

PHYSICIAN PRACTICE OPTIONS™

June/July 1996

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Evaluating the Choices: Investor-owned Versus Nonprofit Health Care

For the last five years, physicians have been following closely the experience of the capitated health systems on the West Coast, thinking these integrated models would become widespread. But today a new model for reforming health care has risen in our midst: the Wall Street financed corporation. Such companies as Columbia/HCA, PhyCor, Caremark, MedPartners/Mullikin and other publicly owned hospital and physician management companies are building market share by engaging in joint ventures with for-profit health companies by buying physician's practices or by buying failed or failing academic medical centers.

These investor-owned hospital systems, public physician corporations, and disease management companies have risen to power quickly. For-profit HMOs are flourishing while nonprofit HMOs are stagnating. Blues plans across the country are seeking to convert to for-profit status to gain access to capital markets.

Two Questions to Answer

Seeing this transformation, doctors are asking themselves two questions: Should I join or create an investor-owned health care company or should I affiliate with or start a nonprofit organization? Two thirds of the 46 new HMOs started last year were independent for-profit organizations. In many cases, these HMOs were started by physicians or were affiliated with hospitals.

Physicians prefer that new health plans be managed by physicians so that doctors can rise up against what they perceive as the

tyranny of managed care. There is, of course, another temptation for physicians, and that is the lure of monetary gain. In March of last year, M.D. Enterprises, in New Haven, Conn., a physician-owned HMO with 130,000 members was sold to Health Systems International, a for-profit HMO in Woodland Hills, Calif., for \$100 million. In 1987, the doctors who started M.D. Enterprises invested \$3,500 for one share of class A stock. When the health plan was sold, each physician member who had class A stock received \$56,000 per share.

It's no wonder that doctors are attracted to the possibility of organizing physician practice management companies, management service organizations, or specialty carve-out companies, or that they find appeal in the possibility of an initial public offering of stock. Moreover, it's no small wonder that many physicians are seeking to cash out by selling to public companies any interest they may have in an existing HMO, IPA, specialty practice, or multi-specialty group.

The question of whether to affiliate with a for-profit or nonprofit system goes to the heart of the matter of why physicians got into medicine initially: to take care of others. Therefore, they are asking themselves often today if practicing medicine is a profession or a business.

In an article in the *New England Journal of Medicine* (NEJM, Dec. 21, 1995), "Extreme Risk—the Corporate Proposition for Physicians," David U. Himmelstein, MD, and Steffie Woolhandler, MD, MPH, professors in the Department of Medicine at The Cambridge Hospital/Harvard Medical

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Regarding Group Practice: Seize the Day

Many physicians today are considering forming a group practice or some type of management service organization (MSO). Our advice on this topic is simple: Don't wait. As managed care matures in markets nationwide, only large groups will have enough capital, clout, infrastructure, management, and information systems to win HMO contracts. But, if you organize the right kind of group and capture 30% of the market, you will attract HMOs, managed care contracts, and potential buyers.

The problem is that forming a group isn't easy. Experts agree that to win in managed care, doctors need a consolidated group with the right mix of physicians, including a minimum of 40% of group members practicing in primary care. Depending on the number of physicians, you may need three to 12 months to compile the requisite data, assess the market, analyze profit-and-loss estimates, evaluate your strategic options, raise capital, hire managers, and implement your plan.

Any physician moving from a solo practice into a larger venture likely would be entertaining any or all of the following questions:

- Where can I get help in assessing the value of a practice objectively?
- Where can I get advice on business plans and on achieving my practice's potential to position it for negotiating and developing deals?
- Where and how can I get capital to develop a new organization or to exit a failing venture?
- Where can I get assistance to mediate issues between my medical group and the local hospitals?
- Where can I get practical information and training to help make the transition from fee-for-service to managed care?

In traveling the country in recent months, I have seen large numbers of independent physicians trying to decide what to do. AMA statistics show that only 868 practices have 25 physicians or more, the size managed care demands. Some two-thirds of physicians work in practices of one or two persons. Therefore, among America's 684,000 physicians, thousands are considering forming a larger group to contract with managed care organizations. If you are one of these thousands who want to reach the proper critical mass to be effective in managed care, you have five basic options:

1. Become part of a larger operation by selling out to a hospital or a group practice, joining an integrated hospital-centered system, or selling to a managed care company.
2. Form a large network with other physicians, then move toward a sale or public offering.
3. Proceed cautiously by participating in a physician hospital organization, MSO, independent practice association, or group practice without walls.
4. Retire or relocate.
5. Seek more information to help you make your decision.

Our mission at *Physician Practice Options* is to be a practical information resource to help physicians succeed in a rapidly changing health care environment. As such, we invite you to call with questions about how best to structure your practice and how to proceed in a market dominated by managed care.

You can reach me directly at 860/395-1501. Or, you can write to me at 15 Banbury Crossing, Old Saybrook, CT, 06475-2363. You also can send an e-mail message to RReece1500@AOL.Com or a fax to 860/395-1512.



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School, criticized U.S. Healthcare, in Blue Bell, Pa., a for-profit managed care organization. Himmelstein and Woolhandler said the HMO had paid its executives excessive salaries, rewarded physicians with bonuses for minimizing care, prohibited physicians from talking with patients about financial incentives, and for deselection of physicians without cause. Before the article appeared, U.S. Healthcare deselected Himmelstein but reinstated him after sharp criticism from the public and the media.

Similar storms have erupted in other quarters as well. In January, *Time* magazine did a sensational piece on a young woman denied a bone marrow transplant for metastatic breast cancer by Health Net, a for-profit HMO in Van Nuys, Calif. The *Time* article left the impression that the profit motive was the cause of the problem. Organizations representing more than 1 million Californians are seeking to qualify an initiative for the November ballot that would end interference by HMOs between doctors and patients. The initiative also would force health plans to disclose profit margins and overhead. Nationwide, state legislatures in 1995 passed some 400 bills, compared with 200 in 1994, restricting HMO activities.

The American Association of Health Plans (AAHP), in Washington, D.C., (formerly the Group Health Association of America) has launched a public relations campaign to counter the negative press. Medical directors from Humana, PacifiCare, United HealthCare, and U.S. Healthcare recently met with reporters in San Francisco to answer questions about managed care. The AAHP has retained Powell Tate, a public relations firm in Washington, to help put other media forums together.

Practicing physicians may soon have to choose between working for a national investor-owned health care organization, working for a regional nonprofit integrated system, or establishing a for-profit enterprise. Physicians will need to choose between two contrasting managerial philosophies. One says management—and all employees, including doctors—should maximize the return on investment to stockholders, and the other philosophy says management and doctors should have an allegiance to consumers. Pressure for

health care organizations to get big and to use corporate leverage against smaller competitors is spreading quickly. If you belong to a group practice of six or more doctors, you are likely to be approached for a buy-out. If you have 25 or more physicians in your group, it is likely that you have already been approached.

A Prediction

Robert Bohlmann, a senior consultant with the Medical Group Management Association, in Englewood, Colo., was quoted in the *AMA News* last year as saying, "My prediction is that a significant number of physicians will work for someone by the year 2000. That someone may be:

or becoming part of an independent group."

And finally, in side-by-side "Sounding Board" articles in the April 18 issue of the *NEJM*, M.M. Hasan, MD, CEO, of the for-profit Health Systems International, and P.M. Nudelman, MD., and L.M. Andrews of the nonprofit Group Health Cooperative of Puget Sound in Seattle lay out the respective merits of for-profit and nonprofit health care. (See table, page 4.)

Next Steps

If you are trying to choose between affiliating with a nonprofit hospital system and an investor-owned company, you may want to call an investment broker about

In 1987, the doctors who started M.D. Enterprises invested \$3,500 for each share of class A stock. When the health plan was sold, each physician member who had class A stock received \$56,000 per share.

- A hospital that acquires practices and directly recruits physicians.
- An investor organization that acquires and operates practices. PhyCor initiated this concept, which is now an established practice.
- Health plans and insurers.
- Employers, at least a few of them, who perceived that internalizing medical services is cost effective.
- Medical groups owned and managed by physicians. These may be large multi-specialty, primary care networks or single specialty practices."

On the same subject, Paul Keckley, president of PhyCor, has said [in an interview in our May issue], "We believe physicians' options are to practice independently or to be a cost center controlled by someone else. In our view, the best model for physicians to perform well in the economics of managed care is in a primary-care-anchored multi-specialty group setting.... From a strategy viewpoint, physicians are looking at joining a hospital-controlled group, a plan-controlled group,

the financial performance and prospects of the investor-owned company. By all means, meet with your local hospital or health system executives and with officials of the publicly traded company so you can weigh their respective merits.

You also may want to consider another route. If your hospital is a member of the Governance Committee of the Advisory Board Co., a membership organization of health providers in Washington, D.C., you might want to attend one of two dozen special conferences being conducted through Aug. 26 in different parts of the country. One session is called, "The Wall Street Phenomenon: The New Frontier and Implications for Health System Strategy." Another is titled, "Competing on Cost and Discipline: Lessons from Investor-Owned Systems and Their Best-of-Breed Nonprofit Peers."

In addition, we have resources that may be useful to physicians looking at taking their practice in a new direction. Feel free to call us directly at 860/395-1501 for more information. ■

Advantages of For-profit Plans	Advantages of Nonprofit Plans
<p>Market-based health care is the only means of guaranteeing high-quality care at competitive prices.</p>	<p>A for-profit plan provides a service so it can make a profit; a nonprofit plan makes a profit so it can provide a service.</p>
<p>Investor-owned plans have proven their capacity to respond to the demands of patients and employees.</p>	<p>Whereas for-profit organizations are accountable to their shareholders; nonprofit organizations have another kind of accountability—to patients, to providers of care, to payers, and to the communities in which they operate.</p>
<p>Nonprofit plans are not structured for market competition. Substantial capital is needed to support growth and being competitive. Nonprofit plans are limited to borrowed funds and internally generated sources of financing.</p>	<p>If they are true to their mission, nonprofit plans behave in ways that make them integral parts of their communities. They support health care for the homeless, childhood immunization programs, efforts to prevent violence and limit tobacco use, and research with publicly available results.</p>
<p>Nonprofit plans provide no better protection for patients than investor-owned plans do. Some people believe that nonprofit plans are better advocates for the welfare of the patient because they are not driven by profit. Yet, there is no basis for this view.</p>	<p>A fundamental difference between for-profit and nonprofit plans is their attitudes toward the “medical-loss ratio,” which is the ratio of premiums collected to medical costs expended. Medical costs expended is the dollar amount returned to consumers in the form of health care services. The for-profit plans try to keep spending as low as possible; the nonprofit plans try to keep it high.</p>
<p>There is an appropriate role for nonprofit plans, but it is not in the operation of competitive health plans. The appropriate role includes, at a minimum, provision of care for the indigent, medical education, and the development of certain experimental procedures.</p>	<p>Another worthwhile investment that voluntary, nonprofit organizations are more likely than for-profit plans to make is in partnerships with patients, from shared medical decision making to customer governance of the organizations. Because Group Health Cooperative is a consumer-governed cooperative, members have a direct say in the overall policies concerning care and management.</p>
<p>The energy and entrepreneurial spirit that have made America a leader in many aspects of the world economy are doing the same in health care. Investor-owned plans are spearheading this change in the health care system by focusing on improving access, and by emphasizing preventive care, affordability, and demonstrable quality.</p>	<p>The real issue is not just a company’s tax status; the issue is attitude and behavior. Group Health Cooperative and similar nonprofit plans have the inherent values that make the patient rather than the profit the most important part of the health care equation. That is the key to true success.</p>
<p>Source: Hasan, M.M., “Let’s End the Nonprofit Charade,” <i>The New England Journal of Medicine</i>, 334:1055-1057, April 18, 1996.</p>	<p>Source: Nudelman, P.M., Andrews, L.M., “The ‘Value Added’ of Not-for-Profit Health Plans,” <i>The New England Journal of Medicine</i>, 334:1057-1059, April 18, 1996.</p>

Seeing the Most in Career Options

By Michael B. Guthrie, MD, MBA



Michael Guthrie, MD, MBA, has been a physician executive since 1979, holding senior positions in two large health systems in Colorado and California. Most recently, he was the CEO of the Good

Samaritan Health System in San Jose, Calif., a diversified health services company that included four hospitals, a medical foundation with a group practice and an IPA, a home health agency, and a small investment company. In addition, he is the author of Decision Point—Evaluating Your Practice Options (Whittle Direct Books, Nashville, Tenn., 1994). A member of the editorial board of Physician Practice Options, he is a frequent speaker for local and national organizations on health care issues, including managed care, integrated delivery systems, physician-hospital relationships, and health care marketing.

Most physicians' career paths once seemed quite certain and predictable. After completing training, you could choose a practice location, based on your personal and professional preferences, and settle down for the better part of a lifetime. There was little chance you would need to move or change your professional focus. Quietly, you could compete for patients in your home town or region, based on your skill and availability. As the population and the economy grew, most practices also grew.

In many major metropolitan markets over the past 10 years, that scenario has changed. The health care market has responded to threatened reform and managed care by rearranging the structure of physicians' finances, control, compensation, and patient flow. Chaotic and incomplete, these changes are forcing most physicians to rethink how they practice, where, under what conditions, with whom, and for what. A way of life that doctors once believed in strongly is disappearing.

Responding Effectively

Some doctors are responding with pessimism and even dejection, but the most effective response should be based on an evaluation of your situation and a focus on the practical, rather than simply emotional, issues. What career alternatives actually exist for physicians such as yourself? How can a doctor evaluate and plan for a reasonable change? What professional and personal considerations should you sort through?

The best way for any physician to adapt effectively is to understand several factors about the new environment, including:

- How and why it emerged.
- What it demands of physicians.
- What new skills are required to survive and thrive.

Physicians are extremely capable at acquiring new skills, and knowing which way to move to increase your odds is the first step. The number of options itself may be confusing at first. Should I join a group practice, maintain a solo practice, an IPA, PPO, HMO, PHO, or other organization? Should the practice have multiple offices, a new location in a new town or state? Should I consider a new specialty, a new business, or a new market segment?

Our emotional reactions to these changes likely will be grounded in personal preferences and expectations. Many physicians are bewildered and angry. The changes are profoundly unsettling, especially for doctors who are age 45 to 60. Being overwhelmed or distracted by your emotional reaction makes change more difficult and responses more erratic.

Rational Personal Planning

No reform of health care can progress without the active involvement, design, and participation of physicians. Recognizing this fact alone should help many physicians develop a rational personal plan to navigate the changes effectively. With such a plan, physicians should be able to make a reasoned transition to an organizational setting that offers the best balance of satisfaction

between personal and professional needs.

There is no reason physicians today can't earn a decent living doing what they have been trained so well to do: take care of people who need medical care.

The nature of possible practice environments varies along a continuum from the most independent, solo practice model, to the most integrated and organized model, such as a group practice within a fully integrated delivery system, perhaps as exemplified by the Kaiser Permanente health plans in California or the Henry Ford Health System in Detroit. In between are several integrated health care delivery options.

No one option is best for every physician. Among the aspects to be evaluated are the nature of each market, the style of the players, where the market is going, how the financing is changing, and what the public and businesses want from health care providers. Balance these aspects with your personal needs for salary, security, inclusion, and control over your practice.

By the nature of their training and personality, physicians can change in their personal and professional lives but are uncomfortable with continuous change. Moving from one location or practice setting to another is acceptable. But if the target keeps moving, that is unacceptable. In this scenario, how can physicians know how to adapt properly? How can they be sure that what they're doing is right?

Evaluating the Market

The first steps should include a careful and rigorous evaluation of your local market. The intense demands on their time and energy make it difficult for most physicians to fit such evaluations into their schedules without making a conscious effort. But it is important to take the time to look, listen, and learn about your market. Talk to people other than physicians and ask about their perceptions and predictions. Remember that we tend to over-emphasize the importance

(Continued on page 6)

of trends in the short term and under-emphasize their importance over the long term.

Your assessment should lead you to a written summary of the facts about popu-

want to consider joining a group. Are the payers pushing gatekeeper health plans? If so, and if you specialize in delivering tertiary-level care and thus depend on referrals, it may be time to join an indepen-

different than operating as part of an organization that has standard procedures, staffing, labor practices, budgets, and schedules. Different skills are required to excel in different environments.

You may have to acquire the necessary skills. If so, you may find the needed resources in the local library, offered as a course by a nearby college or university, or offered as continuing medical education by a local hospital. Find other physicians who have made the shift or visit a colleague in another city. Shadow these physicians for a day or two to see how they practice and what skills they use.

Keep in mind that some choices are distinctly non-linear extensions of what most physicians are doing today. Since the boundary between the clinical and the financial sides of medicine is blurring, physicians are needed in various management positions to shape the emerging health care organizations. Tremendous opportunities exist in turning clinical knowledge and skill into solving new problems in pharmaceuticals, medical

Talk to people other than physicians and ask about their perceptions and predictions. Remember that we tend to over-emphasize the importance of trends in the short term and under-emphasize their importance over the long term.

lation growth, the increase or decrease in the number of health care providers over recent years, information about the trends in payments for health care, the prevalence of health insurance plans by type, the number of physician visits, and the like. There are many resources available locally to provide you with such information, some from news media, some from medical societies or local schools or agencies.

Next take a hard look in the mirror. Ask what kind of a practice you want, what could you settle for, and what won't you tolerate. What do you want to be remembered for? What are your financial requirements? What are your personal interests and needs, including your family requirements, such as children or location of your spouse's work? Can you adapt in a new environment? How well do you work with others in groups or teams? What non-clinical skills do you have that could complement your professional skills and practice? The better you understand your own and your spouse's values and needs, the better you can create a new situation for yourself, or adapt to a given set of opportunities.

The most important aspect of your assessment will focus on your professional situation. During your assessment, you should have an inventory of all of the practice types and options in your community. You must take a thorough look at your situation and opportunities for improvement. You may be in a solo primary care practice without a supporting organization, for example. If so, you may

dent practice association. Are you overwhelmed by the requirements of managing the business aspects of your practice? If so, you may want to consider selling to a practice management company or health system.

Remember that not every option may be available in your market. Of course, each option has positive and negative implications, depending on your needs and inter-

Since the boundary between the clinical and the financial sides of medicine is blurring, physicians are needed in various management positions to shape the emerging health care organizations.

ests. Read what other physicians do, not just what they say. Be objective. Consider that something you never thought could work for you, may be the right business decision now. Keep in mind that such choices do not need to be made as if they were forever. The health care market will continue to evolve. Plan with the idea that new opportunities likely will emerge in several years.

Different Skills Required

If you plan to join a group, merge your group, sell your practice, and work for a company, anticipate that you will need to learn new organizational and clinical skills. Working in your own office with total discretion over all clinical and business details and managing your own staff is completely

devices, information systems, clinical protocols, and utilization review.

After reflection, some physicians have chosen to use their clinical skills in missionary work, clinical pharmacology, or medical management. The number of clinical settings for physicians in most specialties has exploded, including settings in small rural locations and foreign countries.

Times of great cultural and social change are also the times when the greatest innovations and creative changes occur. This is such a time for health care. For physicians willing to take a hard look at their skills and preferences, the choices for career advancement and change have never been brighter and more varied. Enjoy the journey. ■

Future Care: What Physicians Can Expect from Consolidation



Russell C. Coile Jr.
President
Health Forecasting Group

Russell C. Coile Jr., MBA, is a futurist specializing in health care. As president of the Health Forecasting Group in Santa Clarita, Calif., he provides market forecasts and strategic advice to hospitals, medical organizations, suppliers, and professional associations. In the

past 10 years, he has written four books on the future of health care. In addition, he is the editor of a monthly newsletter, *Russ Coile's Health Trends*, published by Aspen Publishers Inc., Gaithersburg, Md. The newsletter is in its eighth year. Coile holds a bachelor's degree from the Johns Hopkins University and an MBA in Health Services Administration from the George Washington University.

Q: We're in an environment now that is changing dramatically. One has to go no further than the day's newspaper to learn about the latest acquisition and how health care as we have known it is changing before our eyes. What does all this mean?

A: These are signals of the restructuring of health care, and certainly the most obvious one is consolidation. What we're seeing here is the industrialization of what's been America's last cottage industry, and that's private practice medicine. So now, with the emergence of large national companies, we're certainly going to see a kind of market competition that will take health care out of the 19th century and position it firmly in the 21st century.

Q: One of the trends going on is the consolidation of the physician side of the industry, and as evidence of that we see the activities of MedPartners/Mullikin, and Caremark, and so forth. Do you think that consolidation is going to proceed rapidly?

A: Over the next three to five years one of the major changes that's

going to take place is the shift of physicians into group practices. When the dust settles, the only question is: Who will own the group? Will doctors own their own professional corporations, much as we have in law and accounting? Will these be professional corporations that essentially are owned by the partners? Or, will at least some of these large physician organizations be owned by Wall Street-backed companies? That's the scenario of the Caremarks, PhyCors, and MedPartners.

I would speculate that it's unlikely that these physician management corporations will wind up owning or managing more than about 25% of the physician groups, at the most. On the other hand, these groups may be some of the largest and most politically powerful physician groups. But I still think that the average physician will own his own practice and will participate in multiple IPAs and HMO networks.

Q: If you were an average physician, and 70% of them right now across the country are in solo practices or in groups of three or fewer, how would you look at your options?

A: Each regional market is going to be different. The stage of managed care penetration in a market will make a big difference in terms of what the economic situation is and how much pressure some of these doctors will feel. Some may feel they need to move quickly to establish a new kind of organizational base. Regardless of how early it may be in some markets, particularly across the South and other parts of the country where HMOs still have had only a modest market impact, it's going to be important for physicians to check all of their options. This is the time now where they've got an opportunity to come together voluntarily and put together some physician-sponsored organizations that potentially could be very significant.

The issue here is going to be capital. If

doctors can create large medical groups using their own capital, then they can own their own businesses. But if the market is such that doctors have to come together quickly, then they will have to go outside for capital. The most likely sources of capital are either the local hospital and health system or a for-profit physician management company. Either way, if doctors must rely on outside capital, then they will be beholden to whoever brings that capital to the table.

Q: So are you saying that if it's early enough in your market, it's preferable to use your own capital?

A: Doctors with capital can create their own organizations. Physician without capital have to find partners.

Q: Most of the country, outside of California, Minnesota, and some other regions, are in sort of stage-two markets. [See "The Five Stages of Managed Care," February.]

A: Yes, it's still early enough in many markets for doctors to create their own groups.

Q: Doctors are asking, 'What process should I go through to judge the merits of which direction I should take?' In other words, they're asking, 'We know we have to form an organization, but how do we go about it?'

A: Doctors should be looking at their organizational options over the next few years and they should follow what other businesses do in any classic business planning situation. They should look to see both how their competitors are organizing—in their local market and outside of their local market—and then what kinds of sources of capital and sources of management expertise are available to them in the local market.

As doctors look at all of their options, they will have at least three or four broad categories or choices. For physicians who want to stay in solo practice or in small groups, that's going to be possible. But

physicians who are in solo practice or small groups are going to have to be networked, probably on a single-specialty basis, to be most effective. And they will probably also participate in multi-specialty HMOs. It's the combination of that, or one or more single specialty IPA plus multi-specialty IPAs in combination. For solo physicians and small groups, the question is whether eight or ten of those affiliations will be able to channel a reasonable volume of patients into those doctors' offices. The price for remaining a solo doctor or a small group may bring substantially more economic uncertainty, because they won't be big enough to control their own destiny.

Q: Are you saying that specialists should form their own carve-out organizations?

A: Exactly. But that won't work for every specialist. Virtually every specialty has its own special subpopulation. Physicians in each specialty have their own unique subpopulations and payers, and so

got the best doctors.

Q: By using the acronym IPA, what do you mean?

A: An independent practice association, also called an IPO, or independent physician organization. Just in the last six months we've seen a number of single-specialty companies emerge in sectors such as oncology, ophthalmology, orthopedics, among others. This trend is definitely going to accelerate. The subspecialty groups and IPAs also will need capital and will work to find partners. But in this case, the affiliation is with a management agreement to a single-specialty or for-profit company.

Q: Is that choice a sustainable strategy as the market becomes more mature?

A: We don't know yet. If you look at Minnesota, that's not how they've done things. If you look at Portland, Oregon, that's not how they've done things. Even here in Southern California

Q: What does that trend mean for PCP gatekeepers?

A: In more advanced managed care markets, some HMOs and capitated medical groups are finding that the primary care doctor may be redundant in a really efficient system. If you have patients who can be channeled directly to responsible subspecialists, and those subspecialists are capitated, then that's a more efficient model than a narrow-gated network.

Q: Certainly that's the feeling on the East Coast. Some network managers believe that's the more preferable model, but they feel that to do that you need a state-of-the-art information system.

A: That's true.

Q: Is that possible today?

A: Hardly anybody has such a system. But that is one of the things that potentially a proprietary company could bring to the table. They could bring the information network and the contracts.

Q: Some experts have done studies indicating that the price difference between an efficient gatekeeper system and a non-gatekeeper system was only 3%.

A: Right. And so that leads to the question that if consumers really want choice, why not just give it to them?

Q: Right, exactly. Why not just give it to them?

A: Certainly consumers would be willing to pay at least 5% more for a plan that gives them the choice to go straight to a specialist. You know from your own experience in the Twin Cities that consumers won't pay 20% more, but they would pay 3% to 5% more. No question about it.

Q: Do consumers demand access to specialists?

A: I think we're already seeing that trend emerging. I just got off the phone a minute ago with a woman who's got a radio show, and her radio show is a cancer support group. So we're seeing more and more instances of the aware patient, the vocal patient, the patient who wants options. As the population ages, our chronically ill support groups are going to be an increasingly vocal part of

"If doctors can create large medical groups using their own capital, then they can own their own businesses. But if the market is such that doctors have to come together quickly, then they will have to go outside for capital. The most likely sources of capital are either the local hospital and health system or a for-profit physician management company. Either way, if doctors must rely on outside capital, then they will be beholden to whoever brings that capital to the table."

those would be the places that I would look to first to form a carve-out organization.

Q: What sort of structure should those specialty organizations have? Should they have an independent practice association (IPA) initially?

A: An IPA should be adequate for specialty subcapitation, and the bigger the IPA, the better. In most markets, I'd like to see not only a regional IPA but potentially a statewide IPA that's

the cardiology networks, and other carve out networks, haven't done much business. There is some skepticism about whether the single-specialty, carve-out approach can be successful. Certainly mental health has been a very successful carve-out, but a lot of other services haven't done much. It's still early. In fact, one of the trends I'm seeing is a shift away from primary care gatekeeping capitation into specialty subcapitation.

the consuming public.

Q: You've written a great deal about these provider-sponsored networks (PSNs) as a power in contracting for Medicare-risk populations. Do you think the power they will wield depends on the legislation now in Congress? Or do you think that's going to be a self-sustaining movement even without legislation?

A: Even without legislation, providers have an ability, at least potentially, to contract with employers, self-funded plans, and with employer coalitions, but very few providers have done so. While the federal PSN legislation would give a major boost to direct contracting, more employer-provider arrangements are likely even without the legislation.

Getting that seal of approval from Washington, a certificate from the federal Health Care Financing Administration, would give contracting buyers a feeling of confidence in these PSNs. So, it's not legally necessary in all states for these PSNs to come together now. California's insurance commissioner, and commissioners in many other states, do not want physician-sponsored or hospital-sponsored networks to do direct contracting without an insurance license, and they are making it very difficult for the plans that were trying to do that. As a result, Mullikin Medical Group just got a network license here in California. They finally said, 'We're not going to waste any more time waiting for the governor to change insurance commissioners. We're just going to get the license, even if we don't intend to use it to compete with our own HMO buyers.' At least in those direct contracting situations now, groups like Mullikin will be able to take global capitation, which isn't legal here in California without it. I think the PSN concept would get a big boost psychologically if providers could get that federal certification.

Q: Do you think those that control the Medicare-risk contracts are going to control the managed care markets?

A: Certainly the mass conversion of seniors to Medicare HMOs is going to be a huge trend in many markets. The number of seniors who have signed up in

HMOs right now is still less than 10%, leaving the other 90% of that absolutely critical Medicare market still to be converted. Even though we're only talking about less than 15% of the population on a national basis, for hospitals and physicians, income from seniors can easily represent 50% to 70% of revenue. Where Medicare goes, the rest of the system's going to follow. If we get a new administration that wants

also their own HMOs. Others will be hospital-sponsored, like the Sisters of Providence in Oregon and Washington State, Intermountain in Salt Lake City, and Harris Methodist in Fort Worth, all of which own HMOs. We're going to see system integration from three sides—hospitals and health systems, physicians, and insurers. Everybody is going to try to put together a fully integrated organization.

"In more advanced managed care markets, some HMOs and capitated medical groups are finding that the primary care doctor may be redundant in a really efficient system. If you have patients who can be channeled directly to responsible subspecialists, and those subspecialists are capitated, then that's a more efficient model than a narrow-gated network."

to convert seniors to Medicare and raises the average fee to \$300 or \$350 per member per month in every market, as is outlined in the Republican's budget reconciliation bill, then we'd have an absolute "land rush" of senior HMOs.

Q: It would be a complete rush to managed care.

A: Absolutely. Medicare HMOs would convert that population, and in three to five years, a majority of seniors would be in managed care.

Q: So your basic outlook on the future is inevitable?

A: Yes. The industrial companies are basically HMOs, fully integrated health care delivery companies, and physician practice management companies. America's largest "industrial health care company" is Columbia/HCA, which, if it bought an insurance company, would become a fully integrated health care service delivery organization with its own financing.

Large medical organizations, such as the Geisinger Clinic, for example, not only have their own delivery systems but

Q: And, finally, what will the physician organization of the future look like?

A: The physician organization of the future will be like a professional law or accounting practice, with a smaller number of senior partners who manage the business and a larger number of associates who are trying to become partners. All physicians will be on salary and have a set of incentives to provide quality care and to be cost efficient. Some of these medical groups are going to have thousands of physicians in satellite clinics across the nation.

Q: So it will be like the big six accounting firms?

A: Definitely could be. And that leads me to ask: What happens with Caremark and PhyCor? What's their ultimate strategy? Can they exist as free-standing companies that are focusing on the physician, or do they need to be part of another larger integration strategy, meaning are they going to be sold to Columbia/HCA? The answer is that I think there's a place for independent physician companies that are well managed. ■

PPMs Are Helping to Drive a Strong Market

Physician practice management companies (PPMs) have enjoyed extraordinary strength in the stock market over the past three years, according to Mark Copman, principal in health care services with Piper Jaffray, an investment banking and securities brokerage firm, in Minneapolis. The accompanying charts were part of a presentation by Copman at the Physicians' Capitalization Conference, in Boston in May.

PPMs have had strong growth in the num-

ber of companies entering the stock market (Figure 1). Also, the stock price has been high (Figure 3). Showing particular strength are single-specialty PPMs (figures 3 and 4).

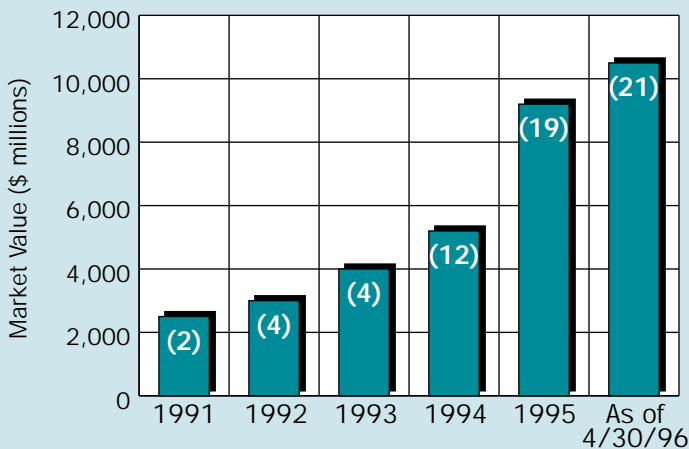
A sign of strength is the average stock price over earnings per share (P/E), shown in Figure 5. Figure 6 shows what a company can expect to spend when entering the stock market with an initial public offering (IPO).

Figures 7 and 8 show the strength of the overall stock market. Figure 7 shows how the

flow of money into the stock market—much of which comes from mutual funds—relates to the amount of money going into IPOs. Figure 8 shows how IPO prices relate to a range of IPO prices. If many IPOs are priced above the mid range, the market is hot and Wall Street has not yet adjusted pricing to reflect market trends. Over the past 18 months, IPO prices have been set relatively within the mid range, meaning the market is strong, but not overheated.

Figure 1: Growth of Publicly Traded PPMs

Number of public companies in parenthesis



Source (for all charts): Piper Jaffray Inc., Minneapolis, 1996.

Figure 2: PPM Categories

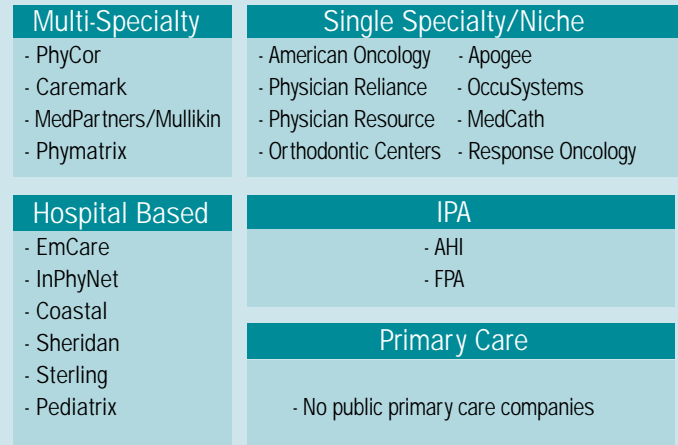


Figure 3: Stock Price as a % of 52-Week High

By category

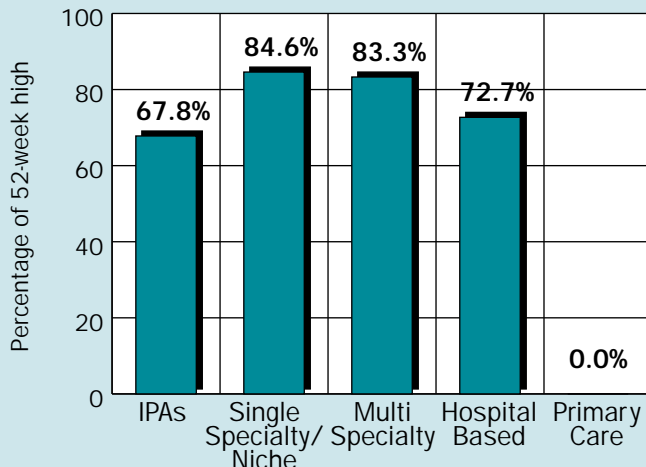


Figure 4: Average 1996 P/E Ratio

By category

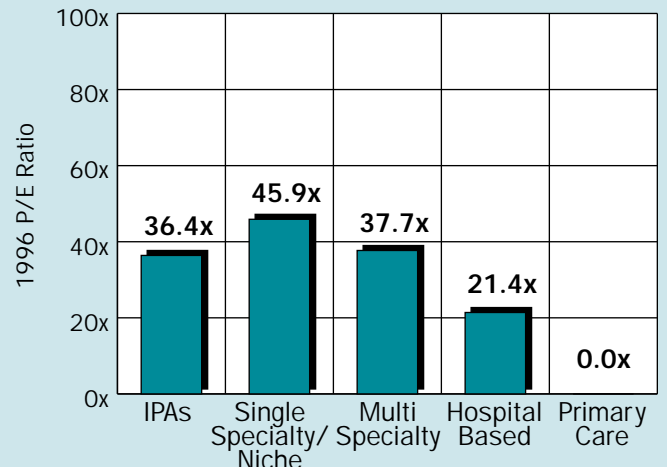


Figure 5: 1996 Average P/E and Earnings Growth

By category

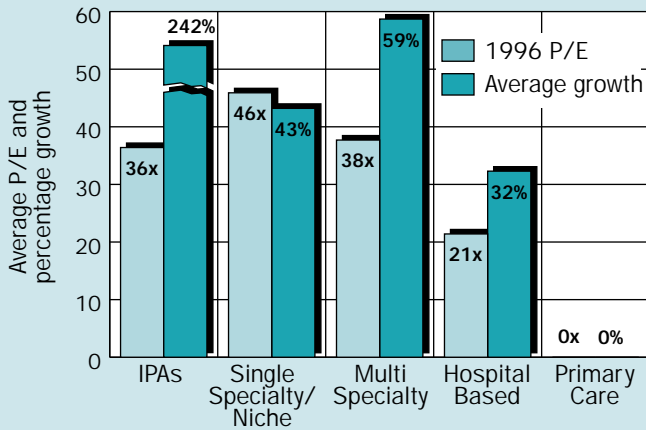


Figure 6: Transaction Economics

Company expenses

Legal	\$200,000 and up
Accountants	\$100,000 and up
Printing	\$100,000 +
Registration fees - SEC	\$ 10,000
NASDAQ	\$ 5,000
Registrar/transfer agent	\$ 10,000
Roadshow and miscellaneous	\$ 50,000
Typical Total	\$475,000+

Figure 7: Net Equity Inflows vs. IPO Volume

(\$ in millions)

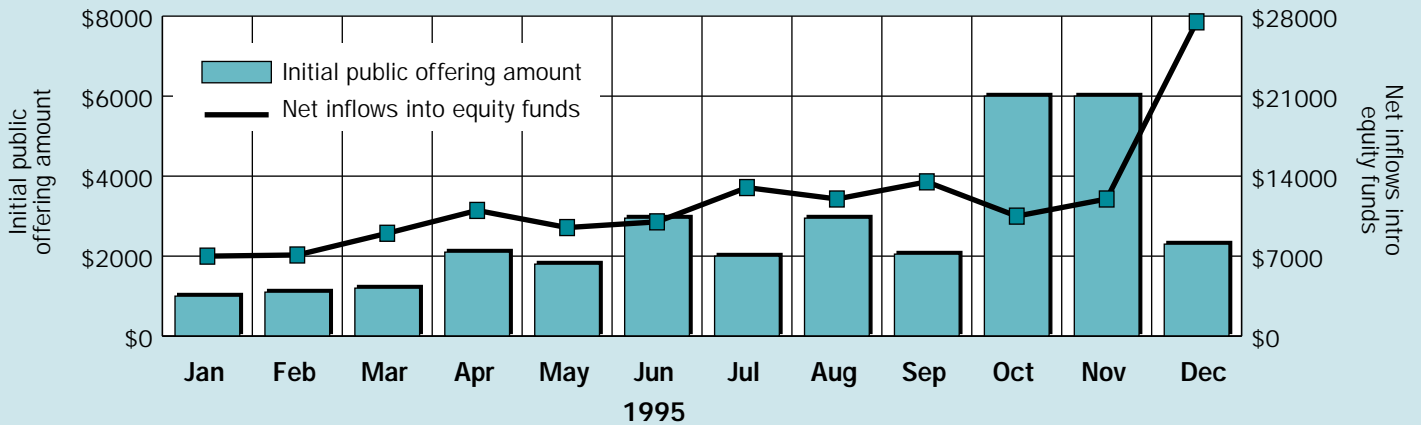
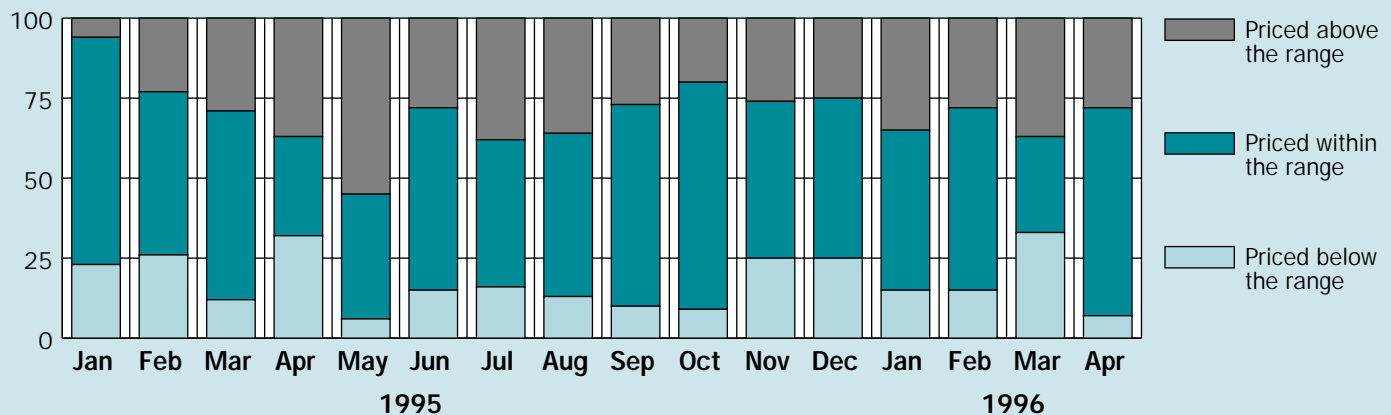


Figure 8: IPO Pricing

Total number of offerings (Jan. 1, 1995, through April 30, 1996)



Preparing for Investment Part One, Creating Leverage

By Marc S. Margulis



Marc S. Margulis, CFA, ASA, MBA is a managing director with Houlihan Lokey Howard & Zukin, in Los Angeles, and a co-director of its health care practice. An Accredited Senior Appraiser and a

Chartered Financial Analyst, Margulis has more than 10 years of experience as a financial adviser to physician practices, HMOs, hospitals, and other health care providers. He holds a bachelor's degree in political science and economics from the University of California, Santa Barbara, and an MBA from UCLA.

Houlihan Lokey is a 25 year-old diversified financial services and specialty investment banking firm that is the nation's largest provider of business valuations and fairness and solvency opinions. It also has an active mergers and acquisitions practice that negotiates, structures, and executes transactions for buyers or sellers, including those in health care. In eight offices around the country, Houlihan Lokey has 250 employees.

This article was part of a presentation Margulis made at the Physicians' Capitalization Conference in Boston in May. It is the first of two parts.

Most physicians and medical group administrators will not be taking their practices public. Many simply want to build physician organizations that are significant assets in their communities and strong enough to remain so over a long period. Alternatively, they may be interested in selling their practices and organizations. In either case, they likely are concerned with building and sustaining value in their organizations.

Building value is difficult today because of changes that have permeated health care

in the past 10 years. In about the middle of the 1980s, when corporate growth slowed, the trade deficit mushroomed, and America's global competitiveness was questioned, executives searched for ways to pare costs. At that time, the managed care era was born. As managed care penetrates deeper into more markets and as integrated delivery systems aim to eliminate inefficiencies, we are witnessing a sea change in health care delivery.

Changes in Health Care

The first change involves moving from treating illness to maintaining wellness. A

for a commercial member. Of that amount, the health plan retains about 18%. Some keep as much as 24%, and some nonprofit HMOs keep as little as 9%. The percentage that they pay out is termed the medical loss ratio.

Out of the 18%, approximately 6% goes for marketing and administration, 9% goes to managing the actual services or the managing of managed care, and about 3% goes to profit. In this example, 82% goes to provide care. Out of that amount, 5% is withheld off the top for risk pools, which provide incentives to primary care physicians, specialists, and hospitals to reduce unneces-

For those who know how to do it, a tremendous amount of money can be made in managed care today and for some time to come.

corollary of this change is that instead of after-the-fact intervention we are moving to before-the-fact prevention. We went from individual patients seeking care from individual doctors, to organizations of providers managing the wellness of entire populations. We went from no risk on the part of providers to providers sharing risk or taking full risk, and from hospitals being profit centers to becoming cost centers.

What we're moving to is an era of managed care but not necessarily one dominated by HMOs. Generically speaking, managed care refers to any cooperative alliance or network of providers intended to promote health, ensure quality of care, and eliminate the unnecessary or inappropriate use of medical resources.

At the top of the current health care structure, we have those who pay for health care, the government and employers. Into health plans, they pay premiums ranging from \$100 to \$135 per member per month

sary utilization. Therefore, only 77% of premium is directly available to pay for medical services.

Under global capitation, one entity takes the fee for the PCP, the specialist, the hospital, and any ancillary care and is at risk for the cost of those services. Under full risk capitation, only the physician and ancillary component is taken under risk. To manage care, including utilization review, case management and discharge planning, member services, provider services, billing and claims adjudication, and all related functions, the company taking the capitation must build or associate with an administrative services organization (ASO) or as a third-party administrator (TPA) or some form of management services organization (MSO). Be aware, however, that the term MSO generally implies the management of managed care plus the ownership of the tangible assets, plus the employment of the front- and back-office

Payers will cut fees to all non-essential players in the market, and physicians will return from the periphery of the system to the center of the system, from near the bottom of the food chain to near the top once again.

staff. In general, market rates for administrative services only are between 11% and 16% of the physician component, or roughly about 4% of the premium. It costs between 9% and 11% of premium to provide these administrative services. Many IPAs and medical groups simply treat their MSO or ASO as a cost center. They charge the system 11%, and it costs them 11%. There's no profit at this level.

Other companies are in business to make the MSO as valuable as possible. Therefore, they'll charge the market rate, which is between 14% and 16% of premium for ASO services while these services cost them between 9% and 11%. So, they make a handsome profit. On a larger scale, this strategy is—in essence—what the public physician practice management companies (PPMs) are doing. They're really MSOs, not medical groups, that have gone public, and the profit is what provides the return to shareholders and the capital to expand.

Under this system, there are many squeeze points where additional profits are available to providers in the short-run and which, in the long-run, will contribute to reductions in premiums. Some observers see these squeeze points as a form of arbitrage. Arbitrage is the opportunity to make a profit risk free from buying and selling the same asset when that asset is priced differently in two markets or when one has two similar assets priced differently in the same market. For those who know how to do it, a tremendous amount of money can

be made in managed care today and for some time to come.

Obviously, one squeeze point is the cost of specialists, which can yield profits to those groups that take full risk capitation. Another point is the cost of hospitalization, which can yield profits to provider organizations that accept global capitation. And another point is the redundant expenditures for administrative services at the HMO level as well as at the provider level.

In the long run, the only two groups that have any control over the patient and the

Many pay lip-service to controlling lives but few fully appreciate its critical importance to the survival and profitability of providers in the future. One health care administrator in Illinois has a plaque that reads: "It's covered lives, Stupid."

health care dollar are the employers (and the government) and primary care physicians. Everyone else in between has only tenuous temporary control over those patients regardless of what they think.

So as costs come down, those savings are going to be passed on in the form of reduced premiums and increased reimbursement to some groups of physicians. In other words, employers and government payers will benefit from eliminating or curtailing fees to all

non-essential players in the market, including HMOs. Physicians will return from the periphery of the system to the center of the system; from near the bottom of the food chain to near the top once again.

Creating Leverage

The result of all this ratcheting down will be over-supply in many sectors. In addition to about 50% over-capacity in hospitals across the country, we're going to have a tremendous over-capacity, by the year 2000, among specialists and an under-supply of primary care physicians.

Thus, the end game strategy is to capture lives now. Many pay lip-service to controlling lives but few fully appreciate its critical importance to the survival and profitability of providers in the future. One health care administrator in Illinois has on his desk a plaque that reads: "It's covered lives, Stupid." Covered lives are highly valued for several reasons.

1. Pre-paid lives or capitation provides a

predictable source of funds. The physician has no receivables, no collection problems, and the ability to plan for expenditures because he or she can be relatively confident of a consistent source of capital.

2. The more covered lives you have, the more leverage you have with payers, assuming you're not dealing with a single large payer in a given market. The more lives you have with any one plan,

the more leverage you will have in future rate negotiations.

3. Having more lives affords leverage with providers. A PCP or multi-specialty group practice with a lot of lives gains significant leverage with outside providers, including specialists, ancillary services, and hospitals that will discount their services or sub-capitate in return for access to the population you control. Next is critical mass. Some estimate that between 25,000 and 35,000 lives are needed for an organization to have capital and cash flow sufficient to invest in the infrastructure needed to manage care effectively. As the organization grows from there, economies of scale begin to play a key role. As a rule of thumb, one administrative full-time employee is required to manage each 1,000 enrollees. The problem is that if you have 25,000 to 35,000 lives, you may still need 50 people in your MSO. But if you have 100,000 lives, you may need only 65 people in your MSO. Therefore, economies of scale can improve profitability as the number of covered lives rises above a certain point.

Moreover, one should consider the effect that large numbers of covered lives have on actuarial risk. The economic risk associated with adverse selection and catastrophic occurrences drops significantly as the number of covered lives increases. Stop-loss insurance through an HMO can cost \$3 to \$4 per member per month. But if your group has 100,000 covered lives, you may not need stop-loss insurance. Instead, you may be able to self-insure and let cash flow cover any adverse consequences.

Choosing a Partner

In the quest for covered lives many doctors form partnerships with other doctors. Naturally, some of these partnerships have been successful, and others have been failures. From each one, there is a lesson to be learned. One such lesson is that the most successful deals are those that are reasoned and reasonable. The best deals are those in which all parties share a common vision for the long-term practice of good medicine rather than focusing on near-term monetary gain. Doctors must realize that an acquisition is an investment and that only a fool makes an investment without

expecting a return on that investment. Sadly, many doctors fail to realize that point. Even sadder is the fact that many hospitals and others have squandered scarce resources pursuing acquisitions such as these.

After fairly compensating the physician,

occupied with administrative and entrepreneurial tasks. That time becomes available in a group or MSO, allowing the physician to see more patients.

If exorbitant premiums are paid and indefensible incomes are guaranteed in the absence of a realistic plan to create or sus-

Doctors frequently ask, "Where am I going to get the time to see more patients without affecting the quality of care?" In private practice about 30% of your work day is occupied with administrative and entrepreneurial tasks. That time becomes available in a group or MSO, allowing the physician to see more patients.

something must be left on the table for the investor. There must be a bottom line and the surest source of such funds is a reduction in physician compensation. But as we all know, physicians are not amenable to reductions in compensation. So if the seller initially retains the entire bottom line from the practice that he's selling you, are you acquiring anything more than stethoscopes and examination tables at an exorbitant premium? Actually, the answer is a qualified, yes, because one could argue that an acquisition of a physician practice is not an acquisition but a partnering of two professional entities. One of the entities may have management skills, and one may have clinical skills. The partners hope that something greater comes from the combination than they could accomplish separately.

Any payment in excess of hard assets is being made for the acquirer's expectation that the practice's earnings will increase as a consequence of consolidation. This increase could result from a number of factors including economies of scale in the front office, control of more lives, managing more of the patient dollar under shared risk contracts, and from increased productivity by the physicians.

Doctors frequently ask, "Where am I going to get the time to see more patients without affecting the quality of care?" In private practice about 30% of your work day is

tain additional value from the partnership, then any sense of victory will be fleeting. If there is no shared vision and no alignment of incentives, losses will mount and reserves will be depleted.

Many organizations are currently experiencing tremendous losses as a result of haste, bad judgment, and poor structuring. There are innumerable examples of PHOs, HMOs, and PPMs that have been either foolish or strong-armed into paying indefensible prices for doctors' practices without making the post-transaction moves necessary to make the partnerships sustainable.

If you become a part of one of these ill-conceived partnerships, you can expect that your compensation will be reduced at the acquirer's first legal opportunity. The result of such an action, of course, will be disaffection and disassociation, likely coupled with lawsuits. Even with seemingly unlimited resources, HMOs, MSOs, PHOs, and even PPMs cannot lose money indefinitely without incurring the risk of confrontation with shareholders, regulators, or a bankruptcy court. The moral of the story is clear: Choose your partners, whether they be financial or strategic partners, carefully. ■

Coming next month, "Preparing Your Organization for Investment: Building Value in a Physician Practice."

Primary Care Network Forms in Boston

Seeking increased leverage with insurers and managed care organizations (MCOs), some 150 primary care doctors in metropolitan Boston have formed a network called Primary Care. The group plans to serve more than 250,000 patients in 60 communities in and around Boston. The doctors in the group will negotiate jointly with insurers and MCOs and share computer systems and managerial and administrative operations. The group says it is the first large doctors' network in the state that will focus on primary care and that is independent of hospitals.

"What we're offering is a new model for this region," Guy A. Spinelli, MD, an internist in Quincy, Mass., told *The Boston Globe*. "This is a grassroots effort of physicians joining this organization."

The doctors are working together to gain more autonomy in treating patients, Spinelli told *The Globe*. To

date, physicians have been passive participants in the changes in health care, Spinelli said. "Some of the terms have been dictated by hospitals and insurers," he explained. "We don't want to see outside interests coming in and being in a position to tell physicians, 'You have to do such and such.' We want to make sure that care is guided by the patients' interests, not being controlled by other interests."

The group plans to raise more than \$1 million over the next three years, hire a chief executive, a financial officer, a medical director, and other staff, Spinelli said.

Comment: Doctors in New England, and Boston in particular, are notorious for working in solo practices. Given the pace of managed care in Massachusetts, physicians need to aggregate just as hospitals and managed care organizations have done.

Managed Care Brings Hospital Job Losses

A merger between Boston City Hospital and the Boston University Medical Center will mean 1,300 job losses within five years, according to a union local. City officials questioned the union figures and said Boston would suffer even more job losses without the merger. One city official said New England would lose 45,000 health care jobs by 2001 because of managed care, declining hospital stays, and new technology.

Nationwide, uncertainty about hospital-provided health care has led to a decline in morale among hospital workers. A recent survey of hospital executives showed that 81% of 691 respondents said employee morale was their No. 1 issue, up from 75% in 1994 and 69% in 1993, according to *Modern Healthcare*, a news magazine in Chicago, and Deloitte & Touche LLP, consultants in Los Angeles.

About half of the hospital executives reported uncertainty over

health care reform as a key reason morale has dropped, according to the ninth annual Hospital Human Resource Survey. Other sources of anxiety include a change in job duties, layoffs, lack of communication, and competitive pressure. A distant second in terms of challenges was the effect of downsizing (53%), followed by benefit costs (50%), staff reductions (49%), and control of salary increases (46%). Some 55% of respondents expect to keep their labor force constant over the next 12 months.

For a copy of the survey, call Deloitte and Touche at 213/688-3358. The price is \$10.

Comment: A fully capitated, efficient managed care market requires one hospital bed per 1,000 HMO enrollees. Eastern cities have 2.5 to 6 beds per 1,000 HMO members. In New York City alone, two recent studies showed that 33% to 50% of beds may close in the next three years.

Methodist of Houston Builds PCP Network

To increase its flow of patients, Methodist Hospital in Houston is developing a group practice of primary care physicians (PCPs), according to *The Houston Chronicle*. The Methodist Medical Group will start with 11 physicians and expand to 100 doctors in five years, officials said. The group plans to sign affiliation agreements with 100 other doctors who are not ready to join the group practice. The hospital needs PCPs, the gatekeepers of managed care, because 99 percent of the doctors who admit patients to Methodist are specialists. Methodist and the doctors will share ownership in a new organization that will run the group practice.

Comment: With its reputation as a specialized world-class referral center for cardiovascular disease, Methodist has not needed managed care. But by adding a PCP group practice, it is admitting that it is no longer at the pinnacle of health care.

Trials Planned for Medicare-choice Plans

To give Medicare recipients more choices among managed care plans, the federal Health Care Financing Administration (HCFA), which manages Medicare and Medicaid, is developing a trial for health plans in several markets. Some 25 managed care plans in eight cities and five rural areas are final candidates for the trial program, called the Choices demonstration project.

Currently, Medicare enrollees can get care from one of 300 HMOs nationwide. Under the Choices project, beneficiaries in some areas would be able to choose from among nine provider-sponsored networks, eight provider-owned HMOs or providers with HMO partners, and eight HMOs or preferred provider organizations. Some of the programs will begin this summer, and others will be operating by December.

Comment: Most of the Choice plans are in markets that currently have limited Medicare enrollment in managed care. The eight cities are San Diego; Jacksonville, Fla.; Orlando; Atlanta; New Orleans; Columbus, Ohio; Philadelphia; and Houston. The rural areas are in Illinois, Montana, New York, North Carolina, and Virginia.

Some HMOs Are Eliminating Referral Red Tape

Finding referral bureaucracy expensive and annoying, some HMOs and medical groups are letting primary-care doctors refer patients to specialists without getting HMO approval.

Blue Shield of California, in Los Angeles, is letting patients schedule appointments directly with specialists at medical groups and small regional physician networks that have contracts with the HMO, according to *The Orange County Register*, in California. The patients must pay \$20 to \$25 above their normal co-payment of \$5 or \$10.

PacifiCare, of Cypress, Calif., plans to spend about \$250,000 for computers for two medical groups to eliminate referrals for 120 conditions. By the end of the summer, Health Net, in Woodland Hills, Calif., will use a computer at a Philadelphia medical group that has 30,000 members to streamline referrals. Patients seeking referrals for costly procedures will continue to go to medical

directors and committees.

The California Public Employee Retirement System, which administers health care for 1 million Californians, found difficulty in getting referrals was the second most important reason its members switched health plans. The No. 1 factor was cost.

Such changes may not mean patients will get to see specialists more frequently. But removing the procedural hurdles will save time, and the inability to see specialists quickly has been among the biggest complaints of HMO members, the newspaper said.

"You get happier members. You get happier physicians. And you lower costs," said Chris Wing, vice president and general manager of PacifiCare Health Systems' Southern California operations. "This ain't rocket science."

Comment: Evidence is mounting that shunting all patients through primary care gatekeepers doesn't save money.

Health Plan Removes Capitation

Physicians Health Services (PHS), an HMO in Trumbull, Conn., is eliminating individual physician capitation and returning to a fee schedule. Richard O'Connor, MD, PHS' senior medical director, said the decision means that patients' health care will not be compromised due to financial pressure on physicians. The HMO operates in Connecticut, New Jersey, and New York.

In a capitated health plan, physicians are paid a set fee each month for each member in the plan, regardless of the level of illness among plan members. Therefore, the physician is at risk for any health plan member whose costs exceed the capitation payment. Conversely, if plan members are healthy and require few health services, the physician may profit.

Comment: PHS may be first example of an HMO buckling under pressure from consumers and the media, which view capitation negatively because it gives doctors a financial incentive to limit care.

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