

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

CONTENTS

Features

Commentary
Global Pricing Due for
Episodes of Care 3

Strategy
Capital Sought Through
Debt and Equity 6

Book Review
Is Managed Care
Evolution Inevitable? 11

Interview
Successful MD, Solo
Practitioner Seeks
Law Degree to Help
Preserve Medicine 13

Departments

Editorial
Why Can't a Woman
Be More Like a Man—
in Earnings? 2

Capital Ideas
PPMCs Pull Out of
Capital Markets 10

Profit From Subcapitation Requires Patient Access, Limits on Procedures, Tests

A physician group enters into risk-sharing arrangements with health plans when it accepts prepaid, per patient, per month reimbursements, a compensation system known as capitation. The group's members, including specialists, share that risk when they agree to accept subcapitated payments for treating a specified population of patients, regardless of how much service they provide. Determining how much subcapitation to pay individual physicians—or distributing the risk—is a complicated process, say health care compensation analysts, that requires data, expertise, and a willingness to control treatment costs.

"When an organization—regardless of whether it is a health plan, hospital, or physician group—makes a capitated payment to a specialist department, the payer has limited its risk. This is so because the organization pays the specialist a set amount of money regardless of how much service the specialist provides," says Susan Cejka, president of Cejka & Co., physician compensation consultants in St. Louis. "So, the organization transfers risk to the specialist. To make a profit under subcapitation, logic would tell you to lock the doors and go to Florida. But then, you'd have angry patients and malpractice suits."

The purpose of subcapitation is to encourage cost savings through the modification of physician practices, experts say. Success under subcapitation involves nearly unlimited patient access, which results in a high degree of patient satisfaction, while limiting expensive tests and procedures, when appropriate, experts say.

"If the physicians' goals are patient satisfaction and earning a decent living, which I assume are the goals of every physician, then physicians need to change how they behave under subcapitation," Cejka says. "It is a different world from fee-for-service, where physicians are paid more for doing tests and procedures. Under subcapitation, physicians should want to provide high access but with a low utilization of procedures and tests. Utilization uses up money in the fixed pool of money available."

James Nuckolls, MD, medical director of Carilion Healthcare Corp., in Roanoke, Va., says that because both health care and how physicians are paid are changing, doctors need to practice cost-effective medicine. Carilion is a medical group of about 170 primary care physicians which subcontracts with specialists on a capitated basis. "Physicians who were used to being paid for piecework have to learn how to think in terms of controlling health care costs," he says. "That is creating some tension among physicians."

Not controlling costs can be financially devastating under subcapitation, say Cejka and others. "The problem for the specialists is that if they continue their fee-for-service practices, they will probably use up the entire annual capitated payment in about nine months. What you have then is a group of specialists who are furious, who think the cap is too low," Cejka says. "But the problem often is not that the cap was wrong. The problem is that no one showed the specialists how to make a profit. Nobody gave them an education about

(Continued on page 8)

Why Can't a Woman Be More Like a Man—in Earnings?

In the 1964 movie *My Fair Lady*, Professor Henry Higgins asks, "Why can't a woman be more like a man?" Based on the 1912 play *Pygmalion* by George Bernard Shaw, the movie explored social order in Shaw's London.

Undoubtedly, much progress has been made during this century in the area of women's rights. Even so, as we approach the end of the millenium, many women are still asking, "Why aren't I earning as much as my male colleagues?" In medicine, for instance, why isn't a woman earning as much as a man who is doing the same type of job? Why is she unable to attain the high positions that men attain? Many might answer that women aren't locked out of the opportunities available to their male colleagues. And they could be right; but the reality is those opportunities are usually available to women who forgo—or delay—marriage and childbearing. The women who seek to raise children and pursue a career in medicine usually find it impossible to earn as much as men.

Women hold few of the positions for deans and tenured faculty members, and their numbers are sparse in surgical specialties, according to *The New York Times*. Women earn only about 66% of the salary that men earn (\$155,590 versus \$273,690), and there are fewer women in high-paying specialty positions, the *Times* has reported (see table, page 16). What's more, women physicians' income could also be affected because they may spend more time with patients, rather than on revenue-producing procedures.

The composition of the traditional American household may explain some of the discrepancy in earnings. Many male physicians' wives have elected to stay home and raise children, but fewer female physicians' husbands have chosen to do the same. As a result, male doctors can work late and earn more, while the children are being cared for.

In choosing to raise children rather than practice—or to try to do both—women physicians may be away from the practice of medicine for years, thereby missing out on specialty developments and career advancement. "Basically the picture is bad," says Wendy Chavkin, editor of the *Journal of the American Women's Medical Association*. "There are still issues about career pathways that are the least bit off track, like taking time off for childbearing."

That picture may be changing. Women are gaining in numbers, pay, and rank in the medical profession. For example, Bernadette Healy, MD, was the administrator of the National Institutes of Health during the Bush administration, and Nancy Dickey, MD, is the current president of the American Medical Association. And women currently account for 45% of all medical students; are in high demand as pediatricians, obstetrician-gynecologists, and breast surgeons; and are favored by other women for their compassion.

Perhaps one reason the picture is changing is due to an increase in patient demand. "The minute we put a female physician in a practice, the appointment book becomes fully booked," says Myron L. Weisfeldt, MD, chairman of medicine at New York Presbyterian Hospital.

If this increase in demand for their services results in a corresponding increase in income, women physicians may soon be singing, "I'm glad that a woman can't be more like a man." And if male physicians' income has a corresponding decline, their refrain could be: "Why can't a man be more like a woman?"



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Global Pricing Due for Episodes of Care

By Douglas W. Emery, MS, and Richard L. Reece, MD

The ground beneath the current managed care system is quaking. The irony of this statement is that the principal technique considered essential to managing care—the effort to integrate health insurance with health care—lies at the epicenter of the disturbance. The functions of health insurance and health care cannot be integrated, and the attempt to do so has caused physicians and consumers to rebel against the coercive strictures on patient choice and on physician freedom flowing from such a crude economic assumption.

Managed care is based on the assumption that health care can be integrated with health insurance, and then packaged into one all-encompassing system that competes with other systems on the basis of price and quality. Such systems include HMOs, PSOs, integrated delivery systems (IDSs), and physician practice management companies (PPMCs), and represent concepts such as vertical integration, capitation, and population management (the concept of putting physicians at financial risk for the health status of an enrolled population). Over the past decade, these systems and concepts have dominated conventional health care markets, suffusing the industry with the widespread belief that there is only one orthodox pathway to implementing managed care.

Signs of the Times

There is no doubt that managed care was a shock wave that roused the medical industry from its fee-for-service slumber, and it has been somewhat effective at controlling costs. But as a valid and economically sustainable practice, it is permeated with flaws. Yet some of the flaws in managed care could be eliminated under a system that represents a fundamental shift so that the provi-

sion and reimbursement of care are accomplished through integrated episodes of care.

The dysfunction in managed care is not a temporary blip on the screen, nor is it the price managed care must pay for being the noble agent of change. The deep, systemic, and wholly intractable problems under the present configuration include the following:

- Limited choice
- One price for all care
- Forcing integration of insurance and care
- Shifting risk

Limited choice. In 1985, experts predicted that within 10 years, HMOs would put

to be nearly universal. Instead, multiple surveys show that capitation is still fairly uncommon, representing only 9% of overall physician and hospital reimbursement. Global capitation, which many predicted would be the ultimate payment strategy for managed care, has been hovering at only 6% of national IDS income, and shows no signs of budging.

For several reasons, capitation is inherently inefficient as a means of purchasing medical services. On the supply side, it asks providers to become insurers, adopting a business logic wholly at odds with the logic of care. Moreover, it is impossible to derive

Some of the flaws in managed care could be eliminated under a system that represents a fundamental shift so that the provision and reimbursement of care are done through integrated episodes of care.

PPOs out of business. Instead, PPOs are growing faster than HMOs, according to the 1998 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans by William M. Mercer Inc., benefit consultants, in New York. Consumers simply prefer PPOs because they represent less restriction on the choice of providers. In fact, the call for greater provider choice and enhanced access to specialists has forced HMOs to offer point-of-service plans and open-access options, both of which increasingly make HMOs look like PPOs.

Commenting on this trend, R. Channing Wheeler, CEO of Uniprise, a division of UnitedHealth Group, in Hartford, Conn., glumly declared recently in *The New York Times*, “The market is telling us the HMO is on the decline. It’s a product whose time has come and gone.” Last year, HMO membership dropped for the first time since the HMO Act of 1973 was passed, according to published reports.

One price for all care. Industry analysts had predicted that by now, capitation was

one efficient price for an undefined number of care process permutations. On the demand side, it forces patients to abide in an exclusive monopoly of the payer’s choice, since it is impossible to capitate an open panel where patient choice is sovereign. One is hard pressed to find any markets outside of health care that so disenfranchise consumers.

Richard Wesslund, managing director of BDC Advisors, health care consultants in San Francisco, has said, “We have a consumer and purchaser backlash regarding accountability, value, access to care, freedom of choice—all problems emanating from capitated systems.” Writing about capitation in the *Healthcare Forum Journal*, J. Daniel Beckham, says that the organizations and physicians who have invested heavily in this system of reimbursement “are poised to have their ships wrecked on the rocks of market reality.” Last year, PPMC—originally designed to embrace capitation—found out how right Beckham is: The aggregate value of the

(Continued on page 4)

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(Continued from page 3)

top 10 publicly traded PPMCs plummeted 68%, from \$11.6 billion to \$3.7 billion. Beckham is president of the Beckham Co., physician and hospital consultants, in Whitefish Bay, Wis, and a member of the editorial Advisory Board of *Physician Practice Options*.

Capitation does not allow for an efficient tracking of the resources required to treat clinically homogeneous episodes of care.

Forcing integration of insurance and care. By this time in the evolution of managed care, experts had predicted that IDSs would have dominated many large urban markets. Instead, we have entered into the "era of disintegration," says Jeff Goldsmith, PhD, president of Health Futures Inc., consultants in Charlottesville, Va. Examples of integrated systems that are losing money, restructuring, or spinning off their physician components abound. They include Swedish Health System and Group Health Cooperative of Puget Sound, both in Seattle; Sutter Health Systems in Sacramento; Presbyterian Health Systems, in Dallas; and the Allegheny Health System, in Pittsburgh.

Shifting risk. Whether discussing PPMCs, HMOs, IDSs, or the concept of population management, all assume an overly simplistic notion of risk. Managed care executives believe risk is a commodity one economic entity (payers) can shift to another economic entity (physicians), so long as both are agreeable. In fact, different types of risk result from different types of economic activities, and may not be so easily or appropriately shifted. Consider, for example, two forms of risk: probability risk and technical risk.

Probability risk is the risk associated with pricing future demand for medical care; it's the traditional economic activity of insurance. Probability risk governs the price that one economic agent, the insurer, exacts from another economic agent, the insured, to offer indemnification against future, costly events before those events occur. Other names used for probability risk are actuarial risk, insurance risk, population risk, and risk

of occurrence.

Technical risk, on the other hand, is the risk associated with pricing a product according to the cost of all the components required to produce the product or service. A producer sets a price, then assumes the risk of efficient production: If the compo-

nents cannot be managed and used efficiently, then the cost of production will exceed the product's price.

Inefficient Tracking

Capitated systems are unsuccessful at combining these two types of incompatible risk. Since capitation sets a premium price, and not a product-line price, it does not allow for an efficient understanding or tracking of the resources required to treat clinically homogeneous episodes of care. The probability risk component in capitation requires pricing care for an entire population as a statistically determined, actuarial abstraction. But physicians do not care for abstract populations, they care for real patients in real time, one episode at a time. Furthermore, because capitation generally reimburses only the professional component of the episode, it misallocates the technical risk component by ignoring the cost of other services, such as hospital care. Thus, capitation forces providers to reconcile both clinical outcomes and cost effectiveness against an intangible actuarial price, which does not reflect the costs of treating a particular class of care episodes but rather reflects an estimate about the indeterminate future of a population.

Global Prices

While probability risk applies to health insurance and the orthodox forms of integrated care, such as HMOs, PPOs, and IDSs, technical risk is associated with globally priced clinically integrated episodes of care. The episode of care was first suggested by Jerry Solon in 1967. Since then, a rather significant body of scientific literature has built

upon his pioneering work. Today, an episode of care could be defined as the complete, self-contained sequence of medical interactions between a patient and providers of health care services in pursuit of a defined clinical objective over a specified period of time. A provider is reimbursed for treating an episode of care according to a global fee; providers are paid a negotiated rate for the treatment of a given injury or diagnosed condition. This case rate is negotiated based on a prepared budget that accounts for all aspects of treating the injury or disease from beginning to end. Global fees can be applied to acute episodes (such as anterior cruciate ligament repairs) or to episodes designed to prevent illness in simple lump-sum payments. They can be applied to chronic episodes, such as diabetes mellitus, by using periodic maintenance payments.

Globally priced episodes of care efficiently allocate risk to physicians in a way that the physicians are technically competent to manage, since they can assume control for a given episode of care and can price this care accordingly. Moreover, this approach is intrinsically collaborative in that it requires physicians and hospitals to cooperate in defining episodes of care, delineating the resources required to address each episode, and agreeing on a fair price structure. All parties have the incentive to use resources efficiently so that the cost of care does not exceed the negotiated price.

Global Delivery Systems

Managed care must develop new organizational forms to accommodate the treatment and reimbursement of episodes of care. Of particular interest to physicians is the concept of a global delivery system (GDS), a physician-driven system designed to organize the delivery of care around disease states or procedures. Using data from an associated hospital, for example, a cardiology group could develop a global fee for coronary artery bypass, an orthopedic group for hip replacement, and a general surgery group for gallbladder surgery. Generally, each group of specialists would be responsible for designing 15 to 20 common global fees. Organizing according to episodes of care means that a GDS can deliver care as simple as globally priced carpal tunnel surgeries for a workers' compensation plan, or

care as complex as managing all patient care under an episodic format.

The attraction is that, unlike an IDS, a GDS is designed to manage technical risk, not probability risk. The physicians and hospital administrators who form a GDS can derive an intelligent, information-based price estimate for the treatment of each defined episode of care based on the cost of the required components of care, and can negotiate these prices with insurers. Subsequently, insured patients, who receive coverage per specific episode of care, could choose a GDS when treatment is needed based on various factors, such as quality and geographic proximity, and may pay an out-of-pocket cost that varies with the competitiveness of GDS prices. Thus, patients are given the ability to choose when and where they receive their care with as little regard as possible to their choice of insurer.

Less Capital Needed

Global fees are a form of direct contracting between physicians and payers that do not require an HMO or a PPO to coordinate elaborate population-based contracts. Because a GDS is not organized around an insurance component, it does not have to raise tremendous amounts of capital. Contrast this system with IDSs and PSOs, which not only must assemble all the delivery mechanisms needed to cover a fully insured population—including hospitals, primary, specialty, ambulatory, ancillary, and skilled nursing facilities—but must also meet regulatory requirements, clear statutory reserve hurdles, and create an administrative superstructure needed to run such a complex operation. A GDS merely needs to organize the delivery mechanisms required for each episode of care it undertakes. It allows hospitals and physicians to align themselves into one economic entity without a high capital cost, and it places the physicians where they want to be: in a position of directing patient care.

Diverse payers, such as the federal Health Care Financing Administration, and Anthem Health Plans, the large health plan in Indianapolis, have begun to reimburse care according to globally priced episodes. HCFA is currently undergoing its third demonstration project, and by nearly all measures, it has been a resounding success.

Under the project, HCFA has contracted for only a few select episodes, including coronary artery bypass graft (CABG) surgery and hip replacements, with seven hospitals (St. Joseph's, Atlanta; Boston Medical Center; St. Joseph's, Ann Arbor, Mich.; Ohio State University Hospital, Columbus; St. Luke's, Houston; Methodist, Indianapolis; and St. Vincent's, Portland,

experiment in managed care that's proving to be consistently successful. In contrast, attempts at capitating Medicare HMOs have been dismally unimpressive. In 1998, managed care organizations yanked HMOs out of 97 markets, leaving 440,000 disenrolled Medicare beneficiaries, according to *The Wall Street Journal*.

As documented in *The Great Product*

"The market is telling us the HMO is on the decline. It's a product whose time has come and gone."

—R. Channing Wheeler, Uniprise

Ore.). The demonstration project has already saved Medicare \$50 million, due to fee discounts of 3% to 5%. In many instances, the physicians and hospitals are earning more money, profiting from higher volume and fees than they would gain from HMOs or other insurers as well as lower costs due to enhanced efficiencies. Similarly, Anthem's global pricing scheme for cardiology services has saved over \$15 million in four years with demonstrably improved mortality rates: Survival rates for inpatient CABG surgery increased 7% over two years.

The New Managed Care

HCFA has the authority to expand the program to 95% of all DRGs. The only barrier to expansion is that the payers with whom HCFA contracts do not maintain administrative structures that can handle global fees. New companies are forming to create the global payment systems required to overcome the limitations of the old fee-for-service transactions systems. Before its Wall Street implosion, Oxford Health Plans, in Norwalk, Conn., had been spending millions to develop such a system, but other companies are building similar systems, including Applied Medical Software, in Pennsauken N.J., and Health Partners Inc., in Athens, Ga. In addition, few provider organizations are capable of handling global fees for integrated episodes, forcing HCFA to limit its next round of expansions to PHOs, which are the most similar in configuration to global delivery systems.

Providing global reimbursement according to episodes of care is the one Medicare

Enterprise: Second Theory of the Case, a publication from the Health Care Advisory Board, in Washington, D.C., some niche-oriented companies are forming or reconfiguring their delivery systems to treat and finance episodes of care.

Physician-Friendly

Established companies reconfiguring around the product line or episode concept include the Mayo Clinic, Columbia/HCA, and HealthSouth. New companies include Accordant (rare diseases), Matria (high-risk obstetrics), Intensiva (subacute care), Pediatrix (neonatal intensive care), Integramed (gynecology), Raytel (cardiac care), AmSurg (office-based surgery), and Diabetes Treatment Centers of America (diabetes care). In the last two years, over \$2 billion in venture capital has been invested in new companies specializing in managing and developing information systems for such discrete episode of care providers.

Global pricing for episodes of care is a powerful, proven, physician-friendly, and patient-centered model of managed care that resolves most of managed care's current problems. Integrating health insurance with health care through a top-down regime that compresses patient choice, physician choice, revenue, and fiduciary roles is no longer tenable. In its wake, however, a new form of managed care will arise based on self-organizing systems interacting in choice-based, information-rich environments in which price competition exists in both the market for health insurance and the market for health care. ■

Capital Sought Through Debt and Equity

Managed care has forced physicians to practice in larger groups. These groups need money to purchase equipment and real estate, to hire administrators, and to fund acquisitions and mergers. Until recently, physicians had a relatively easy time getting money from potential suitors, such as physician practice management companies. But the public PPMCs that had been spending cash most liberally to attract physicians ran into deep financial trouble last year, and many have yet to recover.

The recent financial problems of PPMCs—such as MedPartners of Birmingham, Ala., which is selling its physician practices—and the falling profits of many HMOs, mean fewer venture capitalists are willing to invest in physician practices, says Daniel M. Cain, chief executive officer of Cain Brothers, investment bankers and capital advisers in New York, a company that works primarily with physician groups. “Every time bad financial news about the health care industry hits the newspapers and the stock value of a PPMC falls even further, doctors find it harder to get capital, especially from venture capitalists,” says Cain.

While one source of financing may be constricting, other entities remain viable for physicians seeking financing, Cain says. “These entities can bring with them more than an infusion of capital,” he says. “In many instances, these partners also offer savings through the power of group purchasing and their management skills. The array of partners includes traditional sources, such as hospitals and private investors, but the spectrum of investors

today also includes insurers, venture capitalists, and hospital management companies.” What’s more, some publicly traded PPMCs are continuing to negotiate with physicians, offering access to capital, among other benefits, in exchange for long-term deals, and some privately held PPMCs also are seeking to work with physician groups.

The best capitalization option for individual physicians and group practices depends on the costs of capital and the effect the capital acquisition strategy will have on how their practices will be run, says Cain.

“The one constant in a changing health care marketplace is the need for capital,” says Cain. “Regardless of the size of a physician group practice or network, access to capital is critical if the practice is to compete successfully.” Typically, physicians acquire capital by borrowing money (also known as debt financing) or through equity financing, which is selling part ownership of a practice to other physicians, hospitals, a health care organization, or other investor. They also might use a combination of the two, Cain explains.

“Access to capital is essential to growth whether it is obtained through private or public sources,” says Douglas Goldstein, president of the health care investment firm Medical Alliances Inc. in Alexandria, Va. “Capital enables an organization to develop management information systems infrastructure, to integrate with or acquire other physician groups, to extend its geographic market, to fund the development of new products and services, to market services, and to create value and wealth for its employees and owners.”

Physicians needing capital to expand their practices often have used personal resources and borrowed from commercial banks while pledging personal and practice assets to secure a loan, Cain explains. But in recent years, the consolidation of physician practices and the formation of large physician networks have forced physicians establishing or acquiring practices to investigate other capital sources. “With the array of financing mechanisms available, the question becomes which to choose,” says Cain. “Both debt and equity financing are attractive alternatives for capitalization, but each has advantages and disadvantages that a group practice or network must carefully consider before deciding on a strategy to pursue.”

Debt Financing

For a large physician group practice or network, debt financing often may be the cheapest source of capital available, says Cain. But interest rates on debt can range from about 5% to more than 20%, depending on the credit profile of the borrower. As a capital formation tool, debt financing requires security or collateral for the lender and a credible credit profile of the borrower that shows the group’s market position versus that of its competitors, its revenue, and its earnings. Debt financing also requires timely payments.

For group practices, debt financing can be particularly useful for providing working capital, for acquiring income-producing businesses, and for purchasing real estate and equipment, Cain says. Debt usually carries with it a fixed term that can be structured to coincide with business cycles. For

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—Douglas Goldstein, Medical Alliances Inc.

"In choosing the appropriate capitalization strategy, a physician group practice or network must balance its financial needs with its managerial and ownership goals."

—Daniel M. Cain, Cain Brothers

instance, debt can be used as a short-term financing vehicle (for a period of several months to a year) to ease periods of negative cash flow, such as during planned growth phases or when business is slow.

Properly structured, debt can be a flexible tool for acquiring income-producing businesses, Cain says. A growing physician network, for example, can structure an intermediate-term financing arrangement for two to five years to fund new physician practice acquisitions. "As the newly acquired practices generate revenue for the network, the revenue can be used to redeem the outstanding debt," he says. Long-term debt can be used to finance equipment, and the term of the debt could be matched to the expected useful life of the equipment.

"An advantage of debt financing is that a network's principals retain ownership and control of the organization, which is not true of equity financing," Cain says.

Debt financing as a capitalization strategy has disadvantages, too. For example, it often carries restrictive contract terms, such as the required use of group equity as collateral. "No matter what the form or source, debt financing always requires that the borrowers have a substantial amount of equity in the network or group," Cain says. "The greater the amount of equity the borrower has, the greater will be the lender's willingness to offer lower interest rates and less restrictive debt covenants."

Equity Financing

Most physician group practices are financed initially with personal equity, that is, money raised through debt financing, usually by the group's original owners. "This is true for the sole practitioner as well as for physicians who join together to form a large group practice," Cain says. "As practices grow and become members of networks, the need for additional capital increases. The most obvious and flexible source of this capital is investor equity," which requires the sale of part ownership in the practice.

Investor equity is permanent capital that

does not need to be repaid. Unlike financial entities, such as banks that provide debt financing, equity investors generally are not seeking monthly or quarterly repayments on their investments. "The ultimate goal of equity investors is to earn an attractive rate of return on their ownership investment and expand their own wealth," Cain says. "Consequently, they will invest in vehicles that have the potential to increase earnings rapidly."

To attract equity investors, a physician group practice or network must show that it will grow. To do so, it must meet three basic requirements for equity investors: sustainable growth, a high return on the investment, and a decisionmaking role in the organization. Three sources of investor equity are available to practices or networks: strategic partners, such as hospitals; venture capitalists; and the public stock markets, Cain says.

Hospitals and Health Systems

Hospitals and health systems are likely strategic partners for physician group practices and networks. They often are willing to invest capital to integrate with physician practices, says Cain. "Strategic partners tend to be less demanding in terms of the relationship between dollars invested and the percentage of ownership and control acquired," Cain explains. "However, a hospital's or a health system's primary concern is its own net income, rather than the growth in earnings of the physician group practice or network."

In forming a strategic partnership, a physician group may need to decide whether to join a nonprofit or for-profit hospital or health care system. A major difference between the two is that for-profits have greater access to capital through the equity markets than nonprofits do, says Cain. "Greater access to capital is likely to translate into a greater ability to spend money on technology that will enhance the competitive advantage of the physician practice or network," he says. "Better access

to capital also should allow for-profit entities to create a larger, economically linked, integrated network faster than nonprofit entities could."

Venture Capitalists

As a source of equity capital, venture capitalists are likely to be more demanding than a hospital or health system would be. Venture capitalists may want to have an ownership stake in a group in return for their investment and may want to have some control over decisionmaking, Cain says. "Venture capitalists will want a significant amount of equity ownership in return for their investment," he says. "For instance, investors typically seek 40% to 60% ownership in the group practice or network, which often translates into decisionmaking power through representation on the group practice's board of directors."

Venture capitalists invest only in organizations that have sound business plans, experienced management teams, growth potential, and the prospect of being attractive to the public stock market, Cain says. "Their goal is to earn their investment back over a period of two to eight years," he says. "They often view their job as one of preparing a physician network for its initial public offering of stock. To that end, venture capitalists will demand one or more seats on the board of directors and will actively participate in the network's decisionmaking and governance processes. This active participation dilutes the network's ownership interest and governing control and, therefore, may not be an appealing alternative," he says.

"In choosing the appropriate capitalization strategy, a physician group practice or network must balance its financial needs with its managerial and ownership goals. The capital structure chosen should enable the practice or network to build a strong organization that delivers the highest level of clinical care possible," says Cain.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

(Continued from page 1)

what changes they need to make. They aren't told that the goal in capitation is to have high patient satisfaction without using extensive, costly tests and procedures. No matter what type of specialist you are, the goal is high patient access and low utilization of test and procedures."

probably contact capitation," she says.

Panelized Methods

Panelizing is the assignment of patients into demographic groups, evaluating the degree of risk involved in treating those groups, and distributing a subcapped payment

\$12 per member per month (PMPM); that is, \$10 per member, times 2,100 members, times 12 months annually, or \$252,000 a year," Cejka explains. "That is the fixed revenue stream, and it is paid for providing care to 2,100 patients. It is the physician's responsibility to care for that panel of patients effectively and efficiently."

For many PCPs and specialists, the panel's size is refined by age and sex. "Adjustments for age and sex are important. By making those adjustments, the average internist may have only 1,500 paneled lives because he or she may spend more time with older patients, while the average family practitioner may have 2,300 lives," Cejka continues. "The age- and sex-adjusted panel is further refined through a point count. We know, for example, that a 15-year-old boy is worth about 0.4 of a point because a boy that age usually won't get sick and won't go to the doctor often. So you can have 2.5 times as many 15-year-old boys in your panel as you would 35-year-old women, who are given a point count of one when their risk of pregnancy is factored in."

Most physician groups determine their own point counts, based on a historical review of standard patient billing codes, such as current procedural terminology (CPT) codes, Cejka says. "We recommend that each of our clients does its own point count because every patient population is different," she says.

Demographics

Using the example above, in a group receiving \$40 PMPM from a health plan, \$10 would be allocated to PCPs, leaving a pool of \$30 PMPM to be divided among specialists. Many nonprocedural specialists also would be assigned a demographically point-based panel of patients. "But the difference is that rheumatologists, for example, would get a different cap rate for a different panel of patients," Cejka says. "That would also be true of other specialists, depending on the demographics of the patients in their panels. So, within a multispecialty group, groups of specialists are panelized based on their demographics and how many expensive procedures they normally do."

Disciplines requiring a high number of expensive procedures often are not panelized, but are compensated through contact

"If the physicians' goals are patient satisfaction and earning a decent living, then physicians need to change how they behave under subcapitation."

—Susan Cejka, Cejka & Co.

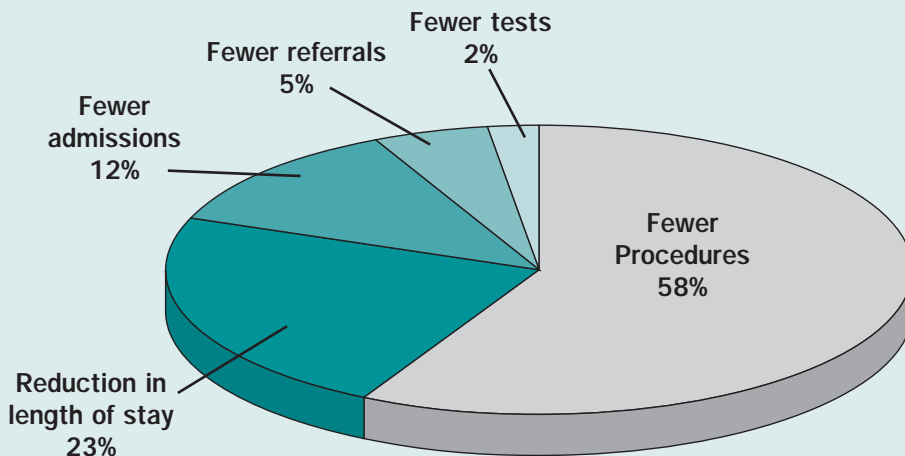
Although limiting the number of tests and procedures is important for all subcapitated specialists, the disbursement of subcapitated payments among specialists should be related to the type of specialty, Cejka says. "A specialist who deals primarily with chronic disease, such as a rheumatologist, endocrinologist, or neurologist, usually has few expensive procedures. Therefore, for subcapitated compensation, they should be panelized in a way that is similar to how primary care physicians are panelized. Cardiologists and gastroenterologists both do invasive and expensive procedures. They should be compensated under a different method,

among specialists treating those groups. It is a preferred method of risk distribution for primary care physicians, such as those in internal medicine, and pediatrics, and for specialists who rarely do expensive procedures, such as rheumatologists, endocrinologists, or neurologists, Cejka says.

In a panelized disbursement model, a specific number of lives is assigned to each physician in a medical group. "In round numbers, based on national and regional historical data, let's say each primary care physician provider is assigned 2,100 lives and is responsible for the care of that panel of patients," explains Cejka. "In return, each physician is given between \$10 and

Savings Potential

Several strategies will produce savings under capitated contracts



Source: Health Care Advisory Board, Washington, D.C.

capitation, Cejka says. "For most groups, the money is really won and lost among those groups, such as orthopedics, cardiology, and gastroenterology. The best way to deal with them is contact capitation," Cejka explains.

Contact Capitation

Under contact capitation, a health plan pays a specialist a fixed amount per referral. This fixed amount is intended to cover all associated treatment costs for a specified period of time, explains Allan Fine, senior manager in the health care consulting practice of the accounting firm Ernst & Young in Chicago.

A physician gets one point every time a new patient is assigned under contact capitation, Cejka says. In 12 months, for example, even if a cardiologist sees a patient eight times, he or she receives only the single point. "In contact capitation, if a cardiologist sees a patient one time and orders a catheterization, and another cardiologist sees a patient eight times and then orders an angioplasty, they both still receive only one point. In other words, access is encouraged and procedures are discouraged."

Contact points can be assigned by the types of procedures generally prescribed, Cejka says. "If I am a spine surgeon, I see only really sick people who truly need surgery," she says. "Generally, groups and medical departments pick their top 20 diagnostic codes and assign a point system to them on a one-to-five scale. An orthopedist may get one point for every new patient he or she sees, while the spine surgeon may get three to five points for every new patient he or she sees because he or she is going to see fewer patients."

Contact capitation can encourage cooperation among specialists within a discipline, says Fine. "Specialists who might otherwise be competitors for covered lives have an incentive to work together to reduce costs within their pool of capitated funds," Fine says. Any physician considering a contact capitation contract must carefully evaluate the proposed payment amount, duration of the contract, and services to be covered, he says.

Some specialists, such as ob-gyns, divide a subcapped rate equally within a department. "Ob-gyns often deliver

babies for each other's patients, so it makes sense to do equal share," Cejka says. "Also, it's a simple method, and simplicity is best when possible." Some other specializations, such as anesthesiology and radiology, do not fit well into a panelized or contact capitation methodology. Subcapitated payments for those disciplines can be tied to discretionary models, Cejka says. "The anesthesiologist's customer is the surgeon, not really the patient, and it is the surgeon's level of satisfaction that counts most," she says. "Therefore, reducing length of stay could be a criterion because it will reduce the surgeon's overall cost, and a reduced LOS could be tied to a reward point system."

Revenue Allocation

Technically, subcapitation is not a pay plan, Cejka explains. "It is a revenue allocation methodology often used in conjunction with standard fee-for-service

compensation," she says. "Once we get revenue allocated, we run it through the pay plan just like we always did, often blending subcaps with a fee-for-service system." Regardless of methodology, there are "no simple answers to subcapitation reimbursements," she says. "The real bottom line is patient access and patient satisfaction, and determining how to make a living while providing quality care."

Jeffery M. Alexander, an attorney with Brown, Rudnick, Freed & Gesmer, in Boston, says, "In the future, there will be two types of specialists: those who know how to work in a managed care environment and those who no longer practice medicine." And, those who understand how to profit from capitated reimbursement systems will be the ones who will be most likely to continue in medicine. Subcapitation, Cejka predicts, is here to stay.

—Reported and written by Martin Sipkoff, in Gettysburg, Pa.

Adequate Information Is Critical to Success

Subcapitation can be profitable, says Jeffery M. Alexander, a health care attorney with Brown, Rudnick, Freed & Gesmer in Boston, but it requires careful preparation. "To be successful, most specialists need to be able to take advantage of risk contracting because managed care is so prevalent in today's market," says Alexander. "These specialists need to know their referral sources, their costs of providing care, and how to adapt to care delivery methods that meet their referral sources' needs and payer requirements. After specialists contract subcapitation agreements, they can decide which payment option is best for their practice and distribute payments fairly."

Adequate information about how much service has been provided to specific populations in the past is critical to determining how much subcapitated reimbursement is needed to earn a decent living, experts say. Specialists need to use internal and comparative utilization and cost data to operate profitably within the subcapitation amount. Without adequate data, a specialist paid under subcapitation can fail financially. "You must always have knowledge of your practice's treatment experience and history," says Susan Cejka, president of Cejka & Co., physician compensation consultants in St. Louis. "Without that, you are really sunk."

While some physicians say they prefer capitated reimbursement systems, they often do not understand how such a compensation system can change a practice. "Many specialists who want subcapitation aren't sophisticated enough to handle it," says Patrick E. Kapsner, chief executive officer of the 100-doctor Bristol Park Medical Group Division of the St. Joseph Health System in Mission Viejo, Calif. "When the specialists get fixed subcap payments in a lump sum, they may not know how to divide the money among themselves, which can lead to a great deal of unhappiness."

—MS

PPMCs Pull Out of Capital Markets

By W.L. Douglas Townsend Jr. and Jill S. Frew

As the stock prices of physician practice management companies have plummeted, it has become more difficult and more expensive for them to raise capital in the public equity markets. Last year, PPMCs raised only \$127 million in equity, an 80% drop from 1997 levels (Table 1). Since their ability to raise equity in both the public and private markets has declined, PPMCs have increasingly used debt to fund their capital needs (Table 2).

Debt financing, however, does not have the limitless capacity that equity offerings appeared to have when PPMCs' price-to-earnings ratios were soaring. Furthermore, when companies incur debt, they take on the fixed cost of the interest on that debt. The companies then face the risk that if cash flow slows, they will not be able to make interest payments. FPA faced this difficulty. Last July, when FPA filed for chapter 11 bankruptcy, its debt amounted to 90% of its total capital. In the meantime, just as other industries experience business cycles, the PPMC business is likely to regain its growth and stability.

As the sources of capital for PPMCs have become more constrained, PPMCs have used cash or notes when acquiring practices. In some cases, these companies have slowed or halted their acquisition efforts. Because many PPMCs are not likely to be attractive sources of capital for physician groups in the near term, physicians may need to consider other sources of capital. These other sources can include retained earnings, partnering with hospitals, and securing capital from receivables lenders. Given that each of these sources has benefits and drawbacks, physicians should proceed cautiously. ■

W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Physician Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.

Table 1: Total Equity Raised by PPMCs (1995-1998)

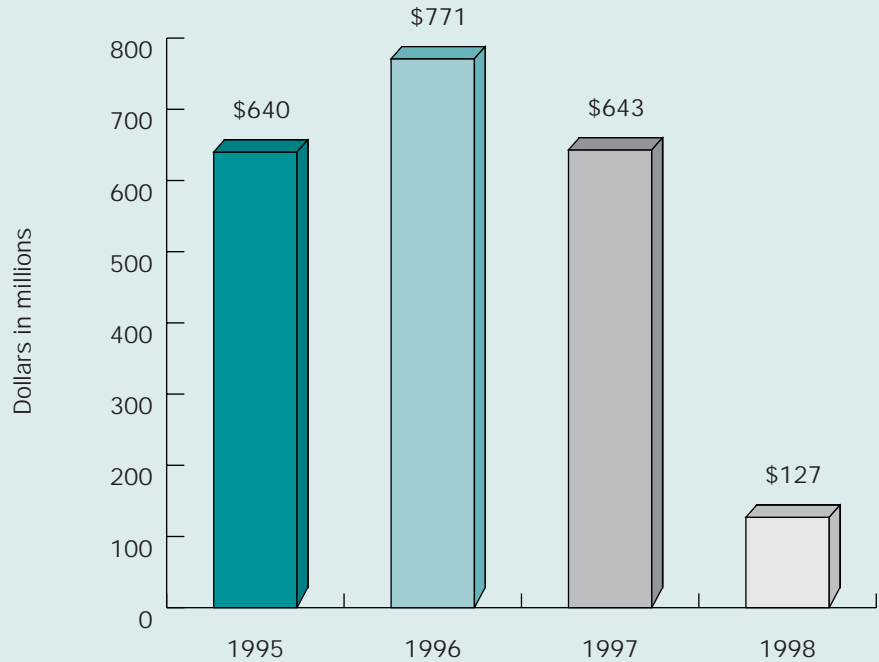
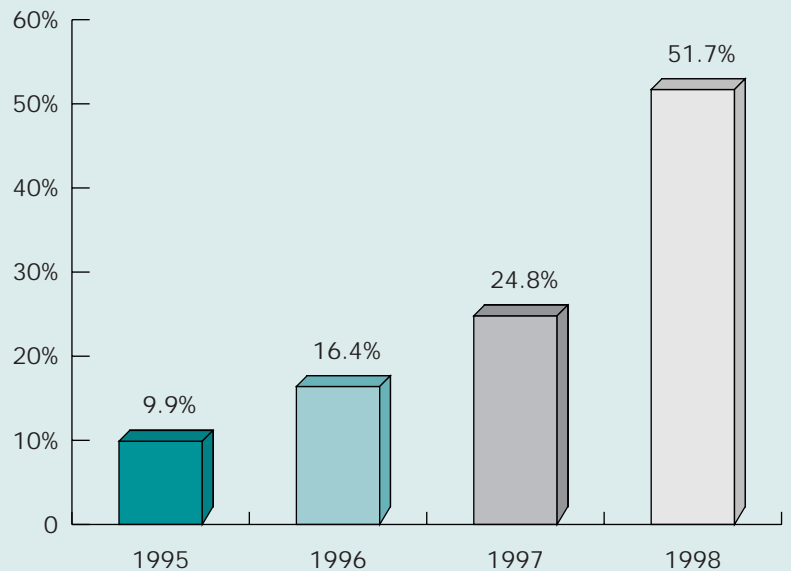


Table 2: Debt-to-Total Capital Ratio (1995-1998)



Debt-to-capital ratio equals total debt as a percentage of total debt plus shareholders' equity.

Source: PPMC, Sherlock Co., Gwynedd, Pa. Note: Tables include data from all publicly traded PPMCs during the period.

Is Managed Care Evolution Inevitable?

By Derek van Amerongen, MD, MS

Managed care is frequently portrayed as the 800-pound gorilla crushing all in its path. Yet in many ways it is a fragile thing.

It is only now moving into a sort of adolescence, and it is not unlike children who need rigid rules to learn boundaries. I date the true advent of managed care as 1994, when Congress and society decisively rejected the single-payer model proposed by the Clinton administration. Therefore, in the first five to six years of its existence, it has necessarily relied on strictures, mandates, oppressive rules, and punitive measures to impose some order on a medical system that knew no order, nor had any desire to control its excesses.

The result has been real attempts to integrate science with practice and to create fiscal accountability for the medical establishment. Given that this segment of the economy consumes over \$1 trillion annually, such attention has been overdue. Fundamental changes are never easy. They are poorly tolerated by those who are wedded to the traditional framework, and who benefit (or at least are not overtly harmed) by doing business as usual.

Managed Care Evolution

Yet there is a historical imperative in such change. Painful as it may be, we must work through it to bring us to a better place. Hence, we are in the midst of an *evolutionary* process, one that may well last 20 or 30 years. It should also be apparent that we have progressed to the stage that a return to the old fee-for-service system, despite however much organized medicine desires such a return, will not happen. Given that long view, we now must ask: How will the present model of managed care evolve? This

Derek van Amerongen, MD, MS, is the national medical director for Anthem Blue Cross Blue Shield, a managed care organization in Cincinnati. He is also the author of Networks and the Future of Medical Practice (Health Administration Press, Chicago, 1998).

question is one of the most important health care strategists will face, and it should be of intense interest to anyone who works in health care.

Bleeding Edge: The Business of Health Care in the New Century (Aspen Publishers, Gaithersburg, Md., 1998), by J.D. Kleinke, attempts to answer this question. From the title, I expected the book to be a standard diatribe against the injection of business into medicine (as if physicians and hospitals have worked for

determines that such improvement will result only from competition among providers who will have an incentive to attain higher levels of quality because of the increased compensation it brings. There is further benefit from market differentiation that will distinguish a mediocre group from an excellent one. He makes good use of several key concepts of market change that are well known in business but relatively unknown in medicine.

Lest physicians resent the application of business theory to medical practice, it is important to remember that the entire concept of quality improvement originated in industry and came to medicine many years after it was routine in American business.

free for the last 100 years). Rather, it is a thoughtful and surprisingly optimistic look at where our medical care system can, may, and should go.

As someone who has spent many years in medical management and in managed care, I found much to like. I have some important disagreements with Kleinke on process and implementation issues, but none on core philosophy. He, too, sees managed care as an evolutionary event, and even predicts its disappearance, sooner rather than later. It is his description of how these events will unfold, and what structures will replace it, that makes this book a thought-provoking read.

Performance Standards

As stated, Congress rejected a single-payer solution, particularly one driven by the government. The private sector, then, necessarily becomes the focus of the most meaningful change. Raising performance standards—meaning improving clinical quality—may well be the most important legacy of managed care. Kleinke correctly

Lest physicians resent the application of business theory to medical practice, it is important to remember that the entire concept of quality improvement originated in industry and came to medicine many years after it was routine in American business. Quality improvement efforts lead to an understanding of the need to generate value in medical practice. The consumer is demanding value in all sectors of our economy, and medicine is no different. Kleinke views this compelling need to create and deliver value as a key motivator for change, and one that will ultimately move health care beyond managed care.

Market Pressure

We are currently in the midst of a massive backlash against managed care. It is being led by consumers and legislators, with assistance—if not overt support—from the medical community. Many health care writers have begun to shy away from the financially driven logic for managed care that one heard routinely just a few

(Continued on page 12)

(Continued from page 11)

years ago. To his credit, Kleinke pulls no punches. He clearly believes that only market pressures will force health care to change. He advocates for many of the economic disciplines that managed care has come to be known (and criticized) for, demonstrating their effectiveness in "getting the attention of the system" to wean it from its profligate ways: "Managed care organizations' stridency will prove to have been necessary to deliver the shock to the system necessary to transform it," he says.

There is a bit of conflict here, however, when Kleinke then condemns those forces for injecting "profitization" into the system. On one hand, one cannot drive the behaviors of the providers using financial incentives and then protest when they perform as one would expect. On the other, you must be careful about what you wish for: You just may get it.

Throughout the book, Kleinke speaks

Managed care was never meant to be permanent. Once we have accomplished what the entity was created to do, it is time to move on.

of the impending demise of managed care. But by forecasting its demise, he does not see a movement backward. Rather he accurately identifies managed care as one stage, albeit a critical one, on the path to the ultimate solution to the nation's medical delivery system crisis.

Managed care was never meant to be permanent. We tend to become far too attached to institutions, delivery models, and business practices that are simply no longer relevant. Once we have accomplished what the entity was created to do, it is time to move on. The need to perpetuate a program or an institution as an end in itself has been one of the failings of the medical establishment.

So, if managed care is to be a method to progress to the next stage, what will that new environment be? Here Kleinke does his best work in describing a transition that seems almost to be an historical inevitability. His brave new medical world of the next millenium consists of

what he calls emerging health organizations, vertically integrated and provider driven. EHOs will control the means of production and, by concentrating expertise and information, will replace the managed care organization as the prime intersection point for medical care determination and delivery. MCOs will be reduced to a status similar to the insurers of old. They will be responsible for collecting and dispersing premiums and some other routine routing of information and dollars, but not much more.

The beauty of Kleinke's model is his assertion that it will accomplish everything the Clinton plan of 1994 was supposed to deliver, with less fuss, and using the market as the facilitator. This model would also be delivered faster than the government could do so.

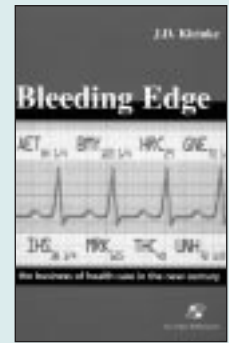
As stated, there is much to like in this scenario. Although I work for an MCO, I would gladly see it and all others rede-

efined on more modest terms if indeed EHOs could fulfill the objectives of delivering population-based, cost-effective care. If we are telling hospitals and physicians that adaptation and change are inevitable, then we must acknowledge it for all sections of the medical system.

The Hospital's Role

My reservations about the process for this transformation revolve around the role of the hospital. The complete failure of the physician hospital organization in the early 1990s does not bode well for the viability of a physician-hospital alliance that is essential to the EHO. Furthermore, there is also doubt as to the current validity of vertically integrated organizations. These organizations were quite the rage as medical administrators sought lessons from industry to translate into medicine. What they overlooked was that industry has been aggressively shedding the infrastructure demanded by vertical integra-

**Bleeding Edge:
The Business
of Health Care
in the New
Century**
(Aspen
Publishers,
Gaithersburg,
Md., 1998), by
J.D. Kleinke



tion because of the realization that it no longer makes sense in the 1990s. Why should a manufacturer make the steel, design the electronics, and support the factories, when these components can be purchased more cheaply and delivered sooner by specialty contractors? Likewise, what the farsighted physician organization of the near future will do is seek virtual integration with key suppliers (such as hospitals and home health agencies), own as little infrastructure as possible, and keep itself flexible and adaptable.

Kleinke says, "This is the worst time to be a practitioner." He seems to agree with the critics of managed care who paint the current period as a dark age, coming after the Golden Age of fee for service.

I disagree strongly with this view. For the first time, we have the ability to integrate scientific evidence with population-based knowledge to design delivery systems that do more than take care of one individual at a time. For the first time, physicians have access to national, evidence-based guidelines that can be implemented in the community.

This is the most exciting time to practice because for once we are beginning to understand how we might improve the health status of the entire population. Kleinke's observations are useful because they cause us to raise our focus from the present debate and consider what is just over the hill. No doubt we will look back in 10 years and be amused by the error in the predictions being made today. But without thoughtful analyses like this, we may not be prepared with the proper tools to reach that lofty place. ■

Successful MD, Solo Practitioner Seeks Law Degree to Help Preserve Medicine



Brant Mittler, MD, is a cardiologist who practiced medicine in San Antonio for 23 years before enrolling in August in St. Mary's University School of Law, in San Antonio.

Mittler received his medical degree from Duke University School of Medicine, where he is also an assistant clinical professor of medicine. This interview was conducted by Richard L. Reece, MD, editor in chief.

Q: The burning question I would like to begin this interview with is: Why, at age 52, did you decide to sell your thriving solo practice and go to law school?

A: First, I didn't enter law school because I was losing money in my practice. In fact, for 23 years I never had a managed care contract and was able to be successful. During that time, I was fortunate to care for some of the prosperous citizens in San Antonio. I also cared for some of the poorest people in South Texas through my consulting practice in Del Rio, Tex., along the U.S.-Mexico border, where most of my patients were on either Medicare or Medicaid or were unfunded. Caring for these two very different groups of people allowed me to develop an interesting viewpoint on the state of U.S. medicine in the last quarter of the 20th century.

I decided to enter law school because I believe that it is important to preserve the last vestiges of the doctor-patient relationship and the Hippocratic tradition. To try to do that, I knew I would need the tools to work within the legal system—which may turn out to be our last hope in preserving a health care system that's concerned less about the public welfare than about some corporation's bottom line.

Congress has become almost a wholly owned subsidiary of the managed care industry, large insurers, and big business.

Today, the big three automakers have more say over health care than the American Medical Association does. Any businessperson or any economist is considered to know more about the practice of medicine than a physician.

So, to whom do we turn? Government regulators? We won't get far with them. Government agencies like the Health Care Financing Administration are, for the most part, promoting entities like Medicare HMOs. And most insurance regulators in the major states have done little to fix what's wrong with the system. So we may have to turn to the courts to get the changes we need to protect the public. Remember, unlike legislative efforts to change the system, the U.S. jury system is one of the few areas where people can participate directly in the democratic process.

Q: Did the legal medical climate in Texas lead you to this decision? After all, Texas is a hot bed for activism. It was the first state to make HMOs liable for damages, the first state from which Kaiser Permanente exited the market, and the first state in which the attor-

inform the public and the media about the activities and consequences involved in the corporate practice of medicine and of managed care. My concerns have always stemmed from specific examples of abusive practices by managed care.

Whether Texas has had more abusive practices than other states, I don't know. But Texas certainly has been a hot bed of managed care activity. The average Texan, as reflected in our jury system and in our legislature, has responded to the abuses of managed care and medical practitioners by basically allowing those who were wronged to seek redress in courts and to achieve some measure of compensation. So, to that extent, the court system has been a powerful force in Texas.

Q: From what you've seen in Texas, do you think of the state as the Alamo for managed care resistance across the nation?

A: The overall resistance to managed care in Texas is coming not from physicians but from aggrieved family members of those who have died at the hands of managed care; that is, those family members

"Congress has become almost a wholly owned subsidiary of the managed care industry, large insurers, and big business. Today, the big three automakers have more say over health care than does the American Medical Association."

ney general brought a suit against Aetna and other big insurers.

A: I became critical of the corporate transformation of American medicine and the managed care movement almost 15 years ago. That criticism was based on specific examples of abusive practices of corporate medicine and managed care in Texas that were uncovered through Physicians Who Care, a group that Stephen Cohen, MD, and I formed in 1985 to

who were able to obtain the assistance of the creative, tenacious, and gritty Texas attorneys who have been able to get around the exemptions provided in ERISA [the Employee Retirement Income Security Act of 1974] and take their case to the court system. So, in Texas, managed care is suffering more in the courtroom than it is at the hands of the Texas Medical Association or state regulators or legislators. In fact, doctors are signing managed care contracts as

(Continued on page 14)

(Continued from page 13)

fast as they're put in front of them. So I don't think the public in Texas should expect that the physicians in this state will do much to save them from managed care. The resistance to managed care is coming more from consumers than from physicians.

Q. *What has been the aftermath of the Texas law that holds HMOs liable for patient care?*

A. The impact of SB386, the Texas HMO liability law, is that HMOs have been put on notice that they can be sued directly for neglect that causes harm. It clearly establishes the liability and responsibility of HMOs for medical decisionmaking. Now, that doesn't mean that doctors are off the hook, but it does acknowledge the fact that the managed care organizations have an enormous influence on physicians' decisionmaking. So, the law puts HMOs on notice that their actions are going to be scrutinized and that their activities are going to be open to the discovery process through the court system. A federal

relationship at the same time they're signing HMO contracts.

Q. *Is that because of arrogance, ignorance, complacency, or panic?*

A. Perhaps it's due to all of those factors. I expected doctors to be more courageous than they've turned out to be. I found little courage, and frankly, poor leadership by organized medicine. The profession has not been well served by the leadership of the medical associations in the United States, which early on responded to what Physicians Who Care was doing by saying our organization represented "obstructionism unhealthy for the profession."

Now, fast-forward to today: We see the AMA doing with its vast resources and saying the things it should have been back in 1985. But today, it's too late. The quality of care and the abusive practices of HMOs are much worse than the public knows, and the HMO horror stories that are well publicized by the media are just the tip of the iceberg. A few smart plaintiffs' attorneys have done

A. It might be. I don't claim to be an expert on how that program should be structured, but I would like to see patients own their own insurance, receive a voucher, or a lump sum, with some subsidization based on need, and allow them to buy their own health care. That might save the doctor-patient relationship. Of course, if the only choice they have is something offered by an HMO or a managed care entity, then the only options might be choosing between one bad-quality program and another bad-quality program, which would not be much choice at all.

Q. *So, where does Brant Mittler, MD, the law student, go from here?*

A. I'm concentrating now on learning to think like a lawyer and develop legal skills. I want to be active in health care law. I'm also interested in managed care consumer protection entities, both at the state and regional levels, such as those being proposed in California.

Q. *How does a lawyer think versus how a doctor thinks?*

A. The first thing they tell you in law school is that there are no right answers, whereas in medical school, we are taught that there are always right answers. Of course, the history of medicine is the history of conventional wisdom proved wrong.

You see this fact reflected in the naive beliefs about practice guidelines; that is, that we can write down a set of guidelines for the right way to practice medicine. But what do we do next year when new drugs or new clinical trial results come out? What happens to our guidelines then? Maybe we change them and maybe we don't. Or maybe managed care decides that we can't afford the new guidelines and we have to stick with the old ones. And how much were the old guidelines based on science and how much were they based on cost concerns?

In the study of law, an open, innovative kind of thinking that uses hypotheticals can, to some extent, help you expand your mind in thinking about possibilities to answer such questions. It's a kind of thinking that will be useful as we consider new ways of dealing with our health care system. We're going to have to spend a lot more time thinking about the realities of quality and to some extent the unintended consequences of managed care. So, in that way,

"The notion that medical care is free is a concept that has been fostered by the third-party payment system."

district judge has upheld the right of patients to sue HMOs directly, but that decision is currently on appeal.

Q. *Over the last 15 years, you've been a political activist warning of the industrialization of medicine in numerous letters you've fired off to editors and in pieces published in The Wall Street Journal, The New York Times, and leading Texas papers. You have, in short, been a thorn in the side of managed care. Have your worst fears come true?*

A. The situation is actually worse than I expected. I naively thought back in 1985 that doctors would rally in greater numbers. What has astounded me over the years is how little physicians are disposed to fight for their profession and how unwilling they are to give money for that fight. There's no comparison between what doctors give to defend their profession and what trial lawyers give to defend the right to sue. In fact, physicians constantly invoke their concern about the doctor-patient rela-

more to protect the public from the abusive practices of managed care than have all the local medical societies in Texas. It's unfortunate that so many medical societies have been working overtime to set up their own HMOs.

Q. *So, where do we go from here?*

A. At this point, where we go from here will not be a function of what physicians do. Improvement will come entirely from the patients' side. As more patients are harmed or inconvenienced by the system of managed care, there will be calls for change. One of the inevitable changes will be a move for some type of socialized Canadian-style system of health care. I would rather see us move to a system of medical savings accounts where individuals own their own insurance.

Q. *Would this be a variant of the current Federal Employee Health Benefits Plan?*

“Experts have promoted the view that medicine is some sort of assembly line, almost like an industry that makes widgets, and if only the assembly line could be made more efficient by standardizing the widget makers and the widgets, then we would have a much more efficient process. That model has been shown to fail miserably.”

legal thinking is different.

It's also interesting to learn to use the research systems in law, where you can ask a specific question, such as, “What is the liability of a homeowner if someone comes on his or her property and is bitten by a vicious dog in the backyard?” You can pose that question to the legal databases and get quite specific answers. Right now, you can't pose that kind of question to most of our medical databases. Why? As a bright colleague of mine said when we were discussing this, “The reason is very simple: Nobody pays for those kinds of questions.” Yet those are the kinds of questions we ask in practice. What's the best way to treat this 55-year-old man with angina, hypertension, and Type-2 diabetes? Even though the cardiology department at Duke University has a sophisticated database that would allow these kinds of questions to be asked, neither the insurance industry nor anyone else wants to pay for it.

Q. *One of the fundamental practical differences between lawyers and doctors is that a client pays to talk to a lawyer on the phone but a patient doesn't pay to talk to a physician.*

A. That is a very important point because the notion that medical care is free is a concept that has been fostered by the third-party payment system. Patients have been conditioned to think that it is free. Not having to pay for their care is magical thinking because they know it's not free. When clients call a lawyer, they expect to pay. When patients call a doctor, they expect not to pay. That's one of the fundamental disconnects that has been so perniciously eroding our system. And both the government and managed care have been behind this.

What do the HMO ads say? That you can get all of the care you need, which is all of the care we think you need, and you don't

have to pay anything. But somebody's paying. It's this kind of magical thinking that has played a big role in destroying the American health care system. Now, the legal profession has not allowed any of that kind of magical thinking. It has understood the economic reality that when you deal with a professional you have to pay for the professional's advice, time, and expertise. That fundamental notion is the basis for the preservation of any profession.

Q. *Given the traditional doctor's disdain for lawyers, isn't it ironic that the legalization of medicine may be the antidote for the industrialization of medicine?*

A. It is a great irony. But it's not just a Brant Mittler speaking or a few individual physicians who decided to become lawyers. Others in the medical profession—including the AMA, which came late to

One is the media, which until recently was a cheerleader for managed care. The other entity is the group of so-called experts who have had a pernicious influence on American medicine.

If you look at the national conversations about health care that are conducted through the American media and through various conferences, you can see that only a few people are always quoted as being the experts to speak on American medicine. All of these people have promoted the view that medicine is some sort of an assembly line, almost like an industry that makes widgets, and if only the assembly line could be made more efficient by standardizing the widget makers and the widgets, then we would have a much more efficient process, wouldn't spend as much money, big business and the country would become more

“The first thing they tell you in law school is that there are no right answers, whereas in medical school, we are taught that there are always right answers. Of course, the history of medicine is the history of conventional wisdom proved wrong.”

the game—are vigorously defending or supporting various legislative measures that deal with managed care issues, patients rights to sue, ERISA, tort reform, and so on. So, physicians are beginning to understand that it will take the legal system to save the medical profession. As you say, it's ironic that ultimately the preservation of the medical profession may depend on the strength and intervention of the legal profession.

But I want to make clear that I believe two major entities have been responsible for the current mess in American medicine.

competitive, and American medicine would be saved.

That model has been shown to fail miserably. So, it's time for a new model or at least a realization that the model they propose doesn't fit American medicine because HMO premiums and health care costs are rising once again, as are consumer complaints. We are all getting older. And I don't think anyone wants to suffer the end that many of us will get at the hands of managed care.

—Edited by Paula D. Grant, in Lincoln, Va.

EDITORIAL

(Continued from page 2)

Women Physicians Earn Less (Based on 1997 income data)

Selected Specialties	Median income for men	Median income for women	Difference
Anesthesiology	\$250,149	\$197,622	\$ 52,527
Invasive cardiology	\$381,819	\$222,886	\$158,933
Cardiology (non invasive)	\$268,405	\$195,892	\$72,513
Family practice	\$138,833	\$118,800	\$20,033
Gastroenterology	\$231,300	\$196,329	\$34,971
Internal medicine	\$145,315	\$122,601	\$22,714
Neurology	\$166,000	\$139,807	\$26,193
Ob-gyn	\$221,280	\$190,350	\$30,930
Pediatrics	\$138,176	\$116,331	\$21,845

Source: Cejka & Co., St. Louis, and Medical Group Management Association, Englewood, Colo., 1998.

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Richard L. Reece, MD
Editor-in-Chief
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