

# PHYSICIAN PRACTICE OPTIONS™

March 1997

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

## Features

**Commentary**  
The Physician's Role  
in Counteracting  
Managed Care Excesses 6

**Case Study**  
Connecticut Physicians  
Create an MSO 9

**Interview**  
Today's Information  
Systems Should  
Meet Tomorrow's  
Market Needs 11

## Departments

**Editorial**  
Our One-year  
Report to Readers 2

**Current Trends**  
Practice Management  
Returns Declined 13

**News and Commentary 15**

## Rising Costs Predicted to Squeeze Physician Profits

Health care premium costs rose by 2.5% in 1996, the second consecutive year of single-digit premium increases, according to a recent survey by Foster Higgins, health care consultants in New York. Over the past two years, health care premiums have risen at or below the rate of inflation as measured against the Consumer Price Index (CPI). But those relatively low costs are likely to end, Foster Higgins said. Costs will rise more sharply and when they do, physicians will need to deliver high-quality, cost-effective care.

"There'll be more pressure on providers, including physicians," says Richard Lilledahl, MD, a health care consultant with Milliman & Robertson Inc., actuaries, in Seattle. "Although what happens will be determined on a market-by-market basis, traditionally when prices rise, physicians find they need to cut costs."

Nathan Kaufman, president of the Kaufman Group, physician consultants in San Diego, agrees, saying costs will rise, but the effect will differ depending on the market involved. "The providers and the HMO premiums in Southern California have been squeezed to the point where we can expect both physician payments and HMO premiums to increase," Kaufman says. On the East Coast, however, sophisticated managed care organizations are still being developed. There, HMO premiums may rise but payments to physicians may not, he says.

In the East, physicians are paid between \$120 and \$140 per member per month (PMPM); on the West Coast, they are paid \$90 to \$110 PMPM, Kaufman says. As a result, health care payers on the East Coast will become more aggressive in containing premiums and provider costs than their counterparts on the West Coast, he says.

Beginning this year and continuing for the next two to three years, health care costs are likely to rise by about 4%, says David Rahill, a principal in New York for Foster Higgins.

Several factors are forcing prices up, says John Erb, the Foster Higgins principal who manages the National Survey of Employer-sponsored Health Plans. "First of all, with over three-fourths of active employees now in managed care plans, most employers have already enjoyed the one-time savings of moving workers out of expensive indemnity plans," he says. "In addition, HMO rates are rising for 1997, following two years of premium rollbacks and a year of sagging profits in 1996. Another factor is the ongoing consolidation of health care providers, which are gaining more bargaining clout with managed care plans."

Another significant reason costs are rising is the price of prescription drugs, says Lee Newcomer, MD, chief medical officer for United HealthCare Corp., the large managed care organization (MCO) in Minneapolis. "When you look at the trend in our organization, half of that trend is driven by rising pharmaceutical costs," he says. "Pharmaceuticals have been rising at a rate of about 15% per year for the last two to three years, and that's way above CPI.

"Physicians are directly responsible for the increase in pharmaceutical costs because they are writing prescriptions for new medications," Newcomer adds. "So, in a sense, they have some control over these costs."

### Backlash Costs

Federal and state legislation also is affecting costs. The backlash against managed care has been gathering momentum for at least two years, and new rules are limiting the

(Continued on page 3)

## Our One-year Report to Readers

We introduced *Physician Practice Options* one year ago. At that time, we promised in our editorial mission statement to assist physicians in evaluating their strategic practice options, to empower physicians to reposition their practices, and to provide physicians with the information needed to be a stronger, more effective force in health care. We remain committed to the goals we stated then:

- To empower readers with the knowledge needed to survive and thrive under managed care;
- To assist physicians in organizing professionally managed, physician-led group practices; and
- To show through our case study examples how physicians are responding to the new demands of health care purchasers, managed care organizations, and consumers.

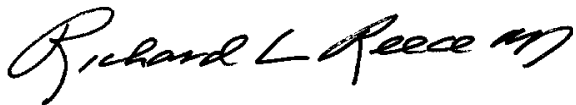
Each article in *Physician Practice Options* is based on research to identify current market trends and to understand our readers' needs for strategic information. We make sure that each issue of the newsletter focuses on at least one—and possibly several—of five specific areas that we believe are most important to practicing physicians:

- Managed care and its effect on markets;
- Capital—where it is and how to get it;
- Data collection and outcomes management;
- Practice management and marketing; and
- Provider network affiliation.

While we neither favor nor oppose managed care, it has become the *de facto* health care policy in the United States, and we believe it should not be ignored. More than 75% of U.S. workers belong to managed health plans, and managed care is growing rapidly among the Medicare and Medicaid populations. Since managed care apparently is here to stay, physicians should be a driving force in ensuring that the best care is delivered, at the most appropriate time, and at the most competitive price.

In just over one year, *Physician Practice Options* has become the most widely distributed newsletter of its kind in the country. We attribute this success in part to our continuing effort to ensure that we're meeting our readers' needs. Toward that end, we encourage your feedback: suggestions for articles, comments or criticism, and recommendations for improving the newsletter. We also welcome your questions about practice options and other health care concerns. If you have a story you would like to write, we can offer editorial advice and counsel. If you want us to write it, we would be pleased to consider your suggestion thoroughly. You are invited to contact us at our toll-free telephone number, 888/457-8800, or at my mailing address, e-mail address, or telephone or fax numbers, which are included in each issue.

With your feedback, we can make *Physician Practice Options* even more effective in helping you make a more efficient health care system for all Americans.



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# Recent History Shows Why Costs Are Rising

When health care costs rise this year, several inflationary forces will be at work, and those forces will exert more pressure on prices in the next several years, experts predict. Among the factors that are exerting the most pressure currently are these:

- The need for HMOs to satisfy stockholders after delivering low profits last year.
- The consolidation of HMOs into fewer and larger entities, eliminating competition and allowing the remaining HMOs to raise prices without fear of losing market share.
- More expensive medical technologies and an aging population.
- The demand among consumers for more access to specialists, and the growing popularity of point-of-service HMOs that let patients go outside of managed care networks if they pay a fee.
- Federal and state legislation and other regulations that make it difficult for managed care plans to control costs.
- The insurance underwriting cycle, in which cost increases are rel-

atively low for several years and then rise sharply for several years.

- New, more costly prescription drugs for many ailments, including mental health care.

One mitigating factor has been efforts by state and federal governments to move Medicare and Medicaid patients into managed care plans. Also, employers are moving retirees into managed care plans. Among large employers, 52% of early retirees (those under age 65) are enrolled in managed care plans, and 30% of those retirees over age 65 are in managed care, Foster Higgins said. The number of large employers offering Medicare-risk contract HMOs rose from 21% in 1995 to 38% in 1996, Foster Higgins said. Nationally, only 8% of Medicare-eligible enrollees are in the Medicare-risk plans, but in the West, the proportion is 25%. Under a Medicare-risk plan, the federal government pays a capitated rate for each patient in the plan. The strategy of moving the elderly into managed care generates a one-time savings in the first year. After that, costs rise again, albeit more slowly.

(Continued from page 1)

ability of health plans to control expenditures. Federal regulators released new rules governing HMOs late last year. Congress and state legislators have been writing new legislation governing managed care limits on mental health coverage, pre-existing conditions, and hospital stays for maternity. This year, Congress will consider a bill mandating a minimum length of hospital stay for mastectomies. Many states have passed any-willing-provider laws that limit the ability of health plans to exclude providers, such as physicians and pharmacies, from managed care networks.

"Mandates are beginning to add significant costs," says Newcomer. "I've had some self-insured customers tell me that they predict their costs will rise by 1% to 1.5% just as a result of the maternity length-of-stay mandate when it goes into effect in January 1998."

Two other factors affecting costs have to do with market cycles. One cycle began last July when the stock market had a correction and many stocks, particularly health care stocks, lost value overnight. In response, managers of for-profit health plans—under pressure from Wall Street to deliver a better return on investment—have been raising prices to regain lost value and to muster more net profit. Another cycle involves underwriting. In insurance, rates are typically low for several years until losses mount. Then, rates rise again for a few years.

## Effect on Physicians

"Rising health care costs is the worst thing that can happen to physicians," says Kenneth R. Jacobsen, a senior vice president and national health care practice leader for the Segal Co., actuaries and health care consultants, in New York. "Increased costs could reactivate anti-physician sentiment in the market because payers believe physicians benefit when costs rise. Under these conditions, market pressures on physicians become exacerbated.

"My concern is that press reports predicting that prices will rise—and some estimates put the increase at 6% in the coming years—give HMOs and other insurers the excuse to raise rates," says Jacobsen.

"When costs rise, there are two effects on the managed care market," explains Jacobsen. "Smaller, financially weaker MCOs fail or get acquired, while larger MCOs and insurers get stronger because of their sheer size. Physicians end up with few options. The number of MCOs that physicians can contract with for access to patients becomes smaller and the physicians' bargaining position is further diluted by the oversupply of doctors."

Health care buyers will be unwilling to pay more because they paid double-digit increases through the late 1980s and early 1990s. In some of those years, annual health care premium cost increases exceeded 15%, and health care purchasers developed

## Increases by Region

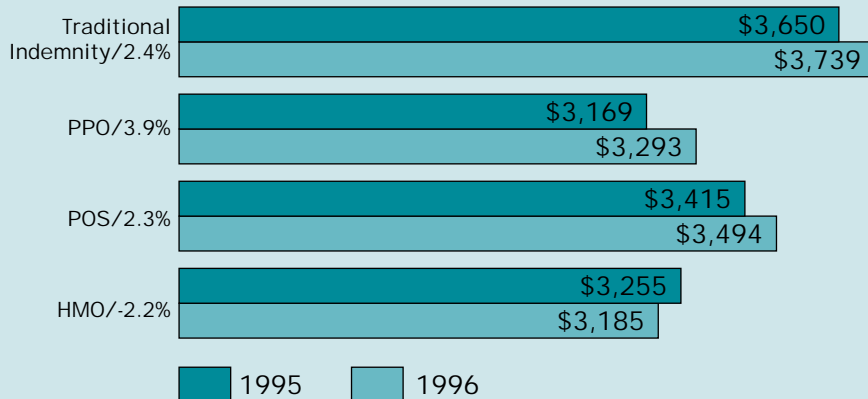
(Percentage change in total health care premium costs)

	1993	1994	1995	1996
National	8.0	-1.1	2.1	2.5
Northeast	10.1	-9.7	8.3	4.8
Midwest	9.4	0.7	0.8	4.1
South	6.6	3.9	-0.2	-0.1
West	5.3	2.0	1.0	3.6

Source: Foster Higgins, New York, 1997.

## Medical Plan Costs

(For active employees by plan type, 1995-1996)



(Continued from page 3)

sophisticated cost-control strategies. When costs are stable or declining, purchasers may be reluctant to ask for concessions.

When costs rise, however, purchasers will relent only if they can win certain guarantees, Jacobsen says. Buyers are likely to require multi-year rate guarantees, for example. Some will join or form purchasing coalitions to gain more market clout, and many will require physicians and MCOs to develop quality improvement programs and to report outcomes data. In addition, purchasers are likely to install performance guarantees in which fees will be tied to results from performance-measurement initiatives, Jacobsen says.

## Cost Increases Could Lead to a Flight to Quality

“Since price is the name of the game in health care, price increases will drive the flight to quality,” says Kenneth R. Jacobsen, a senior vice president and national health care practice leader for the Segal Co., actuaries and health care consultants, in New York.

While purchasers have had some success in controlling costs by forming purchasing groups and by negotiating on price, they are beginning to see that price controls alone don't work. Sophisticated health care buyers now recognize that there is an economic cost to delivering a service. When a purchaser drives price below that cost, it is incumbent upon providers to become more efficient and to deliver high-quality services at the new lower market prices. Purchasers today believe that developing initiatives that measure the performance of physicians and health plans against rigorous national standards may be the only way to control costs over time.

“In fact, you can deliver care for less if you put quality measures in place,” says Jacobsen, the former president of the Georgia Forum on Health, in Atlanta, a group that represents health care purchasers.

As in other industries, quality and performance initiatives force organizations to develop more efficient operations, to eliminate duplicative services, and to identify

best practices. Applying these lessons to health care will help physicians deliver high-quality care in the most cost-effective manner, Jacobsen says.

“We will be forced to eliminate a lot of duplicative services,” adds Lee Newcomer, MD, chief medical officer for United HealthCare Corp., in Minneapolis, “and that includes not only administrative services but physician services as well.”

“For example, three lithotripsy centers in a city may not make sense in terms of cost or efficiency,” Newcomer explains. “Many provider organizations may decide to support the overhead of one and let the other two go out of business.”

Such measures will reflect attempts by providers to deliver care more efficiently. “In addition, we're going to start seeing competition based on results and not just on production,” Newcomer explains. “By results, I mean, the best quality care and the best outcomes, not just the most care, the most production.”

Physicians will need to develop ways to analyze practice patterns and to develop sophisticated data bases that will provide the information they need to manage practices efficiently, Jacobsen says. These systems will include information on clinical pathways, benchmarks, and best practices. “By doing so, physicians will have greater access to the information

needed to do business efficiently and they will have guidelines in place to streamline practice procedures. Ideally, once you have such systems, more routine health management can be handled by physician assistants and nurse practitioners, enabling physicians to concentrate on the more difficult diagnoses and to focus on practice management,” he explains.

“Rising costs mean the days are numbered for the solo practitioner,” Jacobsen says. In order to develop and use practice protocols, physicians must be organized into groups, he adds. Another reason physicians should be in groups is so they can afford to buy the information systems and to hire the experienced managers they will need to run practices efficiently.

“Physicians cannot ignore the market reality that they are in oversupply,” Jacobsen says. “They need to set their sights so that they can compete based on what they do best, which is delivering highly efficient, quality medicine.”

Until now, most cost-control strategies have involved managing cash, not managing care, Jacobsen explains. Under current market conditions, the guarantees extracted by purchasers will force the health system to deliver only the best care and providers to gather and report data on the quality of that care.

The 11th annual Foster Higgins' National Survey of Employer-sponsored Health Plans, the largest of its kind, found that health benefit costs averaged \$3,915 per employee last year. Health benefits include medical care costs and ancillary benefits, such as coverage for dental and mental health care. In 1996, Foster Higgins received responses from 3,290 employers. ■

## Other Findings

Here are other findings from the Foster Higgins survey:

- Average costs for large employers (those with 500 or more workers) rose 3.6% in 1996, while the cost for smaller employers (those with 10 to 499 workers) decreased by 2%. Costs declined for small employers because more workers were being enrolled in managed care plans. Among large employers, however, enrollment in managed care had slowed somewhat, resulting in increased costs.
- Traditional indemnity plans remain the most expensive health plans, at \$3,739 per employer per year, an increase of 2.4% over 1995 levels.
- HMO costs fell by 2.2% per employee to \$3,185.
- PPO plan costs rose 3.9% to \$3,293.
- Point-of-service (POS) plan costs rose 2.3% to \$3,494 per worker. POS plans are also known as open-ended plans.
- HMO enrollment nationwide stood at 27% in 1996, as it did in 1995. POS enrollment rose from 14% of all workers to 19% in 1996. In particular, POS plans in the Northeast grew from 23% of total enrollment to 38%.
- PPOs had a marginal increase in enrollment, from 29% to 31%; and enrollment in traditional indemnity plans dropped from 29% in 1995 to 23% last year.
- The cost of managed care plans has grown at a slower rate over the last four years than that of traditional indemnity plans, as managed care enrollment has grown in that time from just over 50% of U.S. workers to more than 75% of workers, Foster Higgins said. Since 1993, the cost of indemnity plans has risen 29%, PPO plan costs have risen 8%, and HMO costs have risen 3%.
- Employees have enjoyed a respite from high health care cost increases. On average, U.S. workers pay about 20% to 25% of the premium for individual health care coverage and about 30% to 35% for family coverage.

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# The Physician's Role in Counteracting the Excesses of Managed Care

By Richard L. Reece, Editor-in-chief

Managed care is falling short of its promise and is failing to provide adequate health care to many Americans, says George Anders, a reporter for *The Wall Street Journal* and the author of *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (Houghton Mifflin, New York, 1996). Anders believes physicians can play a major role in restoring balance to a system that in the past few years has emphasized cost control over quality treatment.

"Most of the men and women who run HMOs and other managed care plans think they are providing good quality medicine at a reasonable price," Anders says in an interview with *Physician Practice Options*. "The problem is that they are too removed from individual patients' concerns. Administrators sit in big suburban office parks and worry about columns of numbers on computer spreadsheets. I call them 'the new Mandarins.' They are like the powerful bureaucrats of dynastic China, ignoring individual cases so they can set rules that will affect millions of people.

"That type of setting encourages neither compassion nor personal sensitivity. And unless changes are made by both doctors and consumers, important parts of the health care system—such as emergency care, family care, and mental health treatment—may be in peril," Anders says. The book details abuses that have occurred under managed care and outlines steps to reform the system. Anders' proposals include the continued emergence of physician-managers who can combine cost effectiveness with compassion. He also argues for increased consumer advocacy and a range of new regulations.

## The Physician's Role

"I see two approaches that physicians can take," Anders says. "The first is for them to work together in larger groups, because in a world where data and dollars will dominate the process, individual practitioners are sure

to be crushed by the managed care steamroller. Medical groups of 50 to 500 doctors are large enough to steer their own course, yet small and manageable enough that individual patients have faces. In these groups, cases can be handled well, and a good reputation can be preserved in the community," Anders says.

"The other approach is to accept that cost-effective medicine is here to stay.

1965, that cost had risen to \$45. By 1985, it was averaging more than \$600, not including the cost of doctors' fees or diagnostic tests. By the end of the 1989, national medical spending totaled \$604 billion, or 12% of the gross domestic product. Many employers attributed this explosive growth to greed among physicians and hospital administrators, Anders says.

"Managed care was a power grab by

**"Physicians should work together in larger groups, because in a world in which data and dollars will dominate the process, individual practitioners are sure to be crushed by the managed care steamroller."**

Doctors who fight managed care at every step will find themselves in a losing battle. In a way, they almost play into insurers' hands when they argue that all managed care is equally bad because that argument allows insurers to say to employers and the government that the doctors can't be trusted. Physicians should take the lead in health care delivery by admitting that we are dealing with finite resources. But they should also be aggressive in arguing that they are better at making medical decisions and are more compassionate than utilization review clerks at giant insurance companies."

Echoing sentiments heard often from experts in the physician industry, Anders says, "Physicians practicing in large group practices who develop their own managed care capabilities would result in a system that is both cost effective and compassionate."

## The Growth of Managed Care

About a decade ago, managed care organizations, including HMOs, began to increase their influence in the delivery of health care by promising payers large reductions in health care costs, which at the time were rising at double-digit rates. In 1945, a single night's stay in a hospital averaged \$9.39. By

employers and the insurance industry because they no longer trusted the medical profession or the hospital industry to make decisions about health care," Anders explains. "When physicians and hospitals were calling the shots, we got some great medicine. But the costs were unaffordable to society."

## Why Managed Care Thrives

By the end of last year, HMOs and other managed care plans controlled more than \$200 billion a year in insurance premiums and provided health care to more than 120 million Americans, including more than 75% of all U.S. workers with health insurance. Currently, managed care plans are adding about 8 million new members each year. According to some estimates, 80% of all Americans will be enrolled in managed care plans by 2000.

Managed care has thrived for two reasons, Anders says. "First, these plans save money. That's very appealing to corporate employers that provide health benefits for 180 million workers. It is also alluring to the government, which runs the Medicare program for the elderly and the Medicaid program for the poor. Under the old system, without any checks and balances, medical

expenses were becoming totally unmanageable. The folks paying our medical bills, whether it's General Motors or Uncle Sam, have embraced HMOs as the surest way to get medical costs under control, without fully realizing the consequences.

"Second, HMOs provide convenient, low-hassle care for people who are basically healthy. In any given year, 80% of us really won't need much medical attention. Treatment may consist of a few visits to a doctor's office for small ailments, and a prescription or two. For such people, managed care means less paperwork and smaller copayments than traditional insurance. That sounds like a winning ticket, as long as members don't need a lot of care," he says.

### The Effect on Quality

In theory, Anders says, managed care could do a great deal to improve clinical quality by standardizing treatment and promoting the widespread adoption of best practices. But, in many cases, the pendulum has swung too far in the direction of cost control, he says. This over-correction has hurt health care quality at times, he argues. "We've ended up in a situation where we have insurers and payers calling all the treatment shots," he says. "They are saving money, but in the process, they are damaging some of the aspects that I think are the very best of American medicine."

In a crusade to trim costs, HMOs are setting the priorities for which treatments are necessary and which patients should receive them, frequently with negative effects on patient care. Anders gives the following examples:

- The pharmaceutical industry, whose prosperity has funded much of the most valued medical research of this century, faces highly selective paying practices by managed care companies. Often-secret formularies govern what pills HMO members will receive. HMO pharmacy benefit managers demand discounts from pharmaceutical manufacturers and also frequently phone independent physicians to guide their prescribing habits toward cheaper, older, and sometimes less effective drugs.
- The heart care industry is a major battleground for care rationing. Top-level surgeons are often deemed off-limits in the interest of holding down costs.

"Hospitals are cutting their budgets to the point that one nurse is managing 10 patients," said David Perkowski, a heart surgeon in Laguna, Calif., quoted in Anders' book. "That's nothing but crowd control. It used to be one nurse for every three patients."

- The nation's 900 expensive but highly prized teaching hospitals also are under fire from HMOs. Some of the country's

**"Medical groups of 50 to 500 doctors are large enough to steer their own course and yet small and manageable enough that individual patients have faces, cases can be handled well, and a good reputation can be preserved in the community."**

top medical schools are fighting for economic survival. Teaching hospitals have traditionally taken nearly hopeless medical cases in the belief that the nation's best doctors, when affiliated with teaching facilities, may be able to treat such patients successfully, or at least provide instructional opportunities for interns and residents. But there is no way to prove the cost effectiveness of such cases to managed care administrators, and MCOs frequently will not authorize care in these expensive facilities.

- No group of specialists has become more bitter about the effect of HMOs than psychiatrists. Its leaders contend that HMOs deny sick people necessary care, violate patient confidences, and refuse to treat mental illness as a serious disease, all in the interest of saving money.

### State of Emergency

Among the most serious issues is emergency care, Anders says. "As a nation, we have spent nearly 30 years building up a reliable, first-rate system of emergency medicine. It's expensive, but it works. Now managed care companies are instituting all kinds of restrictions on when people can call an ambulance or go to the emergency room, and still qualify for insurance. That's supposed to save money, and in a purely financial sense, I'm sure it does. But some of those savings carry a horrific price. I begin my book with the story of a mother worrying in the middle of the night about her

feverish baby son. The mother's health plan told her to take him to a hospital 42 miles away, instead of one much closer. On that long drive, the baby's heart stopped. Doctors were able to revive the child, but he suffered such severe damage that both his hands and feet had to be amputated."

Anders is particularly critical of the wealth of HMO executives, whom he describes as emerging as the "corporate

raiders of the 1990s." "HMO executives perform best when they ration care, when they spend a smaller percentage of premiums on health care, and when they say 'no' to treatment, so they are cutting down on the number of tests and on lengths of stay. But the HMO industry has created quite a few millionaires over the past few years. The men and women who run our health plans have bought their own jets, Rolls-Royces, and 75-foot yachts. One HMO tycoon whom I profile has moved into one of the most exclusive ski resorts in Colorado, and filled his \$3.8 million home with tapestries and copies of antique French furniture from Versailles. That's not the purpose of managed care. And if this is becoming a system to shortchange the patient so a few guys can live large, it's pretty jarring to patients and doctors who are being told to get by with less."

### A Backlash Against Greed

The excesses of managed care and the greed of some of its brokers may be starting to have an effect, Anders says. Consumers are encouraging legislators to develop regulations to guarantee access to care and to provide regulatory oversight of managed care profit margins. But it is an uphill battle.

"Regulators are trying, but they are up against tough odds. After the failure of the Clinton health plan in 1994, Congress and the White House don't have the stomach for tackling health care in a major way. At the state level, many attempts to police the

abuses of managed care have been stymied by the powerful insurance industry. I call them the best lobbyists in America. Managed care companies portray almost any attempt to regulate them as something that will jack up health costs. They circulate some outright preposterous numbers about the potential cost of regulation. And they use all kinds of intermediaries and surrogates to do some of their most aggressive lobbying,” Anders says.

“The truth is that trying to stop managed care is like trying to stop the internal combustion engine: We’ve got it and it’s the way

we run our vehicles. Similarly, managed care is the way we run our health care systems, but in the same way that the car industry is better for having seat belts and airbags and disclosure of dealer incentives and of mileage efficiency, the managed care industry can be made much better through regulatory steps that will keep health plans honest, will force them to make crucial medical decisions in a more open setting, and will strengthen the ability of consumers to appeal the decisions of managed care officials.”

Anders offers 10 suggestions to reform the nation’s health care system. The reforms he

proposes are “geared toward methods that preserve the best of managed care—including some of the cost efficiencies and good preventive care—but that also bring in new ways to ensure that sick patients are treated well, that hard cases are handled fairly, and that consumers are able to make better decisions with more information.

“The best way to reform the system is to bring doctors, consumers, and regulators to the table and have decisions made with collegial consensus, rather than having payers and insurers dominate the discussions and our health care treatment.” ■

## Ten Remedies for an Ailing Health Care System

Here are 10 suggestions to reform the nation’s health care system taken from *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (Houghton Mifflin, New York, 1996), by George Anders, a reporter for *The Wall Street Journal*.

1. Physicians need to accept the principle of cost-effective medicine, but be able to challenge specific managed care rules without fear.
2. Physicians, employers, regulators, and HMOs need to combine forces to develop treatment guidelines that people can trust. The more promising initiatives in outcomes research and treatment guidelines involve wide-ranging collaborative efforts. Academic researchers ought to take the lead, working together with payers, health plans, physicians, and hospitals.
3. Regulators need to patrol the way HMOs pay physicians. Under one current system, known as capitation, physicians and hospitals get a flat-rate payment for each patient in the system, which, in effect, is an incentive not to treat. The only logical remedy involves stricter regulation, allowing state and federal regulators to decide what are and are not sensible payment schemes.
4. Regulators, physicians, and HMOs need to improve the rules for deciding tough cases. When HMOs are faced with a rare, perplexing case, it is good medicine—perhaps even good business—to call in an impartial panel of experts. A model program would provide for the creation of independent review boards for each HMO, staffed partly by HMO members, that would monitor the health plans’ utilization-review decisions and agitate for change when necessary.
5. Consumers need to make the managed care system work for their interests. Newcomers to HMOs and PPOs need pragmatic, written guides to managed care, with candid tips and advice beyond what is provided in the health plan’s own brochures. People who master the unwritten rules fare much better than those who don’t, and the emergence of truly well-informed consumers will be a threat to badly run health plans and a boon to those that are well run.
6. Regulators and HMOs need to open up the emergency room. Health insurance laws may need to be rewritten so that HMOs are obliged to provide fuller emergency coverage, the area in which the most judgments made by managed care plans go painfully awry.
7. Lawmakers and courts need to make HMOs accountable for their mistakes. Currently HMOs are shielded by the federal Employee Retirement Income Security Act of 1974, which governs employee benefits. HMOs need to be subject to the same malpractice restitution methods physicians and lawyers face. This step would provide an incentive to avoid business practices that might put health plans on the losing end of multimillion-dollar civil judgments.
8. Consumers need to know how to file effective complaints.
9. Regulators need to keep the profit motive in check. The public should insist on greater public disclosure of HMO financial results and possibly even seek to limit the amount of private wealth they create.
10. Employers, physicians, and regulators need to establish better report cards on the quality of health plans. As of mid-1996, the HMO industry’s current overseer, the National Committee for Quality Assurance (NCQA), in Washington, D.C., still got 40% of its funding from HMOs. That percentage is too high to allow NCQA to be fully independent of the industry that it ostensibly monitors. With greater autonomy, it could become an effective industry watchdog. If that oversight falters, a system of direct government intervention might be necessary. Such intervention would parallel the approach the government takes to regulating financial markets (overseen by the Securities and Exchange Commission), air travel (overseen by the Federal Aviation Administration), and a host of other industries beholden to the public trust.

# Physicians Create an MSO to Compete Under Managed Care

By Richard L. Reece, Editor-in-chief

Through judicious use of outside capital, ProHealth Physicians MSO Inc., in Farmington, Conn., has retained clinical autonomy while building the infrastructure needed to compete in Connecticut's fast-growing managed care market. A group of 150 primary care physicians, ProHealth Physicians is a management service organization (MSO) that has received about \$2 million in start-up capital from TA Associates, of Boston. The eventual investment by TA will be much more significant and will allow TA a 30% share of the group and a seat on ProHealth's board of directors, but no practice management responsibilities, says David Brown, MD, ProHealth's president and CEO.

"Our goal in seeking financial help was not to create an economic windfall for our physicians," says Brown. "The objective was to allow our physicians to make medical management decisions. We did not want a capital partner whose only goal was to make money and would therefore want a say in every business decision in order to protect its investment. We wanted a partner that would support our vision."

Mezzanine investors maintain a minority and passive investment interest in companies that offer strong rates of return, says Robert W. Daly, TA's managing director. TA has invested in a similar physician group in Denver, and is considering three groups that serve other regions, he says.

Mezzanine capital is not a customary source of funding for physician groups, says Daniel M. Ratner, president and CEO of Physician Capital Corp., in Tarrytown, N.Y., which seeks capital for physician groups. Typically, physicians forming group practices seek venture

capital from investors who get a voice in managing the group's business and clinical affairs. Companies offering mezzanine capital, however, usually serve as passive investors after providing money to help develop an established business.

ProHealth's involvement with TA Associates began about 18 months ago and resulted from a TA Associates advertisement in JAMA. Brown and his colleagues had spent the previous two years preparing themselves to function as a fully integrated multisite group capable of competing in a state in which managed care had grown by 30% as of the end of 1995. Through last year, the rate of managed care penetration and growth in Connecticut was among the highest in the nation, according to InterStudy Publications Inc., a firm in Minneapolis that tracks HMO enrollment nationwide (see table).

Recognizing that the market needed physicians who operate in multisite groups, TA saw the potential of what Brown and

his colleagues envisioned. "We liked this group of physicians for many reasons," Daly says. "It had already organized about 30% of the physicians in its geographic region, an area characterized by a population of more than 500,000 and an average monthly Medicare rate of over \$400, which is a good rate. It was a primary care company that wanted to stay independent. It had favorable per-diem hospital rates. It is in a reasonably friendly managed care climate, whose players were willing to give capitation a try. And this group was unusual in that it was putting together primary care physicians across an entire state."

ProHealth has physicians in 85 offices, doing general internal medicine, pediatrics, and family practice. The group is organized geographically into seven subdivisions, which it calls pods. Each pod serves one or more hospitals and has autonomy over service delivery practices. The pods will become fully integrated this month, Brown says, when they will share a taxpayer identification number, business policies, and a billing service.

## Autonomy Through Capitation

The evolution of ProHealth began in 1993, when primary care physicians in the Hartford area, including Brown, began to hold meetings to discuss methods and costs of developing the capability to compete in a managed care market. Calling themselves Connecticut Primary Care Associates, their efforts were prescient.

Through discussions with managed care executives, the physicians realized that risk-sharing, or capitation, would be necessary if they were to be competitive under managed care while also maintaining control over medical management decisions. Under capitation, managed care organi-

## HMO Enrollment: Top 10 States (As a percentage of population on Jan. 1, 1996)

	HMO enrollment (in thousands)	Percentage of population	Annual growth
1. Oregon	1,435	44.8	14.1%
2. California	12,994	40.3	11.4%
3. Massachusetts	2,368	39.0	1.5%
4. Maryland	1,576	30.9	5.4%
5. Utah	602	30.1	23.7%
6. Connecticut	979	29.8	40.9%
7. Delaware	213	29.3	60.7%
8. New York	5,342	29.2	10.6%
9. Arizona	1,208	29.0	15.1%
10. Minnesota	1,329	28.6	8.4%

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

zations (MCOs) pay providers a fixed, or capitated, monthly fee for each health plan member. Since reimbursement is not based on the number of services provided, physicians are at risk for the cost of care above the monthly fee. If care for each patient costs less than the fee, the physicians keep the difference. If care costs more, the physicians pay.

**“Our goal in seeking financial help was not to create an economic windfall for our physicians. The objective was to let our physicians make medical management decisions.”**

Capitation contracting requires information systems, experienced managers, and accounting expertise to determine competitive rates that allow physicians to make a profit. MCOs believe that risk assumption gives physicians the incentive to be cost efficient. Brown and his colleagues believed capitation would allow them to make their own decisions about the amount and nature of the care to provide to patients. If they entered into capitated contracts, they could determine what services to offer and would be responsible for seeing that those services were cost-effective. “Autonomy creates responsibility,” Brown says.

CPC Associates decided that preparing for capitation would require capital to develop a management team and the requisite information system. To secure that capital, CPC believed it would need to form one group that could cover an area large enough to bring in enough physicians to make risk-assumption financially viable. Most important to Brown and associates, the group would need a structure that would allow individual members to have autonomy over the delivery of care while also holding them accountable for the cost of that care.

In early 1994, CPC Associates convened a meeting of physicians from across the state who were active in local medical associations and who had expressed a desire to consider developing managed care capabilities for their practices. The purpose of the meeting was to discuss formation of a statewide, physician-directed organization that would provide management services to member physicians so that the group could

compete for managed care contracts. The statewide group organized under the name Connecticut Primary Care Management Services Organization.

“We wanted to grow to the point where we would have market clout, where insurers would have to deal with us,” Brown says. “But we weren’t doing this primarily to make money. We felt that we were los-

ing control over the treatment of our patients because of the growth of managed care. By organizing statewide and developing the capacity to assume risk, we were taking back that control.”

### Step by Step

By early 1995, the physicians had established committees to develop management service capabilities, such as determining compensation rates, developing credentialing protocols, and identifying treatment protocols.

A critical step was determining the financial value of each practice, which would allow the physicians to buy stock in the new company based on the value of their practice. “We knew it would take a lot of professional time and work to evaluate the finances of, and legal issues facing, each practice,” Brown says. “Because all of the physicians are full-time practitioners, we looked for outside help to help coordinate this effort.”

The group hired consultants to help the committees and the CPC-MSO business staff make decisions. Their first consultant was Geza Kadar, a health care attorney with Advocates for Primary Care in Santa Rosa, Calif. When the group determined it needed help from consultants more familiar with managed care in the Northeast, it hired Brown, Rednick, Freed & Gesmer, in Boston, a law firm. The head of the firm’s health law department, Jeffery Alexander, served as CPC-MSO’s lead consultant. The group also selected Ernst & Young, CPAs, to help perform the financial evaluations of the individual practices. As needed, the consultants also assisted in developing an

information system, medical management protocols, and managed care contracts.

Developing capitation methodologies was another crucial step in the process. Because the group had decided that risk would be shared at the pod level, Brown says, the utilization practices of the pods were to be monitored and controlled by pod members, thus providing local autonomy. Contracting with payers was done at the CPC-MSO level. Billing, compensation rates, and major infrastructure investment, such as in an information system, also was controlled by CPC-MSO.

In November 1996, CPC-MSO changed its name to ProHealth Physicians MSO Inc. because the group may need to expand beyond Connecticut and may acquire multispecialty group practices, Brown says. The group also formed ProHealth Physicians P.C., a professional corporation that employs physicians, nurse practitioners, and physician assistants, in order to comply with a state regulation that does not allow non-physician investment or ownership in medical professional corporations. Thus, the MSO, which simply performs the business operations of the venture, is the vehicle that allows TA Associates, and any other investors, to put capital into the group in exchange for part ownership.

### Looking Forward

Merging the business and practice aspects of the member practices has required the 150 physicians to adjust to new ways of doing business, Brown says. “A lot of what patients hate about physicians’ offices, such as backup on phone lines or long waiting times for appointments, occurs because physicians are practicing in a physician—not a business—mentality. We have to market our practices to our patients and make ourselves more available to them. We’re learning that there are ways of doing that and about marketing and patient satisfaction.”

The group has no intention of creating an HMO, Brown says. “We are not going to get into the insurance business,” he says. “Most of us went into primary care because we wanted to be in charge of how care was delivered in our offices, and so being part of a larger organization that gives us market clout but allows us to retain autonomy is a major cultural change. This is—and always will be—a physician owned and run organization.” ■

# Today's Information Systems Should Meet the Needs of Tomorrow's Market



**Carl Schramm** is president of Greenspring Advisors Inc., a business development firm in Towson, Md., that specializes in health care information systems. From 1993 to 1995, Schramm served as executive vice president of Fortis

Inc., in Milwaukee, an insurance and financial services company. From 1987 to 1992, Schramm was president of the Health Insurance Association of America, in Washington, D.C., a trade association of commercial health underwriters. Before joining the insurance industry, Schramm taught health policy and management at Johns Hopkins University, in Baltimore, from 1972 to 1987. In 1980, he founded the Center for Hospital Finance and Management at Hopkins. In 1985, Schramm organized HCIA Inc., a health care data services company in Baltimore. A member of the Advisory Board of Physician Practice Options, Schramm has a law degree from Georgetown University and a doctorate in economics from the University of Wisconsin. This interview was conducted by Richard L. Reece, MD, editor-in-chief.

**Q:** As an information specialist and strategist, what can you tell practicing physicians about how data collection can aid them in surviving and thriving under managed care?

**A:** The collection and appropriate use of medical practice information is unquestionably the key to a successful future. In fact, appropriate and accurate data are critical not only in assuring that a practice can run more efficiently, but also in providing a strategic competitive edge.

We are radically changing how health care services are being compensated. We are moving quickly from an indemnity reimbursement system, which provided compensation on a fee-for-service basis, to a prepaid, or capitated, system. I call this “no recourse capitation.” By that I mean physicians will be at absolute risk for the cost of providing contracted care. To determine

whether these arrangements allow for financial survival, physicians need accurate information about the nature and outcomes of the services they provide, and the cost of providing those services.

**Q:** Information systems are a significant investment for a practicing physician or a group of physicians. How should they think about raising the capital necessary for that investment?

**A:** There are several aspects to that question, all of which are important. Many doctors think they already have an adequate data system, but what they really have is an office management system. There are about 1,400 to 1,700 office management systems on the market in the United States right now. The largest market share of any one of them is about 4%. So it already is a highly competitive and fragmented market.

The next generation of systems, however, will do more than simply manage offices and handle billing, scheduling, and so forth. It will also collect clinical encounter data and analyze these data in the context of capitated risk. This information is critical for success. So the real issue is: How is the doctor able to capitalize on the transformation of his information system from an office management system to the next generation system, one that will facilitate survival in the capitated environment?

There are several possible responses. Many doctors are being approached by physician-hospital organizations (PHOs) that offer sufficient data systems to protect doctors in the managed care environment. But doctors need to be careful to ensure that what they are buying isn't “vaporware,” a system that purports to link individual or group practices with hospital systems but, at the moment, does not appear to be very effective or reliable. It is my experience that few PHOs have information systems that are any more advanced than that of the average physician.

Another possible response is investment by groups of physician practices. Doctors are developing group relationships for all kinds of reasons, and your newsletter has often discussed the potential for developing joint

practices as a means of raising capital. Joint practices also offer economic efficiencies, such as the collective purchase of data from outside the practice that could serve all of the physicians. Finally, physicians should appreciate that comprehensive data systems are often quite affordable. The bottom line is, however: If the practice understands the importance of data in being competitive and in making money, the data system becomes an imperative.

**Q:** How does a doctor begin to choose among the hundreds of companies offering information systems?

**A:** There are several aspects to that. It is difficult to say that one company is clearly better than another or that one company offers a more comprehensive product. In fact, one reason physicians are forming joint practices and using practice management companies is that the practice of medicine now requires extraordinarily sophisticated expertise in nonclinical areas, such as data systems. In the future an entire cadre of people will come forward to advise doctors in this area. My firm is dedicated to figuring this out from the very hard-nosed perspective of helping people invest in solutions in medicine.

We are in the very infancy of the health care data business, and there is no clear path through this woods. It is also a very dangerous time because many vendors don't have adequate or proficient technology or enough capital. They may have customers—physicians who made purchases—but those doctors may have made those purchases because of the vendors' good marketing strategies, not because of the quality of the product. In the end, the product won't grow, and it won't meet their future needs. One reason we're watching physicians come together, apart from the capitalization issue, is because technology overhead requires more than one physician to bear the cost of these evolving systems.

**Q:** So doctors often form physician organizations in order to afford the expertise necessary to evaluate these systems?

**A.** That's right. Very few single practitioners will spend the time to research and understand the systems. And the systems offer certain economies of scale. They just aren't supportable by single physicians or even by small groups of physicians. The cost of building an adequate data infrastructure

capitated environment, can offer one important hint, namely, that this is not a hardware problem. Going to the major hardware vendors is almost always a mistake.

In the end, a consultant can help only physicians and practices that want to be helped. Many practices know that trouble lies

experience is that even after such a system is running, the practice manager is still no better equipped to deal with capitation bargaining. The practice has invested in a costly system that will likely become obsolete before the problem it was purchased to solve is under control. That practice is better off doing some low-tech capitation modeling for the immediate future. Remember, in information systems, the job is to solve real problems. Electronic medical records do not solve real problems. They are great to look at, but seldom are doctors aided in practice by today's EMR systems, and they are never aided in capitation bargaining by such systems.

**Q.** *Hospitals have what they regard as sophisticated systems, but do they have adequate systems for inpatient and outpatient data?*

**A.** Many hospitals believe they have a good data systems because they have a chief information officer who shows off a huge piece of hardware. But that's not a data system. In fact, very few hospitals have a

**“The next generation of systems will do more than manage offices and handle billing, scheduling, and so forth. It will also collect clinical encounter data and analyze it in the context of capitated risk.”**

will be so high that it has to be spread among a large number of physicians. There's no way around this problem. For physicians to be competitive in the world ahead, they must bring to the market an empirical demonstration of how efficient they are and how effective they are in terms of clinical practice, outcomes, and patient satisfaction.

**Q.** *I recently read a case study of nine different large clinics and organizations that were investing between \$3 million and \$10 million a year to purchase systems and thereby become competitive. Is that wise?*

**A.** Many times clinics and hospitals are simply over-invested. Often what they are doing is buying a hardware solution. That is, they're putting in lots of wiring and buying lots of machines. They believe their competitive salvation is to put a desktop computer in front of every doctor. In many instances they have purchased hardware where there is no software to sustain it. I've watched groups of very sophisticated physicians and HMOs make particularly dumb mistakes. They have purchased hardware from vendors that promised them they would be set for the future if they bought 400 or so terminals. We come upon case after case of clinics that have spent \$8 million, \$15 million, and even \$30 million in one instance. They're already bearing obsolescence costs with that hardware, and there is no system that is effectively moving data around. It's a very, very dangerous time for investing in these systems.

**Q.** *If it's such a dangerous time, how does one lessen the danger?*

**A.** An experienced consultant, who understands what software is supposed to do to help physicians manage within a

profession being reduced to empirical standards. Smart practices know that the time to develop an information strategy is now. It is important to remember, however, that turning to vendors (usually hardware manufacturers or hospital accounting systems companies that are retooling their inpatient systems for physician offices) can result in a practice purchasing a one-size-fits-all system that is almost always obsolete or ill-fitting from the beginning.

**“Many clinics are simply over-invested. They are buying a hardware solution, but in many instances they have purchased hardware where there is no software to sustain it.”**

profession being reduced to empirical standards.

The good news is that the number of companies that provide software solutions relatively inexpensively is growing. The problem is that a physician practice must shop carefully. It must have its own information strategy, one that fits its overall corporate and marketing strategy.

One good example comes from our growing experience with electronic medical records (EMRs). Many practices believe that if they purchase an EMR system and wire their practices together, the problem is solved. Unfortunately, the nearly universal

good inpatient data system, and almost none have systems for outpatient clinical settings.

**Q.** *So, what types of systems should physicians be looking for today?*

**A.** The key is to select the components needed to do the task at hand with a view toward constant improvement. Today, physicians must have systems that permit them to be competent in capitation bargaining with insurers and health plans. Tomorrow, they will have to have systems that help them manage the risk that has been absorbed by their practice under the capitation contract. This means they need a system that will direct them in practicing in ways that yield high quality within a capitated budget. In time, the practice must be able to relate its outcomes to its costs, while being able to demonstrate to payers that its services and efficiency are competitive. Therefore, as the market places new and increased demands on physicians, they will need systems that help them to meet each of those new demands. ■

# Practice Management Returns Declined

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

The amount of capital physician practice management companies (PPMCs) raised in public markets last year increased dramatically over 1995 levels, but returns on PPMC stocks and the number of initial public offerings (IPOs) by PPMC declined due to turbulent market conditions.

The number of publicly traded PPMC grew to 32 as of Feb. 7, 1997. As more PPMC have entered the market, individual and institutional investors have become more selective when considering these companies. To gain Wall Street's attention today, PPMC must demonstrate a solid track record, excellent management and growth prospects, and a focused strategy aimed at adding operational value to acquired groups. Growth strategies that are focused exclusively on acquisitions do not possess the allure they once did.

## Public Offerings

In 1996, four PPMC completed IPOs, raising a total of over \$150 million. Three of the companies provide services to multispecialty and primary care practices; the other is a single-specialty PPMC.

In addition to raising money through IPOs, PPMC also completed 17 secondary offerings last year, raising a total of \$1.8 billion. The five largest secondary offerings accounted for \$1.1 billion, or 60% of the total. Alone, MedPartners, a multispecialty PPMC in Birmingham, Ala., accounted for \$700 million of the total. It had a \$450 million debt offering and a \$250 million common stock offering. Capital raised by

PPMCs during 1996 was used primarily to fund future acquisitions and expansion.

## Adverse Conditions

Five PPMC canceled, postponed, or reduced the size of planned public offerings last year. The five were FPA Medical Management Inc., in San Diego; EmCare Holdings Inc., in Dallas; GynCor Inc., in Chicago; American Oncology Resources Inc., in Houston; and Pediatrix Medical Group, in Fort Lauderdale, Fla. The primary reason companies delayed offerings

announcement by several leading HMOs that they would raise premiums for 1997, thus alleviating the perception of margin pressure on health care services companies.

## Looking Forward

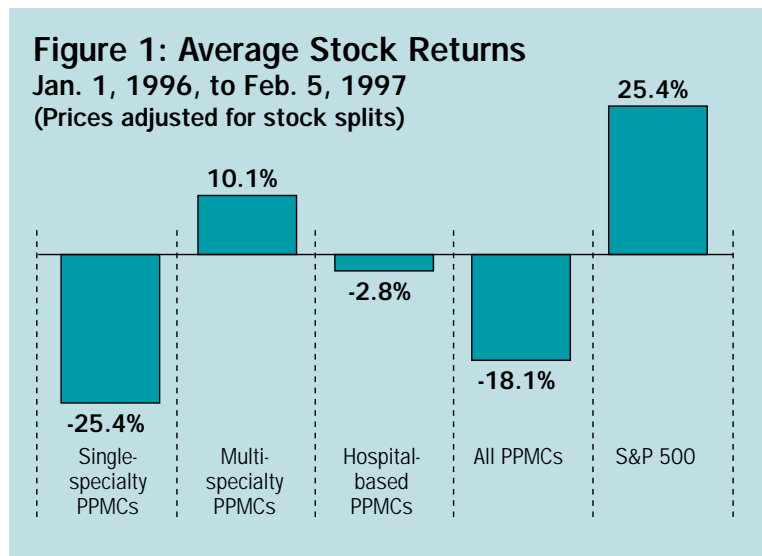
On Jan. 31, First New England Dental Center, a dental practice management company, in Boston, filed for an IPO with the Securities and Exchange Commission (SEC). The company, which has 33 affiliated dental practices in the Northeast, expects to raise \$27.6 million from the offering. It plans to use the money to acquire more dental facilities and to expand those it currently operates. It also may use some of the proceeds to repay debt.

On Feb. 5, PhyCor Inc., a PPMC in Nashville, Tenn., that operates multispecialty clinics and manages independent practice associations, registered 6.4 million shares of common stock with the SEC. PhyCor expects to raise about \$200.7 million from the offering, which it will use to repay bank debt.

Improving market conditions in early 1997 may lead to increased PPMC capital market

activity. Several companies that filed for IPOs last year expect to complete offerings this year (Figure 2). They include Professional Medical Management Co., in Fort Worth, Texas; Castle Dental Centers Inc., in Houston; Gentle Dental Service Corp., in Vancouver, Wash.; Coast Dental Services Inc., in Clearwater, Fla.; Physicians' Specialty Corp., in Atlanta; and Complete Wellness Centers Inc., in Washington, D.C. Specialty Care Network Inc., in Lakewood, Colo., which provides management services to musculoskeletal-disease-related practices, filed for an IPO on Dec. 12, and began trading on Feb. 7. Its shares were priced at \$8, although its Jan. 21 prospectus said it expected the shares would sell for \$9 to \$11. Combined, these companies expect to raise almost \$200 million. ■

**Figure 1: Average Stock Returns**  
Jan. 1, 1996, to Feb. 5, 1997  
(Prices adjusted for stock splits)



was weakened market conditions. PPMC stocks, on average, experienced returns below the S&P 500 due to the poor earnings results compared with analysts' expectations for the last two quarters of 1996. Since the beginning of last year, PPMC stocks decreased 18% versus the S&P 500, which increased in value by 25% over the same period.

Toward the end of 1996 and at the beginning of this year, however, PPMC stocks started to return some of the value lost in 1996. The increase is due in part to the

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**Figure 2: PPMC Offerings**

Company	Filing Date	Offering Date	Offering Size (millions)	Description (headquarters location)
PhyMatrix Corp.	10/10/95	1/24/96	\$107.3	Multispecialty PPMC that provides management services to disease specialty and primary care physicians. (West Palm Beach, Fla.)
The Company Doctor	11/16/95	2/7/96	\$8.4	Manages the practices of physicians who specialize in occupational medicine. Has 11 physician locations in Texas, Louisiana, and Arkansas. (Arlington, Texas)
SunStar Healthcare Inc.	2/28/96	5/16/96	\$6.5	Operates primary care practices in central Florida. Expects to start an HMO in central Florida this year. (Longwood, Fla.)
Advanced Health Corp.	6/19/96	10/3/96	\$29.9	Forms partnerships with physician group practices and provides clinical information systems. Manages six practices with 116 physicians. (Tarrytown, N.Y.)
Professional Medical Management Co.	8/21/96	TBD	\$50.0	Provides administrative and insurance management for physician groups. Affiliated with 76 primary care physicians and 14 physician assistants and nurse practitioners in 16 locations in Texas, Alabama, and Kentucky. (Fort Worth, Texas)
Castle Dental Centers Inc.	9/3/96	TBD	\$55.0	Provides management services to general, orthodontic, and multispecialty dental practices in Texas, Florida, and Tennessee. (Houston)
Gentle Dental Service Corp.	10/4/96	TBD	\$9.0	Provides dental practice management support services to two professional corporations that employ 62 dentists, orthodontists, and other specialists at 20 locations in the Portland and Seattle metropolitan areas. (Vancouver, Wash.)
Coast Dental Services Inc.	10/7/96	TBD	\$18.0	Operates 22 dental centers in Florida that serve more than 105,000 patients. (Clearwater, Fla.)
Physicians' Specialty Corp.	11/29/96	TBD	\$26.7	Provides practice management services to ear, nose, throat, head, and neck medical practices. Has operations only in Georgia but is considering acquisitions in New York, Virginia, Alabama, and New Jersey. (Atlanta)
Specialty Care Network Inc.	12/12/96	2/7/97	\$25.4	Provides management services to musculoskeletal-disease-related practices and is affiliated with five practices and 49 physicians in Pennsylvania, New Jersey, Georgia, Maryland, and Florida. (Lakewood, Colo.)
Complete Wellness Centers Inc.	12/20/96	TBD	\$7.0	Develops multi-disciplinary medical centers and provides certain support services to those facilities, including physicians, physical therapists, chiropractors, acupuncturists, and massage therapists. (Washington, D.C.)

Source: Townsend Frew & Co., investment bankers specializing in health care, Durham, N.C., 1997.

## Study on Beta Blockers Prompts Physician Review

A report in JAMA of Jan. 22/29 shows that inexpensive beta blockers are much more effective than the more expensive and more widely used calcium-channel blockers for patients who have had a heart attack. As a result of the study, federal regulators say they plan to study the use of beta blockers in elderly patients as a way to evaluate the performance of physicians and HMOs.

Despite lower costs and better outcomes, beta blockers, a generic medicine that costs a typical heart patient about \$3 a month, are given to only one in five eligible patients. The study found that patients receiving beta blockers were 43% less likely to die in the two years following a heart attack than those patients who didn't

receive the drug. Use of calcium-channel blockers, costing about \$30 to \$50 a month, double the risk of death, not because they cause harm, but because they are used instead of the more effective beta blockers, the study showed. The study was based on the treatment of 5,300 New Jersey Medicare patients.

**Comment:** *A few health plans collect data on the number and type of prescriptions physicians write for certain conditions as a way to identify patients who may need more targeted interventions. In this way, the plans can identify physicians who are performing what the plans say is optimum care. In the coming years, more plans will use prescription data to measure physician performance.*

## Researchers Advocate Tax on Health Spending

A group of scientists wants to add a 2% tax to all health care expenditures to support research and teaching in academic medical centers, according to *The Wall Street Journal*. Called Citizens for Public Research and Education Funding, the campaign is headed by James Mueller, chief of cardiovascular medicine at the University of Kentucky. "This isn't a grab for more money," Mueller said. "This is to prevent downsizing as we make the transition to managed care."

U.S. Sen. Daniel Patrick Moynihan, a New York Democrat, sponsored a bill last year that would have raised \$4 billion from a 1.5% tax on HMO premiums to help pay for medical research, but the bill was defeated.

Academic medical centers emphasize acute care, training of specialists, and high technology, and treat patients with unusual diseases. These focus areas are antithetical to those of managed health plans, which seek more generalists and prefer community hospitals.

**Comment:** *In an unusual move, Aetna U.S. Healthcare, a managed care organization in Hartford, Conn., has established a \$15 million fund for medical school research on the quality and cost effectiveness of managed care, two issues that managed care practitioners need to understand, Aetna said.*

## Study Shows \$4.2 Billion Spent on Drug Errors

In yet another sign that the health care system needs repair, recent studies show that some 770,000 patients suffer injuries each year due to medication errors in hospitals, according to *The Boston Globe*. These injuries are largely avoidable. Yet the extra required hospitalization adds \$4.2 billion to health care costs nationwide. A typical 700-bed hospital may spend \$5.6 million per year on medication errors, according to the study done at Brigham and Women's Hospital and Massachusetts General Hospital, both in Boston.

Another study, this one done at LDS Hospital, in Salt Lake City, found that drug-related injuries are not rare or unusual. The Utah team concluded that half of all drug errors are preventable. The team in Boston said 28% of such errors are preventable. The studies were published in JAMA, Jan. 23.

**Comment:** *Last year, The Dartmouth Atlas, a study published by the American Hospital Association, showed how widespread variation in health care costs and utilization were symptoms of poor quality. These studies on medication errors add to health care buyers' concerns about poor care and waste and inefficiency in the system.*

## Columbia University Bases Contract on Productivity

New York City has signed a three-year contract with Columbia University for \$44.5 million, \$7 million less than last year, to train doctors for Harlem Hospital. The annual dollar amount will drop during each year of the contract. Columbia also agreed to pay fines if it fails to meet certain performance standards, such as improving levels of child immunization, mammogram rates, and the percentage of PAP smears performed.

"The era of limitless resources with no accountability or productivity measures has ended," said Luis Marcos, MD, president of the New York Hospitals and Health Corp., the city agency that contracts with hospitals. The corporation is expected to sign similar contracts with other academic medical centers that train residents for 11 other city hospitals.

**Comment:** *Echoing the comments of health care purchasers nationwide, Marcos said the agreement will help lower costs, improve quality, and "thereby raise the value of what we get for our dollars."*

## Columbia/HCA Buys Value Health

Columbia/HCA Healthcare Corp., in Nashville, Tenn., the nation's largest operator of for-profit hospitals, has offered \$1.3 billion to buy Value Health Inc., of Avon, Conn., which provides prescription drug and mental health benefits, and workers' compensation programs for more than 1,000 employers. By buying Value Health, the hospital management company would have access to some 40 million consumers and could offer their employers an unusual mix of specialty health benefits and hospitalization.

**Comment:** *If approved by regulators, the sale would nearly double Columbia/HCA's pharmaceutical purchasing power to \$1 billion per year, thus giving Columbia unusual purchasing power with pharmaceutical manufacturers.*

## NEWS AND COMMENTARY

### Nonprofit System to Buy N.E. Medical Center

Lifespan, a nonprofit health care system, in Providence, R.I., plans to buy the New England Medical Center (NEMC), in Boston. If approved by regulators in both Massachusetts and Rhode Island, the sale would be a blow to the expansion plans of Columbia/HCA Healthcare Corp., in Nashville, Tenn. Columbia owns 347 hospitals worldwide and posted about \$20 billion in annual revenue last year.

The last of Boston's major hospitals to choose a partner, NEMC is the principal teaching hospital for the Tufts University School of Medicine. While seeking a partner for the past two years, the debt-ridden NEMC has resisted overtures by Columbia, because it preferred to remain a nonprofit. Columbia, which wants to establish a presence in Boston, continues to pursue other facilities in the region. Terms of the merger were not released.

The merged company would employ 14,500 workers, and have \$1.5 billion in annual revenue, according to *The Boston Globe*. By adding NEMC, Lifespan would become the second largest health system in New England. Currently, the largest health system in New England is Partners HealthCare System Inc., in Boston, which is the parent company of Massachusetts General Hospital, Brigham and Women's Hospital, and North Shore Medical Center. It posted \$1.8 billion in annual revenue in 1995. CareGroup, also in Boston, would be the third largest, having reported \$1.1 billion in revenue in 1995, *The Globe* said. CareGroup includes Beth Israel Deaconess Medical Center and Mount Auburn Hospital.

**Comment:** Columbia already owns MetroWest Medical Center in Framingham, Mass., just west of Boston; has an agreement to buy Roger Williams Medical Center in Providence; and is discussing a purchase of the Neponset Valley Health System, in Norwood, Mass., just south of Boston.

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