

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Dartmouth Study On Variation Offers Lessons for Physicians

Data from the recently released Dartmouth Atlas of Health Care, an analysis of 1993 Medicare data, show a crazy-quilt pattern in which costs for Medicare patients vary widely from one city to another nationwide. Scheduled to be published this spring by the American Hospital Association (AHA), the atlas is the result of 10 years of research into the cost and kinds of treatment provided in markets across the country.

The atlas shows that the cost per Medicare patient in Miami is twice that of Medicare patients in Minneapolis, for example. The rate of back surgery per capita in cities in the West is often three to six times that of cities in the East. The rate of mastectomies per capita, as compared with lumpectomies for breast cancer, varies as much as 33-fold from one community to another.

Opinions about the data vary widely. The main author of the study, John E. Wennberg, MD, an epidemiologist at the Dartmouth Medical School, in Hanover, N.H., says the findings “explode the myth that this country has a health system.” The director of the Dartmouth Center for Evaluative Clinical Sciences, Wennberg is widely respected among health care buyers for his work on variation in medical practice.

Supply Drives Demand

Jack Lord, MD, senior medical adviser for the AHA, says the atlas shows that the more doctors and more hospital beds are available, the more doctors do. In other

words, “supply seems to be the driver of demand,” Lord said.

At *Physician Practice Options*, we take a more pragmatic view of the data. It is not news that Medicare reimbursement rates vary from one section of the country to another. Per-capita costs of more than \$600 are highest in New York, Florida, and Pennsylvania, where costs for all services—not simply medical care—tend to be high. Also, states with the highest costs generally have minimal managed care penetration. Examples of states with high Medicare costs and low HMO market penetration include Texas—where less than 12.4% of the population is enrolled in managed care plans—Alabama (7% in managed care), and Tennessee (5.6%). Finally, high managed care penetration breeds capitated reimbursement rates. Systems where capitation is widespread force cost reductions of 25% to 40%. Cities with significant numbers of Medicare patients enrolled in HMOs, such as Honolulu, Minneapolis, Portland, Ore., and San Francisco, have low Medicare rates.

These caveats notwithstanding, the Dartmouth atlas findings are important for physicians—indeed for everyone in health care—for three reasons:

1. The data add fuel to the debate over the need for market reform. Payers are demanding reform on the theory that uniformity in treatment and costs is a measure of value and an indicator of quality. Many health care buyers believe providers should adopt continuous quality improvement methods. They regard the minimization of statistical variation

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Exercising Our Options as Physicians

The mission of *Physician Practice Options* is to give physicians the information, tools, and strategies they need to exercise their options. Those options include retaining your practice as is, bringing in a practice management consultant, selling your practice, merging with another practice, joining an integrated management organization, becoming a salaried employee at a health plan, or simply retiring.

Under managed care, physicians are facing many new realities in the medical marketplace, new rules, and are finding that new responses are required in a system that has been radically transformed.

- The new realities are that physicians will practice in a delivery system in which 90% of patients will be directed to organized networks of physicians and hospitals.
- The new rules dictate that providers deliver just the right amount of care at the right time in the appropriate setting at the best price and by the appropriate people—no more and no less.
- The new responses will require that physicians work within the context of an organized system of care or a group that provides physicians with the necessary tools, the capital, marketing support, managed care contracting skills, negotiating ability, and the information and data-management systems.

For many of our readers, the forces of managed care are closing in. But while managed care is not your only option, it is one of the most significant forces in the market today. More than 70% of U.S. workers belong to managed care plans, and managed care is growing quickly among Medicare and Medicaid participants. A dominating force in many markets, it is becoming stronger each year.

In the past two years, managed care broke the long string of ever-rising health care costs. For the first time in 40 years, health inflation rates dipped below general inflation rates, a tribute to managed care's effectiveness in containing costs.

A Question of Trust

Lower costs, however, came at a steep price: growing distrust of health care companies among patients and physicians. In this issue, we catalog mounting and pervasive evidence of this distrust and outline how physicians can respond. (See, "Should the Bottom Line Be a Barrier to Care?" page 4.) In the Feb. 22 issue of *The New England Journal of Medicine* two articles (Levinsky, N.G., "Social, Institutional, and Economic Barriers to the Exercise of Patients' Rights," and Weston, B. and Lauria, M., "Patient Advocacy in the 1990s") make the point that by punishing doctors economically and by dropping them from networks when physicians prescribe expensive or last-ditch treatments, managed care companies are driving doctors to defend their patients' rights to quality health care.

After all, physicians are patient advocates. It is our duty to join patients in demanding that managed care organizations reveal economic barriers to care. It is our duty to remove those barriers when they don't serve patients. And, it is our duty to view patients as vulnerable human beings, not as economic pawns in a chess game where profit is the goal.

As physicians, we have another option: to expose managed care's abuses by writing to health plan executives, insurance commissioners, local newspapers, and elected officials about inhumane or arbitrary barriers to intelligent and compassionate care.

Our mission is to help physicians adjust to all of these new realities. Toward that end, *Physician Practice Options* has assembled an advisory board and is preparing an editorial line up with these needs in mind. In the coming months, we will deal with each of these issues and more. In the meantime, we would like to hear from you. What do you think about how physicians should respond to the new rules? How can physicians respond to make the system work for patients, and payers? You can call us or write to us at the addresses on this page. We welcome your comments and suggestions.



Editor-in-Chief

Daniel Beckham

President
Daniel Beckham & Co.
Whitefish, Wisc.

James Darnell

Chief Executive Officer
Alliance of Healthcare Advisors Inc.
San Francisco

Michael Guthrie, MD

Physician Executive
Colorado Springs, Colo.

Hal Kaiser, MD

Specialist, Internal Medicine
Minneapolis

Nathan Kauffman

President
The Kauffman Group
San Diego

Paul Keckley

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Minneapolis

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Vaughn Smith

President
American Association of Health Care
Consultants
Alexandria, Va.

Jacque Sokolov, MD

Chairman of the Board
Coastal Physicians Group Inc.
Los Angeles

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Editor-in-Chief

Richard L. Reece, M.D.
860-395-1501
e-mail: RReece1500@aol.com

Editor

Joseph Burns
508-495-0246
e-mail: 76331.2615@compuserve.com

Publisher

Premier Healthcare Resource
201-701-8250
e-mail: hanyakker@aol.com

Editorial Address: Burns or Reece

Publishing Address: Premier Healthcare Resource, Inc.
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as a key measure of quality. Employers expect similar treatments and similar procedures to be similarly priced. In addition, they expect similar outcomes in various sections of the country.

2. Managed care organizations (MCOs) likely will use the data to market their services to payers on the premise that MCOs can improve care by using clinical guidelines to reduce utilization of hospital services, surgical procedures, and diagnostic services.
3. For the first time, physicians have an authoritative national data source to compare their costs and treatments against their peers in other sections of the country. Many physicians have been functioning in a data vacuum and have had no barometer by which to judge their use of resources.

In response to the Dartmouth study results, physicians should consider organizing themselves into large groups in an effort to minimize variation, improve efficiency, and reduce costs.

Low-cost Regions

Consider, for example, the number of elements the 10 low-cost metropolitan regions have in common. The low-cost cities are Lincoln, Neb.; Rochester, Minn.; Honolulu; Minneapolis; Lacrosse, Wis.; Rochester, N.Y.; Portland, Ore.; San Francisco; Seattle; and Temple, Texas. In these 10 cities costs are 21% below the national average. Also, these regions have 18% fewer hospital beds per 1,000 population than the national average. Doctors in these regions perform 24% fewer coronary angioplasties annually than the national average.

But the numbers alone don't tell the story. The most important characteristics of the low-cost regions are these: A tradition of group practice, long-established systems of care, and the development of managed care is mature in these markets. (See related article, "Study Shows How Managed Care Reduces Costs, Mortality," page 8.) For example, Lincoln, Neb., has several large clinics. Minneapolis has a long history of group practice, a national reputation as a mature managed care market, and a tradition of collective action in all phases of its society, particularly among health care buyers. Honolulu is the largest city in

a state with a 20-year policy of universal coverage, and Kaiser Permanente has an established presence there. Lacrosse, Wis., has two long-established large medical clinics, and Wisconsin has a high managed care penetration in urban and rural markets. Rochester, N.Y., led by its large businesses, particularly Kodak and Xerox, and its hospital consortium, has become a national model of managed care success.

"The atlas should spur a national debate among physicians, health system leaders, and members of their local communities and bring us closer to a rational health system."

— Dick Davison, president, American Hospital Association

Kaiser has a lock on the health care markets in San Francisco and Portland, Ore. Likewise, the Group Health Cooperative of Puget Sound and the Virginia-Mason Clinic, both large HMOs, dominate the Seattle market. The Temple Clinic has long fashioned itself as a mini-Mayo and is the largest group practice in Texas.

Most of these regions are west of the Mississippi and in each one physicians led the movement to managed care. The fact that physician-led collectives can reduce costs and improve care has been shown dramatically in California over the past three years.

Another striking fact about the low-cost cities is their culture. Most are known as safe cities of civility with low rates of crime, poverty, social pathologies, and welfare burdens. In such areas, health costs tend to be more manageable.

High-cost Regions

Conversely, among the most striking aspects of the 10 high-cost metropolitan regions is the fact that managed care penetration is low. The 10 high-cost cities are Miami; New Orleans; Houston; New York City; Chicago; San Antonio; Pittsburg; Nashville; Birmingham, Ala.; and Jacksonville, Fla. The average HMO enrollment in the 10 high-cost cities is 18.9% of the total population, and the average HMO enrollment in the low-cost

cities is 23.2%. Many of the high-cost cities are in the chaotic stage two of managed care maturity. In this stage, physicians are just beginning to consolidate into large groups and there is much realignment among provider groups. The hospitals have excess bed capacity at 4.1 beds per 1,000 population, 24.2% above low-cost cities, and more than twice the rate of 2.0 beds per 1,000 that HMOs need.

In addition, most of these high-cost cities have high Medicare reimbursement rates—an average of \$577 per capita—compared with \$450 in the low-cost cities. Most are sprawling cities with populations ranging from 927,000 to 9.6 million. Many have intractable urban problems, and the average percentage of uninsured is 19.5%, well above the 12.7% rate for the low-cost cities.

Because they have an oversupply of beds, specialists, and high costs, such cities as New York, Chicago, and Miami are especially vulnerable to managed care market reform. Such reform leads to a surplus of specialists and hospital beds and plunging hospital occupancy. Hospitals and specialists in high cost cities in the South are vulnerable too. It is no surprise that such organizations as Columbia/HCA, PhyCor, and United HealthCare have targeted large cities in the East and South for managed care market reform.

Conclusion

The Dartmouth data show that from the payers' view, wide variation exists in cost, hospital use, number of physicians, and procedures. The variations are so wide that payers are likely to conclude they are irrational. To control costs, all payers will promote managed care and other market forces to bring supply in line with demand, to force unneeded hospitals to close, and to deselect specialists from networks. ■

Should the Bottom Line Be a Barrier to Care?

As managed care assumes a larger role in the health system, Americans have become increasingly uneasy about seeking health care from for-profit managed care companies. We're suddenly asking: Can we really trust managed care—or doctors driven by profit to provide less care—to do the right thing for Americans?

Recent Evidence

- In January, a *Time* magazine cover depicts a doctor gagged by his own surgical mask. The accompanying cover lines trumpet an article inside, "What Your Doctor Can't Tell You: An in-depth look at managed care and one woman's fight to survive." The article says managed care reduces costs but compromises the care of those with severe, expensive, and terminal illnesses.
- *The New York Times* reports on the deleterious effects of managed care on mental health and AIDS care. "Managed Care Has Trouble Treating AIDS, Patients Say" (Jan. 15) and "Critics Say Managed-Care Savings Are Eroding Mental Health Care" (Jan. 24).
- *The Boston Globe* reports on Jan. 23 that the Massachusetts legislature wants to bar health insurers from limiting doctors' freedom to talk to patients about coverage and financial incentives. New Jersey considers a similar measure.
- *The New England Journal of Medicine*, in a series of articles, editorials, and reports late last year, questions the morality of managed care, its adverse effects on academic medical centers, its devastation of specialty care, its negative effect on public hospitals and Medicaid populations, its suspect financial arrangements with physicians, and its emphasis on profit.

Perverse Incentives

These news items raise three troubling

issues. First, when the doctor and the HMO have financial incentives to cut costs, can you trust either the doctor or his payer? Second, who will protect the helpless—the old, the poor, the mentally ill, or the terminally ill—against the hard-edged realities of the marketplace? Third, since managed care has moved between doctors and patients, physicians are removed from their traditional role as patient advocates, says James T. Darnell, CEO of the Alliance of Healthcare Advisors in Lafayette, Calif. "Doctors are divided between serving the payer and

serving the patient," he says. "You can't serve two masters."

To be sure, some studies over the past several years have shown that members of managed care plans in many markets are satisfied with the care they received. In some cases, managed care patients preferred their health plans to more traditional plans. These survey results don't get widely reported in the consumer press, however.

Indeed, most complaints about managed care, though sensational and troubling, are scattered and anecdotal in

The Physician's Role

As the center of the health care system, physicians are concerned about any abuses and about any deterioration in the relationship they have with patients. After David U. Himmelstein, MD, an outspoken member of the Harvard Medical School, criticized managed care last year, he was summarily dropped by U.S. Healthcare. In the *New England Journal of Medicine* (Dec. 21, 1995), Himmelstein and his wife, Steffie Woolhandler, MD, wrote an editorial, "Extreme Risk—the Corporate Proposition for Physicians," which questions the motives of managed care and U.S. Healthcare in particular. "This 2.4 million-member plan spends only 74.4% of its revenue on medical care; \$1 million a day goes to profits, adding to its \$1.2 billion cash reserve." In addition, they said, U.S. Healthcare limited what they could say to their patients about the cost of care.

At the end of their editorial, this notice appears: "Addendum: On Dec. 1 1995, Dr. Himmelstein received notice from U.S. Healthcare of his termination without cause, effective Feb. 26, 1996."

On Feb. 4, U.S. Healthcare removed the so-called physician gag rules and instead encouraged primary care doctors to discuss with patients pertinent details of their conditions and the HMO's reimbursement policy. The new provision is designed to encourage doctor-patient communication. Moreover, U.S. Healthcare later reinstated Himmelstein.

HMOs reserve the right to terminate any physician without cause and without due process. These organizations can deselect any physician from their networks without explaining why.

Many doctors are asking: What can I do about managed care? How can I take a proactive approach with my patients without offending the HMO? Doctors must be honest and explain that the health system in general and HMOs in particular must operate within a budget. Explain that conservative medicine is sometimes the best medicine. And, in your judgment, an expensive procedure or treatment is indicated, you will serve

“The most fundamental question raised by the new medicine is one largely missing from public debate: Can you still trust your doctor?”

— Time magazine, Jan. 22

nature. Nevertheless, they lead state and federal legislators to propose to regulate HMOs more closely. These legislative efforts inevitably pit the powerful political forces of business against physicians

and consumers. The result is that HMOs have repeatedly defeated doctor-led rebellions, such as the any-willing-provider laws in many states.

What managed care’s critics don’t real-

ize is that managed care is inevitable. After all, managed health care has successfully controlled the cost of care, and, as a result, American businesses have shifted more than 70% of their employees into such plans. Therefore, any backlash against managed care is simply a sign that Americans are coming to grips with the inherent economic realities that come with reductions in care. The backlash will not persuade businesses to turn against managed care. It may, however, lead businesses and legislators to modify abuses. ■

as the patient’s agent.

“There are many legal ways to confront the backlash against managed care,” says James T. Darnell, CEO of the Alliance of Healthcare Advisors, in Lafayette, Calif. “Physicians, and particularly those in primary care, do not realize their power and have been kept confused by health systems trying to control patients.”

One of the best ways to improve care is to be among those reforming the health system. For example, wherever possible, physicians should be active in seeking to build market-driven systems that control costs and improve quality. When doctors are involved in building such organizations, patients and doctors typically are satisfied with the results. Some of the multi-state health care management organizations begin with primary care, for example, Darnell says. They don’t own specialists or hospitals and they don’t pit specialists against primary care doctors. These organizations are physician driven, provide a level of independence, and educate physicians in managed care issues.

Another suggestion is to engage in a

risk-bearing or risk-sharing arrangement, says Bernard A. Rineberg, MD, a consultant and founder of BAR Health Strategies, in New Brunswick, N.J.

“Since physicians are responsible for 80% of health care expenses and have the responsibility of patient care, they are in the unique position of managing the re-engineering of health care delivery. This strategy allows us to continue to provide the highest quality care while delivering the most cost effective care.”

Clearly, doctors must be on the consumer’s side. One California neurologist, Vincent Riccardi, MD, has established a company, American Medical Consumers, that dispatches “personal medical advocates” to lobby on behalf of patients before managed care plans. Other strategies include the following:

- Survey your HMO patients on satisfaction. In addition to demonstrating your concern for patients, such surveys can help you improve your practice and give managed care plans tangible evidence of your performance.
- Encourage your state government or the large employers in your area

to conduct broad consumer surveys to help patients make informed choices about managed health care. Minnesota has formed the Health Data Institute to question health plan enrollees about satisfaction, physician choice, coverage, access, and customer service.

- Use your role as a practicing physician to question managed care abuses, to praise managed care virtues, and to educate your community about managed care. Do so tactfully and objectively, perhaps in a newsletter to patients or a column or letter in the local newspaper.
- Educate yourself about the clinical and business principles of managed care. View this exercise as an opportunity to understand the objectives of managed care to position yourself to be attractive to managed care plans.
- Put the issue in perspective. Health care buyers are seeking value. They want low costs and high quality for the patient. If you can deliver both by operating more efficiently, you’ll likely survive. ■

How Doctors Can Thrive In the New Environment



The author of Embracing Change: How To Survive and Thrive in Managed Care 1995, Brian C. Smith is an expert in the development and marketing of prepaid managed care organizations.

The founder and president of B. Castle Smith & Co. Inc., in Pasadena, Calif., a managed care consulting and research firm, Smith has 15 years of experience in provider contracting, new product development, and major account sales and marketing with two national HMOs. Previously, Smith served as vice president, network development, for Health Net Inc., in Woodland Hills, Calif., one of the nation's largest HMOs. Editor-in-Chief Richard L. Reece interviewed Smith last month. To order Embracing Change please call 800-679-1200.

Q: Why did you write this book?

A: Two years ago, when I started talking to doctors about managed care, there simply wasn't any tool that I could use to direct them to take home to sit down and think through what these changes mean. And so I wrote the book, and tried to translate the language of managed care into English. So far 25,000 people have seen the book, and I was surprised by the number of entities in California that bought the book. Everyone thinks California is in Stage 5 of a four-stage evolution of managed care. The fact is that you've got a tremendous diversity of markets in California. And so it really surprised me when companies like Mullikin Medical Centers, Scripps Health, Foundation Health Plan, and PhyCor purchased these books for their physicians as a way to help get across from a management perspective why they were adopting some of their strategies and why it was important for physicians to understand the com-

ponents of managed care and where physicians fit in the picture.

Q: Much of your experience is in the California HMO market. Could you briefly describe the impact on medicine HMOs are having there?

A: To do that, you have to tell two different stories. One is the Southern California story and one is the Northern California story. The delivery of health care in Southern California evolved quickly into large multi-specialty groups. In 1979 and 1980 the growth of those multi-specialty groups and the growth of HMOs went hand-in-hand. As the HMOs grew, these very-integrated or relatively-integrated medical delivery systems grew and that growth was expedient for both.

In Northern California, where there are few medical groups, the growth in managed care was very different. By the way, managed care in Northern California is what I call managed care

From Embracing Change by Brian Smith

It's safe to say there is no greater source of anxiety, confusion, and outright fear these days in the lives of private practice health care professionals than managed care. When deciding whether to participate in managed care—or how best to position themselves with managed care organizations—many physicians choose the 'action' of taking no action.

“Or perhaps worse, they organize in reaction to the 'threat' of managed care into ill-conceived networks created to preserve the status quo rather than re-

engineering their processes to meet the changing demands of a competitive third-party payer marketplace.

“Evidence gathered from mature managed care markets indicates that many private practitioners have paid a severe price for their 'ignore-it-and-it'll-go away,' status quo preservationist strategies.

“Clearly, the successes and failures of physicians in managed care's early stages of development suggest the wisdom of maximizing one's options, rather than limiting them.

“Health care in the United States will

always be a regionally idiosyncratic and massively political industry. But research into the profiles of managed care 'winners' in now heavily managed care penetrated markets indicates four common behavioral characteristics:

1. They educated themselves about the clinical and business principles of managed care. Whatever course they ultimately chose with regard to integrating managed care contracts into their practices, they chose with their eyes at least partly open as to what they were getting into.

alternatives to Kaiser because, of course, Kaiser created the managed care market in the 1930s in California. But even Kaiser is different between Kaiser South and Kaiser North. So the point is that the impact of managed care on physicians in California has been very different in Southern California than it is in Northern California and will probably continue to be that way. In Northern California, independent physician organizations play a significant role in health care. While in the south, the tremendous growth of companies such as Friendly Hills, Mullikin Medical Centers, Scripps, and Health Care Partners, has helped shape the market very differently into a model that is focused on full or global capitation.

In Southern California, the medical group purchases a hospital and can negotiate on a global capitation basis of \$75 to \$80 per person per month. That fee is twice the rate of \$40 for professional services only. In addition, these Southern California medical groups can negotiate up to three times that global capitation rate for Medicare-risk populations. That has driven this large integration model in Southern California. Many people point to this model as an important trend for the rest of the country.

Conversely, Northern California is a very different story regarding physicians, hospitals, and global capitation.

Q: *One of the surprises of the California market is how fast the partially integrated organizations, such as independent practice associations (IPAs) have out-maneuvered Kaiser and gained market share. Why is that?*

A: Well, thank God Kaiser limited its vision, or strategy, to being Kaiser. In other words, they defined their business as the pre-paid group practice of medicine. Because if they had defined their business as being a hybrid delivery system for health care, they could have conquered the world.

There's a couple of ironies here. In the late 1970s and early 1980s, when companies, such as Health Net and PacifiCare were just starting, everyone thought Kaiser would take over everything. In fact, that didn't happen. Kaiser used to be very much the low-price prepaid plan, and that's where a lot of their early market dominance came from. But in the last few years, Kaiser became the highest priced health plan. The reason is that Kaiser became very bureaucratic over the years and focused on building facilities planned in an environment of annual growth. In fact, Kaiser has built some hospitals that it never opened

because it lost track of the fact that employers are the top of the food chain. And employers want to buy health care for all of their employees and there isn't any one model that fits all of their employees. So the IPAs and the semi-integrated medical groups that affiliated with network model HMOs could branch out and have a very diverse geographic range. As these IPAs and semi-integrated plans began to gain more members and earn more revenue, they gained more significant market share.

So the irony to me is this: If integrated medical groups believe that one model is going to be the right model, they are mistaken. Here's an example: I sat with the administrators of a group that had 80 physicians, very successful, but they had five dots on the map. In other words, they had five facilities in and around a particular city. What I tried to explain to them five years ago was to look at all of the outlying rural areas where potentially you could do business if you organized your physicians through an IPA. Clearly, it wouldn't be as efficient as your large group practice, but you're in a transitional market, and if you can be the one-stop provider of a well-run IPA, then an amazing thing happens: The entire market increases.

(Continued on next page)

2. They saw change as opportunity. Instead of fighting managed care unilaterally ('I was practicing quality care before you arrived' or 'I didn't go to medical school to report to a nurse' or 'Managed care makes sense for others, but not for me'), they proactively sought to match their personal and professional objectives with those of other professionals in their regions. They sought to become part of the solution, not part of the problem.
3. They somehow moved beyond the external definition of managed care as 'something that someone from the outside does to me' to a more internalized concept of 'a process that seeks to provide the highest quality and most cost effective health care to defined popula-

tions of patients.'

4. They understand the primary objectives of managed care, which are maximize quality, maximize patient service, and minimize total cost per person per year. As David Vogel, a managed care consultant, writes in *The Physician and Managed Care*, 'When physicians and managed care organizations (MCOs) have accomplished all three of these objectives, they have maximized the value of the health care service they are providing to their patients and members. When value has been maximized, physicians and MCOs are producing what the health care market is demanding. It is becoming increasingly apparent that the providers and MCOs that are market-

driven and value-based in their provision of care will have the greatest likelihood of being rewarded with a steady flow of patients.'

"...If you choose to actively pursue the managed care market, you are certain to fail until you can accept the idea that it's conceptually possible for you to become a better utilizer of resources, to achieve better clinical outcomes, and improve your processes within the new world of collaborative, competitive, and accountable health care. Embracing and accepting inevitable change is difficult. But for most physicians who desire to survive and thrive in private practice into the 21st century, the consequences of failing to adapt to change are clearly worse."

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Administrators are always worried about losing market share to other groups. They say, 'If I put other IPAs out there, I'm going to lose patients to them.' Well, that's not true. Those patients that you've captured in your fairly integrated staff models, or medical group models, are going to stay there. But by adding loosely integrated IPAs you're able to increase the total amount of membership that you control and increase your geographic diversity. In essence, you have much bigger network.

Q: You say in your book that managed care is an explosive market force, not just a trend, and you're implying that this is going to happen spontaneously and inevitably and with great force and quickly.

A: Let me offer a market-specific example. Take an area like Portland, Ore., where there are 2 million people. In any area, 20% of the population is going to be uninsured, 11% is going to be on Medicaid, 10% is going to be on Medicare, and the rest are going to be commercially insured patients. The Medicare market segment in Portland went from 0% to 60% penetration within five years. So if you weren't ready, if you had not built plans and were not ready to expand in that market segment, you just lost all ability to go in and be a Medicare provider there in those years.

In California, where the first Medicare-risk project happened in 1975, the Family Health Plan made Orange County its major market area. Well, it took about 20 years to get to 55% or 60% penetration there. In Portland it took three. So the point is that the speed at which a market is going to change in the 1990s is dramatically faster than the it was 20 years ago.

Q: Do you think, for example, in New York City, which has a high rate of reimbursement for Medicare patients, this market penetration will happen quickly?

A: If you look at the markets with the highest average per capita federal reimbursement rate, those marketplaces are going to have the quickest and fastest Medicare-risk reimbursement penetration. Simply follow the dollar. When you have a range of \$752 down to \$290 for average

annual per capita, obviously HMO operators are going to focus on where the dollars are first. Of the 3 million Medicare-risk members today, nearly 40% live in California or Florida, two high cost and high reimbursement areas.

Q: In other words, because 40% of all patients and 70% of all medical revenue come from Medicare, Medicare-risk HMOs can transform a market almost overnight.

A: Absolutely. In fact, take the San Jose Medical Group, for example. It sent a letter to all of its non-Medicare-risk patients that it would no longer accept fee-for-service care. If these patients wanted to con-

with this kind of arrangement. For example, if you are a hospital contemplating being in the Medicare-risk business, you should have a strong network of home care, durable medical equipment, and all the ancillary components, because the game now is to get the patient out of the hospital. The ultimate efficiency is to have no hospital beds filled and have all patients served on an out-patient basis. Obviously that's not going to happen, but that would be the ultimate income-generator if income is a function of revenue minus the expenses required to deliver care.

If the way to be successful under institutional capitation is to have an empty hospi-

"The hospitals that have figured out how to survive have invested in having the continuum of care available and are perfectly positioned for Medicare-risk capitation. Those that are still in the business of filling hospital beds are going to find out quickly that they cannot survive in this new reimbursement paradigm."

tal bed, then that's an incredible re-engineering and complete re-thinking of the way we've done business in the past. The hospitals that have figured this out have invested in having the continuum of care available and are perfectly positioned for Medicare-risk capitation. Those that are still in the business of filling hospital beds are going to find out quickly that they cannot survive in this new reimbursement paradigm.

Q: It's no coincidence, then, that the Good Samaritan Hospital in San Jose lost \$43 million last year.

A: Absolutely. The medical group that is correctly positioned with a hospital can be a very successful arrangement. What I mean by correctly positioned is that all the incentives are aligned so that the system can receive capitation payments for professional and institutional services.

That means that everything you've ever done, or thought or believed or learned about revenue maximization—in other words: more services, more hospital days, and more beds filled, is going to increase your profitability—is turned upside down

Q: In your book you very clearly spell out the managed care food chain in which power is defined as degree of control over out-patient flow.

A: The analogy of the food chain explains everything that's going on in health care today. Everything that those at the bottom of the food chain are doing today—all this vertical and horizontal integration—is an attempt to move up the food chain. (To be continued in the next issue of Physicians Practice Options. Next issue: How hospitals and health plans are positioned for the future.) ■

Study Shows How Managed Care Reduces Costs, Mortality

Acute-care hospitals in cities with high levels of managed care have significantly lower costs, shorter lengths of stay, and lower mortality rates, according to a study by KPMG Peat Marwick, LLP, health care consultants in Los Angeles.

The study, "The Impact of Managed Care on U.S. Markets," shows that hospital costs in high managed care markets were 11% below the national average and 19% below that for hospitals in low managed care markets. Hospital stays were significantly lower in high managed care markets (6.32% shorter than the national average and 12% shorter than that for hospitals in medium managed care markets). Another advantage for high managed care markets: Risk-adjusted mortality rates were 5.25% below the national average.

"Clearly, managed care is driving hospital costs down without negatively impacting patient care," said Michael S. Hamilton, national director of KPMG's health care segment. "However, the study reports that costs are flat or starting to creep back up in many of the managed care markets. This suggests that as aggressive managed care markets begin to stabilize, further cost initiatives are likely to become more strategically focused and linked to the redesign of core business processes."

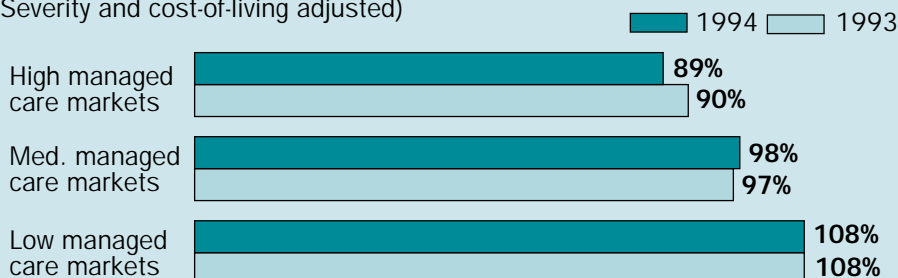
In analyzing the data, KPMG found that the cities demonstrating the greatest improvement in cost reduction were Miami (where costs were 3.9% lower than they were the previous year), Charlotte, N.C., (7.46% lower), and Cincinnati (4.67%). Among the largest metropolitan areas, the San Francisco Bay Area is the most cost effective in terms of hospital care.

Other key findings:

- Hospital costs nationwide increased about 1.44% last year versus 5.59% in 1994. Costs increases were greatest in markets making the transition to managed care.
- Some 30% of metropolitan areas experi-

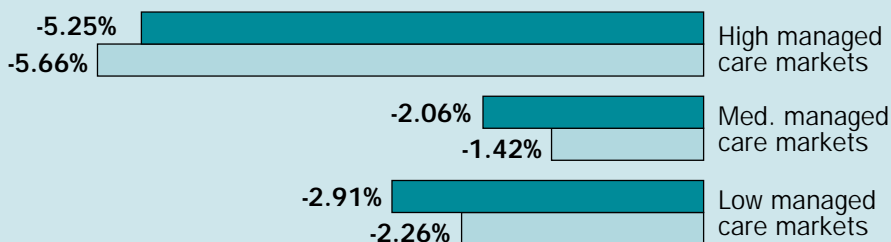
Cost Per Case Compared to National Average

(Severity and cost-of-living adjusted)



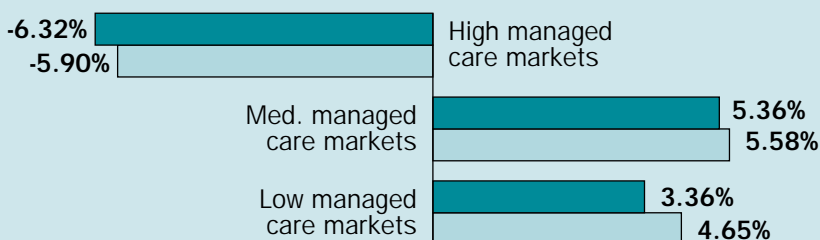
Risk-Adjusted Mortality Compared to National Average

(Percentage below national average)



Severity-Adjusted Length of Stay Versus National Average

(Percentage above/below national average)



Source: KPMG, Peat Marwick, Los Angeles, 1996.

enced a decrease in hospital costs in 1995. In 1994, only 10% experienced reductions. Some 43% of all metropolitan areas had hospital costs below the national average.

- Some 64% of U.S. metropolitan areas report lengths of stay below the national average.

In the study, the second one KPMG has done, the consulting firm analyzed the

effects of managed care on the practices and outcomes of providers. The firm compared costs, charges, severity- and risk-adjusted lengths of stay and mortality rates from more than 3,700 acute-care hospitals nationwide. To design the data base, called "The Guide to Hospital Performance," KPMG contracted with HCIA, health care information consultants in Baltimore. For a copy of the study, call 800/243-1397. ■

Health Plan Costs Rose 2.1% in 1995

Employers' health plan costs remained relatively stable in 1995, rising only 2.1%, according to Foster Higgins Inc., benefits consultants, in New York. In 1994, Foster Higgins reported employers' health plan costs declined by 1.1%. Over the two years, the net change in costs was 1.1%, Foster Higgins said.

The continuing low trend in 1995 can be attributed to the ongoing enrollment shift to managed care, increased competition among health plans, and the lowest increase in the medical Consumer Price Index (MCPI) since the MCPI formula was adopted in 1984, Foster Higgins said. The MCPI rose 4.1% in 1995. Managed health plans now cover more workers than at any time in history, more than seven out of every 10 workers.

"After two years of unprecedented enrollment increases, managed care has become the norm," said John Erb, a principal with Foster Higgins who was the chief analyst of the survey. "Enrollment in all types of managed care plans—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans, also known as open-ended HMOs—rose from 63% percent of all covered workers in 1994 to 71% in 1995."

"Among smaller companies—those with 10 to 499 workers—managed care enrollment rose fastest," Erb said. For these companies, managed care enrollment rose from 58% in 1994 to 67% last year.

This trend has important implications for doctors and managed care plans. "As the transition to managed care continues, costs increasingly will be linked to the ability of managed care organizations to manage both charges and utilization," said Erb.

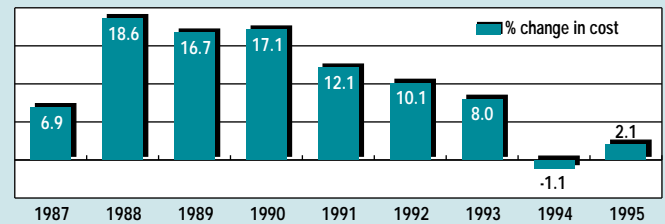
For the first time in the 10-year history of the survey, the average cost of HMO coverage declined nationally, Foster Higgins said. It went from \$3,385 per worker in 1994 to \$3,255 last year, a decrease of 3.8%. "This decrease was driven by an 11.9% reduction in HMO costs among smaller employers," Erb said. Seeking new areas of growth, HMOs have targeted the small employer market, and for this group, HMOs compete largely on price, he explained. HMO enrollment in this market rose from 23% in 1994 to 27% last year.

The Retiree Market

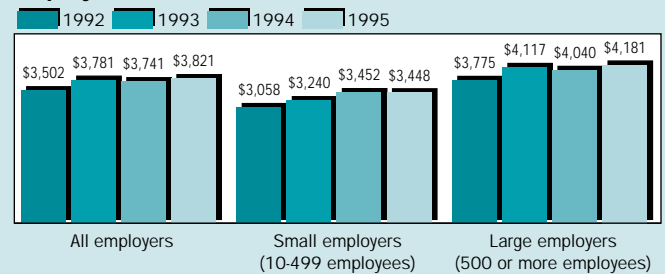
For doctors and health plans seeking growth, employers continue to be concerned about the cost of providing health care to retirees. As Congress considers reductions in Medicare spending, employers are looking to HMOs and other managed care options to help manage costs. In addition, the trend toward downsizing among companies is forcing many employees into early retirement. Among those companies with more than 500 workers, retiree costs rose 9.5% last year, Foster Higgins said.

The Foster Higgins survey data on employer-sponsored health plan costs are widely respected. The 10th annual survey shows that total

Annual change in average total health benefit cost for active and retired employees, 1987-1995



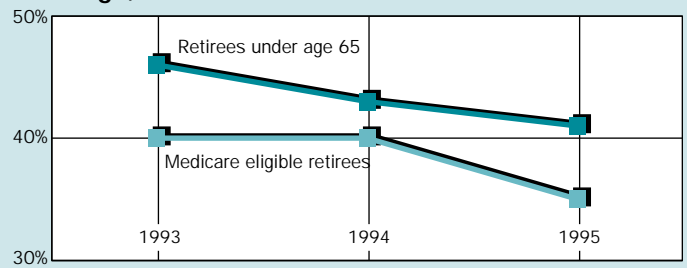
Total health benefit cost for active and retired employees, 1992-1995



Medical plan cost for active employees by plan type, 1994-1995



Decline in employers offering retiree medical coverage, 1993-1995



Source: (for all charts): Foster Higgins Inc., New York, 1996.

health benefit costs averaged \$3,821 per employee in 1995. Some 2,764 employers responded last year. The survey results are weighted to reflect employer demographics for all companies with more than 10 workers. As a result, Foster Higgins says, the results are valid for more than 700,000 companies and 75 million full- and part-time workers.

For a copy of the survey report, write to Lisa Gilleeny at Foster Higgins Inc., 125 Broad St., Fourth Floor, New York, NY 10004, or call 212/574-9025. It costs \$500. ■

Milestones on the Way to Managed Care

Physicians making decisions about their practices under market-driven reform may find it useful to understand what happens in other markets as managed care takes hold.

Here's but one example: Health care payers believe managed care is the only way to control costs. The traditional fee-for-service system has failed to reform itself. Medicare is bankrupting the federal government, and Medicaid is bankrupting the states. President Clinton's

health care reform plan collapsed under its own weight and a hail of criticism from special interests. Yet managed care—the integration of the financing and the delivery of care by limiting hospital stays and access to specialists—has flourished. In fact, managed care was so successful in 1994 that employer health care costs declined by 1.1%, the first such decline in two decades, according to the latest study by Foster Higgins Inc., benefits consultants in New York. In 1995,

managed care enrollment continued to grow sharply, and costs rose only 2.1%, Foster Higgins said.

The forces of market reform have a momentum, a logic, and an inevitability to them. Dedicated to deflating hospital and specialty medicine costs, managed care is shifting the emphasis from individual care to total care of the population. It is doing so by increasing the number of primary-care physicians while decreasing the number of specialty-care physicians.

Tracking Changes

The questions for each practicing physician are these: How do you follow these changes, how do you incorporate them into your practice, and how do you use them to your advantage when choosing your practice options? Readers may find it useful to use a mnemonic device to think of each of these eight changes as “C” changes. The eight “C” changes are:

1. Continual revolution. The revolution to control and rationalize costs is irreversible.
2. Cost control. The focus of the revolution is on costs, meaning less reliance on hospital care, fewer referrals to specialists, more outpatient services, more home care, and more care by primary care physicians.
3. Consolidation. More power and resources are being concentrated into larger organizations. Columbia/HCA has revenue of \$20 billion annually, and the major managed care organizations have revenue of \$2 billion to \$10 billion. The top 25 HMOs control about 75% of the HMO market. Managed care plans care for seven out of every 10 workers today.
4. Communication. This takes many forms—information systems to track utilization, systems to follow physician performance and to credential physicians, systems to identify high-risk and high-cost patients, and marketing to various constituencies.
5. Capital. It takes lots of money to compete in managed care. Money is needed to acquire practices, to establish networks, to build infrastructure for buying information systems, for hiring marketing and management expertise. It takes about \$1 million to form a physician-hospital organization, \$10 million to form a management-service organization, and \$20 million to \$200 million to build and sustain an integrated health system.
6. Corporations. Medicine has been transformed from an independent profession to a huge, sprawling business enterprise, the largest single industry in the United States. As a business, medicine requires marketing, investment in infrastructure, cash reserves, the integration of production and operations, teams of professionals, and standards and controls for productivity and physician performance.
7. Capitalization. The shift of reimbursement from fee-for-service to capitation may never be complete, but even at levels of 30 percent, capitation reverses physician incentives. In California, a study of six large medical groups owned by physicians and operating in capitated environments showed that hospital use dropped to 139 days per 1,000 members, 40% lower than the average for California HMOs of 233 days per 1,000 members, and 60% lower than the national average of 297 days per 1,000 members. In California, and elsewhere, capitation systems often have 20% lower premiums than fee-for-service plans and thus are driving costs down in those markets.
8. California (the California style of health reform). This style involves large integrated medical groups acting in concert with partially integrated IPAs and point of service plans, large HMOs controlling premiums and contracting with medical groups, and a large population of capitated patients. This model is rapidly being transplanted in modified forms to other parts of the nation. As capitated California seeks a bottom price at which it can operate and as it reaches market saturation, its managed care executives, its consultants, and its specialists are fanning out across the country, spreading the gospel about what works in California and serving as catalysts for more rapid change in other sectors. ■

Report Shows How HMOs Manage Drug Prices, Utilization

A report by Ciba-Geneva Corp., a pharmaceutical manufacturer, shows how HMOs manage drug reimbursement and dispensing levels for members. The report is useful for physicians seeking information on how HMOs manage pharmaceutical costs.

HMOs' average per member per month expenditure for drugs was \$12.12 in 1994, for example, but staff-model HMOs paid

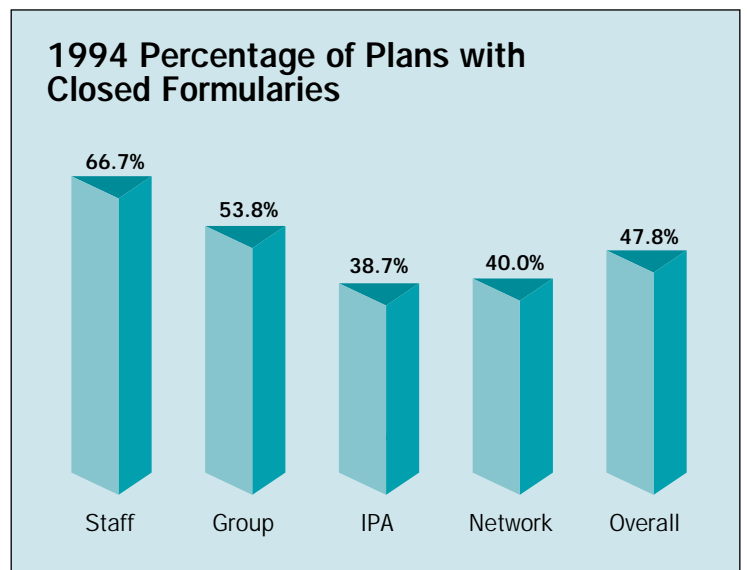
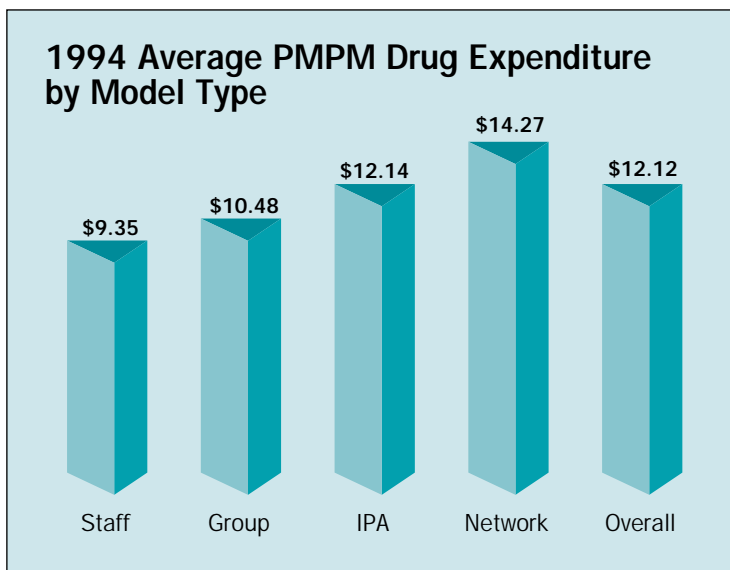
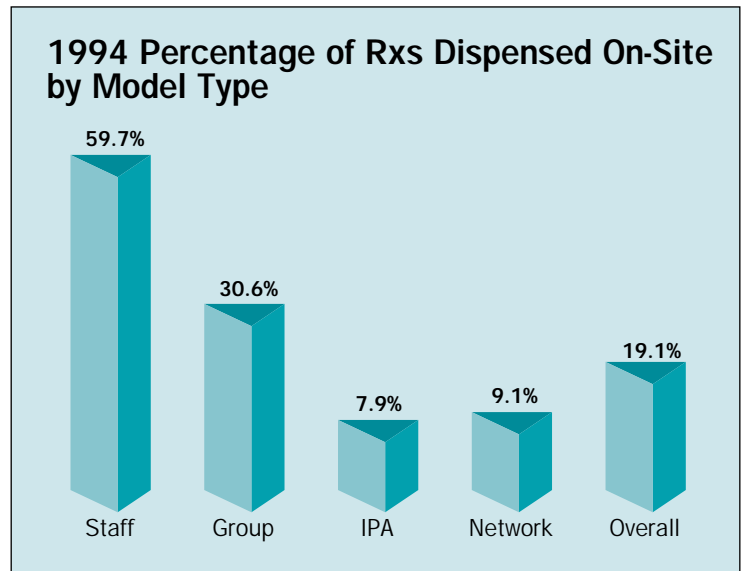
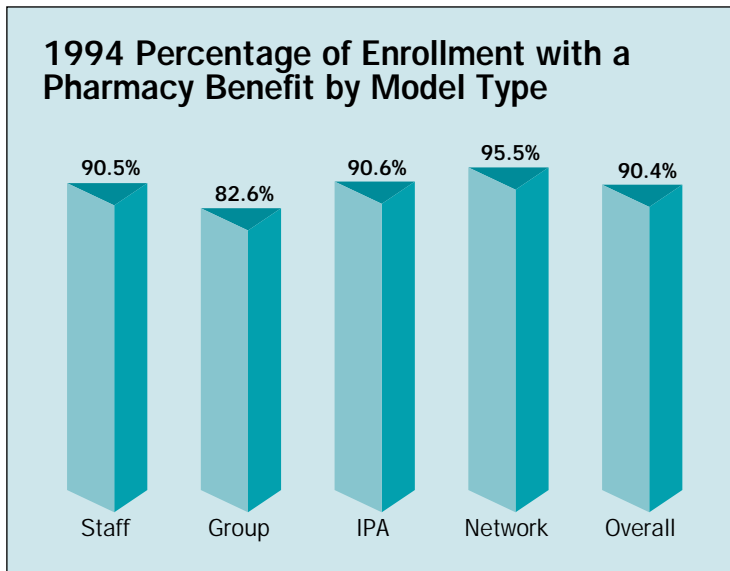
only an average of \$9.35 while network models paid \$14.27. The range was due primarily to the lack of controls in network-model plans versus staff-model plans.

The average HMO lists 857 products on its drug formulary, the report said. The overall percentage of HMOs with closed formularies (in which access to some drugs is more restricted than under an open formulary), was growing, the

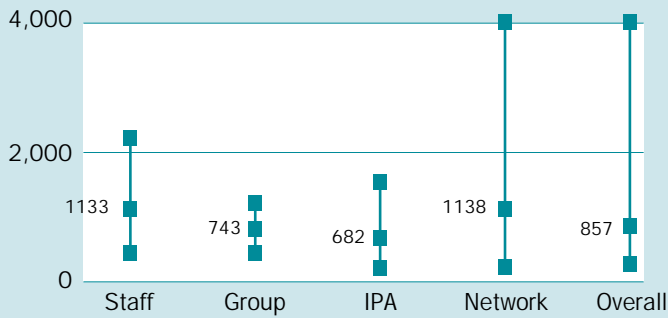
report said. Almost half of all HMOs (47.8%) have a closed formulary. Closed formularies are more common in staff-model and group-model HMOs.

About 62% of all HMOs used a pharmacy benefit managed company (PBM) to administer some portion of the drug benefit. The report was produced by Emron Inc., a managed care consulting firm, in Warren, N.J. For copies, call 800/475-2273. ■

Source (for all charts): Group Health Association of America, Washington, 1994; Emron 1994 HMO Prescription Drug Therapeutic Class Report, 1995, Emron, Warren, N.J.

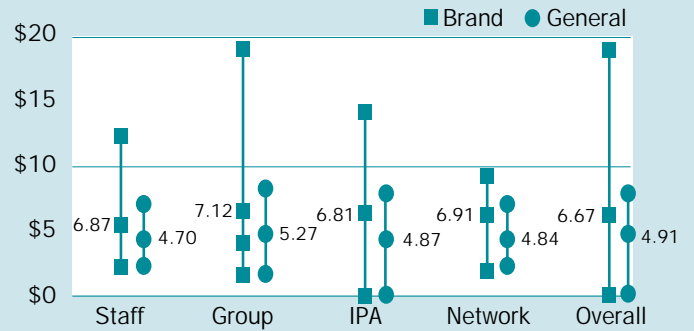


1994 Average Number of Products on Formulary by Model Type, with High/Low Ranges



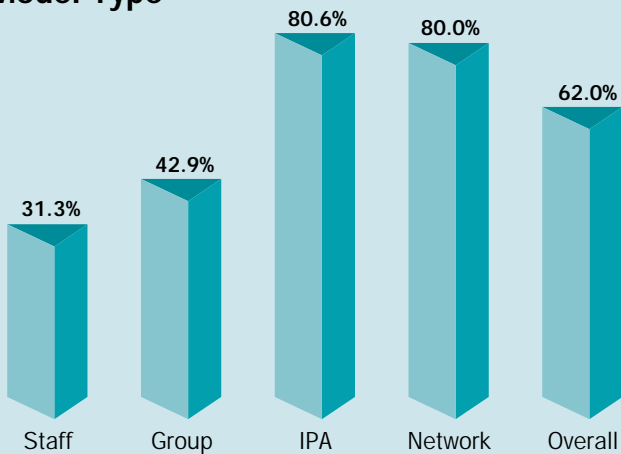
Staff- and network-model HMOs (>1130) each placed over 30.0% more products on formulary than the overall average for all model types (857). Group and IPA models were well below the average.

1994 HMO Average Copayments by Model Type for Products on Formulary, with High/Low Ranges

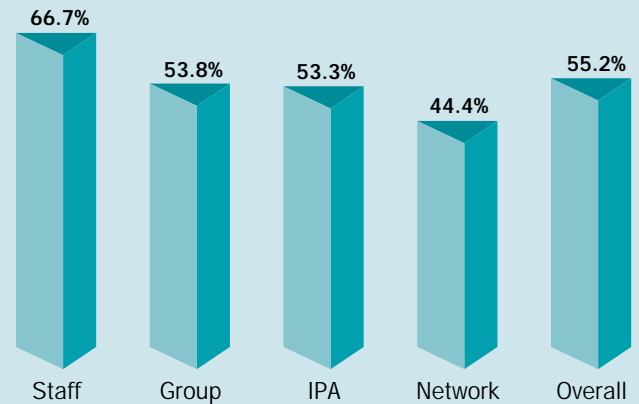


Network models offered the greatest incentive to members to use nonbranded products, granting a 30.0% copayment discount for generics.

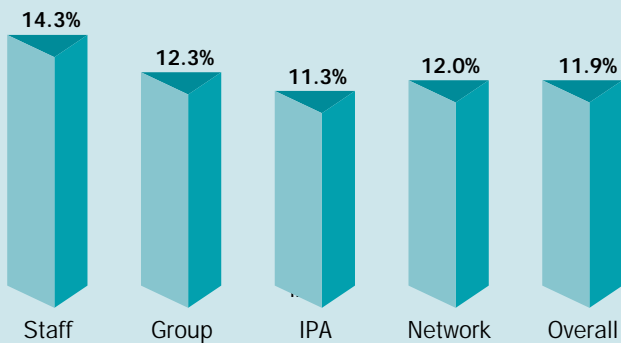
1994 Percentage of Plans Using PBM's by Model Type



1994 Percentage of Plans with Mail-Order Services by Model Type



1994 HMO Average AWP Discount for All Products



On average, plans receive an 11.9% discount off all pharmaceuticals that they manage.

1994 Percentage of Plans with Closed Formularies by Size/Distribution



Plans with fewer than 100,000 covered lives and those that used on-site, prescription drug distribution capabilities were most likely to implement closed formularies to influence utilization.

Physician Management Companies Had a Watershed Year

By Brooks G. O'Neill

Physician practice management (PPM) companies had a watershed year in 1995. Seven companies completed initial public offerings (IPOs), bringing the total number of significant public PPMs to 19, a growth rate of 58% over 1994. The vast majority of the public PPMs performed well during the year: 16 expected to show a profit for the year and all 16 had an increase in earnings for the year.

The PPMs had revenue growth for two reasons. One, they had solid increases in income of 5% to 23% in clinics open more than a year, and two, they acquired additional practices. In general, the revenue growth was supported by modest increases in margins resulting from expense control, as opposed to reducing physician incomes.

Despite a relatively constant need for additional capital, strong revenue growth and margin expansion translated into rapid growth of earnings per share (EPS). For the group, the mean percentage growth in earnings was 50%. During 1995, the market rewarded rapid EPS growth with dramatic appreciation of the shares of PPM companies. The mean appreciation for the group was 60%.

Of the seven IPOs completed in 1995, five performed exceedingly well (see table). MedPartners, which went public on Feb. 21, 1995, at \$13, led the pack with appreciation of 133.7%. The stock was trading recently at \$33.38. AHI Healthcare Systems, a manager of independent practice associations, attempted to expand too rapidly from a small base and was unable to hit earnings estimates analysts had projected at the IPO. From its \$14 IPO price, the stock declined 53.6%.

Five secondary offerings also were completed in the year and four had strong appreciation following the offerings. Physician Reliance Network had the best performance, moving from \$19.50 on May 9, to a recent price of \$43.63, a gain of 123.7%. Only shares of Sterling Healthcare Group declined. The shares declined by 6.5% following its secondary offering of 2 million shares in October.

The Outlook

Consolidation among physicians is at an early stage. Thus, we think it is possible that well run PPMs can show rapid earnings growth this year and in the foreseeable future. Since less than 5% of active physicians are part of a PPM, excellent opportunities exist for investors to acquire practices at fair prices, to improve the efficiency of these practices, and to benefit from the trend toward capitation by changing the

age risk effectively.

While the stock market performance of public PPMs was strong in 1995, the total market capitalization of the group of under \$10 billion remains modest in relation to the size of the market. The current mean ratio of price to earnings is 32 times the 1996 forecast earnings. In other words, physicians' practices are selling at 32 times what they are projected to earn for the year. This ratio does not appear excessive in relation to the prospects

Initial Public Offerings —1995

Company	Date	Offer Price	Price on 14Feb96	Percentage change
MedPartners/Mullikin Inc.	2/21/95	13.00	30.38	133.7
OccuSystems Inc.	5/8/95	14.00	21.25	51.8
American Oncology Resources Inc.	6/12/95	21.00	43.88	109.0
Physician Resource Group Inc.	6/23/95	13.00	22.38	72.2
Pediatrix Medical Group Inc.	9/19/95	20.00	33.50	67.5
AHI Healthcare Systems Inc.	9/28/95	14.00	6.50	53.6
Sheridan Healthcorp Inc.	10/30/95	13.00	12.38	4.8
Secondary Offerings				
Physician Reliance Network Inc.	5/9/95	19.50	43.63	123.7
PhyCor Inc.	6/23/95	37.75	47.88	26.8
Sterling Healthcare Group Inc.	10/5/95	13.50	12.63	6.4
InPhyNet Medical Management Inc.	10/27/95	18.00	27.00	50.0
FPA Medical Management	11/3/95	6.75	9.63	42.7

Source: Piper Jaffray Inc., Minneapolis, 1996.

way physicians practice medicine. Ample room exists for additional well conceived strategies, and early entrance will be rewarded. Competition is still at a minimum in nearly every niche but will increase as time passes. One company, PhyMatrix Corp., completed an IPO on Jan. 23, 1996, offering 7.2 million shares at \$15. Recently, those shares have traded at \$21.75, a gain of 45.0%.

Congress is likely to pass legislation encouraging direct provider contracting in the Medicare market. On the commercial side, we expect employer health care purchasing cooperatives to continue moving toward direct contracting with providers, as is happening in Minnesota. These developments will create exciting opportunities for well run companies that man-

for growth. It is, however, relatively high when compared with ratios for other companies, suggesting that if earnings growth slows or if other events cause market weakness—either in general or specific to PPMs—prices may decline. Therefore, if you were thinking of forming a PPM or selling your practice to a PPM, there may never be a better market. ■

For a copy of the 100-page report, "Physician Practice Management—Just What The Doctor Ordered," contact:

Piper Jaffray Inc.
222 S. 9th St.
Minneapolis MN 55402
Phone: 612/342-6266
Fax: 612/342-6360

Blues Plans Pursue Managed Care Marketshare

Amid mergers to garner marketshare, the number of Blue Cross and Blue Shield plans nationwide has declined by 23% since 1985. Seeking capital to finance managed care network development, the Blues went from 86 plans to 66 in 11 years.

The latest example of this trend is an agreement to merge Blues plans in Texas and Illinois. Together, the plans would have 3.8 million subscribers, almost \$6 billion in revenue, and rank second among the Blues in number of enrollees. Blue Cross and Blue Shield of Michigan has 4.3 million members. The Illinois Blues has 22% of the health care market in its state and has moved aggressively into managed care. The Texas plan has a 12% share.

In a similar strategy, the non-profit Blue Cross and Blue Shield of Colorado wants the state general assembly to allow it to convert to for-profit status. The plan wants capital to finance expansion.

“We strongly believe that the future of health care will be dominated by managed-care plans, and to be successful in managed care requires a great deal of investment in technology and other infrastructure,” said David Kikumoto, president and CEO of BCBS of Colorado. “The other element to the capital issue is that it provides currency to finance acquisitions.” The plan insures 330,000 Colorado residents.

Comment: *The Blues plans nationwide—long a force in the fee-for-service market—are moving aggressively to be competitive in markets dominated by managed care. Toward that end, recent agreements include a merger between Blues plans in Indianapolis and Cincinnati; an agreement by a pair of plans in Tennessee; and six Blues plans in New England have agreed to market their services together and a merger is possible. In developing managed care networks, Blues plans have been hiring physicians and buying physician practices. ■*

Investors See Market for Eye Surgery

Summit Technology Inc., an investment firm in Waltham, Mass., has announced that Stanford University Medical Center in Palo Alto, Calif., the Cleveland Clinic Foundation Eye Institute, and the New England Eye Center at the Tufts University School of Medicine in Boston, have joined the company's Center of Excellence program for providing physician education, clinical research, and patient care. Other members include Rush Presbyterian-St. Luke's Medical Center in Chicago, the George Washington University Medical Center in Washington, and the Jules Stein Eye Institute at the UCLA Medical Center.

Using a hub-and-spoke concept, Summit's strategy is to open vision correction centers that affiliate with prominent teaching hospitals. The hub in each geographic region would be a prestigious national teaching hospital

serving as a center of excellence for teaching and training. The spokes in each region would be affiliated outpatient centers where laser correction of myopia is performed, offering local physicians access to the facilities for patient care.

The centers also may serve as sites for treating moderate to severe myopia, hyperopia, and astigmatism by photorefractive keratectomy (PRK), or laser. An estimated 60 million Americans are nearsighted.

Comment: *A relatively new procedure for curing nearsightedness without surgery, PRK promises to be a bonanza for ophthalmologists, who have been hard hit by managed care and cuts in Medicare funding. As a procedure for a surgical specialty, PRK may be as big for ophthalmologists as laparoscopic cholecystectomy is for general surgeons. ■*

Report Cards Mean Physicians Face More Scrutiny

California Physician magazine predicts in its February issue that doctors soon will be getting report cards on their performance and that the reports will be made public. “Although controversy continues to rage regarding the validity and appropriateness of many health care measurement indicators, report cards likely will become the primary assessment tool as all sides struggle to find the balance needed for delivering quality care at a reasonable cost,” co-authors K.M. Tan, MD, chair of the committee on quality care of the California Medical Association (CMA), and Jill Douglas, CMA's project development director.

A variety of organizations believe reports on physicians' outcomes and patient mortality are an effective way to evaluate performance if the data are adjusted to reflect the severity of illness among patients. Employers and regulators believe report cards help to ensure that health plans use resources judiciously while maintaining or improving quality, the magazine said. Consumer groups say report cards help consumers choose doctors and health plans.

Doctors will need to keep more accurate and detailed records, preventive services will become more important, and doctors will have to assume greater responsibility for making sure patients use appropriate services, Tan and Douglas predict.

The CMA is working to promote report cards that are statistically valid, fair, and do not rank physicians on economic criteria or unfairly discriminate against young physicians not yet board certified.

Comment: *As the movement toward report cards gains support from a variety of sources, doctors should understand exactly how they are evaluated and how to improve their scores. If you want your report card to reflect your work accurately call the CMA at 415/882-5112 for more information. ■*

PSNs Come Under Fire by State Insurance Commissioners

State insurance commissioners want to make it difficult for provider-sponsored networks, including physician-hospital organizations, to accept the financial risk of providing care. In a letter to the U.S. Senate regarding an amendment proposed to the Medicare reform bill, the National Association of Insurance Commissioners says the state regulators should not be preempted from exercising their traditional health insurance regulatory role. The Medicare reform bill would let the federal government regulate provider-sponsored networks by replacing state regulation with staff from the federal Health Care Financing Administration. "Such an amendment would present significant problems for the states and the current privately based health insurance market in two fundamental respects," the National Association of Insurance Commissioners (NAIC) says in a

letter to Sen. Bob Dole last fall. The letter was also signed by the top officials of the National Governors Association and the National Conference of State Legislatures (NCSL). "First, consumers could be harmed greatly by the loss of state-level protections resulting from the amendment. Second, the amendment could eviscerate state regulation of health insurance overall."

The NAIC believes consumers could be harmed if individuals or employers contract with physician hospital organizations (PHOs) and other provider-sponsored networks (PSNs) that lack the needed capital. Any PPO, PHO, or other group that accepts financial risk for providing health care and that is not regulated by the state insurance department, could potentially harm individuals if it failed, the NAIC says. For that reason, the NAIC wants all such organizations to be licensed and to set aside

the necessary funds, which can be \$1 million or more.

The problem is that most PHOs don't have the resources or the access to capital that HMOs and insurers have, consultants say. Therefore, they should not have to leap the same regulatory hurdles. For this reason, Republicans in Congress amended the Medicare reform bill to appease doctors and hospitals. The resulting amendments make it easier for such networks to operate without having to meet state licensing and solvency requirements.

Comment: The key to making PSNs work will be cooperation between doctors and hospitals. To manage risk effectively while delivering quality care at increasingly lower costs, doctors will have to resolve their differences with hospitals or hospitals will need to let physician management companies be the driving force behind many PSNs. ■

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March 1996

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