PHYSICIAN PRACTICE
OPTIONS™

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A Practical Resource to Succeed in Health Care

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Five Lessons for Physicians Seeking Capital

One of the most obvious sources of capital for physicians is physician practice management companies (PPMs). But doctors today also are getting capital from many other sources, including banks, venture capitalists, large equity investors, financial corporations, management service organizations, other physicians, hospitals, insurers, and joint-venture partners. Each source has its advantages and disadvantages. When working with PPMs, for example, doctors can retain equity in their practices while the PPM manages the business itself. (See "Physician Management Companies Had a Watershed Year," March.)

Five Lessons

Another significant source of funding is for-profit hospital systems. Recently, a for-profit hospital chain from Tennessee agreed to acquire a Massachusetts hospital and a stake in a large multi-specialty clinic, both in Worcester, Mass. For physicians in search of capital, the acquisition illustrates lessons about what's happening in markets nationwide.

What happened was OrNda HealthCorp., of Nashville, said it would acquire St. Vincent Healthcare System in Worcester. OrNda also acquired a minority stake in the Fallon Clinic, a 280-member multi-specialty group practice in the city. The nation's third largest investor-owned hospital management company, OrNda owns 48 hospitals nationwide.

Lesson 1

The Worcester deal shows that no health care organization in any part of the country is immune from the need for capital to survive in markets dominated by managed care. New England has long prided itself as a nonprofit safe-haven for hospitals and physicians. Until recently it has relied on community sources for capital. Indeed, since the early 1980s, Arnold Relman, MD, former editor of *The New England Journal of Medicine,* has warned of the evils of health care focused on profit making, calling it the medical-industrial complex. But when economic pressures are great, physicians need financing to survive and thrive. As the St. Vincent story demonstrates, when it comes to survival, hospitals and physicians will turn to outside capital sources, even when those sources were previously thought to be tainted.

Lesson 2

In highly competitive managed care markets, the demand for capital can create unusual alliances. Health care experts consider Worcester to be in stage four of managed care maturity. By this stage, more than 50% of the population is enrolled in HMOs, and the market is dominated by large group practices with hundreds of physicians, integrated physician-hospital systems usually having more than $1 billion in annual revenue, and a high concentration of capitated reimbursement making up 40% or more of total revenue.

In stage four markets, large organizations need capital to grow. Capitation exacerbates the need for capital because it forces physician-hospital systems to invest heavily in acquiring doctors' practices, infrastructure, information systems, and management expertise in order to improve efficiency. Capitated systems seek to deliver a prepaid continuum of care in every possible setting, including the workplace, doctors' offices, hospitals, ambulatory-care centers, recovery

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EDITORIAL

Announcing a Toll-Free Line for Physicians

Our mission at *Physicians Practice Options* is to be a practical information resource to help physicians succeed in a rapidly changing health care environment. Since we published our first issue in February, physicians nationwide have contacted us and expressed a need for business strategy information. In the past two months, we've received phone calls, letters, and e-mail messages from practicing physicians who are facing tough questions, such as:

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

While challenging because each situation and each market is different, these questions are welcome because each caller has a story to tell that illuminates yet another facet of managed care. Since we appreciate that our readers have much to offer us, we willingly make ourselves available to answer any and all questions from readers. If we don't know the answer, we will refer you to the appropriate expert who does.

Recognizing this need among readers, *Physician Practice Options* has formed the Physicians' Advisory Group with two other partners. One partner is the Alliance of Health Advisors Inc., a company in Lafayette, Calif., that provides practice management consulting to physicians. The other partner is the National Association of Integrated Health Organizations, a trade association in Fredericksburg, Va.

The group will serve as a practical resource for physicians seeking practice management and business expertise. The group will help doctors understand what to expect in their markets, what questions to ask when seeking partners, what factors to consider, and what material to prepare before entering into a new relationship with a business partner or when forming a new business organization, such as an independent practice association (IPA), a management service organization (MSO), or a physician hospital organization (PHO).

To reach this group of experienced physician advocates, readers are invited to call this toll-free number, 888/242-2778 (888/AHA-ASST). Readers who call will be referred to a physician advocate or consultant from one of the three organizations. The service is free to readers.

Readers also may call me directly at 860/395-1501, or write to me at:
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Answers to any questions would need to be tailored for each market and for each doctor involved, says James G. Nuckolls, MD, a member of the advisory board of *Physician Practice Options* and CEO of Blue Ridge Primary Care, Galax, Va., a group practice of 120 doctors in rural Virginia. In fact, any advice for physicians would need to take into account whether the physicians involved are specialists or family practitioners, he explains. For example, in some markets hospitals dominate and dictate the direction of the market. In other markets, physicians are strong.

"Many doctors facing the transition to managed care find that it's very easy to get caught up in all the details," says Nuckolls. "There are so many details, that they fail to see the big picture. What they don't see is that they have lots of choices today. Not all of them involve continuing to practice medicine, but there are many choices. They need to understand that."

The questions that physicians have regarding practice options cover a wide range from relatively easy to extremely complicated, says Nuckolls. Answering such questions "is almost like practicing medicine," he says. Some patients can be cared for by a general practitioner in a few minutes. Others will need more intense care from a specialist, he explains.

Regardless of the level of expertise necessary, the Physicians' Advisory Group will have the appropriate answer, or make the proper referral.

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centers, and in patients' homes.

Lesson 3

For-profit organizations can capture market share quickly, either by buying nonprofits or by entering into joint ventures with them. Their motivation, of course, is to grow, to become more profitable, and to reward shareholders. Access to capital and the ability to deploy it quickly are what make for-profit organizations so powerful. Consider the activities—in New England and elsewhere—of Columbia/HCA, the nation's largest hospital management company. In 1995, Columbia/HCA bought controlling interest in MetroWest Medical Center, a hospital in Framingham, Mass., and purchased 41 other hospitals nationwide. Increasing its acquisition activities this year, Columbia is working on 150 individual transactions, one third of which are likely to result in acquisitions. Columbia/HCA has annual revenue approaching $25 billion, owns 340 hospitals, 118 medical clinics, 120 outpatient surgical centers, and 182 home health agencies.

Lesson 4

Joint ventures between nonprofit and investor-owned hospitals may be an attractive way for nonprofits to get out of debt. Through a joint venture, the nonprofit institution, which typically is an academic teaching hospital, receives immediate cash and can still generate future earnings without relinquishing its leadership role in the community. For the inner-city institution, for example, joint-venture capital may be a way to repair a decaying academic teaching center. The funds and future cash distributions resulting from joint ventures also may be used to provide incentives to key physicians and management executives, according to an article, "Focus on Joint-Venture Arrangements: Can Investor-Owned and Not-for-Profit Hospitals Bridge Ownership Differences?," in the spring 1995 issue of *Capital Finance*, a report published by Cain Brothers, New York.

Lesson 5

For-profit health care companies are extremely interested in buying physician practices. They recognize, after all, that physicians are the heart of the health care delivery system. The 280-member Fallon Clinic is one of the largest multi-specialty clinics in New England, and it provides care for the Fallon Community Health Plan, an HMO in Worcester with 175,000 members that has been rated one of the best in the nation. OrNda did not buy the HMO, however.

Physicians don't necessarily need to consolidate with hospitals. On the West Coast, partially integrated large medical groups or large independent practice associations, working with satellite IPA affiliates, are rapidly gaining market share and are either buying or contracting with hospitals.

"Success in managed care requires continued growth, which in turn requires substantial investment in new facilities, management-information systems, and the acquisition of additional member physicians and physician groups," according to an article in The *New England Journal of Medicine* (Dec. 21). "Independent groups have sold all or part of their assets to non-physician organizations with substantial assets, including selling to hospital systems and physician-practice management companies, and are making direct equity offerings to the public." The article describes the work of six of California's largest medical groups, which cover more than 759,000 capitated lives. The article reports that four of the six had sold their assets to outside investors.

Capital Needs

The Fallon-St. Vincent deal is an excellent example of what's happening in many health care markets. To be competitive, provider organizations need to offer one-stop contracting for a broad range of services to all plan participants and a menu of plan choices, including HMOs, PPOs, point-of-service plans, workers' compensation plans, and dental HMOs. In addition, they need to offer lower costs than the competition, and they need to have quality of care efforts in place that can document improvements. They need proof of satisfaction from customers, comprehensive benefits, and the ability to prove that their patients are healthier than those covered by the competition. To deliver these services, hospitals and physicians have to consolidate into large well-capitalized organizations to achieve economies of scale and sophistication.

But physicians don't necessarily need to consolidate with hospitals. On the West Coast, partially integrated large medical groups or large independent practice associations (IPAs), working with satellite IPA affiliates, are rapidly gaining market share and are either buying or contracting with hospitals.

In order to develop the systems needed to compete in maturing managed care markets, physician organizations require capital of $1 million and more for start-up costs, operating expenses, managed care expertise, information systems, and practice management. The competition, after all, is managed care organizations, which have been building in scale and sophistication for years. ■

Addendum

To help physicians gain access to information about acquiring capital, *Physician Practice Options* and its parent company, Premier Healthcare Resource Inc., will participate in the "Physicians' Capitalization Conference, PHY-Cap '96" with the Medical Group Management Association and Alliance of HealthCare Advisors for the National Association of Integrated Health Organizations. This conference offers 11 hours of CME credits for physicians. It will be held at the Westin Hotel Copley Place in Boston on May 9 and 10. For a copy of the program, call the PHY-Cap '96 conference registrar, 510/284-6204.

COMMENTARY

The Managed Care Food Chain And How You Can Move Up

The world's oceans are teeming with large fish that thrive on smaller fish. That's the food chain in action. Doctors today are finding that trying to survive in a world dominated by managed care is like trying to swim with sharks. What's more, doctors find that they are uncomfortable with their current place in the food chain, given that their position was once more lofty.

For those older physicians who were educated and trained during the golden years from 1945 to 1985, the food chain could be described as follows:

1. Surgical specialists
2. Medical subspecialists
3. Hospital-based subspecialists
4. Academic health centers and tertiary referral centers
5. Community hospitals
6. Large medical groups
7. Primary care physicians
8. Insurance companies
9. Payers, such as employers and the government
10. Consumers.

During this era, most doctors made a good living, and many enjoyed a great living. Enamored of medical care as a social good, society entrusted doctors and hospitals with the right to use their best judgment to do what was right.

A New Line Up

But then three trends happened over about 30 years, and health care was changed forever:

1. Medical inflation soared from about 5% of gross domestic product in 1965 to 14% in the early 1990s.
2. In that time, the health of Americans stagnated, as men and women saw only marginal gains in life expectancy and general health.
3. Health care benefits became the No. 1 expense of American businesses, equaling—and in some cases, surpassing—before-tax profit.

The combination of these events caused payers to lose faith in the value of health care as delivered by the medical establishment. More aggressive employers began to treat health care providers as they would any other vendor. In addition, employers spelled out specifications for the product they were buying. Health care became a commodity, and it became subject to market discipline and to market demands for information. Health care and its participants became creatures of the market.

Purchasers began to say, "Give me cost containment, but give me options," says Leonard Schaeffer, president of Blue Cross of California and WellPoint, an HMO in Woodland Hills, Calif. "Give me a plan that incorporates choice but controls costs. I want an HMO, a PPO, a point of service plan, specialty products, and a dental plan. I want quantifiable high quality. I don't trust your word for your quality. Show me. Don't tell me about your prestige. Give me value—the lowest price with the most benefits."

Payers began to analyze outcomes, to demand quantifiable data, to link cost-effectiveness with quality, to ask for across-the-board service, to insist on a single health organization that could serve all their employees in a geographic region, and to request evidence of employee satisfaction.

When health care cost equaled or exceeded corporate profits, payers decided to wrest control of spending from the medical establishment. As a result, the food chain has been turned upside down.

Here's how Brian C. Smith, the author of "How to Survive and Thrive in Managed Care in 1995," describes the current system:

1. The employer and government. (These are retail buyers.)
2. Managed care organizations (wholesale buyers)
3. Primary care physicians (gatekeepers)
4. Primary care medical groups (prepaid providers)
5. Specialists (wholesale providers)
6. Hospitals
7. Specialty hospitals
8. Hospital-based subspecialists

In its publication, *Capitation I: The New American Medicine*, the Advisory Board Co., in Washington, an association of service companies, describes the current status of physician groups as follows:

1. Large primary care group practice.
2. Large multi-specialty group practice, weighted in favor of primary care.

Purchasers began to say, "Give me cost containment, but give me options," says Leonard Schaeffer, president of Blue Cross of California and WellPoint, an HMO in Woodland Hills, Calif. "Give me a plan that incorporates choice but controls costs. I want an HMO, a PPO, a point of service plan, specialty products, and a dental plan. I want quantifiable high quality. I don't trust your word for your quality. Show me. Don't tell me about your prestige. Give me value—the lowest price with the most benefits."

As Markets Mature, Capital Needs Rise

Generation	Managed Care Maturation	Physician Organizations	Hospital Organizations	Capital Needs (In Millions)
First	Unstructured	Independent practice associations (IPAs)	Physician hospital organizations (PHOs)	Up to $1
Second	Loose Framework	Group practices and management service organizations	MSOs	$1 to $10
Third	Consolidating	Single-specialty, multi-specialty groups, equity company or comprehensive MSOs	Hospital staff model or comprehensive MSOs	$2 to $20
Fourth	Partially Integrated	Core medical groups with affiliated independent practice associations (IPAs) and MSOs	Core hospitals with affiliated hospitals, physician groups and MSOs	$20 to $40
Fifth	Totally Integrated	Vertically integrated systems in which health plans and hospitals are under one umbrella organization		$50 and Up

Source: "Capital Survey of Emerging Health Organizations," 1994, a collaborative survey by *Integrated Healthcare Report*, Arrowhead, Calif.; Zeigler Securities, Los Angeles, Calif.; Medical Group Management Association, Englewood, Colo.; IPA Association of California, Oakland Calif.

3. Vertically integrated health systems with a strong primary care base.
4. Primary-care-dominated independent practice associations (IPA).
5. Vertically integrated health systems with a large specialty base.
6. Primary-care-dominated physician hospital organizations (PHO).
7. Single specialty groups positioned for capitation.
8. Multi-specialty groups with a large specialty base.
9. Specialty-dominated PHOs.
10. Solo practitioners in primary care.
11. Solo practitioners in a specialty.
12. Academic medial center subspecialists voting Republican in the prior election.

Reading between the lines, the message from both of these lists is:

1. Physicians should join or merge into larger groups,
2. Physicians are probably better off in an integrated group, and
3. The number of primary care physicians in groups is rising while the number of specialists and hospitals is falling.

Moving Up

These messages have not been lost on American physicians. In a survey of physicians last year, a medical journal found physicians are merging into larger groups; joining group practices without walls; joining PHOs, management service organizations (MSOs), and physician organizations (POs); and selling to large health care companies, such as HMOs, hospitals, health insurers, and physician practice management companies. Specialists are doing more of these activities than primary care physicians.

The data show that primary care physicians are selling their practices at a much higher rate than specialists, that specialists are more likely to merge, and that both are joining PHOs, MSOs, and POs at about the same rate. In other words, physician consolidation is well under way. What the data do not show is that physicians are forming and joining groups primarily to cut overhead and to be in a position to negotiate better contracts with managed care third-party payers; that physicians are consolidating to attract capital to finance management, information systems and to achieve growth; and that those organizations outside of hospitals, such as IPAs, POs, and large group practices, are growing fastest.

To move up the food chain in maturing managed care markets, physicians are advised to do the following:

1. Join primary-care dominated organizations.
2. Create either multi-specialty groups or carve-out specialty groups that can accept capitation.
3. Look for organizations with strong, professional management.
4. Make sure the organization has attracted HMO contracts, has a sufficient enrolled population, and the number of covered lives is growing annually.
5. Find an organization that has invested in a sound information system.
6. Make sure the organization selects the right kind of physicians and has strong selection criteria.
7. Assure yourself that the organization has enough capital, skills, and the capacity to assume and manage financial and clinical risk.
8. Join a winning organization before the managed care enrollment as a percentage of the population in your region gets to 15%.
9. Keep in mind that physician-centric outpatient-based organizations, particularly those with strong physician leadership, have the best chance of future success. ■

How Doctors Can Thrive Under Managed Care (Part II)

Brian C. Smith

Last month, Physician Practice Options *brought you the first part of our interview with Brian C. Smith by Richard L. Reece, MD, editor-in-chief. The following is the conclusion of the interview. The author of* Embracing Change: How To Survive and Thrive in Managed Care 1995*, Smith is an expert in the development and marketing of prepaid managed care organizations. The founder and president of B. Castle Smith & Co. Inc., in Pasadena, Calif., a managed care consulting and research firm, Smith has 15 years of experience in provider contracting, new product development, and major account sales and marketing with two national HMOs. To order Embracing Change please call 800/679-1200.*

Q: *Is the late-blooming phenomena of physician-practice management firms an overt attempt to move up the food chain?*

A: Yes, it is. And that part of the phenomena is following the venture capital. Venture capitalists focus on industries that they believe will be dominant in their category in five to 10 years. Today there are 684,000 practicing physicians in the United States. Fewer than 2% are involved in publicly traded physician-practice management companies. Wall Street values a physician-practice management company that has a minimal track record and only a belief about what their earnings will be three to five years down the road. That's why you see average price-to-earnings multiples of physician-practice management companies today that are approximately 40 times earnings.

At the same time, this trend creates an extraordinary opportunity for physicians in medical groups. Let's say you have an eight-story medical facility with 150 physicians in solo practices. That's 150 accountants, 150 lawyers, 150 bookkeepers, 150 billing systems, 150 information systems. It's a totally fragmented, extremely inefficient system. But you could aggregate all of that back office work into a management services organization that would make the tough business decisions about staffing and contracting and let the physicians focus on the clinical components and learn to become accountable for delivering appropriate care. Most individual physicians are under-capitalized. They don't have the ability to acquire the information systems or the data to begin to benchmark there practice patterns to know what is appropriate.

All of these are reasons Wall Street is valuing physician practice management (PPMs) so high. PPMs can go out to the public market, raise the capital, invest in the systems and the infrastructure, become efficient at the back office functions of billing and utilization and protocol building. From Wall Street's perspective, all of that drives up the value of physician practice-management companies.

Q: *It is said that 70% of America's 684,000 physicians are in one or two-person practices or they are in small groups. What do you advise these people to do—other than read your book, of course? What moves should they be making now?"*

A: The real question they should be asking is, '*How* should I integrate or align,' not *if* I should. Those physicians in one- and two-person practices have to realize that this is a changing market. The lights are not going to get turned off tomorrow. But these physicians must have a clear vision of how they are going to affiliate and who they are going to affiliate with. They must have a cogent action plan. They have to begin to think through the three 'Rs" physicians face today. Those three 'Rs" are: re-engineer, relocate, or retire. All of which are strategies that one can lay out, depending on how long you want to practice medicine in the United States. If you want to be practicing for the next 10 to 15 years, you have to make a clear and objective assessment of who your affiliation candidates are, which affiliation candidates fit closest to your beliefs and clinical goals, and then go make it happen. Go do it.

Q: *In those affiliations, the candidates are: number one, physicians; number two, hospitals; number three, practice management companies; and number four, HMOs.*

A: Correct. One of the things that struck me in 1991 was when Kaiser North hired the entire graduating class of the University of California at Davis Medical School. That was when I realized that something big was going on for the 40-year-old or 55-year-old physician who has built a successful practice. One of the hardest things these physicians face, and one of the reasons we wrote this book is for thousands of doctors who are seeing their practices—or the practices they originally envisioned—die. When Elisabeth Kubler-Ross wrote the book, *On Death and Dying,* she described what patients go through as they die. First, they face anger, then denial, and then finally acceptance of the fact that they're dying.

Likewise, many physicians' practices are dying today. They don't know it, and they don't understand it. And you see a lot of anger initially, a lot of frustration, and a lot of denial. But those who accept the inevitable can use the energy that they've been wasting swimming against the stream. If you use that energy to find exactly where that stream is going and go along with it, it is going to be a much more rewarding direction for you. That's one of the issues that these one- and two-person practices need to face.

I speak to thousands of physicians every year, and I see an incredible amount of fear in their eyes. Fear often causes mistakes, in doing something too quickly in an effort to ease the pain, if you will. And my hope from this book was to help physicians get through that fear, to understand that this is a structural change, and that if you can get to the acceptance phase, there are ways of re-engineering and re-thinking the way

you deliver health care.

At that point, physicians realize that it's okay to become accountable for the care they deliver. Those physicians who demonstrate that their outcomes are in the highest percentile among their competitors are going to win. In, New York, Philadelphia, and Florida today, the outcomes for CABG surgery are published along the morbidity and mortality rates for individual physicians. When that started, physicians were scared to death. But guess what? What has occurred is many cardiovascular physicians in those areas have improved their morbidity and mortality rates. If they came out earlier on the lower end, their initial reaction was to say, 'My patients are sicker and my patients are more complex.' The reality was that when you factored out those kind of components, physicians have different skill sets, and there are some physicians who began to look at what they were doing, and learning from other physicians about how to improve their skills and how to get better results.

Re-think and re-engineer the way that you do particular surgeries and get better results. Ultimately, getting better results and becoming better at what you do is the best decision you can make and it's the best way to position yourself for managed care.

Q: *Do you consult all over the country and do you see this happening with great speed everywhere?*

A: It's happening at different speeds in different parts of the country. I've been lucky to work almost in every state, and the Southeast now is one of the areas that has the highest physician income. Therefore, it has the least HMO penetration, and it's where things are going to happen the fastest. Areas such as California, Southern California especially, they're so far down the road that in many respects it's become just difficult for physicians to do anything there.

So, there's great speed in some areas and you can look at it as a relationship between HMO penetration and physician income.

Q: *In other words, the higher the physician income, the more vulnerable they are to quick penetration?*

A: Absolutely. That may seem counter intuitive, but a large HMO might see a Mississippi or a Georgia with 6% or 7% HMO penetration as an opportunity. It's also an opportunity for physicians to get quickly into the driver's seat before the HMOs do. Physicians in these markets may feel disempowered, saying, in effect, "Well, this HMO's going to dictate everything and I've lost all my power." But the physicians who take the opportunity to create physician-driven affiliations or physician-hospital-driven affiliations and lock up the premier hospitals and the premier physicians into organized delivery systems suddenly have a tremendous amount of clout with the HMOs.

One of the things that HMOs have always had the advantage of is that physicians were unaffiliated, unorganized, unsystematic in the way they delivered care. Therefore, the HMO could come in and draw up individual contracts with each one and literally dictate how they were going to practice. U.S. Healthcare is a great example of that. For the most part, U.S. Healthcare has direct individual contracts with their primary-care physicians and direct individual contracts with their specialty physicians, and literally dictate, because of the market share that they now command, physician behavior. Divide and conquer, if you will. Compare this behavior to that of PhyCor or Mullikin/MedPartners, which are beginning to dictate pricing and quality issues to the HMOs.

So the lesson is this: If you can approach health care in an organized, systematic, and accountable way—and there's a variety of mechanisms to do that—you're going to have a tremendous advantage when it comes to managed care. And that advantage will be related to the degree that you can differentiate yourself from other physicians in the market.

Q: *One last question: There's a rising tension between hospitals and physicians as to who should be the integrator and who's in charge. What's a healthy relationship?*

A: First, I'll describe an unhealthy relationship and then compare that to a healthy relationship.

An unhealthy relationship is where the dominant hospital in town, because it has the capital, places its entire staff of physicians in an entity that literally has hundreds of specialists and primary care physicians. The driving force behind the hospital is to create a cartel of physicians in the belief that doing so will keep their bed days up and life will go back to the old days of cost reimbursements. That is exactly the wrong reason to integrate physicians and hospitals.

The other way is for a number of hospitals to look at a particular marketing area and recognize that they are in the business of delivering appropriate levels of inpatient care. They allow themselves to be driven by a strong primary care system with a wide geographic range of delivery sites. They have a good regional and geographic spread of hospital availability, of bed availability, and a strong affiliation with home health and infusion services and all the other ancillary components, including long-term care and medium-term care facilities. In essence, they present a system that an HMO can't refuse. They offer a far-reaching, primary-care driven professional services component combined with an institutional capability that ranges from primary and tertiary care down to long-term care. Therefore, the HMO managers see that with one contract they can provide a tremendous diversity of care and can fix costs through global capitation. The HMO can do what it does best, which is market and administrate. And the delivery system can do what is best, which is deliver care. ■

Capitation: A Primer on Pricing Risk

By David Wilson, FSA, FCIA, MAAA

A health care actuary, David Wilson, FSA, FCIA, MAAA, is a managing director of the Apex Management Group Inc., in Princeton, N.J. Wilson specializes in health care product development and health care financing. Considered one of the nation's experts in stop loss insurance and managed care financing, Wilson leads the firm's efforts in actuarial and strategic consulting with insurers and managed care organizations. A graduate of the University of Manitoba, Wilson has a Master's of Science degree in statistics and is a Fellow of the Society of Actuaries, a Fellow of the Canadian Institute of Actuaries, and a Member of the American Academy of Actuaries.

Physicians considering capitation contracts sometimes use overly simple methods to calculate prices. They rely on opinions rather than facts.

When an actuary prices capitation rates, finding, using, and managing pricing data is the key. By its nature, capitation is a risky, but manageable, business. Whether you are contracting with an HMO, an insurer, another provider, a physician hospital organization, or some other entity, the following basic principles of capitation will help you to understand the risks.

The many risks associated with a capitation contract can be grouped into four types:

- Business control risk
- Morbidity risk
- System risk
- Pricing or underwriting risk

Business Control Risk

This class of risk comes in several forms. A provider may be capitated for services it does not order. If so, the physician doesn't control utilization. Examples include private laboratories, drug companies, and home-infusion therapy firms. A doctor who directs the utilization of its own services has more control to achieve positive results. But, in the case of home infusion therapy, for example, where another provider orders the service, the physician is limited to controlling only its own service costs.

Another business control risk could take the form of a bad deal, for instance, an unreasonable offer from an HMO. The contract may contain provisions that clearly put you at additional risk outside of your control, such as multi-year guarantees or coverage for out-of-area claims. Or, the HMO might be poorly organized, or be a weak manager of other services for which you may have financial responsibility. It may not be open to sharing utilization data. If so, you could find yourself hoarding data and knowledge to maintain a confident bargaining position.

Trying to get to the true cost of services is a business problem. If cost accounting systems are not in place, for example, you may have to make judgments about the value of time, which means calculating the opportunity cost versus the hard dollar cost. If you are squeezed too hard by a contract, you may be under pressure to reduce services that could affect quality and generate malpractice problems. On the other hand, you may not know how efficient you can become until someone pressures you to do so.

Business control risks also arise when you don't control the price of goods and services you purchase from others. As an example, you may be capitated for all lab tests provided by a third party. The third-party's costs to you may rise while you have a fixed capitation rate.

Morbidity Risk

Morbidity risk should be what the whole game is about. Once you enter a capitated contract, you become a small insurer. In essence, you are taking the risk for sick enrollees. Two types of risk are found here: "bad" patients and excessive overall demand for services.

Bad patients can affect your bottom line quickly. Financing health care is a risky business because members generate different demands on the delivery system. The process is stochastic. Some people are sicker than others and require more services. Sometimes you just get unlucky: A virus may attack the heart muscle of a patient, and you end up with a transplant candidate. Or, a normally healthy mother-to-be could be in a car accident and deliver prematurely. Some delivery systems attract members with more health problems. These patients produce both opportunity cost and hard dollar cost.

One study of a Midwestern Blues plan showed a nested effect in the population. In the study, 10% of the population was using more than 90% of the resources, and 20% of those within that really sick 10% were consuming 80% of the 90%.

The overall demand for services also may exceed expectations. This demand occurs when many random events are compounded by other random events. A major flu epidemic may break out along with an unusual number of pregnancies and the outbreak of a rare virus. This unexpected demand would have hard dollar and opportunity cost implications as well.

System Risk

On the question of system risk, a physician needs to know who will gather what data and how. The challenge is obtaining the data to evaluate what's happening financially in the capitation arrangement. Because little or no billing takes place other than on a gross per-member-per-month basis, details on encounters, procedures, lab tests, and diagnoses may be lost. Renewal pricing will continue to be a problem as long as these data are not collected or are hoarded by the organizer.

If the HMO you contract with builds a data repository, will you be allowed access to the data? If not, you would be at a significant disadvantage. How would you know, for example, who is ordering baseline EKGs on 8-year-olds and whether eligibility is being verified? You also would be at a disadvantage when negotiating the next contract.

Your agreement may require additional expense to modify existing computer systems to be compatible with the organizer's systems. Some of these changes may facilitate on-line verification of eligibility and be worthwhile, but you need to know up front

who will pay the bill and what you'll gain.

Pricing or Underwriting Risk

This is the most obvious type of risk. Did you project utilization correctly by demographic class? If so, did you predict costs of the capitated population accurately by subclass? If you don't control the cost of all goods and services covered under your contract, did you forecast changes in price for these goods and services?

Most providers have a good idea of what services a patient of a given age and sex with a certain morbid condition would use. Pricing risk comes when trying to predict the number of patients and the correct mix of diseases and severity in a population.

Demographics can help or hurt depending on how they work out. Generally, utilization will be greater for an older population. The disease mix will change, and the severity of any morbid condition will increase. An older population will generate higher costs and disproportionately more large claims. Average medical claim costs will increase 2% to 6% a year as average age rises.

You also need to know the general underwriting characteristics of the business the HMO sends your way. Is the HMO writing small group policies? Does it use medical underwriting and does it anticipate changes in the mix of morbidity classes in its offer to you? The expected morbidity of a newly underwritten small group changes significantly after the initial medical underwriting.

Evaluate your capacity for assessing and managing these risks before you get caught up with the rewards. As an observer once stated, "Don't let the perfume of the premium (or capitation revenue) overpower the odor of the risk."

The Rewards

Any contract should not be a one-way street. In return for assuming financial risk, you should have some upside potential. Insurers typically build in risk margins above expected expenses for contingencies. Risk margins vary by the volatility of the risk being assumed. Realizing the margin creates a planned underwriting gain. If actual experience is even more favorable, you achieve an additional unplanned underwriting gain.

Occasionally you could be lucky with the enrollment. You can have good experience because demographics in the actual versus priced enrollment are more favorable. You also can have a lucky year.

Once the capitation rate is set, you are living on a budget. All the incentives are reversed. Where you were financially rewarded for excess utilization, you now are penalized. This budget should stimulate some management activity to improve treatment efficiency. Then you can generate larger "profits" on the capitation contracts or revisit the financial agreements with organizers to lower overall plan member costs and pump up the member sales volume.

With capitation, you are in control because you will have some influence over utilization procedures. Utilization management is now something that helps you guard your bottom line rather than something that interferes with your ability to practice. Utilization protocols protect you from abusive patients who would needlessly consume your resources. This control also allows you to explore re-engineering your processes to improve costs and outcomes. Conceptually, re-engineering deflates the required capitation rate. Since capitation rates are set prospectively and may reflect no anticipated productivity gains, any benefits of productivity efforts will fall to your bottom line.

The Future

Some observers say the era of capitation has just begun. Fitch Investor Services, in New York, for example, predicts that "Seventy percent of hospital revenue will be capitated before the turn of the century." The Hospital Council of Southern California says, "Traditional indemnity's market share will shrink to less than 10% of the total U.S. population in five years."

Managed care is growing rapidly, and most of the recent growth has been driven by providers. In its National Survey of Physicians conducted in 1994, the Physician Payment Review Commission determined that half of the 2,000 respondents were affiliated with a capitated health plan or a fee-for-service plan with withholds. As providers continue to spearhead this movement toward capitation in order to retain control of their financial future, these numbers will rise. The bellwether states, such as California and Florida, have shown that the evolution of provider reimbursement leads to capitation. ■

For more information, contact The Apex Management Group Inc. at 609/452-2488.

Definitions

Capitation: A per capita payment for providing specific services to an identified population.

Global capitation: A capitation rate for all health care services performed by the organizer contracting with the provider.

Organizer: An organization developing and marketing a managed care network, such as an HMO or insurer.

Control: Direct or indirect authority over the ordering and use of services.

Case rates: A fixed payment for treatment. The case rate may cover all services for the treatment or a defined set of services. For example, a case rate could include all specialist charges and any outpatient diagnostic services.

Pareto's Law: The so-called 80/20 rule, which states that 20% of a given population will use 80% of available resources.

Stochastic process: A process that involves chance or probability theory.

One study of a Midwestern Blues plan showed a nested effect in the population. In the study, 10% of the population was using more than 90% of the resources, and 20% of those within that really sick 10% were consuming 80% of the 90%.

IPAs Drive up HMO Membership

HMOs gained 7.7 million new members in the year that ended July 1, 1995, according to a new report by InterStudy, an HMO research organization in Minneapolis. Nationwide enrollment in HMOs reached a high of 54 million individuals, InterStudy said. The 7.7 million-member increase represents the largest 12-month gain that InterStudy has recorded in its 17 years of surveying and reporting on HMOs. Group-model health plans had 30 million members, and IPA-model plans had 24 million members.

While members was rising, so was the number of health plans, which rose by 46 to 593 nationwide. Most of the new plans were sponsored by providers, including large group practices, physician-hospital organizations, and integrated delivery systems.

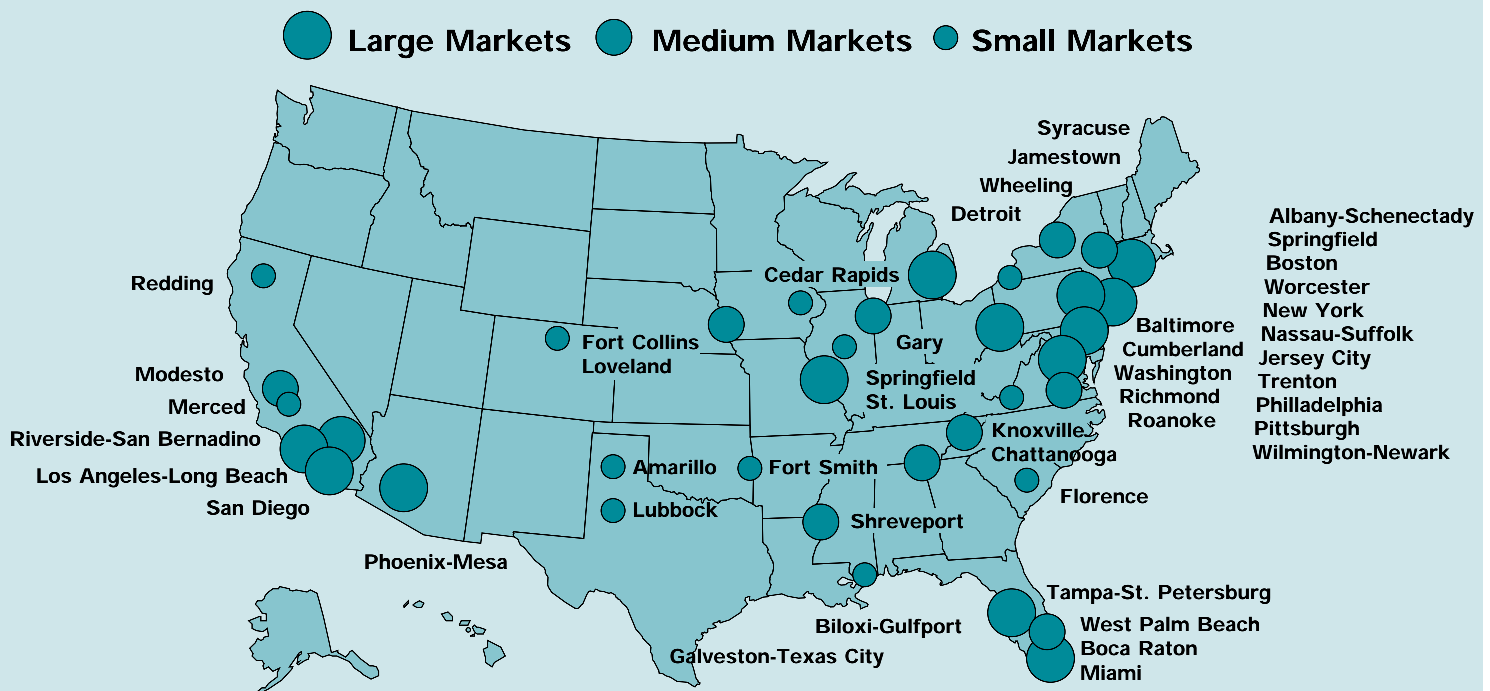
HMOs, especially independent practice association (IPA) plans, reported a rapid expansion of physician networks. Since mid-year 1994, the number of contracts between group-model HMOs and primary care physicians increased 23%, InterStudy said. Also, the number of contracts between IPA-based HMOs and physicians increased 18%, InterStudy said. The number of contracts increased between group-model HMOs and specialty-care physicians by 5% and between IPA-model HMOs and specialty physicians by 14%.

These increases in contracts between HMOs and physicians shows that HMOs are increasing their market reach and need physicians to expand current networks and into new markets, said Richard Hamer, a spokesman for InterStudy. In other words, the demand for physicians is great, and few doctors are being shut out of managed care plans, as had been feared, Hamer said.

One of the fastest growing plans was the so-called open-ended health plan, which gained 1.8 million new members, an annual growth rate of 56%, InterStudy said. An open-ended plan lets members pay more to get care outside of the HMO. Despite the increase in open-ended enrollment, the strongest growth remains in the traditional closed-panel HMOs. Excluding members in open-ended plans, HMO enrollment in traditional closed-panel HMOs totaled 48.3 million members in 1995.

About half of the new members in open-ended HMOs came from six health plans, four of which are in the mid-Atlantic region. Managed care had been slow to grow in the mid-Atlantic states until recently. The six health plans are Oxford Health Plans (New York), Keystone Health Plan East (Philadelphia), HMOBlue (New Jersey), HMO Blue (Boston), Cigna HealthCare of California (Los Angeles), and Oxford Health Plans (New Jersey).

Unlike 1994, when half of all new HMOs were affiliated with a national managed care company, some two-thirds of the new HMOs opened in the first half of 1995 were started as independent organizations. In

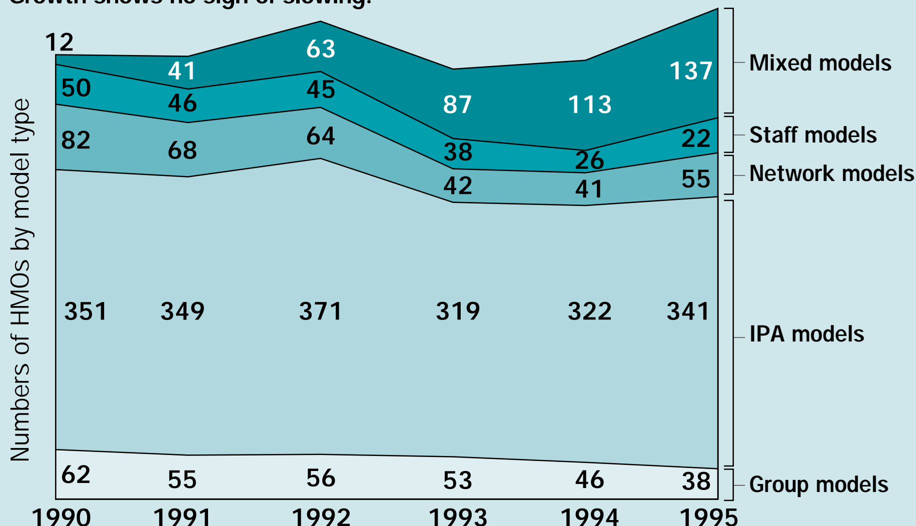


Source: InterStudy, Minneapolis, 1996.

many cases, these HMOs were started by physicians or were affiliated with a hospital.

The region that includes Ohio, Indiana, Illinois, Michigan, and Wisconsin had the most new HMOs, nine in the first half of 1995. In 1994, six HMOs were started in this region, InterStudy said. Overall, in the first half of 1995, new HMO activity was recorded in every region except the Northeast.

The data from InterStudy come from The *InterStudy Competitive Edge*, a semi-annual publication that reports on HMO market growth and trends. It contains three parts: The HMO Directory, which profiles every HMO; The Industry Report, which reports on patterns of enrollment growth and plan characteristics; and The Regional Market Analysis, which reports on market structure, penetration, product diversification, and Medicare and Medicaid enrollment. For more information on *The InterStudy Competitive Edge*, call 800/844-3351. ■



Source: *Interstudy*, Minneapolis, 1996.

Definitions: Five Models of HMOs and Two Types of Services

Seeking market share, managed care organizations have developed various models of HMOs to serve different markets. InterStudy, a research organization in Minneapolis that has followed the growth of HMOs for 17 years, has identified five HMO model types and two types of services. In general, model types define the relationship between the health plan and its providers.

Staff model
An HMO that delivers health services through a physician group employed by the HMO.

Group model
An HMO that contracts with one independent group practice to provide health services.

Network model
An HMO that contracts with two or more independent group practices, possibly including a staff group, to provide health services. While a network may contain a few solo practices, it is predominantly organized around groups.

IPA model
An HMO that contracts directly with physicians in independent practice associations (IPAs) or contracts with one or more associations of physicians in independent practices or contracts with one or more multi-specialty group practices (but the plan is predominantly organized around solo or single-specialty practices.)

Mixed model
Any HMO using a combination of the model types.

Open-ended HMO
Also known as a point-of-service (POS) product. Patients are pre-paid enrollees of the HMO who may receive services from providers who are not part of the HMO's panel. Usually, however, there is a substantial deductible, co-payment, or co-insurance charge for using a non-panel physician. These products are governed by state HMO regulators.

Point-of-service plan
More properly termed non-HMO point-of-service plan or non HMO POS. This is an indemnity type of managed care product that provides beneficiaries with the option to use a selected panel of managed care physicians. If the patient uses a panel physician, the out-of-pocket expenses would be near zero, or the same as an HMO. If using a non-panel physician, the beneficiary pays more in a deductible or co-payment. All provider reimbursement is on a fee-for-service basis. These products are not governed by state HMO regulations. In some states, however, HMOs cannot offer non HMO POS products.

State Facts at a Glance

Physicians seeking markets that managed care has still not reached may be interested in practicing in Alaska, Wyoming, or West Virginia. In these states, managed care has not made a dent in enrollment, according to a report on state HMO enrollment and drug prices, the *Ciba-Geneva Pharmacy Benefit Report*. The report was published by Emron, a managed care consulting firm in Warren, N.J., and Ciba-Geneva Corp., a pharmaceutical manufacturer. The states with the highest enrollment in HMOs and the largest Medicaid populations are California and New York.

Interestingly, the state that spends the most on retail prescriptions per resident is West Virginia, which spends $278 per resident per year. New Jersey follows closely in second place, spending $276 per resident per year. For a copy of the report, call 800/475-2273.

State HMO Enrollment

Highest

State	Number of enrollees	% growth (over prior year)	Percentage of pop.
California	12,930,000	9.9%	37.9%
New York	4,419,000	12.7%	24.3%
Florida	2,827,000	17.1%	20.2%
Pennsylvania	2,591,000	13.0%	21.4%
Illinois	1,997,000	5.6%	16.9%

Lowest

State	Number of enrollees	% growth (over prior year)	Percentage of pop.
Alaska	0	0.0%	0.0%
Wyoming	0	0.0%	0.0%
West Virginia	0	0.0%	0.0%
North Dakota	7,000	141.0%	1.1%
Mississippi	7,000	127.0%	0.3%

Third-Party Payer Share of Retail Rx Market, Ranked by State

State	Percentage of all payers	Growth over Prior Year
Hawaii	68.0%	-1.0
Michigan	64.3%	8.0
Arizona	62.3%	18.3
Maryland	56.3%	11.9
Nevada	55.1%	15.7

States with the Most Retail Rx Dollars Spent per Resident

State	Dollars per resident	Prescriptions per resident
West Virginia	$278	9.8
New Jersey	$276	7.9
Kentucky	$263	10.1
Tennessee	$255	10.1
Florida	$252	8.4

States with the Greatest Retail Prescription Expenditures for Selected Therapeutic Classes

Antibiotics	Antidepressants	Gastrointestinals	ACE Inhibitors
New Jersey	Utah	Kentucky	West Virginia
Hawaii	Idaho	Tennessee	Rhode Island
Nebraska	Minnesota	West Virgina	New Jersey
Mississippi	Montana	Alabama	Illinois
Michigan	Vermont	Michigan	Michigan

States with the Largest Medicaid Populations

State	Recipients	% in Managed Care
California	4,833,824	16.9%
New York	2,742,484	12.1%
Texas	2,308,443	2.8%
Florida	1,744,945	28.2%
Ohio	1,490,583	11.8%

Source (for all charts): Emron 1994 HMO Prescription Drug Therapeutic Class Report, 1995, Emron, Warren, N.J.

Physicians' Salaries Decline, AMA Survey Shows

For the first time since the AMA has been collecting salary data, physician income declined in 1994, the AMA said. Median income fell 3.8% from 1993 levels.

Decreases occurred in nearly every category of physician. The specialties with the greatest percentage decline in median income were pathology, anesthesiology, and obstetrics/gynecology. At best, median income remained unchanged for general and family practice physicians, those in internal medicine, and psychiatry.

The AMA said the impact of managed care on doctors' income is not fully understood. Primary care doctors seem to have benefited most from the growth of managed care. At the same time, managed care seems to have affected surgical subspecialties and procedure-oriented specialties adversely. Managed care places a premium on primary care physicians because it uses them as gatekeepers.

Not surprisingly, income varies considerably from one specialty to another. In 1994, average income was lowest among general and family practitioners and pediatricians and highest for radiologists and surgeons, the AMA said.

From 1993 to 1994, the share of physicians with managed care contracts increased 2 percentage points while the percentage of revenue from managed care contracts declined 1 percentage point, the AMA said.

Here are some of the highlights of the survey report:

- The trend away from self-employment and toward employee status continued last year. The proportion of physicians who are employed grew from 36% to 39% and almost all of the additional employees came from the ranks of the self-employed. Since employees in general earn less than the self-employed, this trend may explain the overall decline in salaries, at least in part.
- Incomes of self-employed physicians are about 40% higher than those of employees, the AMA said. Self-employed doctors tend to be older, have more years of experience, work more hours, and are more likely to be board certified. All of these factors tend to raise income.
- Income varies less across geographic regions than among specialties. In general, physicians in the Central and Southern states did better than their counterparts in the Northeast and West.
- Physicians controlled expenses effectively in 1994. Median tax-deductible practice expenses for self-employed doctors rose 1.4% in 1994, and fell 2.1% in 1993.

In the survey, some 4,000 physicians were interviewed over the telephone. For the purposes of the survey, called the Socioeconomic Monitory Systems (SMS), a physician is defined as a nonfederal, post-resident MD involved typically at least 20 hours per week in patient care. Some two-thirds of the nation's 684,414 physicians meet this definition. ■

Net Income (Mid-Point)

Mean physician net income (in thousands of dollars) after expenses before taxes for non-federal physicians, by specialty, employment status, and census region, 1994.

	1994	% change from 1993
All physicians	**$182.4**	**-3.6%**
Specialty		
General/family practice	121.2	3.8
Internal medicine	174.9	-3.3
Surgery	255.2	-2.9
Pediatrics	126.2	-6.8
Obstetrics/gynecology	200.4	-9.7
Radiology	237.4	-8.6
Psychiatry	128.5	-2.1
Anesthesiology	218.1	-2.7
Pathology	182.5	-7.5
Other	158.2	-6.8
Employment Status		
Self-employed	210.2	-3.6
Employee	148.2	-1.7
Independent contractor	168.5	5.4
Census Region		
Northeast	171.1	-5.7
North Central	189.3	-4.9
South	192.8	0.5
West	172.7	-6.2

Net Income (Average)

Median physician net income (in thousands of dollars) after expenses before taxes for non-federal physicians, by specialty, employment status, and census region, 1994.

	1994	% change from 1993
All physicians	$150	-3.8%
Specialty		
General/family practice	110	0.0
Internal medicine	150	0.0
Surgery	219	-2.7
Pediatrics	110	-8.3
Obstetrics/gynecology	182	-9.0
Radiology	220	-8.3
Psychiatry	120	0.0
Anesthesiology	200	-9.1
Pathology	152	-10.6
Other	150	0.0
Employment Status		
Self-employed	176	-4.9
Employee	130	-4.4
Independent contractor	140	-4.1
Census Region		
Northeast	140	-6.7
North Central	160	2.6
South	160	0.0
West	150	-6.3

Source: AMA Socioeconomic Monitoring System 1994 and 1995 core surveys of nonfederal patient care physicians excluding residents, Chicago, 1996.

Capital Deals Can Make Strange Bedfellows

By James T. Darnell

Many varieties of capital partners are available to physicians. Each of these sources of capital offers its own niche that varies according to its business plan and philosophy. For most physicians, evaluating the myriad potential partners can be frustrating and time consuming. But physicians should make the time necessary because proper preparation before making a decision to enter a partnership will increase the likelihood of identifying an appropriate partner. Also, it will decrease the time needed to negotiate an agreement.

Studies over the past eight years have shown that only one-third of all the mergers and acquisitions that physicians have made with capital partners are successful financially, despite their popularity. Among the various reasons offered for the high failure rate are these: doctors choose the wrong partner, pay the wrong price, and do not understand how productivity changes when managed care and capitation formulas go into effect. In addition, physicians may merge at the wrong time, integrate too quickly, or hold out too long for independence. In fact, most medical groups do not have a formal business plan and therefore expect their capital partners will supply the needed funds if an untenable decline in income results. Often when income declines, doctors have little or no understanding of how or why revenue has fallen. Physicians frequently think of capital partners as banks that will continue to provide financing during the difficulties inherent in moving to managed care.

Avoiding Surprises

Doctors seeking capital may be reminded of a quote from George Bernard Shaw, who said, "There are two sources of unhappiness in life. One is not getting what you want; the other is getting it." Those physicians who lack capital are unhappy for one reason; and those who get it are unhappy for another reason.

To avoid unpleasant surprises after finding a capital partner, physicians need to develop mutually beneficial partnerships that are grounded in good business practices. To do so, physicians should take the following steps:

- Have an objective due diligence assessment done on your practice or group. An objective outsider will help to insulate you from being deluded by unsupported speculations or personal bias regarding your financial condition. For example, the medical group that approaches a capital partner with the attitude that the partner should "make me an offer," does not understand the expectations of a hospital, a management service organization, or a publicly traded company interested in growing market share. Before contacting any interested parties, have a written business plan that clearly illustrates your financial and practice strengths, your potential for managed care growth, and your ability to generate revenue.

James T. Darnell, CEO
Alliance of Healthcare Advisors Inc.
Lafayette, Calif.

- Become a student of reimbursement. Identify the level of managed care penetration in your market and educate yourself on compensation and distribution formulas. Doing so will enable you to negotiate rates, identify costs, and manage contracts more efficiently. For example, the medical group that accepted an income guarantee from a hospital became complacent about productivity. The physicians in this deal erroneously thought they could close their practices to new patients after accepting prepaid contracts. This error resulted in continuous battles between the physicians and the hospital over productivity and income. Since the hospital wanted the physicians to increase capacity, the partners did not have their incentives aligned. Capital to stabilize income requires physicians to remain productive, and manage issues of excess capacity by becoming more efficient. As managed care revenue rises, efficiency is critical.
- Understand your partner's mission. Ask your partner for a copy of its business and marketing plans. Require that your partner provide verifiable data about the organization. Ask who owns the capital, who the partners are, what is the expected return on investment, and what are the criteria for changes in the management of your practice over time. Physician figureheads and CEOs in management companies are seldom experienced in the clinical and business efficiencies that need to be implemented to meet the expectations of both partners. For example, companies that have the ability to buy medical practices manage them with business accounting principles. For them, it is easier to fire a physician rather than apply the practice management principles necessary to help a medical practice grow and be productive as the number of managed care lives increases.

Identify the level of managed care penetration in your market and educate yourself on compensation and distribution formulas. Doing so will enable you to negotiate rates, identify costs, and manage contracts more efficiently.

Preparation to accept financial opportunities begins when physicians understand their own circumstances and determine whether a capital partner offers real advantages in implementing their business plans. ■

For more informaiton, call the Alliance of Healthcare Advisors Inc. at 510/284-6200.

The Medical Center as a House of Cards

In mature managed care markets, hospitals in overbedded communities are like houses of cards. They can collapse quickly without a capital partner. A stunning example of this problem is the prestigious New England Medical Center in Boston. The region's oldest hospital and the main teaching hospital of the Tufts University Medical School is in danger of disappearing.

Last year, its inpatient visits dropped 15%, it lost $2.3 million; and it laid off 800 employees. Seeking a capital partner, it has met with Caritas Christi, a network of Catholic hospitals which may not have enough money; Boston University Medical Center, which was tied up with its own merger discussions with Boston City Hospital; Columbia/HCA, which may not see enough profit from an academic hospital in an overbedded community; and Partners Healthcare System, the parent company of Massachusetts General and Brigham and Women's, which would have little use for NEMC other than as real estate, according to *The Boston Globe.*

Comment: In the game of academic-hospital musical chairs, the New England Medical Center needs a capital partner before the music stops. Perennially listed among the nation's best hospitals, this 200-year-old institution may collapse for want of capital, demonstrating that, regardless of stature, no institution is immune from market forces. The market wants lower costs, a broad primary care base, appropriate-care sites inside and outside the hospital, and services spread across a broad geographic area. No more and no less. ■

Academic Health Center Seeks Success in Merger with Hospitals

When the Academic Health Center at the University of Minnesota found itself in deep trouble in a managed care environment, it turned to an academic with entrepreneurial experience to be its provost. It hired William Brody, MD, a radiologist who had served as a professor and director of the department of radiology at Johns Hopkins University, according to the *St. Paul* (Minn.) *Pioneer Press.*

Previously Brody had been president and founder of Resonex Inc., a privately held company formed to build and market magnetic resonance imaging devices. One Friday, after the company had landed three new customers and was months away from shipping its huge magnets, he was told the machines didn't work. He consulted with his engineers, and they worked nonstop all weekend to fix the machines and came up with a solution, *The Pioneer Press* said.

Similarly, the health center was in trouble financially and had few options when Brody took over in 1994. Brody turned to an unlikely solution, a merger with Fairview Hospitals, a community hospital chain in Minneapolis. Announced in November, the merger is much like the action of a man who jumped from a burning oil rig into a raging sea, Brody said. He chose possible death over certain death.

At Hopkins, Brody had chaired a committee to restructure the medical center to meet the challenges of managed care and learned that the marketplace looks at health care strictly as a business. This experience, coupled with his stint as an entrepreneur at Resonex, which had run into the buzz saw of market reform and was sold to GE, led Brody to conclude that the University of Minnesota was better served by concentrating on research and teaching and let the Fairview Hospitals run the hospital business, the newspaper said.

Comment: Executives at many academic medical centers are concluding that they cannot do three things well: run the hospital business, conduct research, and teach. To survive, these centers are going outside academia to find capital, business skills, and managed care expertise. The threat of imminent economic demise has a way of concentrating attention on limited options. ■

Continued on page 16

HMO Backlash Gains Momentum

As more Americans are enrolled in managed care, many are losing patience with managed care strategies that limit care. Studies show that HMOs are enrolling 14,000 Americans a day, but Americans' ire has led legislators in 40 states to introduce some 400 bills since January to curb managed care initiatives, according to an Associated Press article March 15. For comparison, only 239 such bills were proposed in all of last year. Among other requirements, these bills would force managed care plans to pay any doctor or hospital a participant uses, allow plan members to see specialists without prior approval, and pay for emergency room care even if the emergency were imagined.

In California, organizations representing more than a million Californians are seeking to qualify an initiative for the November ballot that would end interference of HMOs and other health insurers between doctors and patients, according to Business Wire, a news service. Titled the Health Care Consumer Protection Act, the initiative would require HMOs and other insurers to maintain minimum safe staffing levels and to disclose the portion of fees going to profits and overhead instead of to health care. The drive is being sponsored by Health Access, a coalition of more than 200 consumer groups; the Service Employees International Union, which represents 300,000 Californians; and Neighbor to Neighbor, a citizens group with 50,000 members.

Comment: Many national trends begin in California, and the fact that managed care was started in California more than 50 years ago lends credence to this initiative. ■

No Easy Answer Seen in Issue of Needless ER Visits

Conventional wisdom says that one of the single biggest sources of waste in health care is the hordes of anxious patients seeking routine care in emergency rooms. In one year, emergency rooms will get 90.5 million visits for such non-emergency conditions as sore throats, ear aches, and ankle sprains.

On the theory that these patients could be seen at much lower cost in physicians' offices, the Kaiser Permanente Medical Group, an HMO in Oakland, Calif., introduced a co-payment of $25 to $35. As a result, ER visits dropped by 15%, according to the *New England Journal of Medicine*, March 7. Calculating that routing patients to primary care doctors instead of the ER would save $5 billion to $7 billion annually, many managed care plans require co-payments, prior authorization, and telephone triage to curb emergency room use.

Yet, Robert Williams, MD, an ER physician at the University of Michigan School of Public Health, in Ann Arbor, said in another article in the same issue of the journal that the true cost of a nonurgent visit is about $62, comparable to that of a doctor's office visit and much lower than widely expected. Moreover, after subtracting the high fixed costs required to keep an ER open, he said, the actual cost of one additional routine visit is $25. The problem is that hospitals charge about twice what it costs to deliver ER care because insurers reimburse for about half of the charges. In other words, the idea that significant savings are possible from cutting ER visits is not supported by the evidence, Williams said.

Comment: In 1994, national ER visits fell 2.2%, after rising each year for the 10 previous years. In the West, where managed care penetration is greatest, ER visits fell 14%, the journal said. The downside of such curbs is that ER physicians are accumulating anecdotes about commercial HMOs refusing to pay for critical conditions—such as broken necks or a patient in a coma—in which the patient is in no condition to seek prior authorization. ■

More Fuel For Managed Care Growth

By the latest AMA count, there were 684,414 doctors in the United States, an increase of more than 14,000, or 2%, over the year-earlier figure. The figure is based on a survey completed in January 1994. The number of women physicians continues to grow, the AMA said, increasing by 6% to 133,263 in one year. Women now account for 19.5% of all U.S. doctors.

Comment: The growth of managed care has created a surplus of physicians. Some observers say that by 2000, we'll have 150,000 too many doctors, most of them specialists. The excess of physicians is most acute in major cities with teaching centers, such as Boston, Chicago, New York, Washington, San Francisco, and Portland, Ore. Because women are more likely to accept salaried positions, are more likely to be in primary care specialties, and are more likely to join groups, they prefer managed care over male physicians, the AMA said. ■

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