PHYSICIAN PRACTICE
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Texas Physicians Press Case for Antitrust Relief

Many physicians maintain that current antitrust laws place them at a competitive disadvantage when negotiating with managed health plans. The AMA and state medical associations have pushed legislation introduced at the state and federal levels over the last two years to permit collective contract negotiations by most physicians. But those efforts have been dogged by setbacks, including a failure to secure national legislation and delays in implementing a two-year-old Texas law that could offer some antitrust relief.

Approval Required

The Texas law, SB 1468, gives physicians relief from antitrust legislation as long as they follow rules set by the state attorney general. Since it was passed in 1999, only one group of 11 physicians in Henderson, Texas, a town of about 14,000 residents southeast of Dallas, has tried to negotiate with a health plan. But those physicians, known as the physician-joint negotiation group, have been stonewalled by a significant feature that weakens the Texas law. The law does not require health plans to negotiate with any physician group, says Fred Hellinger, PhD, an economist with the federal Agency for Healthcare Research and Quality (AHRQ) in Rockville, Md. "Although there was considerable interest in the physician antitrust law in Texas at the time of its passage, it has elicited little response from physicians," he says.

Under the law, Texas Attorney General John Cornyn must approve an application to negotiate collectively before a group can be protected from federal and state antitrust laws. What's more, regulations from the state attorney general's office make implementation of the Texas law by physicians cumbersome and expensive, say officials with the Texas Medical Association in Austin. TMA regards the implementation rules as burdensome and unrealistic for physicians. "The TMA is working with the Henderson group as a test case of the joint negotiation law," TMA officials say.

An issue of concern to the TMA is whether the information submitted by a group of physicians, including fees, would be made public under the state's Public Information Act. In May, Cornyn said that fee information in an application is protected from disclosure under that act as a trade secret.

In its application to the attorney general's office, the Henderson physicians said they were seeking to negotiate fees, anesthesia payments for colonoscopies, and administrative issues with Blue Cross and Blue Shield (BCBS) of Texas, which controls about 25% to 30% of the region's managed care market, observers say.

"Our group has tried to get Blue Cross to address important issues regarding patient care, payment of claims, and authorization of care,"

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EDITORIAL

Doctors See Hope for Several Reasons

Recently, a magazine in New York ran an article about how managed care plans have treated physicians badly over the past decade. Under managed care, it said, physicians have been buried in paperwork, had their income reduced, and have been limited in their power and independence.

Physicians in New York may have been fortunate in that managed care did not arrive there in full force until the late 1990s. But today, New York is like many other managed care markets: Physicians have little market clout compared with what they had before managed care and their income has been cut sharply. In New York and nationwide, physicians have little choice but to contract with HMOs, like it or not.

There is something physicians can do about this state of affairs; namely, support efforts to change federal and state antitrust laws. As we report in this issue, antitrust concerns have limited physicians' ability to negotiate collectively with managed health plans. But efforts are under way in California, Texas, and other states to rewrite these laws. Last year, Congress considered legislation to provide antitrust relief, and that bill may be revived this year.

And there is more hope for beleaguered physicians. In a recent interview, Uwe Reinhardt, PhD, a health economist at Princeton University, said the next few years could be good for physicians. For one reason, the physician surplus that was predicted in 1994 never occurred. Instead, the nation has a shortage of physicians in some specialties, such as anesthesia, pathology, and radiology. Also, he says, physician income will rise with inflation, in part because HMOs have lost the market clout to resist increases in fees.

As we report in this issue, some physicians are managing to make the best of the current health care market. A recent report by the Medical Group Management Association, in Englewood, Colo., *Performance and Practices of Successful Medical Groups: 2000 Report Based on 1999 Data*, shows that the profit margins of successful practices exceed the margins of other groups by more than 30%. Successful groups increase profit by closely managing spending and profitability; by focusing on physician productivity, capacity, and staffing; and by not neglecting accounts receivable and collections. These physician groups seek advice, try new approaches, maximize efficiency and productivity, and understand and exploit ways to generate revenue.

In other words, physicians who work for successful practices think and act as high performers. This issue contains the first of several articles (page 6) on high-performance physicians in which we will explain how these physicians are able to succeed in such difficult markets.

Richard Reece, MD
Editor-in-Chief
Phone: 860/395-1501
Fax: 860/395-1512
E-mail: Rreece@premierhealthcare.com

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Publisher
Premier Healthcare Resource, Inc.
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054
888/457-8800
Fax: 973/316-5989
publisher@premierhealthcare.com

Editor
Joseph Burns
508/495-0246
editor@premierhealthcare.com

COMMENTARY

HMOs Encounter Stormy Weather

By Richard L. Reece, MD, editor in chief

In August, after much last-minute blustering, the U.S. House of Representatives approved patients' rights legislation that would give consumers some federally sanctioned legal remedies under managed care. Earlier in the summer, the U.S. Senate also had passed a patients' bill of rights, but its version would offer consumers broader protection than the House's version.

So, by late summer 2001, after years of stormy debate over the condition of the nation's health care system and how to cure it, Congress had finally voted on health care legislation. The scene was set for members in both Houses and on both sides of the issue to rise above partisan bickering and iron out patients rights' legislation that consumers want and the nation needs. Whether that will happen this year has many industry pundits' tongues wagging.

Health Plans or Insurers?

The fact that such legislation is needed and so hotly debated shows how far managed care has dug down deep in the nation's health care system. But it wasn't always like that.

The June 1, 2001, cover story by Andy Pasternack, in *Health Leaders*, provides a short history of managed care, noting that the theories behind today's form of managed care were conceived by Paul Ellwood, MD, only about 30 years ago. In the article, Ellwood, who coined the term "health maintenance organization," related how the concept of care he envisioned in the 1970s has become so much a part of today's health care system, and how that concept has been twisted along the way.

In theory, managed care, as Ellwood conceived it, would stop medical inflation and promote accountability and quality in the health care system because health organizations would compete with each other on the basis of price and quality, and give the public data on patient outcomes. However, as Ellwood stated in the story, "By HMO, we meant medical groups or physician-created independent practice associations. But when people say HMO today, they think of Aetna, Cigna, and UnitedHealthcare. They're all insurance companies."

Another problem is that the current reimbursement system does not reward health care systems for providing quality care, Ellwood continued. "Let's say Kaiser was the best place in America to treat AIDS, or breast cancer," Ellwood explained. "Kaiser would have attracted all the bad risks; and [the resulting financial losses] would have broken them." One reason HMOs have left such a negative impression among many Americans is that they and employers have never had access to adequate data about quality and outcomes.

In the article, Pasternak delves deeper into the fundamental theories behind managed care by relating how Alain C. Enthoven, a professor at Stanford University and another strong proponent of managed care, characterized the elements behind the model. According to Enthoven (Pasternak explains) under managed care "consumers would have a wide range of responsible, individual, and informed choices among health care financing and delivery organizations, and that the competitors would create 'accountable health partnerships'—between physician organizations, bearing full responsibility for managing medical care, and insurance companies—to market the services of the physician organizations and provide insurance functions. In the case of small businesses and individuals, these partnerships would contract with health insurance purchasing cooperatives that would spread risks over many people. Competing health partnerships would agree to meet at least minimum standards, provide standardized benefits, and compete on quality and price."

In theory, managed care was designed to stop medical inflation and promote accountability and quality by fostering competition on the basis of price and quality and by publishing data on patient outcomes.

Now, 30 years later, it is enlightening to contrast what managed was envisioned to be with what it has become.

Vision and Reality

The vision of HMOs that Ellwood, Enthoven, and others so hopefully conceived is not the stark reality that pervades among HMOs today. Recent polls show that the public has placed HMOs at the bottom of many institutions when it comes to expressing confidence in our nation's organizations. According to a poll of 1,000 consumers by Harris Interactive, a private consulting and research firm in New York, only 29% of respondents believed managed care providers took good care of customers. For comparison, tobacco and oil

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companies ranked 28% and 27%.

Other bad news for HMOs concerns ominous talk about the failure of HMOs. In an op-ed article in *The New York Times* in June, the newspaper said, "It is becoming apparent to nearly everyone that our experiment with private managed care has failed. The system is imploding, and a patients' rights bill, by increasing costs, will accelerate its demise. High time. But without anything in its place, many Americans will be left without adequate health coverage during its death throes."

Questions Raised

James C. Robinson, associate professor in the School of Public Health at the University of California, Berkley, also sees the failure in managed care, but acknowledges some success as well. In the May 23/30 issue of JAMA, he wrote: "Managed care embodies an effort by employers, the insurance industry, and some elements of the medical profession to establish priorities and decide who gets what from the health system. After a turbulent decade of trial and error, that experiment can be characterized as an economic success but a political failure. The strategy of giving with one hand while taking away with the other, of offering comprehensive benefits while restricting access through utilization review, has infuriated everyone involved. The protagonists of managed care are in full retreat, broadening physician panels, removing restrictions, and reverting to fee-for-service payment. Government entities are avoiding politically volatile initiatives to balance limited resources and unlimited expectations. By default, if not by design, the consumer is emerging as the focus of priority setting in health care. The shift to consumerism is driven by a widespread skepticism of governmental, corporate, and professional dominance; unprecedented economic prosperity that reduces social tolerance for interference with individual autonomy; and the Internet technology revolution, which broadens access to information and facilitates the mass customization of insurance and delivery."

Success or Failure?

While it may be true that managed care is a political failure, it is not an evil empire. Even detached observers know that managed care would not have become the huge industry it is today if it was not needed. And, indeed, it has had its share of successes: It compelled employers, health plans, and physicians to work together; it slashed costs for 10 years; it eliminated much unnecessary care; it brought a measure of discipline to patients and physicians; it served well those young families and healthy individuals by offering them comprehensive benefits; it fostered serious discussions and helped introduce the nation to disease management; it focused on the standardization of treatments; it introduced and articulated the concept of total quality management; and it sought to coordinate and consolidate a badly fragmented system.

But managed care has overreached itself. It has failed among patients and physicians. It promised what it could not deliver: comprehensive care, reduced costs, better outcomes, and improved quality. It misjudged

Who Stands Where on Managed Care Reform?

The Center for Responsive Politics, a nonpartisan, nonprofit research group in Washington, D.C., that tracks money in politics, and its effect on elections and public policy (at www.opensecrets.org) says the following organizations can expect to see changes in their operations under patients' rights legislation. The center's Web site has more information.

Health plans are opposed to efforts to regulate the industry. Trade groups representing the industry, such as the Health Insurance Association of America and the American Association of Health Plans, have argued that lawmakers should increase efforts to provide health coverage to the uninsured, rather than enforce new mandates on HMOs. They also oppose allowing patients to sue their health plans.

Health professionals, led by the AMA, are major proponents of the patients' bill of rights legislation. They contend that health plans are overriding their ability to prescribe necessary treatments for patients. Physicians also contend that they have not been receiving fair compensation from health plans.

Consumer groups, such as Consumers Union and the American Association of Retired Persons, contend that health plans care more about profit than patients and support provisions to let patients sue their health plans. Also, they want to allow patients wider access to specialists and doctors outside of their plans.

Business groups, such as the National Association of Manufacturers and the National Federation of Independent Business, have lobbied for managed care reform. Many argue that reforms that increase the cost of health insurance would have a negative effect on business revenue and profit.

the American people, who want access to the best specialists and best technology, and physicians, who insist on individual autonomy.

The negative results are there for all to see. According to InterStudy, managed care researchers in Minneapolis, HMOs stopped growing in membership in 1998, and HMOs are losing 400,000 members of their 81 million enrollees annually. Perhaps a culture of affluence and access to high-tech medicine spoiled American patients and physicians, making them ill-prepared to swallow the bitter medicine HMOs prescribe: strict utilization review and frequent denials of care. In addition, the fact that HMOs took as much as 25% of premiums and made visible millionaires out of HMO founders and executives did not sit well with either the public or physicians. But the bottom line is this: Rising expectations and unrestricted access fly in the face of one Wall Street reality—for-profit HMOs, which make up 75% of the HMO industry, must limit access and dampen expectations to satisfy investors.

Erosion of Quality

Embedded in Ellwood and Enthoven's vision of managed care is the idea that HMOs would compete on the basis of accountability and quality. But the reality is that managed care has failed to sell patients and physicians on the notion that HMOs improve quality. Just the opposite is true. Most physicians believe that HMOs erode quality. In a July 1999 poll by the Kaiser Family Foundation in Menlo Park, Calif., and the Harvard School of Public Health, researchers found that eight of 10 doctors said their patients had been denied coverage that resulted in deterioration of their patients' health because of these denials. The percentage of doctors who felt that the denial of the following specific services harmed their patient's health were as follows: referral to a specialist, 50%; hospital stays, 46%; diagnostic tests or procedures, 39%; and prescription drugs, 37%.

The managed care industry's failure to incorporate the quality component of the managed care theory has resulted in pressure on Congress to do so. Ellwood acknowledged in the *Health Leadership* article that it might be difficult to get members of Congress to press for "risk-adjusted outcomes data." However, quality of care is a more easily understood concept today, especially by consumers who have been denied care, or have received inadequate or improper care. This summer's stormy political legislative wrangling in Washington, D.C., over patients' rights may result in more attention being focused on "risk-adjusted outcomes data."

Many observers believe that HMOs are not the main problem with managed care; quality of care is.

In fact, Congress took steps in 1986 to use data to afford patients some protection from incompetent doctors by establishing the National Practitioner Data Bank. Although this action encompassed both the outcomes data and quality emphasis of the managed care theory, they were but small steps toward full endorsement of the quality element. And even then, the validity of the data bank has been questioned repeatedly, as it was in a report released in May by the Inspector General's office of the Department of Health and Human Services. The report stated that managed care organizations and hospitals were failing to report the disciplinary actions being taken against doctors, as they were legally required to do. What's more, the data, valid or not, are not available to the public, so the use of data measures to promote quality, accountability, and competition among health care providers is thwarted. And, now Congress is stepping in to draft legislation that would impose more remedies for beleaguered patients, frustrated practitioners, and an industry already overwhelmed by rules and regulations.

Misplaced Focus

But no matter what form of patients' rights legislation Congress passes, HMOs will survive, albeit in a much looser form of managed care, principally as PPOs offering choice, flexibility, and higher premiums. The focal point of the patients' rights debate—on whether patients should be allowed to sue HMOs and for how much—is misplaced. The crisis in health care is not how much HMOs deny care, but rather the quality of care being delivered in either a managed care or a fee-for-service environment.

Lucian L. Leape, MD, professor at Harvard School of Public Health and co-author of two Institute of Medicine reports, *To Err Is Human* and *Crossing the Quality Chasm*, says a crucial quality problem is how little of what doctors do is backed by scientific evidence. One answer to this problem, he says, is widespread adoption of information technologies at the point of care (that is, while patients are in their doctors' offices) so that doctors can review that evidence when it could make a difference.

What it comes down to is that quality of care is the main problem with managed care. In that regard, the lack of timely and relevant evidence of what works and what harms patients is the problem.

—Additional reporting and editing by Paula Grant, in Lincoln, Va. More information is available on our Web site (see page 16).

Working in Five Areas Gets Results

By John W. McDaniel, MHA

In every field of endeavor, benchmarks exist to judge the performers. In sports, there are benchmarks attesting to the outstanding performances of baseball player Cal Ripken Jr., golf pro Tiger Woods, and basketball player Michael Jordan. In business, consistently outstanding stock performance is a benchmark of high-performing companies, which often achieve such success because they have recognized high-performance executives at the helm. So, in medicine, what benchmarks can be used to recognize high-performance physicians?

Setting Standards

Utilization standards exist, against which quality medical care can be compared, such as the incidence of Cesarean section rates for obstetricians, nosocomial infection rates for pulmonologists, and postoperative complication rates for surgeons. The business of medicine also has benchmarks for judging both financial and operational excellence. Indeed, even though many successful physicians are at maximum capacity for their patient volume, some have shown that they can improve financial performance, even in an era of increasing governmental regulations and declining reimbursement.

In medicine, high-performance physicians constantly review, develop, and implement performance improvement opportunities for their practice in five areas of financial and operational performance: reimbursement systems, billing and collections processes, accounts receivable management, operations improvement, and practice growth. This is the first in a series of articles that examine these areas in relation to high-performance physicians.

Over the last year, the High Performance Physician Institute in Davidson, N.C., was developed for physicians who have decided to become high-performance physicians by applying new technologies and processes in order to practice more effectively and efficiently. The institute, which sponsors regional conferences in major cities, focuses on how physicians can automate workflow to make their practices run more efficiently, avoid external intrusions, increase patient satisfaction, and make practice more enjoyable.

The institute has determined that high-performance physicians share four characteristics: They want practical solutions; they know how other physicians think; they recognize what physicians need and want in order to succeed; and they can achieve superior financial performance.

To ensure long-term success, physicians must compare themselves to and learn from organizations that have a record of achieving excellent results. Like other businesses, medical practices must adopt business solutions from other industries, such as workflow production models and customer service strategies, in order to differentiate themselves as high-performance practices.

Benchmarking criteria are available from the Medical Group Management Association, in Englewood, Colo. (at www.mgma.com) for primary care and specialty medical practices. While most medical groups find it beneficial to compare their historical performance, they must also compare themselves against their most successful peer groups in order to determine their overall level of performance and to evaluate further opportunities for improvement.

Physicians who do random samples of patient accounts to ensure that managed care payers are reimbursing properly often find a surprising number of errors.

Seeking Improvement

One of the first areas of excellence to examine involves reimbursement systems, focusing primarily on evaluating coding patterns, practice fee schedules, managed care contracts, fixed-fee payer analyses, and compliance program management.

While physicians in most medical groups believe the single most important priority for improved profitability is managing overhead, expenses are only one of the five levers for improving medical practice profitability. The other four areas focus on revenue improvement and practice growth. Expense management is important for practices seeking a short-term way to increase profit, but appropriate revenue cycle management can lead to sustained financial improvement for years to come.

John W. McDaniel is president and CEO of Physician Management Group Inc., physician practice improvement advisers, in New Orleans. For a copy of a checklist related to starting a group practice, readers may contact McDaniel by phone at 800/764-2633 or by e-mail at pmgcode@eatel.net. More information on practice management is available on our Web site (see page 16).

Physicians should know as much as possible about the 20% of their business that represents 80% of their income.

Coding compliance is an area of management that is of particular concern to all physicians today. Most doctors tend to undercode claims by underbilling for the services they provide. High-performance physicians, however, conduct ongoing analyses of levels of service utilization for major evaluation and management codes against the audit standards established by the federal Centers for Medicare and Medicaid Services. CMS uses these audit standards to determine potential undercoding or overcoding. The results of these analyses enable physicians to conduct (or contract for) chart audits to ensure that the documentation of medical necessity supports the levels of service provided. This information can then be presented to individual physicians to improve coding accuracy, if necessary, and provide evidence for coding compliance in the event of a government audit.

Revenue Management

Another revenue cycle management technique that high-performance physicians use involves consistent review of managed care contract terms and reimbursement rates. These physicians also compare the charge and collection ratios of all major payers to determine the effectiveness of various managed care contracts and whether the contracts should be renegotiated or renewed.

Few practices conduct managed care contract compliance audits, and of those that do, many physicians are amazed at the rate of errors uncovered. In such audits, a random sample of patient accounts is reviewed to ensure that the managed care companies involved are reimbursing properly under the contracted fee schedule. Today, practice management software is available that includes modules to ensure that appropriate payments are received from payers.

For physicians who want to benchmark their performance in this area, experts recommend that they follow the 80-20 principle, which holds that 80% of a practice's income comes from 20% of its procedural (CPT-4) codes or 20% of its diagnosis (ICD-9-CM) codes. To be a high-performance physician, it is therefore imperative to know as much as possible about the 20% of the business that represents 80% of the income.

According to the MGMA report, *Performance and Practices of Successful Medical Groups: 2000 Report Based on 1999 Data*, successful medical groups manage all contracts comprehensively by seeking areas that could affect the financial, clinical, and operational aspects of the practice. A focused approach to contract management permits early, deliberate intervention to resolve any problems or issues that could have a detrimental effect on a medical group. The types of questions addressed by successful medical groups include the following:

- Have we attracted the patients we expected in terms of volume and type and severity of illness?
- Did we receive the expected level of reimbursement?
- Are we competitive with our peers in the scope of our services and the quality of our clinical practice delivery?
- Did we comply with contract provisions related to such issues as access and timely filing?
- Was the health plan in compliance with contract provisions, such as those involving prior authorization and timeliness of payment?
- Have we developed effective partnerships with the health plan?
- Are we positioning ourselves for successful future contracts and renegotiation and renewal?

As high-performance physicians seek solutions to promote efficiency in their day-to-day practice, especially solutions that relate to reimbursement, they should consider taking advantage of new technology such as that offered by James Weintrub, MD, a plastic surgeon in Providence, R.I., who has developed Paladin Coding Software (at www.dpnx.com) that allows physicians to determine within minutes precisely the right codes for clinical situations involving CPT-4 codes and E&M guidelines.

Other examples include Allen Wenner, MD, a family physician in Columbia, S.C., who is the founder of Primetime Medical Software Inc. and who helped develop a program called The Instant Medical History that assists physicians in collecting patient-generated medical history information. Lloyd Hey, MD, an associate professor of orthopedics at Duke University and founder of mdeverywhere.com, has developed a charge capture system using a handheld device that allows physicians to capture the codes required for billing accurately. David Bright, MD, a solo family physician in Stuart, Fla., has developed an electronic medical record system that uses speech recognition software.

These are just a few of the companies aimed at improving reimbursement systems, one of the business areas that physicians need to consistently focus on in order to become high-performing doctors. ■

(Continued from page 1)

says Linda Davis, director of managed care for Henderson Memorial Hospital and the physician group's designated representative. "Because Blue Cross has a large market share, individual physicians have little or no ability to negotiate effectively. Since this is the first group to test this law, the ultimate outcome remains uncertain. We hope the attorney general will authorize these negotiations and that Blue Cross will agree to participate."

As of late August, the application had not been officially accepted by the attorney general's office, which was seeking additional information before beginning its review. The attorney general had requested descriptions of each of the 11 physician's 10 most commonly used CPT codes.

BCBS officials will not comment on the case until the attorney general rules on the validity of the application. BCBS officials have told the TMA that they want to know more about the concerns of the Henderson physicians and instead of negotiating may want to hold informal discussions with the doctors. A decision from Cornyn's office on the validity of the application is expected this fall.

Since six health plans dominate the private health insurance market in California, physicians there have little choice but to sign the plans' contracts, officials say.

Pushing Legislation

To physicians, the Texas law seemed promising when it was passed because it addresses many important contractual issues, including fees, patient referrals, utilization review, quality assurance, reimbursement methods, preventive care services, disease management, clinical guidelines, patient education, fraud and abuse, physician selection and termination criteria, and the timing of payments.

The Texas legislation was the first of its kind, and since it was enacted in 1999 about 20 states have considered legislation modeled on it. In June, a bill that would provide antitrust relief passed the California state assembly and was being considered by the senate's judiciary committee.

"Those who are providing care are at a serious disadvantage compared with insurers," says David van der Griff, a spokesman for California Assembly Speaker pro tem Fred Keeley, who introduced the bill, AB 1600. "Because just six health plans in California dominate the private health insurance market, doctors have little choice but to sign the plans' contracts," he says.

The California senate was expected to pass the bill by the end of the current legislative session on Sept. 14, van der Griff says. "We are uncertain at this point whether the bill will be signed by the governor," he adds, saying that state officials are dissatisfied with some provisions of the bill.

While some actions in state legislatures are promising, the AMA has been lobbying aggressively for passage of antitrust relief at the federal level. Last year, it supported the Quality Health Care Coalition Act of 2000, known as the Campbell bill, in the 106th Congress. That legislation, sponsored by former Rep. Tom Campbell, a California Republican, would have allowed physicians and other health care professionals to negotiate jointly with health plans the fees and other terms of their contracts.

To date, no similar legislation has been introduced in the 107th Congress, but the AMA is pushing the issue. "Physician antitrust legislation is a top priority," says Donald Palmisano, MD, an AMA trustee. "We are aware that several legislators are worried that joint negotiation legislation could lead to price fixing. We want to assure them that will not happen."

Seeking Clout

Antitrust relief is important because physicians have experienced a significant decrease in bargaining power over the last several years, says Hal S. Katz, an attorney with Hilgers & Watkins, a law firm in Austin, Texas. "Consolidation of many large insurance companies has forced physicians to enter into unfavorable financial and professional relationships in order to maintain access to their patients," Katz says. "Current federal and state laws have made it extremely difficult for physicians to organize and negotiate with such insurance companies."

Health plan officials believe joint negotiation would lead to higher health premiums for consumers. "It's bad for everyone," says Walter Zelman, president of the California Association of Health Plans, the state's managed care industry group. "It will drive up prices and undermine managed care. By allowing practitioners to fix prices without coming together into organized medical groups, it gives those doctors the chance to raise fees without coordinating their care."

The federal Department of Justice and the Federal Trade Commission regard collective fee negotiations by physicians with managed care plans to be price fixing, a violation of antitrust law. The purpose of federal and state antitrust laws is to promote competition by limiting restraints of trade and collective activity by competing entities, particularly when it involves pricing, Hellinger explains.

Physicians who are members of unions can negotiate collectively. Of the 710,000 physicians in the United States, an estimated 284,000 are employees, and the AMA estimates

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Texas Issues Joint Negotiating Rules

Legislation passed in Texas in 1999—SB 1468—allows physicians and payers to conduct joint negotiations under state supervision. The Texas law has been a model for similar legislative initiatives in about 20 states. Last fall, Texas Attorney General John Cornyn issued rules for those negotiations, saying the attorney general's office would not sue competing physicians who discuss forming a negotiating group and seek approval under SB 1468. But, physicians cannot share or discuss specific fee-related information until Cornyn approves the group for negotiations.

"The rules are detailed and complicated," says Michael Cushman, director of the Department of Health Care Delivery for the Texas Medical Association in Austin. "Physicians still aren't clear exactly how they will be implemented."

An application for joint negotiation requires a physician group to provide the attorney general with detailed information about its practices, the local market for health care, and its contracts. The group must specify exactly which contract provisions it wants to negotiate and needs to estimate the effect of its negotiations on the quality of patient care and on consumers and competitors.

The application process is expensive. The attorney general's office charges $2,000 to review an application for a joint negotiation group if the proposed negotiations are for contract provisions other than fees, and then collects an additional $500 for reviewing a contract produced by the negotiations. Groups proposing to negotiate fees must pay $5,000.

The rules are stringent as to what fee information can be shared among group members and how that information is shared. Under antitrust law, competitors cannot share fee and pricing information, so the rules suggest that competing physicians choose a third party to collect fee information and manage the application process. "The representative should avoid sharing the information with the group members until the group is approved," the rules say.

Fee information exchanged among competitors before approval should be at least three months old and general enough to make it impossible to identify fees for individual practices. "Before an application is approved, discussions of fees and related issues must be limited to general expressions of dissatisfaction and evaluation of whether a negotiation group is warranted," the rules say.

Physicians are instructed under the rules not to discuss the fees or reimbursement rates they are seeking until the joint negotiation application is approved. If the approved negotiations fail or are discontinued, "doctors should cease discussions within the group, or they could face antitrust scrutiny," the rules say.

Parties will not be allowed to begin the contract until the attorney general approves the contract in writing. For negotiations involving fees, the physicians group will be asked to show how fee-related contract terms have already adversely affected or threaten to adversely affect the quality and availability of patient care.

"No doubt the rules will become more refined over time," Cushman says. "Since Texas is at the forefront of this issue, much of how all this will be handled remains uncharted territory."

—MS

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that about 35,000 are in unions. Physician antitrust relief legislation is designed to help the more than 420,000 physicians who are not employees to collectively negotiate with managed care plans, Palmisano explains.

Those who support antitrust relief for physicians say most doctors and group practices treat a relatively small portion of the population in their markets, while health plans have significant market power in many areas of the country. In four out of five metropolitan statistical areas, a managed care plan covers at least one third of the population in those markets, Hellinger says.

What's more, many insurers maintain regional monopsonies, which are defined as market situations in which the product or services of several sellers is sought by one buyer, Palmisano says. "A monopsony enables payers to pay below competitive levels by allowing them to dictate contract terms," he adds. Too much power in the hands of payers adversely affects quality, Palmisano explains.

Under physician antitrust relief, price fixing would not be an issue, Palmisano adds. "We aren't arguing for the right to strike or to arbitrarily jack up prices," he explains. "We want to be able to negotiate in good faith with the people who set the payments. We want the ability to advocate as a group for quality care."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on physician practice strategies is available on our Web site (see page 16).

Ruling Puts Union Efforts in Doubt

The future of unions for physicians is in doubt. Just as more physicians are becoming employed, the union movement has suffered a setback in the courts. A ruling earlier this year by the U.S. Supreme Court involving a group of nurses in Kentucky could slow the union movement, perhaps to a halt, by making it more difficult for physicians to unionize.

Efforts Suspended

On May 29, the Supreme Court ruled in *National Labor Relations Board (NLRB) v. Kentucky River Community Care Inc*. that if a professional employee uses independent judgment to direct the work of another, he or she is a supervisor, even if the employee giving the direction is a professional who customarily gives professional direction to other employees and has nothing to do with hiring, firing, or discipline. The ruling severely curtails the collective bargaining rights of physicians employed in the private sector by effectively defining all health care professionals as supervisors not eligible for collective bargaining, experts say. This holding is in direct contrast to a series of decisions issued by the NLRB since 1994 in which health care professionals who exercised ordinary professional or technical judgment in directing less-skilled employees were not exercising the type of independent judgment needed to make them supervisors.

Although the ruling may be a setback, the push to organize bargaining for employed physicians will continue, especially for physicians negotiating to be more involved in making decisions about patient care, says Susan Adelman, MD, a pediatric surgeon in Detroit and president of Physicians for Responsible Negotiation (PRN), the AMA's physician union.

"There have always been ebbs and flows in the federal labor laws with regard to collective bargaining rights," Adelman says. "We're confident that the pendulum will swing back in the future, allowing physician collective bargaining. We represent the future of collective bargaining for all physicians and our continued existence is vital to the protection of patients' rights."

It has long been accepted that physicians, such as those employed by hospitals and clinics, are considered to be employees and thus eligible to unionize, says David J. Goldberg, MD, a surgeon at the New Jersey Medical School and a professor at Fordham University School of Law, where he teaches health care law. The physicians' right to unionize was reinforced by an NLRB decision in 1999 that gave employed physicians the right to organize. It is unclear what effect the Supreme Court's ruling in *NLRB v. Kentucky Community Care* will have on that right, Goldberg says.

While the union movement may be in doubt as a result of the ruling, AMA officials and leaders of physician unions (which claim representation for about 10% of the nation's 710,000 physicians and osteopaths) argue that unions are a necessary option for physicians today. About four out of 10 physicians are employees of a group practice, hospital, health plan, medical university, or the government, the AMA says.

"As many as 90% of doctors who complete their residency today are going to be employed," Adelman says. "Doctors who can come to a satisfactory agreement with their employers don't need collective bargaining. But where their employers are obdurate, doctors will be protected by labor laws and will legally be able to collectively bargain."

Building Support

Current union enrollment numbers are still low. Fewer than 10% of all physicians participate in unions, says Robert Weinmann, president of the Union of American Physicians and Dentists, an organization in Oakland, Calif., that has about 5,000 members. Others, including the AMA, estimate the percentage of unionized physicians to be only about 5% of the total number of physicians practicing, or roughly 35,000 medical doctors and osteopaths. Eric Scherzer, director of the 1,000-member United Salaried Physicians and Dentists in New York, estimates that more than 30,000 physicians are in unions, and about 11,000 of this total are residents and interns.

"Doctors who can come to a satisfactory agreement with their employers don't need collective bargaining. But where their employers are obdurate, doctors will be protected by labor laws and will legally be able to collectively bargain."

—Susan Adelman, MD, Physicians for Responsible Negotiation

Conflicting Laws Govern Union Activity

The ability of physicians' unions to represent their members in negotiations with managed care organizations (MCOs) is controlled by two conflicting bodies of law: labor and antitrust, says David J. Goldberg, MD, a surgeon at the New Jersey Medical School and a professor at Fordham University School of Law, where he teaches health care law.

"Antitrust laws condemn joint-contract negotiations by competitors as illegal price fixing," Goldberg says. "Labor laws, however, provide an exception to the antitrust laws by allowing selected groups of individuals to bargain collectively for the purpose of improving wages and working conditions."

Among the laws governing physicians are federal antitrust laws, such as the Sherman Antitrust Act, which seek to safeguard competition by ensuring that market participants do not injure consumers by making illegal collaborative agreements that restrain trade. One form of illegal collaboration is price fixing. "Price fixing can subject physicians to criminal sanctions," Goldberg says. "Although most people think that antitrust laws affect only big businesses, the Supreme Court has made it clear over the years that professionals such as physicians also are subject to these laws."

Physicians are also governed by the labor exemption to antitrust labor law, which allows labor organizations to represent their members through collective bargaining. The law permits collective agreements to raise wages and improve working conditions. "The rights to band together and bargain collectively are extremely important for employees who are at a disadvantage in negotiating terms of employment," Goldberg says. "While employers may consider a single employee or a small number of employees expendable, they may not be able to fire a large group of employees. Therefore, the employer may be forced to agree to terms that are more favorable to the employees."

But excluded from the definition of "employee" are independent contractors and supervisory employees. "Therefore, independent, nonsalaried, or self-employed physicians ostensibly do not fall under the labor exception, and their efforts to bargain collectively have been considered price fixing and illegal under antitrust laws," says Goldberg.

Federal legislation also may affect the issue, Goldberg adds. The Quality Health Care Coalition Act of 2000, commonly known as the Campbell bill, was among the first attempts to provide a measure of antitrust immunity to independent physicians for the purpose of bargaining with health care payers. The House passed the bill last year but it failed in the Senate. The bill provided that health care professionals engaged in negotiations with a managed care organization should be entitled to the same treatment in negotiations as other recognized NLRB bargaining units have. Thus, under the Campbell bill, a health care professional might not be regarded as an independent contractor, manager, employer, or supervisor. It should be noted, though, that the bill expressly denied health care professionals the right to strike, Goldberg says.

"Even though Congress did not pass the Campbell bill, it is the first opening of the door in an attempt to allow physicians the right to bargain collectively with MCOs," Goldberg adds. To date, it has not been reintroduced in the Congress.

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Though the numbers vary depending on the source being cited, those involved in organizing physicians say that union membership has increased steadily over the past five years. Barry Liebowitz, MD, president of Doctors Council, a union in New York that represents about 3,500 physicians, dentists, and other health care providers, says momentum and support for physician unions is building. In the past five years, the Doctors Council has lost only one organizing drive out of the eight it has conducted, and the union has managed to raise physician salaries in each contract it has negotiated.

"The due process carries a tremendous amount of weight," Liebowitz says. "It gives physicians the most mental security, knowing that they will not be summarily dismissed. What's written in stone in all of our contracts is due process."

Not surprisingly, physicians have turned to unions as a result of increased feelings of powerlessness against the negotiating leverage of managed care plans, says John Ferman, a principal with Health Policy Alternatives Inc., health care researchers in Washington, D.C. Unions also afford physicians some protection from antitrust laws. "Their frustration, fueled by the continued evolution of larger and larger managed care plans, has produced the critical mass necessary to break through organized medicine's traditional resistance to unions and collective bargaining," Ferman explains.

Two years ago, the AMA's House of Delegates voted to form PRN to organize employed physicians seeking to form local or regional collective bargaining units. The delegates denied PRN members the right to strike, and those opposed to the

(Continued on page 12)

> **"Most physicians, and some of the unions that have tried to organize them, object to the use of strikes by medical staff, thus diluting the effectiveness of unionization as a tactic for achieving physician goals."**
>
> ***—Michael F. Anthony, McDermott, Will & Emery***

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union said physician professionalism would be harmed by unionization. Supporters of the measure said changes in the practice of medicine, especially the effect of HMOs and large insurers that dictate treatment conditions, made unions inevitable. Later that year, the NLRB ruled that medical residents and interns are employees who can form unions.

Continuing Efforts

Today, PRN's membership includes two physician groups: the 170 staff physicians at Advocate-Lutheran General Hospital in Park Ridge, Ill., who have organized as the LGH Housestaff Association; and 20 emergency medicine physicians in Chicago, who have formed Austin Emergency Medicine Physicians for Responsible Negotiation, LLC (AEMPRN). These physicians are employed by Third Coast Emergency Physicians, which provides staff to hospitals in Illinois.

PRN is currently having discussions with 38 physicians employed by The Wellness Plan, a Medicaid HMO in Michigan, and with 19 physicians in New Jersey who work for Concentra Inc., a company in Dallas that operates occupational health centers. The NLRB is hearing a dispute between PRN and the 19 physicians, who had voted to unionize. The company is contesting the vote. Both organizing efforts began before the Supreme Court ruling.

Since PRN has organized only two groups of doctors, it is difficult to assess whether it has improved conditions regarding reimbursement, scheduling, and patient care for its members, legal experts say. "Several practical and legal factors hamper successful physician unionization," says Michael F. Anthony, a partner with McDermott, Will & Emery, a law firm in Chicago.

"Most physicians, and some of the unions that have tried to organize them, object to the use of strikes by medical staff, thus diluting the effectiveness of unionization as a tactic for achieving physician goals," Anthony says.

Some hospitals and medical centers may not be able to answer all of the questions and concerns physicians have about patient care issues, reimbursement rates, the administrative burdens, job security, even the number of hours required to do the job, Anthony comments. "In health care, few of these issues are within the sole control of a given organization, and third-party payers will almost never be willing to sit at the unions' bargaining tables," he says.

But Adelman is enthusiastic about PRN's growth potential and says the union is continuing to develop affiliation agreements with labor groups established or being created by local and state medical associations, although those efforts too could be affected by the Supreme Court's May ruling. The Medical Society of the State of New York (MSSNY), for example, voted in November to form an affiliation with PRN. The relationship provides an educational resource for society members seeking to consult with PRN on labor issues before making the decision to unionize.

Mark Fox, MD, of Scarsdale, N.Y., chairs MSSNY's task force on collective bargaining, and says that many physicians have turned to the society for guidance. "We had meetings with almost all of the existing unions," Fox says. "And we felt for a number of reasons, including potential conflicts of interest with health care members of other labor unions, that the physician orientation of PRN was something many of our physicians considering a labor union would be interested in."

Seeing Progress

In Pennsylvania, a proposed Pennsylvania Physicians Guild would permit employed physicians to bargain collectively. The effort is being lead by Robert B. Sklaroff, MD, president of the Pennsylvania Society of Internal Medicine in Philadelphia. The guild would represent employed physicians and be governed by a consortium of medical specialty societies.

In New York, the physicians at Brookdale Hospital have recently received a raise and better benefits as a result of affiliating with the Committee for Interns and Residents, a 20-year-old organization in New York that bargains for doctors in training. It has 11,000 members. "I think that the union helped us achieve progress," says Gail McDonald, MD, a resident at Brookdale Hospital. "Before that, we did not have a united front."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on physician practice strategies is available on our Web site (see page 16).

Former Rep. Campbell Urges Support for Federal Antitrust Efforts

***Tom Campbell** is a professor of law at Stanford University Law School in California, teaching courses on antitrust, separation of powers, and legislation, among others. He is also a principal in LECG, LLP, a law and economics consulting firm, and has served as a member of Congress from the Silicon Valley. He joined the faculty at Stanford in 1983, after working in the Reagan administration in antitrust enforcement at the Federal Trade Commission. He had a White House Fellowship in the Office of the Chief of Staff from 1980 to 1981. Among physicians, Campbell is best known for drafting the Campbell bill (H.R. 1304, 106th Congress). Richard L. Reece, MD, editor in chief, conducted this interview.*

Q: *When did you serve in Congress, and what is the purpose of the Campbell bill?*

A: I was first elected in 1988, and served until 1993. I returned in 1995 and served until January 2001. The bill is my effort to make more equal the bargaining situation between the collective power of the HMOs and the fragmented physician establishment. I am involved in this effort because I truly believe that this will ultimately benefit patients.

Under existing antitrust law, whenever two physicians agree on a matter that might relate to their own reimbursement, they risk being sued for antitrust violations by the U.S. Department of Justice, the U.S. Federal Trade Commission, a state attorney general, or the HMO (which might sue to win treble damages).

When applied to health care providers, the antitrust laws are not conducive to the best care of patients. Doctors should be free to negotiate with HMOs in the best interest of their patients, and occasionally that includes negotiation for adequate reimbursement so that they can do a professional job and provide proper, clinically warranted care for each patient they see.

Q: *When did you introduce the bill, and what did it propose?*

A: I introduced the first version of the bill in 1996. My original idea was for an expert agency to match the market power of the insurer with a certain degree of collective power on the side of the physician. As a result, my original bill was quite complex: It required the FTC to study conditions of competition in local markets for each medical specialty to determine if HMOs or other managed care organizations had significant market power with respect to each specialty in each geographic area. If such market power was present, the bill would require the FTC to grant the affected specialists a "certificate of antitrust exemption," which would allow them to bargain collectively with the HMO.

Since that bill did not progress, I wrote a simpler bill, which says that in collective bargaining, medical professionals shall have the same status under antitrust law as though they were members of a union. For example, physicians who are employees of a hospital can meet to present a united front to the hospital in bargaining over the terms of their employment. The same ought to be possible for physicians who are independent, but who, within the same geographical area and specialty field, are involved with the same HMO.

Q: *California is the state in which provider reimbursement from HMOs is the lowest, and yet the cost of living is the highest. That dichotomy has created a disastrous situation whereby many of the state's physician groups are said to be on the brink of bankruptcy. Did these issues prompt your development of the Campbell bill?*

A: Yes. The situation in California and in my district was brought to my attention by physicians. Several prominent doctors were retiring or leaving the state to practice elsewhere. The HMOs had denied them the freedom to advise what was best for their patients, or the time necessary to give adequate attention to each patient in an office visit. They had entered a profession to help heal people and found that they had become, effectively, agents of large organizations driven by a profit motive.

But the fundamental point for me

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"Under existing antitrust law, whenever two physicians agree on a matter that might relate to their own reimbursement, they risk being sued for antitrust violations."

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is that patients are the ones who are ultimately harmed by physicians' lack of leverage in the contracting process. If the HMO discourages a particular diagnostic test, for instance, the physician's ability to diagnose may be compromised, to the patient's detriment. As a result, the patient feels like an item on an assembly line rather than a recipient of professional advice.

I believe that physicians try their best to diagnose and to heal their patients, and that they do not enter the profession for the sake of charging patients exorbitant sums by asserting monopoly power. Yet that is how the antitrust law enforcement agencies have often treated physicians. When contract terms are such that they severely harm the physician's ability to provide optimal care, then health care decisions are not and cannot be made in the patient's best interest.

Unfortunately, the faith I have in those who practice medicine is not shared by those who would apply the antitrust laws identically to medicine as they would to steel or petroleum industries. The Justice Department and the FTC have, too often, ignored the professional aspect of a physician's calling. Antitrust has developed rules for large industrial and commercial enterprises. For example, two competitors that make steel can't discuss the price they'll charge the same auto manufacturer. Applying that kind of rule to the profession of medicine, the antitrust enforcement agencies concluded that specialists agreeing on a capitated rate below which they could not afford to provide quality service would be a per se antitrust violation of federal antitrust laws.

Q: *What was the fate of the Campbell bill?*

A: I introduced the bill in the House of Representatives in 1996, 1997, and 1999 at the start of each session of Congress. Representatives who favored the insurance industry were strongly opposed to it. In fact, the bill's opposition included the Republican leadership. Nevertheless, despite the fact that the Republicans were in the majority when I brought this bill for a vote, the bill passed the House of Representatives by a vote of 276 to 136.

The administration at the time was Democratic, and whereas President Clinton's views were never made clear, the antitrust enforcement agencies testified against the bill, both in 1998 and in 1999. It is traditional for both the FTC and the Justice Department to oppose any exemptions to antitrust. I asked the chairman of the FTC whether he would have been opposed to the exemption that labor unions have from antitrust as well, and he answered that the labor exemption was motivated by societal factors not present in the context of physicians. To me, however, the logic of his position would compel him to oppose allowing physicians to do what they currently can do, legally, if they are employees of a hospital. It would have been difficult, however, for a Democratic administration to go on record opposing an existing antitrust exemption that benefits unions. Had the bill come to President Clinton's desk, it was my hope he would have signed it; in large part, because organized labor, and its friends in Congress, recognized the inconsistency of allowing an exemption for some doctors and not for others.

After it passed in the House, the bill was delayed by the leadership so that it came up very late in the season, such that there was insufficient time to introduce it in the Senate. Since then, the patients' bill of rights has taken top billing.

> **"Physicians try their best to diagnose and to heal their patients, and do not enter the profession for the sake of charging patients exorbitant sums by asserting monopoly power."**

Q: *Now that you are no longer in Congress, what are you doing to carry forward this effort that you initiated?*

A: The most important issue that was used against us on the House floor was that the bill's provisions might increase the cost of medical care and that these increased costs would be borne by patients.

The Congressional Budget Office had done some calculations based on the assumption that physicians' reimbursements would increase 15% and had determined that, based on that assumption, the cost to patients would be less than 1%. However, that estimate included an assumption that total private health care costs would increase by 2.6%—the difference between 2.6% and 1% being eaten up by HMOs and employers. All of these numbers depended on an assumption, not a finding, that physicians' reimbursements would shoot up by 15%. That number was taken from studies of industrial unions in the 1940s and 1950s, which exercised the right to strike. And no part of this study took into account the improvement in quality of care that would result from allowing physicians more of a role in setting the terms of their contracts with HMOs. As quality improves, cost-savings would result that were nowhere captured in the CBO's estimate.

In response to these deficiencies, I want to undertake a credible economic study about what the increase in cost will be, instead of simply allow-

> **“Managed care has migrated from being strongly promoted to the public as the road to effective, low-cost health care to a universal perception that it has led to lower quality medicine and impersonal medical care.”**

ing others to make assumptions about cost increases that might not be accurate. This study will also provide scenarios as to what the U.S. health care system will look like without this bill, in terms of how the participation rate in physician specialties correlates with the concentration of HMOs and managed care organizations in particular markets and geographic areas.

Q: *An article by James Robinson in the May 23/30 issue of the* Journal of American Medical Association *argued that managed care, although it may be an economic success in the eyes of its backers, is a political failure. Do you agree?*

A: I do. Managed care has migrated from being strongly promoted to the public as the road to effective, low-cost health care to a universal perception that it has led to lower quality medicine and impersonal medical care. The competing versions of the patients' bill of rights prove this point. Both versions are motivated by a shared perception that something has gone seriously wrong with the way medical care is delivered in our country since HMOs became dominant. It's remarkable how little separates the two competing bills; both recognize that HMO contracts often leave out important provisions on emergency care, for instance, and that HMOs are making medical decisions without being subject to the same constraints private physicians would have for the same actions.

Q: *How does being a law professor compare with being a member of Congress?*

A: I'm a happy man. I have great students and colleagues, and I am allowed to specialize in the area that interests me—health care antitrust. A member of Congress is obliged to move from one topic to another with a rapidity that often prevents deep analysis. A professor is not required or expected to be a master of a huge number of fields but rather to know one or two quite well. It would be hard to find two careers that are more different in terms of developing an understanding of an issue.

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

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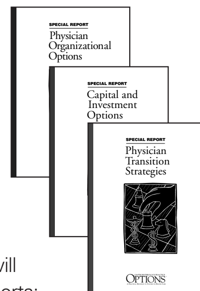

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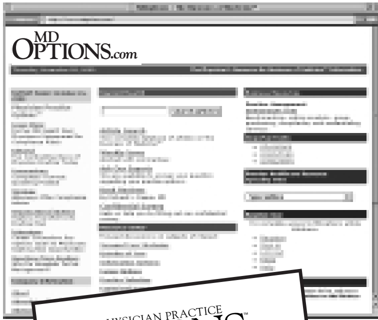

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December 15, 2000

A Practical Resource to Succeed in Health Care

Top Ten Trends for 2001

By Richard L. Reece, MD, editor-in-chief

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In the coming year, physicians may finally begin to find more satisfaction in practicing medicine than they have in the recent past. While managed health plans will continue to cause discontent among physicians in many markets, doctors nationwide are finding ways to practice more effectively and to use technology to their advantage to improve patient care and increase production while worrying a bit less about having utilization management teams questioning their decisions about patient care.

Based on our review of the news over the past year and our daily discussions with health care experts and physicians practicing in a wide variety of settings nationwide, we have compiled the following list of trends in 10 major areas. In addition, we invite readers to comment on these issues by visiting our Web site (www.mdoptions.com) or contacting the editor directly (see page 2). The trends are as follows:

1. **Technology.** Information systems and the Internet will continue to change how physicians practice medicine. Practical solutions that physicians develop will help solve complex office problems. Information systems that doctors can use at the point of care to capture data, code for billing and management systems, document care, and help reduce the number of claims that payers reject have the potential to change medicine significantly. These new information systems will use a combination of hand-held devices, desktop and laptop computers, speech recognition software, and the Internet to strengthen medical practices by increasing revenue and reducing rework.

Physicians will rapidly gravitate to the Internet one step at a time as they gain confidence in specific applications that help them improve the quality of care they deliver and deepen their relationships with patients. As they become comfortable with these information systems, the mood of despair among American physicians will lift and begin to turn to optimism in part because doctors will regain a modicum of control over data at the point of care.

In fact, the Internet has the potential to turn health care upside-down. It is possible that some day health care will no longer be dominated by centralized institutions such as government payers, corporations, managed care organizations, academic medical centers, and hospitals. Instead, the Internet will allow patients to contract with physicians directly—although companies that will do so are just now enrolling patients. But in theory, physicians and patients could use the Internet to work together more closely than ever before.

The emphasis in medical data management will shift from comprehensive on-site mainframe systems to Internet-access devices such as palmtop computers, personal digital assistants (PDAs), and cell phones. Information systems companies will aim to provide tools to allow physicians to prescribe, code, refer patients to other physicians, and document services at the point of care. Speech-recognition systems, for example, will move to the forefront as a physician productivity tool,

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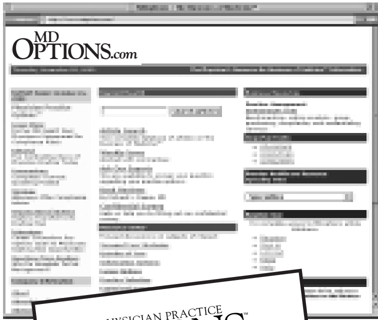

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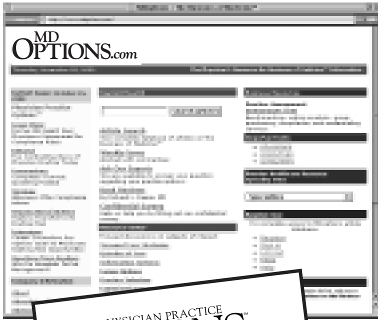

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