician outside of a network, permit patients with chronic diseases and other special needs to select specialists as primary care physicians, and disclose limits on experimental treatments. In addition managed health plans would need to give patients access to all federally approved drugs and devices.

Comment: *One problem with the new rules is that most large employers are exempt from state regulation because they self-insure their health benefit plans under the federal Employee Retirement Income Security Act of 1974.*

NEWS AND COMMENTARY

Two Health Care Buyers Start Health Plans

Two large health care purchasers are developing their own health networks and will begin buying directly from providers this year.

One of New York's largest health care unions is building its own managed care plan for all of the state's 2.5 million union members, according to *The New York Times*. Local 1199, the National Health and Human Services Employees Union, represents 120,000 workers in New York. In years past, its members were offered a version of the plan that covered outpatient care. The full plan, including hospital benefits, will be marketed to other unions beginning this year, *The Times* said. The union is negotiating contracts with doctors and hospitals, establishing claims processing systems, and starting health-monitoring programs.

The union created its own nonprofit health plan out of frustration when nonprofit insurers, such as Empire Blue Cross, began limiting benefits and seeking profits, union officials said. "What bothers us is for-profit companies taking health care dollars, putting them in their pockets, and then not delivering health care," Dennis Rivera, president of Local 1199, told *The Times*. "We think we can do it better and cheaper ourselves."

A coalition of 23 companies in Minneapolis—including General Mills, Honeywell, and 3M—has negotiated prices and quality standards directly with physician groups and will begin sending patients to the groups this year. "Employers started this in the hopes of getting more value for the money they pay and health benefits that are more responsive to employees' needs," said Patricia Drury, the director of quality measurement and consumer information for the coalition, called the Buyers' Health Care Action Group.

Comment: Buyers need the expertise of intermediaries, such as HMOs, to negotiate prices, build networks, and develop health policy, said Kenneth Abramowitz, a health care analyst with Sanford C. Bernstein & Co., a financial management firm in New York. Without such help, only 1% of such efforts would succeed after three years, he said.

A Toll-free Line for Physicians 888/457-8800

Our mission at *Physician Practice Options* is to be a practical information resource for physicians seeking to thrive in health care. In a search for new practice options, physicians are asking themselves a variety of questions, including:

- Should I sell my practice?
- Should my colleagues and I form a physician organization?
- Where should I go to get capital?

We are available to answer all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will refer you to the appropriate expert.

To reach us, readers are invited to call this toll-free number: **888/457-8800**. The service is *free* to readers. Also, readers are invited to call our editors directly:

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