

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

December 15, 2001

CONTENTS

Features

Commentary
Can Direct-Capitation
Plans Work? 6

Interview
Strong Growth
Predicted in Health
Care Information
Systems 13

Departments

Editorial
Getting Paid for
Practicing Preventive
Medicine 2

Health Policy
Seeking New Systems
of Care, Group Offers
Plan for Reform 3

Strategy
How to Get More
From the Web 10

Experts Debate Issue of Fairness in Federal Compliance Effort

Federal efforts to eliminate fraudulent health care claims are a violation of the most basic rights of physicians, say doctors. Yet experts who have closely followed the government's actions disagree. They argue that the enforcement effort is essentially fair and that physicians caught filing false claims are guilty of serious wrongdoing and deserve substantial sanctions.

It is difficult to know who is right. Have physicians been unfairly targeted for harsh enforcement and stiff penalties? Or has the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services simply been doing its best to eliminate fraud among those doing business for the federal Centers for Medicare and Medicaid Services (CMS) and for other health care payers? What is clear is that most physicians have seen a large increase in paperwork, which is distracting them from delivering patient care. Government officials say they will continue to pursue physicians who file fraudulent health claims for Medicare, Medicaid, or other payers.

Enforcement Questioned

Tom LoIudice, MD, DO, a gastroenterologist in Akron, Ohio, and president of the Summit County Medical Society in Akron, says most physicians believe the government's fraud

enforcement effort is unfair to physicians and to the U.S. public. "It makes physicians angry, particularly good physicians with nothing to hide," he says.

Physicians find the Medicare regulations and monthly updates to be so voluminous, complex, and contradictory that they represent an unreasonable legal standard for enforcement and penalties, LoIudice adds.

Seeking to comply fully, LoIudice installed a compliance program in his office—an effort that consumed more than six hours a week for three months. "That's almost 100 hours away from patient care," he says. "Whether it will do any good in an investigation is unclear." Experts advise physicians to develop and implement a compliance plan; simply having a plan is a good defense in a federal audit, they say. The burden on physicians to comply with regulations from Medicare and other payers requires three or more hours each day. That's about triple the time it took him 15 years ago, LoIudice says.

"Doctors are always fearful that one slip will destroy their lives," says Jane M. Orient, MD, a physician in Tucson, Ariz. Orient is executive director of the Association of American Physicians and Surgeons, an organization of 5,000 members. "Each CPT code holds a potential federal crime," Orient says. "While

(Continued on page 8)

Getting Paid for Practicing Preventive Medicine

Physicians who are having trouble being reimbursed for the time and effort they spend to assess and counsel patients about illness prevention may find help in a recently published book by Steven Jonas, MD. Jonas is a professor of preventive medicine at the State University of New York at Stony Brook and an expert in health promotion. His book is *Talking About Health and Wellness With Patients: Integrating Health Promotion and Disease Prevention Into Your Practice* (Springer Publishing Co., New York, 2000).

One way for physicians to be reimbursed for practicing preventive medicine (doing health assessments, wellness counseling, and health promotion before symptoms and chronic disease manifest) is to ask patients to focus on relevant symptoms and dangerous lifestyle habits before their office visit.

A number of Web sites help patients to evaluate their health and then e-mail or fax the results to their doctor. Such previsit appraisals save time, highlight potential health problems, and focus doctors and patients on relevant problems. The appraisals also provide documentation of the complexity and nature of the patient-physician encounter. Web sites that offer this type of health appraisal include WellMed.com, a free site that helps consumers establish a health quotient or level of health risk on a scale of 0 to 200. It calculates and personalizes the level of risk for heart disease, diabetes, colon cancer, prostate cancer, depression, and stroke, and it tells patients which risks are modifiable.

Another site, Patientcenters.com, charges users for its services. For \$100 a month, physicians can subscribe to the site and have their patients answer questions based on their chief complaint or on preventive health measures. Patients of physicians who do not subscribe to the site can pay \$4 to fill out the questionnaire and bring it to their doctor. Users of the site can create a medical record, review symptoms, and record physical findings according to documentation guidelines established by the federal Centers for Medicare and Medicaid Services.

A third site, meddiet.com, also is free. It lets patients take a HealthStatusIQ test. It also offers details on the Mediterranean diet, which is designed to promote a low risk of heart attacks, stroke, and cancer.

If preventive medicine is to become a larger force in improving Americans' health, two things must happen. First, patients must have the tools to assess their health, to judge major risk factors, and to have a basis for taking action. Second, physicians must streamline the process of engaging and motivating patients to improve their health, and they must be paid appropriately for routine physical examinations and health counseling.



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

Neil Baum, MD
Urologist
New Orleans

Daniel Beckham
President
The Beckham Co.
Physician and Hospital Consultants
Whitefish Bay, Wis.

Thomas M. Gorey, JD
President and CEO
Policy Planning Associates
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA
Executive Vice President,
Premier, Inc. and
Premier Practice Management
San Diego

Harold B. Kaiser, MD
Allergy & Asthma Specialists, P.A.
Minneapolis

Nathan Kaufman
President
The Kaufman Group
Division of Superior Consultant Co. Inc.
Physician and Hospital Consultants
San Diego

Paul H. Keckley
President and CEO
webEBM
Nashville, Tenn.

Peter R. Kongstvedt, MD
Partner
Cap Gemini Ernst & Young
McLean, Va.

Richard Lilledahl, MD
Senior Vice President, Chief Medical Officer
M&R Care Guidelines
Milliman USA
Seattle

Lee Newcomer, MD
Executive Vice President
Vivius Inc.
St. Louis Park, Minn.

James G. Nuckolls, MD
Medical Director
Carilion Healthcare Corp.
Roanoke, Va.

Bernard Rineberg, MD
Physician Consultant
BAR Health Strategies
New Brunswick, N.J.

Jacque Sokolov, MD
Chairman
Sokolov Schwab Bennett
Los Angeles

W.L. Douglas Townsend Jr.
Managing Director and CEO
Townsend Frew & Co., LLC
Investment Banking
Durham, N.C.

This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

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

Seeking New Systems of Care, Group Offers Plan for Reform

By enlisting the support of multiple health care constituencies nationwide, a new organization is seeking to drive reform of the current health care system. The Center for Practical Health Reform has developed seven principles of reform that it says can create the framework for an improved health care system while balancing special interests.

The founder and executive director of the center in Jacksonville, Fla., is Brian R. Klepper, PhD. Klepper is also president of Healthcare Performance Inc., a health care business development practice in Jacksonville.

Concern About Costs

Klepper's idea for the center stemmed from his concern about the confluence of escalating health care costs and the general economic slowdown. "About a year and a half ago, I realized that two immense problems in health care were going to cause unprecedented ramifications in the industry," he says. "The first problem was that our health care system was just at the point of crossing the threshold of affordability. Annually for the last three years, health care costs have increased at double the rate of general inflation. Employers that had previously been successful at managing health care costs have suddenly been hit with premium increases of 10% to 30%. Some small employers have even been faced with premium cost increases of 40%.

"At the same time, the economy has been cooling," Klepper continues. "As a result of these two factors, many employers are going to have no alternative but to cut back on benefits or lay off employees, which will drive increases in the number of people with no health insurance."

To discuss these topics, Klepper invited a number of health care professionals to a meeting held last year. "I put together a panel of Floridians from virtually every health care sector," he says. "There were physicians, physician practice managers, health plan executives, hospital administrators, disease managers, technology

says, the adversarial relationships among the various stakeholders actually led to a focus on best solutions for the system as a whole rather than on benefits for any one special interest.

"For example, an executive of a large and renowned physician group practice suggested that health plans serve no useful purpose, that they

A concern about the cost of care and a slowing economy led a Florida consultant to put together a panel of experts to develop a workable plan for health reform.

experts, and reinsurance personnel. Each person on the panel has a reputation for thoughtfulness and holds a position of responsibility as an active field manager of some type."

A Common Focus

"After founding the Center for Practical Health Reform, I recognized the clarity of the principles developed by those who participated in the initial discussion," Klepper says, adding that some of the participants clearly had business interests. "Our first meeting was characterized by a certain chilliness," he comments. "Many of these people knew each other and were adversaries. They certainly were not inclined to agree on anything. We did agree, however, to discuss our views on how to fix the health care system. But before embarking on our discussion, we acknowledged that everyone sitting around the table was a stakeholder in the industry, with a legitimate role to play, and that each one was trying to do his or her best."

Despite some early tension, Klepper

only inject a layer of wasteful bureaucracy into the health care system," Klepper recalls. "But another participant, a medical director for a large Florida health plan and one of the founders of a large California physician organization, responded immediately that this viewpoint was incorrect, and that the role of health plans is to inject accountability into the system. That made sense to everyone at the table. And so the conversation moved on with a new, clarified understanding among all panel members. There were many examples of this kind of give and take among group members. The participants were willing to transcend their own special interests in favor of coming up with solutions that would work."

In fact, the importance of including all industry stakeholders in the center cannot be underestimated, according to Klepper. "Many sectors lie within our health care system, and each of them is important," he states. "Physicians, long-term care facilities, hospitals, health plans, reinsurance companies, support programs, and

(Continued on page 4)

(Continued from page 3)

others exist, but they are somewhat divorced from each other. We need to impose a new set of disciplines that will allow each sector to operate efficiently, interconnect with others, and ultimately be accountable for its own activities. For example, we need discipline regarding how risk is handled and how health management is handled in order to improve the operations of health plans. Physicians need to be held accountable for what they do as well."

Principles of Reform

Such discipline is the goal of the seven principles that the panel members derived to fix the health care system in a way that is practical.

"An executive of a large group practice suggested that health plans serve no useful purpose. But another participant responded that the role of health plans is to inject accountability into the system."

The first principle is universal coverage of basic health benefits for all Americans. "In the panel's view, the rationale for universal coverage is not social justice or altruism, but rather to ensure that the gaps in insurance will not grow so large that the system will collapse on itself," Klepper explains. The center has not yet defined precisely what is to be included in basic health coverage. "This definition will be attacked as a health services research effort," he says. "We do not yet know the details of what will be included, but we do know that access to primary care and basic acute care should be available to everyone."

The second principle is the ability to purchase additional health care coverage. "Anyone who wants more insurance and has the means to buy it should be allowed to buy supplemental coverage," says Klepper.

The third principle is that the private sector should manage the health care system and that the organizations that serve as managers should be rewarded for doing a good job as measured by patient outcomes. "Financial incentives for health care innovation and performance work," Klepper asserts. "That is why American health care is the best in terms of technological advancement."

The fourth principle is the uniform adoption of evidence-based best practice guidelines. "This principle reflects the idea that physicians are at the top of the scientific hierarchy in health care," Klepper says. "We need to identify the best practices of physicians across the country, and then we

need to disseminate these best practices to all physicians and caregivers nationwide, who should be encouraged to adopt them. In Minnesota, efforts are already underway in this direction. There's no reason that the center shouldn't follow that example around the country."

Even so, protocols cannot and should not be policed by an oversight body, Klepper asserts because such an organization would create another layer of bureaucracy for physicians. Yet, physicians still need to be accountable for their performance. "Therefore, our fifth principle is that data on the performance of all health care professionals, institutions, and procedures should be available to the public," he says. "We should take health care service provision as seriously as we take the provision of service in every other sector of the

economy, whereby the performance of competitors is measured and compared so that consumers can make informed purchasing decisions."

Risk Reduction

The sixth principle is arguably the most challenging: distinguishing between preventable risks and non-preventable risks. "Nonpreventable risks include conditions that result from catastrophic events, diseases, and congenital defects," explains Klepper. "They are acts of God, rather than acts of man. In contrast, preventable risks are self-inflicted and relate to lifestyle behaviors that cause an increase in the demand for health care services. Certain lifestyle choices—such as smoking, consuming excessive amounts of alcohol, refraining from exercise, and having poor eating habits—are individual decisions that cause chronic maladies.

"We believe people should be required to pay for the lifestyle choices that have a negative impact on their health," Klepper continues. "For example, some people choose to ride motorcycles without wearing a helmet, just as others choose to consume too much fast food. By making such choices, these people should be required to pay a bigger share of the care that would be required if they get a head injury from a motorcycle accident or heart disease from poor eating habits."

The seventh and final principle calls for multiyear arrangements between patients, physicians, other providers, and health plans. "Why are we using an archaic risk model of a single-year health plan time horizon?" Klepper asks. "We know from 25 years of research and experience that multiyear health plan contracts let us use programs, like wellness and disease management, that pay generous returns on investment, but take several years to do so. In fact, as much as 30% of health care costs could be eliminated if health plans had more

than one year to tackle health risks.”

Among HMOs, the patient turn-over rate can be as high as 20% a year. “If 20% of enrollees are turning over every year, why invest in preventive care?” Klepper asks. “Why should Aetna invest \$100 to teach an enrollee about the value of eating a high fiber, low fat diet—even though average costs could be reduced by \$500 a year—if Blue Cross will eventually get that windfall?”

Next Steps

After identifying the seven principles, the group agreed to try to use them as a framework for national reform. “We wanted to try to create a political movement,” Klepper says. “To do that, we established a network of professionals from across the country who could lend the effort legitimacy. I began to find people who were like the people on the original panel, who were involved in different roles in health care and business, and who deeply understood the effect that policy nuances have on daily health care operations. We wanted to include people who had been in the trenches of health care or business and therefore would be sensitive to the issues.”

Like the original panel, the network represents many different health care sectors. “We don’t want to wait for the health system to fail, at which point special interest groups will be eager to come forward and offer their approach for how reform should be handled,” Klepper says. “Rather, what is needed is a well-conceived, balanced, nonpartisan, multiconstituency plan that can be deployed like a life raft so that the system doesn’t sink. This plan will require every constituency to give up something, but in return we all get something much, much more. It will not tolerate a particular group getting the grand prize at everybody else’s expense.”

Accordingly, the center has named an advisory panel that includes influential individuals who can begin

“We know wellness and disease management programs pay generous returns on investment, but take several years to do so.”

explaining the center’s principles nationwide. Among the panel members are John Erb, a benefits consultant with Deloitte and Touche, in New York, who founded the South Florida Business Health Coalition; Joe Spiak, senior national vice president for health care public finance at Bank of America in Jacksonville; Gregg Lehman, CEO of the National Business Coalition on Health in Washington, D.C., which represents 8,000 self-funded employers and 34 million covered lives; Harris Berman, CEO of Tufts Health Plan, Boston; Jack Lynch, COO of St. Luke’s Episcopal Health System, Houston; George Lundberg, former editor of JAMA and currently editor of Medscape, an Internet site; and Ann Llewelyn, a nurse and medical case manager in Fort Lauderdale, Fla.

Currently, the organization has three objectives. “We are working now with health care and employer groups around the country to replicate and refine the principles,” Klepper says. “Getting different groups to develop approximately similar principles will demonstrate that there’s consensus on the broad approaches. The next step will be to pursue the details.”

Second, the center will coordinate the research required to identify the financial and operational implications of each of the principles. “What does it mean to have a basic benefits package?” Klepper asks. “How do we distinguish between preventable and non-preventable risks without running afoul of the Americans With Disabilities Act? Each of the principles generates these types of research questions, and they need to be answered before changes are made. Third, we

have to find a way to translate these principles into adjustments of existing policy. To do that, we need to get the support of influential organizations that already have a lot of clout and that can help us to drive change.”

Utilitarian Views

While health care problems are similar nationwide, Klepper believes, the solutions that are developed must address the particular needs of each market. “Health care is like the Wild West,” he continues. “Everybody has a gun and throws his weight around and makes decisions without protocol or accountability. We seem to have made an implicit decision in this country that health care should be a commodity and not a utility, which means that at some level, health care is up for bid. I agree to some extent that health care should be a commodity, but it should be regulated like a utility, which would keep the focus on the good of the patient, rather than on the financial success of each individual player.”

The center’s principles are not designed to develop an ideal system, but rather to bring stability and balance to the existing system, Klepper asserts. “The U.S. health care system is fundamentally right in many of its aspects,” he concludes. “We offer spectacular health care here. If we lay down certain simple principles and rules and then create the infrastructure to make these principles and rules work, the present system is correctable. It will not be easy, but our health care system is worth saving.”

—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).

Can Direct-Capitation Plans Work?

Kurt J. Wrobel, ASA, MAAA

As health care cost increases again reach double digits, the media and health care experts remind us that we need to find ways to cut costs while maintaining the gains that have been made in provider choice. Invariably, these experts offer solutions that use the most popular buzzwords in the industry, including “consumer choice,” “care management,” and “defined contribution.”

Surprisingly, one solution being offered involves the capitation model that was often cited as a way to cut costs in the early 1990s. In its reinvigorated form, the product being touted by some experts and at least one company allows consumers to build a private network of physicians and other providers based on the capitation rate of the participating physicians and hospitals.

Ostensibly, this model preserves provider choice for consumers and allows physicians to develop reimbursement rates based on what the market will bear rather than their relative bargaining position with health plans. The model has a number of advantages for both consumers and physicians; one of its disadvantages involves its use of the capitated model of reimbursement.

Kurt J. Wrobel, ASA, MAAA, is the director of product design and pricing for HealthMarket Inc., in Norwalk, Conn., which has developed an alternative to managed care self-directed health plans. Available in several states, these plans shift decisionmaking from insurance intermediaries to physicians and patients. Readers may call Wrobel at 203/229-1036, or they may send him an e-mail message at kwrobel@healthmarket.com. More information on self-directed plans is available at www.healthmarket.com and on our Web site (see page 16).

Aware of the problems associated with provider choice and physician reimbursement in the traditional capitated model, the new model slightly modifies the capitation concept. In its new form, the model allows consumers to select a personal physician, as many as 16 specialists, a hospital, an outpatient surgery facility, an emergency room, and a home health facility. To encourage consumer-members to consider the underlying cost of the providers they choose, each choice has an associated per-member-per-month (PMPM) rate that is determined by the providers. Consumers are also provided with an insurance wraparound product for the services that are not included with the providers they have chosen. After selecting a panel

tract capitation model become evident when one considers the timing of the consumer choice and the potential for adverse selection.

Consumer Empowerment

From a consumer's perspective, the performance of the health plan will depend largely on the importance the member places on the selection of providers. If a consumer already has strong preferences for particular physicians in each specialty and a single hospital, having the ability to choose allows the consumer considerable flexibility in constructing a network that best meets the needs of that consumer. Such consumer choices, however, come at a considerable cost to the provider. Consumers who have little preference for a particular

A new health plan model offers advantages for consumers and physicians, but uses capitated reimbursement.

of capitated providers, the consumer is presented with a premium rate based on the individual PMPM rates for the entire provider panel.

By facilitating a direct contract between providers and members and allowing members to choose providers, the model appears to offer a more palatable alternative to a traditional managed care program under capitation. Providers have more control over the contracting process, and consumers appear to have a greater opportunity to choose among providers. In addition, physicians are financially accountable only for providing services under their control, and no medical management protocols are required. Despite the advantages relative to the traditional capitated model, the real problems with this direct-con-

tract capitation model become evident when one considers the timing of the consumer choice and the potential for adverse selection.

provider before they become sick lock themselves into a small network. Being locked into a small network could have a dramatic effect on a member who experiences an unpredictable medical event that requires specialized attention.

Because of how it is designed, this plan puts members at risk for making poor choices that do not adequately consider the full range of possibilities after sickness occurs. One of the most significant disadvantages of this arrangement involves the wholesale transfer of risk to a physician group. What's more, the model also includes an additional wrinkle that makes it even worse for providers. Unlike any other managed care arrangement, this model allows a consumer to choose providers

based on a PMPM rate that is adjusted based only on the age and sex of the individual consumer.

This specific feature adds the potential for adverse selection. Since consumers can choose providers based on a PMPM cost, sicker individuals will likely choose providers that they are already seeing or that have a reputation for delivering quality care within the community. In the first case, the specialist will go from receiving fee for service for each service to receiving a much smaller PMPM rate based on a broader population.

As such, a highly regarded physician will be likely to see patients who are predisposed to need a particular type of service. In either case, by offering the consumer a choice of providers and by adjusting the PMPM rate only for age and sex, better quality providers may suffer financially under this arrangement.

Rising Risk

In some presentations, advocates for this model have suggested that the consumer's choice of primary care provider may automatically result in the selection of a predetermined specialist panel. This plan design feature would mitigate adverse selection, but make the provider selection problem even worse. In addition to the problems outlined above, the model suffers from many of the same problems associated with the standard capitation model. Like the standard capitation approach, this model fails to offer an efficient risk transfer between providers and payers.

Initially, the concept of capitation appears to be both intuitive and attractive. Because the fee-for-service system reimburses for each successive service, physicians have a clear economic incentive to overutilize services.

As the standard capitated argument goes, physicians respond to a fixed PMPM by reengineering care and providing it in a more cost-effective manner. In this case, profits are no longer

determined by maximizing the volume of unit billing, but rather by using the capitation budget prudently.

Unfortunately, the prudent utilization of the capitation budget is unachievable because the transfer of risk from the health plan to the provider is too broad. Instead of ceding a manageable level of risk, insur-

Instead of ceding a manageable level of risk, insurers ask physicians in capitated plans to accept a portfolio of risk that is well beyond the providers' capacity to control.

ers ask physicians to accept a portfolio of risk that is well beyond the providers' capacity to control, including the risk associated with the health status of a population and the risk of a population experiencing an abnormally high number of unpredictable health events. The cost efficiency of this risk transfer can be summarized by the two simple questions presented below.

First, should a physician be financially liable for attracting relatively sicker members before the members are enrolled with the physician?

Second, should a physician be financially responsible for a population that experiences an abnormally high number of unanticipated health events?

A defender of capitation may respond by saying that these problems are mitigated if the capitation rate is adequately risk adjusted and the population is sufficiently large to smooth out the risk of unanticipated health events. Ironically, this argument suggests that the capitated provider should develop the core competencies of a health insurer. Differentiating financial losses caused by actuarial anomalies from those caused by provider performance makes changes at the practice level almost impossible.

Less Choice, More Risk

The direct-contract capitation model was developed to respond to the most harsh criticisms of the standard capitated model: specifically, that consumers have limited provider choice and providers are required to acquiesce to the financial demands of a powerful health plan. Unfortunately,

the direct-contract capitation model leaves consumers with an even more limited set of providers after a medical condition emerges, while physicians have traded a negotiation problem for a potentially major adverse selection problem.

In addition, the model suffers from the risk transfer problems inherent in any capitated program. Although the model has some features that incorporate consumer choice and defined contribution, it is essentially a capitated model that offers consumers significantly less choice and gives providers additional financial insecurity caused by adverse selection.

Ultimately, a long-term solution must provide a more efficient economic framework for providers and consumers to purchase health care. This framework will give providers a manageable level of risk that will include sufficient motivation to practice in a cost-effective manner, while consumers will get to choose and purchase bundled health care services from competing providers that account for the underlying cost of the entire episode. Likely, this solution will need to be technologically sophisticated and will go well beyond the more simple and expedient solutions offered in this and some other models. ■

(Continued from page 1)

few physicians go to jail, many are investigated and pay fines. The system is designed to collect a lot of money." Even so, a physician under investigation who refuses to settle with the government fears something worse than fines, she says. "Physicians have no confidence that they will receive a fair hearing," Orient explains. "The 110,000 pages of Medicare regulations are so inconsistent and subjective that a physician could likely be guilty of some kind of infraction."

The Paperwork Burden

The government's efforts amount to legalized extortion, Orient argues. "We have triple damages and \$11,000 false claims judgments per infraction, which far exceed any reasonable standard," she says. "That's not recovery. It's a revenue source for the federal government."

The government receives a return of at least \$8 for every \$1 it invests in health-related activities stemming from enforcement of the federal False Claims Act, according to *Reducing Health Care Fraud*, a report issued earlier this year by Taxpayers Against Fraud, a nonprofit public interest organization in Washington, D.C. Of the government's total civil fraud recoveries of \$1.2 billion last year, about 61% (\$733 million) came from health cases alone, almost three times the \$244 million that was collected in health-related civil fraud cases in fiscal 1999, the report says.

These efforts by the federal government have arguably resulted in physicians choosing to leave the profession and in medical school applica-

tions declining for the past four years, Orient says. Solutions include opting out of Medicare or billing on only an unassigned basis so that the patient receives the government check, she says.

Alice G. Gosfield, a lawyer in Philadelphia, says the government's efforts have profoundly affected the anxiety of physicians. Gosfield chairs the board of directors of the National Committee on Quality Assurance, a health plan accrediting organization in Washington, D.C. What's more, physicians are correct to complain that the paperwork burden is excessive and often unproductive and unnecessary, Gosfield says. "Evaluation and management codes have become more convoluted and complex," she adds. "The time it takes to comply with the rules has become counterproductive and is undermining patient-physician relationships."

John Cleary, a lawyer with Clark & Sevilla, a law firm in San Diego, and a professor of criminal justice at San Diego State University, believes the federal government is trying to build a self-sufficient enforcement apparatus. "There is a coercive aspect to such enforcement: accept a quarter million dollar settlement or face more onerous consequences," explains Cleary, who represents physicians who have been charged with criminal fraud.

Alan Bleyer, president of Akron General Health System in Ohio, concurs. "There is a financial incentive for the government to go too far," he says. "When a potential for abuse exists, there will be abuse. The penalties for anything other than

outright fraud should be eliminated."

OIG spokesperson Judy Holtz says that any claim proposing that the government is trying to raise money through fines collected in enforcement is false. "Last year, our total health care savings from the OIG was \$15.4 billion. Of that, \$1.2 billion came from the investigative side," she says. "That money is returned to Medicare or to the U.S. Treasury to use as intended."

Actionable Claims

Relatively few physicians have faced enforcement action, and claims of abuse of triple penalties and false claim judgments are without merit, Holtz asserts. "Over the last three years, an average of only 20 physicians on the civil side and 18 on the criminal side (of about 650,000 physicians in the Medicare program) have faced OIG action each year," Holtz says. "A provider might be fined for only one count on a plea bargain that listed 300 counts."

In the past few years, the OIG has had about 300 criminal convictions related to health care fraud. That number includes individuals who worked for nursing homes, ambulance firms, laboratories, medical equipment companies, hospitals, and physicians, Holtz explains. Contrary to the opinions of many physicians, the government does not prosecute for simple errors, Holtz adds. "We are very clear that a mistake is a mistake," she says. "We refer those cases to CMS and the Medicare contractors." Also, OIG protocols help to ensure that concerns of wrongdoing are credible before investigators

(Continued on page 9)

"Physicians have no confidence that they will receive a fair hearing. The 110,000 pages of Medicare regulations are so inconsistent and subjective that a physician could likely be guilty of some kind of infraction."

—Jane Orient, MD, Association of American Physicians and Surgeons

(Continued from page 8)

become involved and that Justice Department attorneys decide which allegations are worthy of action, Holtz says.

“Our investigators don’t automatically open a case when we get an allegation,” Holtz explains. “We do some checking. We may ask CMS for the records or conduct a preliminary investigation to determine the validity of the allegation. This process may take from six to 10 months. The results of the preliminary investigation are presented to the appropriate U.S. attorney’s office. Based on the facts presented, the U.S. attorney decides whether to close or to move ahead with the investigation. The investigation does not move forward unless there is validity to the claim.”

Leverage Questioned

Experts in coding compliance (including attorneys representing physicians under investigation for fraud) do not believe that innocent physicians have been abused by overly aggressive investigations by the OIG or any other investigative entity. However, they are concerned that government investigators have significant leverage in any investigation simply by suggesting that a physician can settle a claim brought by the government for what it perceives to be a fair amount; the alternative is to face the possibility of criminal charges. Many argue that this leverage has been sufficient to force many physicians to settle rather than fight the government’s allegations.

“In cases in which federal enforcers create situations where it is far safer for physicians to settle rather than engage in protracted litigation, the settlement option is being used as a hammer against physicians,” says Gosfield.

Cleary agrees, saying federal investigators tend to frighten physicians who have heard horror stories from colleagues who have been investigated. “Physicians pay because the cost

“It is important to note that many billing problems are resolved with no penalties.”

—Roy Snell, Health Care Compliance Association

to take the case to trial and defend it is prohibitive,” he says. “Some people pay penalties to avoid prosecutions.”

Other experts are not so sure that the government is abusing its position. Roy Snell, CEO of the 3,000-member Health Care Compliance Association in Philadelphia, a group championing ethical practice and compliance standards in health care, says penalties appear to be based on clear cases of fraud. “The physicians who are not paying enough attention to their billing systems are having the triple damages applied, primarily because they did not put enough effort into compliance programs,” he says. “It is important to note that many billing problems are resolved with no penalties.”

In fact, there have been exaggerations on both sides of the issue, Snell says. “We need to move away from the rhetoric and look at the facts,” he explains. “The facts are found in the settlements.

“I look at the settlements every week, and many appear to be settlements associated with coding and billing issues that are fairly clear,” Snell continues. “The Department of Justice agents and others in enforcement are skipping over the gray areas and picking the low-hanging fruit, the cases that are more black and white than the others.”

Complex Causes

Inevitably, the complexity of health care contributes to the confusion on both sides and to the voluminous regulations, experts say. “The main difference between the government’s current Medicare fraud investigation initiative and other enforcement initiatives is that medicine is too

intensely regulated, and that regulation is extremely complex, confusing, and subject to ongoing change,” says attorney Amy Woodhall, of Walter & Haverfield, a law firm in Cleveland. “The biggest problem is that it’s difficult to keep up with the complexity and to comply.”

Even government workers find the regulations to be challenging, Woodhall adds. “The General Accounting Office, which audits the performance of insurers, recently reported that when it tested provider inquiry phone lines at Medicare carriers, it found that only 15% of the answers to frequently asked questions were accurate and complete, 53% were incomplete, and 32% were entirely incorrect,” she says.

Clarification Needed

The complexity of regulations is overwhelming many physicians, Woodhall continues. What’s more, each month CMS issues new regulations and explanations in a newsletter of 50 pages or more. “It’s almost impossible for individual physicians to keep up with the Medicare regulations,” she says. “The regulations need to be streamlined and clarified.”

While there is disagreement about many issues regarding compliance, many do agree on one issue: the need for more education. “If our national purpose is to make the system work, a large part of the enforcement or correction effort ought to be on education and simplification,” says Charles E. Colitre, a former supervisory agent for the FBI who specialized in health care fraud investigations.

—Reported and written by David Kettlewell, in Akron, Ohio. More information on physician practice strategies is available on our Web site (see page 16).

How to Get More From the Web

By Jonathan Bush

It will take more than technological innovation to fuel wide-scale physician acceptance of the Internet. First and foremost, physicians need the Web to help them eliminate the “work” from “workflow.”

The AMA recently conducted a survey of more than 1,000 physicians to determine the extent of their Internet usage. The results were somewhat bittersweet. While physicians’ use of the Internet is at an all-time high, the disheartening commentary about how they use the Internet is enough to make the most stoic health care technology investor reconsider any long-term investment in the sector.

Improving Efficiency

While 85% of the physicians surveyed said the Internet was a useful tool for gathering medical information, only 25% reported using the Internet to communicate with their patients. In fact, physicians believe the Internet is more useful as an online source of leisure information than as a way to streamline medical office processes and improve the delivery of care. Among those surveyed, 86% use the Internet to obtain travel information, while only 8% use it for electronic claims processing. In an industry fraught with inefficiencies, those statistics ought to be reversed.

Jonathan Bush is co-founder, chairman, and chief executive officer of athenahealth, a company in Waltham, Mass. (at athenahealth.com), that offers practice automation, billing, and collection services to physician groups. Readers may contact Bush at his email address: jrbush@athenahealth.com. More information on practice management strategies is available on our Web site (see page 16).

The Internet was once lauded as the health care industry’s white knight because it offers universal access, and it can help organizations of all sizes cut costs. But today, the Internet seems to be falling short of these expectations. Or is it?

Perhaps the reason that physicians have not wholeheartedly embraced the Web is because they have not been given the right reason to accept this open communication platform as the solution to many of the industry’s problems. Wireless personal digital assistants (PDAs)—which can capture clinical information at the point of care or enable physicians to view a patient’s EKG just before tee-ing off on the ninth hole—make exciting use of Internet technology. But since they do not work very well, they have

day-to-day management of their medical practices.

An Information Injection

Internet applications that infuse time, money, and control into a physician’s medical practice could represent the proverbial pot of gold at the end of a rainbow for technology vendors. The onus falls on technology vendors to develop practical Internet applications that help physicians save time, rather than developing the next generation of wireless solutions or yet another physician-focused portal. But technology vendors are not the only ones who need to do some refocusing—physicians do too.

The second necessity for physicians to adopt the Internet involves having doctors alter their views of

In a survey, 86% of physicians said they use the Internet to obtain travel information, while only 8% use it for electronic claims processing. In an industry fraught with inefficiencies, those statistics ought to be reversed.

been relegated to the nice-to-have list of priorities in physicians’ offices. They do not offer enough value to physicians so that doctors will alter their pen-and-paper ways.

There has been much conjecture about how to expedite physician adoption of the Internet, but there are truly only two primary catalysts. The first catalyst is the need for more widespread use of the Internet. Like most people in business, physicians are seeking more time (either to spend with their patients or with their families), more money (which means getting reimbursed in a timely fashion), and more control over the

the Internet and begin to regard it as a powerful information standard. Once this concept has achieved wide-scale acceptance, physicians will move beyond being users of Internet tools to becoming investors in information services that arm them with the necessary intelligence to manage their practices effectively, to communicate more efficiently with patients, and to gain some control back from payers.

Recent studies have shown that there is a clear need for an information injection at the practice level. In 1999, nearly five billion medical claims were filed. According to a

By infusing knowledge into claims processing and its associated administrative tasks—such as eligibility verification and authorized referrals—these systems can free physician practices from the burdens that cost time and money and detract from patient care.

report last year, *Healthcast 2010: e-Health Quarterly* by PricewaterhouseCoopers, CPAs and consultants in New York, one third of those claims were erroneous. Most of these errors were attributed to incorrect coding, insurance ineligibility, inaccurate formatting, and unapproved referrals. Currently, the expense associated with adjudicating just one inaccurate insurance claim—including phone calls, faxes, and staff time—can be \$30 or more. This is a tough pill to swallow for medical practices that are already strapped financially. The only way to vaccinate medical practices against costly mistakes is to apply the required payer-specific reimbursement rules to medical claims before they are submitted.

Eliminating Errors

Contrary to the belief of most physicians, the cost of this reimbursement snarl tugs on the payers' purse strings as well. By some estimates, health plans spend more than \$10 billion annually fixing incorrect claims sent to them by physicians. This figure is 10 times more than the estimated and fabled float that payers are said to pocket by delaying payment of claims at the expense of physicians.

Even though physicians may be slow to embrace the Internet, the nation's largest health care payers have been making significant investments in Web-enabled technology. Almost universally, payers agree that medical groups need accurate and timely information if all health care entities are to operate more efficiently. In recent moves to combat administrative waste and claims denials, payers have embraced the Internet as

a mechanism to deliver up-to-date, payer-specific reimbursement rules to physicians.

While this approach represents a wise use of technology for health plans and insurers, any Internet portal built by a payer is not going to solve physicians' problems. And, just because payers build it does not mean that providers will use it. The mere fact that an Internet application has been developed by a payer is sometimes enough to make physicians reject the concept faster than a cross-species organ transplant.

Physicians are quick to point out that simply connecting physicians with payers over the Internet via portal technology does not solve the inherent problems that plague health care. Portals do not integrate with medical office workflow; medical practice employees are frequently opposed to new technological challenges; and, in many cases, portals add more work to an already burdened staff by making them re-enter vital patient information. Inevitably, this process leads to frustration, mistakes, and denied claims.

In the gap that exists between payers and physicians lies an opportunity for Web-based service providers. These vendors hold the key to igniting physicians' use of the Internet through an intelligent administrative infrastructure, a service that ensures a physician's proprietary information is secure, while facilitating successful electronic transactions with payers the first time the claim is submitted.

Intelligent infrastructures can be a win-win scenario for providers and for payers. Each payer provides its own specific reimbursement rules

necessary to send complete, clean claims to practice management vendors. In turn, these vendors incorporate the payer-specific rules into the practice's daily workflow. The intelligent practice management system can guide users through each step needed to ensure that clean and accurate claims are submitted for timely reimbursement.

Timely Reimbursement

By infusing knowledge into claims processing and its associated administrative tasks—such as eligibility verification and authorized referrals—these systems can free physician practices from the burdens that cost time and money and detract from patient care. Instead, physicians get the peace of mind that comes from knowing that they will be reimbursed in a timely manner for the services provided. Through the integration of an intelligent practice management system, physicians gain the time, money, and control that they so desperately desire. For insurers, the payoff is the obvious reduction in significant adjudication costs associated with claims denials.

Once physicians—and payers—see the obvious advantages associated with an intelligent practice management system, should the industry expect to see them flocking to leverage the Internet to manage their practices more efficiently? Those who favor efficiency in practice would answer this question with a resounding yes, but the delivery mechanism needed for such a system remains a potential barrier. Regardless of the magnitude of the benefits, physicians have historically refused to shell out

(Continued on page 12)

Want to make certain that you receive each month's issue?

SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS

OUR ARTICLES FOCUS ON:

- Understanding the dynamics of managed care
- How to strategically position your practice for success in today's health care market
- Effective organizational options
- Maximizing your practice through health care informatics



1 year (12 issues) - \$110

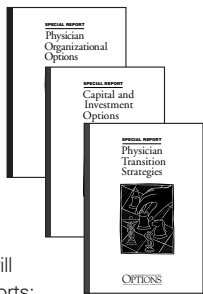
A 50% savings off the regular price. Act now and you will receive one free Special Report of your choice:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES

2 years (24 issues) - \$170

An additional \$50 savings off the special 1 year subscription rate. Act now and you will receive a complete set of three Special Reports:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES



Please call 888-457-8800 to order your subscription now, or fax this order form to 973-316-5989 or mail to:

Physician Practice Options
99 Cherry Hill Road Suite 300
Parsippany, NJ 07054

Name _____

Address _____

City _____ State _____ Zip _____

Email address _____

Payment method: Check enclosed Bill me Credit card.

If paying by credit card, please fill in the following information:

Credit Card (type) _____ Exp. Date _____

Credit Card Number _____

Name on card _____

Billing address _____

Signature _____

Checks should be made payable to: Physician Practice Options

EXPIRES: 02/02

#FSR110.170

(Continued from page 11)

capital for hardware and software. Likewise, their medical practice staffs vehemently protest technological change if it is not intuitive. Therefore, one way to ensure widespread physician adoption of intelligent practice management systems is through the application service provider model.

Intelligent ASPs

J.C. Bradford & Co., investment advisers in Nashville, Tenn., and a subsidiary of UBS Warburg, in New York, has commented that the technological capabilities of the Internet, delivered in the form of an application service provider model, herald the most profound, long-term change in the history of health care information systems.

ASPs literally serve up applications—such as patient scheduling, registration, eligibility, claims processing, and

Regardless of the magnitude of the benefits, physicians have historically refused to shell out capital for hardware and software. Therefore, one way to ensure widespread physician adoption of intelligent practice management systems is via the application service provider model.

collections—to physician medical practices with no up-front costs for hardware and software. With online, real-time access to these mission-critical back-office functions, medical groups can streamline workflow and provide better care for patients.

Taken to the obvious next level, intelligent ASPs—those that can aggregate and apply payer-specific claims and rules knowledge—are the health care industry's heavily anticipated panacea. For payers, intelligent ASPs deliver on the promise of amputating unnecessary administrative costs. For providers, intelligent ASPs inject time, money, and control back into the medical practice in a way that is inexpensive, integrates with the practice workflow, and is not technologically challenging for the medical staff.

It is only through the wide-scale adoption of intelligent ASPs that physicians will regard the Internet as a beneficial communication platform to help manage the business of medicine versus an online tool to help plan their next, much-needed vacation. ■

Strong Growth Predicted in Health Care Information Systems



Daren Marhula is a senior research analyst in the equity research department at U.S. Bancorp Piper Jaffray Inc., an investment banking firm in Minneapolis. Marhula,

who joined U.S. Bancorp Piper Jaffray in 1999, focuses on health care information technology vendors and other health care service organizations, such as health care information systems vendors, emerging e-health vendors, drug distributors, and pharmacy outsourcing companies. Before joining U.S. Bancorp Piper Jaffray, Marhula was with Wessels, Arnold, and Henderson, investment bankers in Minneapolis, where he covered the health care sector. Marhula discussed the findings of several of his reports with Richard L. Reece, MD, editor in chief.

Q: Why does your organization believe that health care information technologies represent a significant and promising area?

A: Health care is one of the largest single industries in our economy and one of the most under-automated. As such, health care information technologies represent a significant area for growth.

Q: In a recent report for U.S. Bancorp Piper Jaffray, you said that health care will probably become a consumer-driven system, and that employers will be allocating a set amount of funds, or a defined contribution, to employees, who will use it to purchase their own health care coverage. Why is defined contribution important?

A: One characteristic that makes health care different from other industries is that the payer of services is not the same as the user of

those services. That is, in most cases it is employers or the government that pays for the health care of the individual consumers who receive the services. Other industries, in which the payer and the user are the same entity, are characterized by a direct correlation between demand and supply, which is determined by price. Since health care is paid for by third parties, the users do not really care about the cost of that care.

As a result, when we go to a physician and pay a \$10 copayment, we do not really care if that doctor provides \$50 or \$500 of service on our care, as long as we feel that the physician is doing a good job. In contrast, a consumer driven-market, in which the consumer must shoulder the financial burden of the cost of services and must decide on the value of those services, will lead to a more competitive industry because the providers of services will compete based on price and quality. A consumer-driven market will make consumers cost sensitive and attuned to whether their expenditures are tied to value.

The next phase of our health care system will be a consumer-driven, patient-centered system. To date, different constituencies have tried to dominate the system. Insurance companies and HMOs have tried to control health care delivery and health care costs; hospitals have tried to build hospital-centered systems; and

physicians have tried to control health care and health care costs by integrating into IPAs or large multi-specialty groups.

Now consumers, aided by information technology, will try to control health care and health care costs. Information technology is critical in this effort because consumers will need data and information to make informed decisions about their care. But equally critical will be the defined contribution form of financing, which will give consumers the purchasing power and financial incentive to purchase their health care wisely.

Q: Have “virtual health plans,” in which people purchase health insurance from an Internet-based company, caught on?

A: Virtual health plans typically refer to themselves as defined contribution companies. That market is very young, but I think it will grow. At the peak of indemnity insurance growth, when little companies called HMOs were starting up, many experts said they would never work. But HMOs have had a pretty good run for 20 years. Similarly, internet-based health plans may take off as well.

Q: Another report examined the interface between patients and physicians at the point of care, and why that interface is important. Could you elaborate on the concept of the ePPI-center?

(Continued on page 14)

“The next phase of health care will be a consumer-driven, patient-centered system. To date, different constituencies have tried to dominate the system.”

(Continued from page 13)

A: Suppose we transition to a true consumer-driven health care market. The primary relationship in such a market will be between the physician and the patient. That is a sacred relationship. Given that no perfect technology exists that can facilitate this relationship, an electronic provider-partner interface, or an ePPI-center, would be the best technology solution. This technology would allow for medical records to be online at the point of care; that is, when the patient is seeing the doctor. You can think of the ePPI center as the electronic link between doctors and their patients.

Since almost everything is auto-

operated largely in a fee-for-service environment, in which hospitals and physicians were given the incentive to bill more so that they would get paid more. Because of this incentive to bill as much as possible and the providers' focus on billing, software vendors installed mostly billing or financial management software throughout the 1980s and early 1990s. Then, when providers realized that the Y2K threat was upon us, they spent their money to upgrade their billing systems. Accordingly, the clinical area has been neglected.

With the Y2K issue behind us, the health care industry is now investing more in clinical systems. Also, elec-

tical records.

For example, the Institute of Medicine's report, *To Err Is Human*, published in 1999, highlighted the number of medical errors in the industry and noted that automated systems could reduce those errors significantly. No hospital wants to be on the front page of our nation's newspapers for killing a patient. Although such errors have always occurred over the years, they have always been swept under the carpet. This IOM report and its successor report, *Crossing the Quality Chasm*, have brought the issue of patient safety to the forefront, and have prompted the creation of such organizations as the Leapfrog Group.

HIPAA legislation is creating pressure to develop and implement electronic medical records by requiring that patient information be secure, auditable, and accessible to patients. Other legislation is also tackling this issue. For example, California Senate Bill No. 1875, known as the Speier Bill, says that all California health care facilities must implement a plan to eliminate or significantly reduce medical errors. The bill, which was passed last year, strongly encourages these plans to use clinical information technology systems.

So, investors see all of these forces as prompting the shift from financial information systems to clinical systems, and they are trying to determine how to invest so that they can profit from that trend.

Q: What is the role of physicians in furthering this trend?

A: To date, most physicians have resisted electronic solutions, unless the systems allowed them to improve efficiency and cash flow. As a result of the old fee-for-service mentality, physicians have always focused on revenue.

Electronic medical records have not caught on because the technology has not been easy to use, and because physicians have not had the

“We will see major growth in the health care information technology industry over the next five to 10 years.”

ated now, people experience technology all the time. They can get their bank statements, file their taxes, and buy food online. Therefore, it is reasonable to expect that within the next five years, their medical records will also be available online.

The ePPI-center is the Holy Grail of medical information technology. If, five years ago, you had asked me where health care information technology would be five years later, I probably would have said that everything would be connected and information would be shared online. We are obviously not there yet.

Q: Several of your reports discuss the shift from a focus on financial and administrative systems toward clinical solutions. Do you believe that more investors are focusing on companies that offer practical and pragmatic clinical solutions?

A: Yes, this shift is unquestionably occurring. The environment has changed considerably. Over the past 20 years, the industry has

tronic medical records software is now becoming more user-friendly than it previously has been. Finally, consumers are beginning to demand more from their health care systems. These factors will drive the development and adoption of health care information technologies. We will see major growth in the health care information technology industry over the next five to ten years.

Q: What other external forces are driving the change in focus from the back office to the clinical arena?

A: Those forces include the Institute of Medicine reports; pressure from such influential organizations as the Leapfrog Group, a coalition in Washington, D.C., of large employers that have agreed to contract with health plans based on their adoption of patient safety initiatives; and the implications of the Health Insurance Portability and Accountability Act (HIPAA). These forces are pushing providers to automate and to create electronic med-

“The e-health market includes some good solutions and products, but the health care industry isn’t quite ready to embrace those solutions.”

incentive to adopt the technology. If physicians begin to face disincentives for not adopting such technologies—when, for example, regulatory bodies start mandating certain aspects of clinical automation—they will not have much choice about their role in furthering this trend.

Q: *What is your view of e-health business-to-business, or B2B, technologies?*

A: Health care B2B technologies currently center on e-commerce and supply chain solutions. From a physician’s point of view, such technologies would enable an office administrator to order office supplies by accessing and using a vendor’s Web page rather than ordering the supplies through a catalog and phoning in an order or ordering through a sales representative who visits the office. Frankly, I do not see health care business-to-business technologies as a huge growth area in the near term. They are “nice to have” not “need to have” solutions. The companies providing those services will be the more traditional, entrenched companies that allow buyers to order through a Web site, rather than new entrants to the market.

Q: *Will big legacy computer systems decline in favor of Internet-based systems for which physicians pay on a subscription basis and can be updated by the vendor?*

A: Yes. In a way, we seem to have come full circle. The Internet is almost like the old mainframe computers: It offers a time-share solution, but with a lot more flexibility. We will see more Internet-based solutions because of the ease of use of the Internet and the new monthly subscription pricing mechanisms. As a result, many electronic transaction

functions needed by small medical practices will be out-sourced to Internet-based companies, although large multispecialty groups may still retain these functions in-house.

Q: *In some reports, you advocate investing in the UnitedHealth Group, based in Minnetonka, Minn. Why is it such a strong company?*

A: UnitedHealth Group has done an excellent job of diversifying its business, unlike other insurance companies whose earnings are based on their HMO businesses.

Only 25% of United’s earnings come from its HMO business, while 75% come from other, more technology-driven business units. UnitedHealth Group is a successful, growing company. All of its business units are growing, and its profitability consistently exceeds Wall Street’s expectations. Those are all good characteristics to note when considering investment in a company.

Q: *Your company also emphasizes pharmaceutical benefit companies, or PBMs, as a growing sector. Why are PBMs so robust?*

A: PBMs do not represent a huge growth sector; however, opportunities exist for investors to make money within that sector. On a macro level, the PBM industry is a mature and fairly well-penetrated industry, since most people who are eligible to be covered by a PBM are already covered by one. Some growth will occur due to price inflation, however.

Q: *Why are the PBMs so important in the industry?*

A: PBMs are big group purchasing organizations that buy in bulk. Their clients are insurance companies or self-insured employers that carve out the pharmaceutical benefit and allocate that business to a

PBM. Advance PCS, for example, is a PBM in Irving, Texas, that represents 75 million enrolled lives, which gives it tremendous bargaining leverage when it purchases drugs from a pharmaceutical company.

Q: *In your report Surfs Up! Time to Catch the Next Wave, what is the next wave?*

A: The “wave” in that title refers to e-health care. The report, which was written in 1999, examines the e-health industry when it was fairly young, as well as e-health companies, such as Medscape and WebMD. Is the wave still up? No, it has crested and come back down. The e-health market includes some good solutions and products, but the health care industry isn’t quite ready to embrace those solutions. Currently, the e-health industry is consolidating and waiting for the winners to emerge. The wave will rise again, driven by companies that provide clinical solutions for physicians. When the market matures and physicians begin buying these clinical solutions, this market will heat up.

Q: *Are you optimistic about the future of health care? Do you have a strong sense about where the industry is headed?*

A: Yes, I am optimistic. After all, people are always going to need a strong health care system. So, there will always be a health care industry. I don’t know what its final form will be, but over the near term we will see more of a shift toward clinical systems and toward consumers. It’s going to be exciting to see these changes happen.

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

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

December 15, 2001



Premier Healthcare Resource
Suite 300, 99 Cherry Hill Road
Parsippany, NJ 07054

PSRST STD
U.S. POSTAGE
PAID
SMITHTOWN, N.Y.
Permit No. 15

SOLUTIONS FOR THE BUSINESS OF MEDICINE™

MD
OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

E-MAIL UPDATES

Let MDOPTIONS.com come to you! MDOPTIONS.com can keep you up-to-date automatically on the latest developments in the **Business of Medicine™**. You can sign up at MDOPTIONS.com or fill in your name and e-mail address below and fax it to us at **973-316-5989**.

Name: _____

E-Mail: _____