
▼ **PART I**

*Business, Management, and Technology
Planning*

▼ CHAPTER 1

The Ripple Effects of Managed Care in the USA

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We are now entering the Age of Unreason, when the future, in so many areas, is there to be shaped by us and for us—a time when the only prediction that will hold true is that no prediction will hold true; a time, therefore, for bold imaginings in private life as well as public; for thinking the unlikely and doing the unreasonable.

—Charles Handy, *The Age of Unreason*

§ 1.01 Introduction

As a physician or healthcare professional, your patients and family trust that you will survive the managed care economic debacle of the next decade. To be successful, you not only have to be a good physician, you must also apply managerial principles to your office and financial planning fundamentals to your personal life. In short, absent a total re-engineering of your future career plans, you must tune up your economic and business skills to avoid becoming a mere healthcare merchant, at all costs.

The current healthcare reimbursement climate has caused much pain and tumult. Both sides of the equation are affected as intermediaries are placed between patient and doctor. Older practitioners are retiring prematurely; mature providers are frustrated and in despair, and young physicians have no concept of the economic servitude to which they are about to be subjected.

Even the U.S. Inspector General has declared healthcare providers to be public enemy #2, behind drug and narco-traffickers, for their federal fraud and abuse initiatives. There is no question that real fraud exists. In 1999, the government reported 326 convictions of all types of Medicare fraud among all providers and HCFA estimates that its tactics are working because the level of payments estimated as “improper” has fallen 45 percent in the past two years to \$12.6 billion in 1998, from \$23.2 billion in 1996. But these numbers may not be accurate, since Medicare cannot separate honest mistakes from fraud and abuse.

Moreover, the Department of Health and Human Service (HHS) began a new “Incentive Program for Fraud and Abuse Information” in January 1999.¹ Under the program, HHS pays Medicare recipients \$ 100–1,000 to report abuses of the program. Obviously, physicians and other providers have criticized the program for

¹ See www.hhs.gov/.

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failing to educate patients about what Medicare does and does not cover, and for fostering negative perceptions of physicians. According to Dr. Nancy Dickey, past president of the AMA and family physician in Texas, this may be the governmental equivalent of “telling grandpa to rat out your doctor”.²

Consequently, the fear, uncertainty, and doubt of this change, as well as a general lack of management and financial acumen, afford a unique opportunity for the contemporaneous re-education of healthcare personnel and their related advisors. For all financial planners, attorneys, accountants, and advisors have all been caught up in the ripple effect that managed care is having on their physician clients.

§ 1.02 Desperate Doctors

Managed care is a prospective payment method where medical care is delivered regardless of the quantity or frequency of service, for a fixed payment, in the aggregate. It is not the individual personal care of the past, but is essentially utilitarian in nature and collective in intent.

There are many reasons why doctors are professionally and financially unhappy, some might even say desperate, because of managed care.

- A staggering medical student loan debt burden of \$100,000-250,000 is not unusual for new practitioners. For example, the federal Health Education Assistance Loan (HEAL) program reported that for the Year 2000, it squeezed significant repayment settlements from its Top 5 list of deadbeat doctor debtors.³ This included a \$303,000 settlement from a New York dentist, \$186,000 from a Florida osteopath, \$158,000 from a New Jersey podiatrist, \$128,000 from a Virginia podiatrist, and \$120,000 from a Virginia dentist. The agency also excluded 303 practitioners from Medicare, Medicaid, and other federal healthcare programs and had their cases referred for nonpayment of debt.
- Despite a flagging economy, medical school applications nationwide have declined during the past five years. In 1996, applications peaked at 46,968; by 2000, they had fallen to 37,137, a 21 percent decline. According to John Parker, of the Association of American Medical Colleges, “[Today] there are a lot of different opportunities out there for young bright people.”⁴ The June 2001 issue of *Physicians Practice Digest* stated, “Medicine is fast becoming a job in which you work like a slave, eke out a middle class existence, and have patients, malpractice insurers, and payers questioning your motives.”⁵ Remarkably, the Cornell University School of Continuing Education has designed a program to give prospective medical school students a real-world peek, both good and bad,

² See www.managedcaremagazine.com/archives/9809/9809/.qna_dickey.shtml.

³ See www.hrsa.dhhs.gov/news-pa/heal.htm.

⁴ www.bhpr.hrsa.gov/dsa/sfag/health-professions/bk1prt4.htm.

⁵ Pamela L. Moore, “Can We All Just Get Along: Bridging the Generation Gap, *Physicians Practice Digest* (May/June 2001).

at life as a physician since “many people who are currently making a great effort and investment to become doctors may be heading for a role and a way of life that are fundamentally different from what they expect and desire,” according to Stephen Scheidt, MD, director of the \$1,000 fee program.⁶

- Fewer fee-for-service patients and more discounted patients.
- More paperwork and scrutiny of medical decisions with lost independence and morale.
- Reputation equivalency (i.e., all doctors in the plan must be good), or commoditization (i.e., a doctor is a doctor is a doctor).
- The provider is at risk for (a) utilization and acuity, (b) actuarial accuracy, (c) cost of delivering medical care, and (d) adverse patient selection.
- Practice costs are increasing beyond the core rate of inflation.
- Medicare reimbursement was cut 5.4% for 2002, prompting AMA president Richard Corlin, MD, to opine that “these are circumstances that cannot continue because we are going to see medical groups disappearing.” Furthermore, he stated, “[T]his is an emergency that lawmakers have to address.” Such cuts also stand to hurt physicians with private payers since commercial insurers often tie their reimbursement schedules to Medicare’s resources. “That’s the ripple effect here,” says Anders Gilberg, the Washington lobbyist for the Medical Group Management Associations (MGMA).⁷
- Doctors and other healthcare providers are making less money, particularly in California where the very future of medical care is in question. More than 126 medical groups and IPAs have gone bankrupt, been sold or closed there since 1996, according to the California Medical Association.
- The Saint Paul Insurance Company in Minnesota exited the loss-plagued medical malpractice business last year, with a pre-tax loss of more than \$900 million in the last quarter of operations.
- A growing number of doctors are abandoning traditional medicine to start “boutique” practices that are restricted to patients who pay an annual retainer of \$1,500 and up for preferred services and special attention. Franchises for the model are also available.
- Regardless of location, the profession of medicine is no longer ego-enhancing or satisfying.

To compound the situation, it is well known that doctors are notoriously poor investors and do not attend to their own personal financial well being, as they expertly minister to their patients’ physical illnesses.

⁶ See www.cornell.edu or www.intranet.cornell/physicians.com.

⁷ Neil Versel, *Cutting Blow: Drop in Medicare Reimbursement Wounds Doctors*, Modern Physician (Dec. 2001).

§ 1.03 The Paradigm Shift

Until several years ago, most doctors were probably more concerned with acquiring, maintaining, or improving their medical acumen than worrying about practice management or personal financial planning. And this was a good strategy until now. In the Year 2002 and beyond, however, medical professionals will not only work harder to earn a living, but that living will not be as lucrative as it once was. Doctors will have to work longer hours; diagnose and treat patients faster; augment their fear of malpractice with the fear of compliance audits; and literally risk their lives as they treat an increasing number of patients infected with HIV, herpes, and hepatitis C. What will they get for all their trouble? Most likely, a lifestyle lower than most of the middle class patients they treat.

This is a dramatic change from the way things used to be in medicine. Some pundits even use the expression “health insurance payment paradigm shift” because the way doctors practice medicine, and the manner in which they get paid, has drastically changed.

For example, under a full-risk medical capitation payment plan, the successful doctor may be the one with an empty waiting room, rather than a full one. Some experts argue that this is a better deal for patients, while others document that there are more uninsured or underinsured patients than ever before. A recent review revealed that almost 45 percent of all physicians are now corporate employees and that private doctors do 40 percent less pro bono charity work than they did in the fee-for-service reimbursement system, because they can no longer afford to work for free.

Regardless of philosophy, one thing is certain: medical professionals have lost their financial clout and social standing. Medical school enrollments have begun to decline; residency programs are shutting down; and hospitals are being paid by the U.S. government *not* to train certain physicians. Twenty percent of medical schools are affiliated with business schools and practitioners are experiencing profound depression because of the managed care insurance crisis. It is a professional crisis of conscience; a personal crisis of economics, and a very real problem that hurts everyone, doctor and patient alike.

How and why this all happened is very complex, but there are three main factors involved: (1) demand and supply side inequalities, (2) healthcare cost escalation, and (3) sociopolitical timing.

§ 1.04 Demand and Supply in Medical Care

The issue is not how to fill or reuse empty beds. In this changing environment, hospitals and health systems must focus on streamlining and simplifying operational processes, facilitating case management, promoting the least costly setting for care delivery, and optimizing resource sharing among departments. When hospitals have addressed these issues, then solutions to the “bed problem” will be obvious.

—Cynthia Hayward, 1996

Medical care is defined as the finite examination and treatment of patients, for monetary compensation. Among other reasons, changes in patient demand occur as a result of the absence or presence of health insurance plans or the encouragement of additional treatments by profit-maximizing providers. Changes in supply occur as a result of physician shortages or surpluses, and a host of other factors. Currently, the glut of physicians has caused them to become “price takers,” selling a homogenous service. How else could aggregate HMO fee schedules drop to some percentage below prevailing Medicare or Medicaid rates in some instances? Or how else could otherwise qualified physicians be de-selected from managed healthcare plans because of large (successful equates with expensive) practices?

A graphical representation of this economic relationship produces the classic downward sloping demand curve and the upward sloping supply curve. At some point in time, however, the treatment plan is completed, the patient is satisfied, and additional services are not needed. This is known as market equilibrium. When an industry becomes more competitive, either by too much supply, too little demand, or both, market equilibrium fees tend to become more elastic, and patient volume becomes very sensitive to even small changes in price. In a managed care environment, every covered service has a low price ceiling, and every “non-covered” service has its own price elasticity. Traditionally, medical services were inelastic to price changes and considered a growth industry, since a fee increase would also increase revenues.

Now, the marketplace has become resistant to pricing pressure by physician oversupply and managed care. Generally, a pricing coefficient greater than one is considered elastic, while a coefficient less than one is inelastic. Interestingly, exact unity prevails when elasticity of supply is exactly equal to one. In the golden days of medicine, the price elasticity of medical care was greater than 1, now it is about .35.

Financially, all this means is that many doctors are “taking what they’re given (by HMOs), because they’re working for a living.” Younger doctors under 40 are especially inclined to work for less since they have had little exposure to fee-for-service compensation. Additionally, physicians have an increasingly smaller share of the medical marketplace because of so-called medical care extenders, such as PAs and nurse practitioners. Many health plans have even done away with many true allied healthcare professionals, such as RNs or CRNAs, in favor of trained, not educated, and less costly technicians. Patients are hurt as well, as the economic cost of medical re-intervention is often much more than the cost of the proposed initial professional care. A study by Deloitte Touche⁸ reported employee satisfaction was decreasing about 10 percent per year, as healthcare coverage represented a fiscal and economic time bomb on corporate books.

⁸ *The Employer Survey on Managed Care—1999*, Deloitte Touche Newsletter, On Health, New York, Spring, 1998.

§ 1.05 Rising Healthcare Costs

New financing and risk management schemes, restructured delivery systems, advanced therapeutics, sophisticated information technology and profound demographic shifts are among the forces that will lead to very different healthcare systems in the first part of the 21st century.

—Clem Bezold, *Future Care*

Traditional organizations, except for the military, provided indemnity (fee-for-service) insurance, which gave patients great freedom and MDs or other medical providers great incentive to supply care. But insurers had little control over the care that was rendered and its associated costs. Healthcare costs skyrocketed to more than \$900 billion, or 15 percent of GNP, by 2002, crippling U.S. productivity.⁹

According to the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), premiums for employer-provided health insurance rose 8.3 percent last year, almost doubling the average 4.8 percent hike of the previous year.¹⁰

Further, consider that Medicare in 2001 cost \$250 billion and is projected to be fiscally insolvent by the year 2008, when healthcare spending will have reached \$2 trillion or 17-18 percent of U.S. GDP. Currently, it has enough to “pay” medical benefits for about ten months, but in reality it cannot pay anything. This creates a rising burden on the young, who subsidize treatment for the old and middle-aged. Workers under 65 pay most taxes, and even among workers there are generational subsidies. In 1999, workers 45-64 years old with employer paid insurance had health costs twice those of workers 18-44, since the young have wages reduced because of elder insurance costs.

Additionally, Medicare C+ programs have fared even worse, as evidenced by the recent wave of plan dropouts and continued MCO concerns about burdensome requirements and inadequate payment rates.

Realize that since 1963 in the Medicare system alone, the following happened:

- Workers contributing to the system decreased from 6:1 to 2:1.
- Enrollees increased from 22 million to 45 million currently.
- The elderly population increased from 10 percent to 15 percent of the U.S. population.
- The average life span increased from 71 to 79 years.
- The Medicare Trust Fund increased from \$3 billion to \$140 billion. (Not really a trust fund but actually an accounting fiction since technically the fund holds interest-earning U.S. government bonds, representing an accounting surplus of payroll taxes collected minus benefits paid. The bonds are essentially IOUs the government has written to itself.)¹¹

⁹ www.healthwise.com.

¹⁰ www.kff.org/.

¹¹ www.hfca.gov/medicare/medicaid.htm.

- Similarly, in a departure from recent trends, hospitals accounted for almost half of all cost increases last year, while prescription drug and physician related costs increased moderately, according to the Milliman USA Health Cost Index. Outpatient and inpatient costs accounted for 43 percent of hospital cost increases and physicians for 28 percent. However, because hospital inpatient costs actually declined the previous five years, inpatient cost increases last year represented a big increase.
- Overall, healthcare costs rose about 8 percent in 2002; they rose 7.5 percent in 2001 and 7.3 percent in 2000. This represents an annual per capita increase from \$4,340 in 2000 to a projected climb to \$7,171 by 2008.

Since then, the following has occurred:

- The Balanced Budget Act (BBA) of 1997 reduced payments to Medicare providers and eliminated DME fee schedule updates.¹²
- The Balanced Budget Act Refinement Act of 1999 restored \$16 billion over five years to hospitals, skilled nursing facilities, home healthcare, and managed care organizations, although the physician community was not dramatically affected.
- The Gramm-Leach-Bliley Financial Modernization Act was enacted in 2000.
- HHS, for FY 2001, provided about \$ 35 billion for the State Children's Health Insurance Programs (SCHIPs), \$12 billion for hospitals, \$11 billion for HMOs, and \$2 billion for home health agencies and Medicare C+ programs, over the next five years.
- APCs took effect in early 2001.¹³

In the past year, the following occurred:

- The Health Care Financing Administration (HCFA) became known as the Centers for Medicare and Medicaid Services (CMS). Administered by Thomas Scully, it is reorganized into three parts. The Center for Medical Management runs the traditional fee-for-service program. The Center for Beneficiary Choices expands the number of Medicare beneficiaries belonging to private plans. The Center for Medicaid and State Operations shares responsibility with state governments.
- The CMS developed two new one-page Advanced Beneficiary Notices (ABNs): one for healthcare items and one for laboratory tests. It is also revising its Medicare Carrier Manual (MCM). Now voluntary, the use of both forms will likely become mandated in the future, when the MCM is complete.

¹² www.hcfa.gov/quality/5b.htm.

¹³ www.ichp.edu/ship/materials/893253826.html.

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- Managed care is in retreat as only 23 percent of covered Americans are enrolled in HMOs, down from 31 percent in 1996. Medicare+C programs are in even more trouble.
- HCFA (CMS) considered allowing PROs to provide information on complaints and actions against doctors, without their consent, in 2002.
- Certain administrative requirements for HIPAA went into effect in Autumn 2002. New privacy regulations gave covered entities 24 months to comply, or by August of 2003. Additional security regulations are to be released.

Furthermore, the rising cost of healthcare, attributed to wide treatment variability patterns by the IOM, could be ascribed more to style than to patient differences. In the classic example, studies by John (Jack) Wennberg, MD, in the early 1970s at Dartmouth Medical School, shocked the health care community when he discovered that differences in hysterectomy, tonsillectomy, and prostatectomy rates in one county were 30-50 percent higher than rates in adjacent counties.¹⁴ By the early 1980s Wennberg's studies concluded that new physician incentives were needed if doctors were to provide appropriate care at acceptable costs. Nevertheless, iatrogenic (doctor-induced) factors contributing to healthcare cost escalation continued into the 1990s despite various risk management precautions.

For example, it is now estimated that:

- 53 percent of all surgeries may be unnecessary.
- 36 percent of all medical office visits may not be needed.
- 35 percent of all hospital admissions may be iatrogenic.
- Iatrogenic medication errors abound.¹⁵
- 98,000 hospital deaths are caused each year by medical errors.

Other causes of spiraling costs included voracious consumer appetite, lifestyle drugs with direct-to-patient advertising, inflation, cost shifting, and the relative insulation of consumers to the true cost of medical care due to the business deductibility of health insurance premiums (starting in 1999, self-employed workers were able to deduct 60 percent of health insurance premiums, then it will rise to 70 percent in 2002 and 100 percent by 2003). Not coincidentally, corporate America looked for methods to contain costs and provide proactive, rather than retroactive-active medical care. Managed care, not national healthcare, was the private result. Moreover, malpractice phobia, misinformed patients, hungry trial lawyers, and class action lawsuits have all contributed to escalating healthcare costs.

For example, the periodical *Jury Verdict Research* estimated statistics for Year 2000 jury awards for medical malpractice claims.¹⁶ The median award for all medical

¹⁴ www.dartmouth.edu.

¹⁵ See www.express-scripts.com.

¹⁶ www.lrpdartnell.com.

negligence claims increased by 14-15 percent over 1995, and in childbirth cases was about \$1.3-1.4 million, more than double the median for any other type of medical malpractice verdict. Other median awards were about:

- \$689,000 for medication errors;
- \$563,000 for misdiagnosis cases;
- \$277,000 for surgical negligence;
- \$280,000 for nonsurgical treatment cases;
- \$284,000 for cases involving doctor/patient relations;
- \$630,000 median award for all medical malpractice cases.

§ 1.06 Socio-Political Timing

When was the last time you had freedom of choice in, of all places, a hospital? One choice is no choice at all, and it only makes people feel frustrated and powerless. People have a fundamental need to choose for themselves—give your customers the power of choice.

—Roger Dow and Susan Cook, 1996

Cultural and sociopolitical timing (i.e., medical care is a right, not a privilege or a responsibility) induces some patients and employers to be unwilling to pay the price for good medical care. According to Steven Wetzell, of St. Paul, MN, in an employer-initiated Buyers Healthcare Action Group (BHCAG), even seemingly small healthcare premium amounts matter. For example, the difference between his group's high and low cost healthcare plan is only about \$19 per member/per month; yet every one of his low-cost provider groups gained enrollment last year, while all high cost providers lost enrollment, up to 18 percent. It was the BHCAG experience that price is now the driver of most health plan enrollment, even more than real healthcare quality or perceived patient satisfaction.¹⁷

§ 1.07 More Bad News for Physicians

Medical professionals of all types have accused both their national and state societies of being slow to respond to their changing needs. In 1962, for example, 82 percent of physicians belonged to the American Medical Association. Today, the figure is about 29 percent, or 290,000 members. Meanwhile, the AMA had a \$3 million operating loss in 2001, including \$2.3 million attributed to advertising losses. There was even more infighting among the AMA ranks as its former executive vice-president, E. Ratcliffe Anderson, Jr., MD, sued the association for \$5 million dollars over its

¹⁷ Piturro, M., *Changing the Game: Steve Wetzell of BHCAG Offers a New Twist on Healthcare*, *Managed Healthcare News*, November, 1998.

handling of the Sunbeam debacle and his alleged wrongful termination for whistle blowing.

Since almost one half of all physicians are employees, they are no longer as dependent upon traditional medical societies. Going forward, it has been estimated that more than 70 percent of all medical school graduates in the first year of the next millennium will be employees, rather than small practice (business) owners and employers.

The strength of medical societies is diminishing, and, as practitioners move into employment positions, the enhanced role of unionization has arisen. Although the AMA has removed barriers to collective bargaining, it is still adamantly opposed to strikes. Traditional constraints under the National Labor Relations Act and other antitrust laws are being litigated, and prominent unionization campaigns are occurring across the country, as the more than 50,000 physician union members unite, despite a simultaneous diminution of union clout in almost all other industry sectors.

For example, the Physicians for Responsible Negotiations¹⁸ (PRN) initially looked to the Teamsters, as the Committee of Interns and Residents (CIR) recently won the right to organize 430 residents at the Boston Medical Center. In fact, the younger, and more aggressive, medical professionals of the CIR do not recognize a “no strike” pledge, as the older and less assertive, PRN group does.

Regardless, how sad it is to tempt formerly proud and independent practitioners and student doctors to join labor unions, and become just another “medical degree with a pulse.”

§ 1.08 Desperate Patients

A recent HMO cost-cutting measure, known as the Drop in Group Medical Appointment (DRGMA) is particularly onerous to some patients. In this still voluntary model, group visits of 10-15 patients take place simultaneously. During each visit, patients are examined in the group or privately, charts are reviewed, vital signs are taken, medications adjusted, tests are ordered, and results discussed.

Virtual e-health visits took a step forward in 2001 as the First Health Group became the first managed care organization to establish another voluntary cost-cutting program that eventually will pay doctors about \$25 for online consultations with patients conducted via their Web site.

In a most unusual court case, a physician and six patients covered by Kaiser Permanente filed suit last year, accusing it of endangering patients' lives by forcing them to accept double-size pills.¹⁹ The plaintiffs alleged that the HMO forced them to buy medication at a higher dose and then split the pills in half. Some pharmaceutical and medical experts opine that the practice is harmful to patients.

According to Charles S. Lauer, publisher of the *Modern Physician*, through a

¹⁸ www.ama-assn.org/ama/pub/category/2554.html.

¹⁹ Patient Protection (Administration Passes Regulations to Speed Up Appeals Process). *Modern Physician*, January 2001, page 12, Alameda County Superior Court.

study conducted by ARA Marketing and HBOC McKesson, which appeared in the Harris Interactive Healthcare News,²⁰ found that pressing patient concerns include the following:

- 60 percent: “forgetting to ask all my questions when I am with my doctor,” and
- 29 percent: “not having enough time with my doctor,” since the amount of face time between patient and doctors now amounts to about three minutes.

Is it no wonder that patients, along with their healthcare providers are also increasingly becoming despondent over the domestic healthcare imbroglio? For example, a recent study by Harvard University reported that more than half of U.S. physicians believe their ability to deliver quality healthcare has deteriorated in the past five years. In another example, according to the most recent survey of the Employee Benefits Research Institute (EBRI):

- Only 23 percent of employees considered themselves familiar with managed care.
- Fewer than 27 percent said that healthcare has gotten better in the last five years.
- Only 43 percent of those who received care expressed high satisfaction with its quality.
- Almost 40 percent said they were not pleased with healthcare costs, despite MCOs.²¹
- In a study by the American Nurses Association (ANA), 40 percent of nurses said they wouldn’t feel comfortable having a family member cared for in their hospital.
- The number of inpatients who bring family members or private duty medical professionals into the hospital to act as personal advocates is increasing.

§ 1.09 The Managed Care Backlash?

We can quibble over the fine points, but the trend is crystal clear. A massive change in the numbers, types and skills of healthcare professionals is underway.
—Richard Lamm, 1996

Some doctors believe that the public will revolt against HMOs and produce a managed care backlash. Unfortunately, they are in denial about the severity of the HMO dilemma. Since passage of the HMO Act in 1973, the growth of HMOs and other Managed Care Organizations (MCOs) has increased to more than 72 million enroll-

²⁰ Modern Physician, Lauer Publishing, Chicago, August/September/October, 1998.

²¹ See www.EBRI.com.

ees. This represents an increase of 14 percent within the past year, with a 19 percent commercial growth rate in the prior year. Medicaid is one of the fastest growing HMO products as enrollment in this field increased 34 percent in 1998-1999. Medicare enrollment is also growing slowly and is expected to accelerate in the future, especially the remaining managed care (Medicare +) segments, although some sponsors, of late, have temporarily left the sector due to diminished profit margins or actual losses.

Also, do not believe that HMOs will be unresponsive if just such a managed care backlash occurs. In 1999-2000, managed care companies and their allies fought against restrictive new proposed anti-HMO regulations and spent \$ 112,000 per lawmaker to lobby Congress. This \$60 million outlay was four times the \$14 million plus spent by medical organizations, trial lawyers (\$1 million), unions (\$1.4 million) and consumer groups (\$8 million) to press for passage of the so-called Patients' Bill of Rights. The \$60 million dollar lobbying tab is 50 percent higher than the \$40 million dollars that tobacco interests spent to kill legislature to raise cigarette taxes to curb teenage smoking.

Futhermore, modification of the so-called Patients' Bill of Rights, in 2001, which would have allowed patients to sue HMOs, is another example of how corporate money apparently buys protection for managed care, in Washington, DC.

§ 1.10 Keep Practicing

In a marketplace dominated by capitation and prepayment, health organizations will rediscover that the core business is the patient.

—Russell C. Coile, Jr.

A survey of 12,107 doctors found that 24 percent of primary care physicians believed that the scope of care they were expected to provide, by HMOs, was too pervasive.²² Among specialists, 38 percent believed patients' conditions were too complex by the time they were referred for further treatment, since HMO gatekeepers limit access to specialists.

According to a 1998 survey of physicians, widespread dissatisfaction was confirmed by the MedStat Group of Ann Arbor, who reported that 46 percent of the respondents indicated frequent thoughts about leaving practice. The survey was sent to 30,000 doctors, in 22 U.S. markets, of whom 6,500 responded. Dissatisfaction was high, primarily because of managed care, opined Kent Bottles, MD, author of the study, who lectures physicians about pursuing alternative medical careers. Doctors were fed up with the loss of financial security, prestige, independent decision making, physician collegiality, and strong physician-patient relationships. Other physicians simply admitted they made the wrong career choice, and stuck it out until the aggravation level was too high.

Gigi Hirsch, MD, a former ER physician and instructor at Harvard Medical School

²² Wechsler, H., Schor, E., Coakley, E., *Physician's Role in Health Promotion—A Survey*, NEJM: Vol. 334, No. 15, April, 1996.

grew so disenchanted with clinical medicine, that she ditched her career and started her own business, MD IntelliNet,²³ in Brookline, Mass. The company places doctors in nontraditional jobs by pairing them with venture capitalists and other businesses seeking physicians. Her new book, *Strategic Career Management for the 21st Century Physician*, was published by the AMA, in October 1999.

In the same light, Michael Burry, MD, a promising young neurologist from Stanford and Vanderbilt, rejected his medical career to become a private portfolio manager for Scion Capital Management, as did Harvard-trained radiologist, Faraz Naqvi, MD, the fund manager for Dresdner RCM Biotechnology Fund.

It is no wonder then, that according to Dr. Regina E. Herzlinger, the Nancy R. McPherson Professor of Business Administration chair at the Harvard Business School, and author of the books, *Creating New Healthcare Ventures* and *Market Term in Healthcare*, that many medical professionals become depressed and want to give up their careers, entirely. But, she implores in her most recent book, *Market Driven Healthcare*, “Don’t give up practice, yet.”²⁴

As an example of a potential recent change for the better, Aetna/US Healthcare dropped its “all products” managed care clause as of January 1, 2001. Further retooling of its operation “restore trust in managed care” program, included the following features:

- Enhancing its specialist program
- Reducing capitation in favor of fee-for-service reimbursement
- Clarifying the external review process for coverage issues
- Possibly reducing its list of procedures that require pre-certification

Similarly, United Healthcare eliminated much of its pre-authorization requirements but replaced it with a retrospective analysis of physician treatment plans that may lead to more physician profiling. Still, according to Archelle Georgiou, MD, Chief Medical Officer, the company’s new policy for 2001-2002 was to pursue the triad of hassle elimination for doctors, enhanced access to care for patients, and to keep both sides from falling through the cracks of bureaucracy.²⁵

§ 1.11 The Future

Pragmatically, the future healthcare industrial complex will offer great opportunities to change medicine for the better, to those who have the foresight to undergo the serious process of re-education and re-engineering.

As an example of this re-engineering, Joseph Orlando, vice president of Health Marketing Inc., in Chicago, opined that if healthcare becomes too expensive, “some

²³ www.MDintellinet.com.

²⁴ Herzlinger, Regina, *Ph.D. Market Driven Healthcare*, Harvard Business Press, Cambridge, May, 1999.

²⁵ www.yourdoctorinthefamily.com.

companies are not even going to bother with group (medical) coverage anymore. They may just give each employee \$350 to spend each month, and then send them into the private healthcare market place,"²⁶ even though this model would be difficult to implement under the current Health Insurance Portability and Accountability Act (HIPAA).

In another example of an out-of-the-box mentality, individuals may ultimately own their own transferable health insurance policies, just as they do IRAs. The Coalition on Health, in Washington, DC, has even postulated the concept of "defined contribution health coverage," which is similar to contemporary defined contribution retirement plans. Under this plan, an employer deposits a defined financial healthcare contribution into an employee's account. The employee has control over the funds and can select a level of healthcare coverage that best meets their individual needs from a "menu" that generally includes various selections among medical, dental, vision, and pharmacy benefit plans. A leader in this revolution is Oregon-based Myhealthbank, Inc.,²⁷ that announced the statewide rollout of its Internet-based defined-contribution health benefit administration service, in 2001-2002, through its partnership with Regence BlueCross BlueShield of Oregon.

According to CEO Dave Sanders, since the company is Internet-based, employees can get online access to their benefits information 24 hours a day, seven days a week. Randy Cline, senior VP for Regence BCBSO, feels that a defined-contribution approach also "raises the employees', and their families', awareness of the costs associated with healthcare." Theoretically, as cost-conscious consumers, employees could put a lid on rising healthcare costs for an employer. However, if healthcare costs escalate, employers could freeze, or decrease, their contribution levels. Employees would then lose purchasing power and control.

In this model, according to Uwe Reinhardt Ph.D., of Princeton University, HMOs will have to change their marketing and recruiting tactics from corporate America, back toward the individual patient.²⁸ The new challenge of managed care will become providing consumers with the specific healthcare and health information, they demand.

In a third example of innovative thinking, the Medical Savings Account (MSA) concept of tax deductibility, ignored a few years ago, may re-emerge to cut employee costs, allow for a return to fee-for-service medicine, expand patient choice, and provide many of the options both doctors and patients profess to desire.

Finally, Physician Practice Management Corporations (PPMC), left for dead by the year 2001, may even make a comeback, as they evolve from first-generation multispecialty national concerns, to second-generation regional single-specialty groups, and finally to third-generation Internet-based Web-enabled service companies, providing both business-to-business solutions to affiliated medical practices, as well as business-to-consumer health solutions to plan members.

Therefore, one way to accomplish these re-engineering goals is to run your practice like a business and integrate management concepts with personal financial plan-

²⁶ www.hmisuperppo.com.

²⁷ www.myhealthbank.com.

²⁸ Jensen, Brian, *In Search of the Next Managed Care Vision*, Washington Post, Wed., Sept. 29, 1999.

ning, using a trusted team of advisors. Online master's degree programs, for medical professionals, like those offered at Regis University (303) 964-5447, the University of Tennessee (423) 974-1768, Washington University (Olin) in St. Louis (888-273-6820), and the University of Wisconsin (608) 263-4889, may help. It is only in this fashion that doctors will be able to regain their rightful place as "conductors of the nation's healthcare symphony."

§ 1.12 Related Advisors

The healthcare industrial complex represents a large and diverse industry, and the livelihood of other synergistic professionals who advise doctors depend on it as well. These include the following professionals who themselves wish to avoid the collateral ripple effects of the current healthcare debacle.

[A] Certified Public Accountants

The nation's 330,000 or so CPAs know little about the new healthcare dynamics and managerial accounting mechanics. Many often feel as though they are laboring away in obscurity and that their doctor clients do not appreciate what they do or how hard they work.

If you are a CPA, your workweek is ridiculously long, especially January through April; and you often deliver bad news to your clients. You do not earn a generous salary, but you do receive their ire for your efforts. Even ex-SEC chief Arthur Levitt said, "Accounting is clearly a profession in crisis,"²⁹ after reviewing Arthur Andersen, LLP's role in Enron Corporation's collapse, in 2002; not to mention the Global Crossing Ltd, fiasco. So, you begin to scratch your head and ponder, quietly at first, and then out loud. Perhaps managing the medical practice(s) of a physician, or providing consulting services to other medical professional is a business and financial planning opportunity that won't require a new client base? You can keep your accounting practice during the first four months of the year, and supplement your income with something that may actually earn more than you are making now. A light then goes off in your head. Epiphany! Enter the CPA/PFS designation, exhorting doctor clients to "never underestimate the value," through an additional 750 hours of financial planning experience and a six-hour comprehensive examination.

However, terms such as capitated medicine; per member-per month fixed fees; payment withholds; activity-based costing with CPT codes; utilization and acuity rates; and much more investment and financial nomenclature is likely quite unfamiliar to you. Furthermore, you may not have the temperament to be a fiduciary, responsible for the financial affairs of others. Then you realize that MBAs and actuaries may actually be the new denizens of the healthcare bean counting and practice management scene. Rather than present numerics of the historic past, they make logical and mathematical inferences about the future. Slowly, you realize that this has oc-

²⁹ Richard S. Dunham, *The Vindication of Arthur Levitt*, Business Week (Feb. 19, 2002).

curred because these professionals are proactive, not reactive, as the accounting profession is losing its premier advisory position within the medical profession. Since doctors are paid a fixed fee amount, regardless of the number of services performed, these futuristic projections are the most important accounting numbers in healthcare today. In fact, your research suggests that as a result, there are now several accountant managers and broker-dealers on the investment scene, as well as an increasing number of accounting-financial planning firms, such as Miller Ray & Houser Business Advisors and CPAs, in Atlanta, who set up a separate investment advisory firm to which they refer clients. Moreover, the AICPA is providing encouragement to CPAs who wish to provide more professional client services by building a financial planning practice for the new millennium.

[B] Tax Attorneys and Lawyers

As a tax, estate planning or bankruptcy lawyer, you already know that almost every legal magazine around has articles or advertisements proposing that you become a financial planning professional or business consultant to your physician clients. Moreover, lawyers of all stripes are being pushed toward interdisciplinary alliances by encroachment on their turf by the Big Four accounting firms. With audits of publicly held companies now a commodity, the giant accounting firms are getting more of their revenues from consulting, and that puts them into direct competition with attorneys, MBAs, actuaries, and other management and financial service professionals.

Of all careers, you know how absolutely onerous it is to practice medicine today and are finally thankful that you did not take that career route many years ago. So, like your neighbor the accountant, you begin to explore that potential of developing a service line extension to your legal practice, in order to assist your medical colleagues who have been hit on hard economic times. In fact, you soon realize that more than 90,000 trust, probate, and estate planning attorneys like yourself are interested in pursuing financial planning in the next decade. Sure, you know its difficult to get a CLU or variable annuity license, or become a certified financial planner (CFP™), but earning your law degree was no cinch either. And, you reckon, advising physicians has got to be easier than law, or less stressful than the corporate lifestyle of your MBA-trained brother-in-law, right?

So, you set out to stretch your legal horizons and explore the basic legal nuances of those topics not available in law school when you were a student. Things like medical fraud and abuse; managed care compliance audits and Medicare recoupments; OSHA and EPA standards; antitrust issues; and managed care contract dilemmas or de-selection appeals.

What a brave new world the legal profession has become! Even the American Bar Association's commission on multidisciplinary practice has recommended that lawyers be permitted to share fees and become partners with financial planners, money managers, and other similar professionals. As a real life example, the venerated Baltimore brokerage firm of Legg Mason, Inc., has recently teamed up with the Boston law firm of Bingham Danna, LLC, to create one of the first marriages between

a law and securities firm. If you want in on the challenge, and bucks, you'd better acquire at least a working knowledge of healthcare administration, or perhaps help craft some new case law, or assist your doctor-clients in some fashion; otherwise, you will remain a legal document producer.

[C] Financial Planners and Investment Advisors

As a CFP™, CFA, investment advisor or general securities representative, you realize that the financial service sector is going to become the next great growth opportunity of the twenty-first century. Even H & R Block, and the Charles Schwab Corporation are trying to build medical professional interest in their respective firms and compete with your independent practice. They are fervently wooing away one group or another to interface with their embryonic management, accounting, or advisory programs. For example, it has been estimated that more than one-third of the nation's 60,000 accounting firms are contemplating the introduction of investment and medical management services to their business line. Another 100,000 solo CPAs are interested in personal financial planning for their physician and lay professional clients; a survey of senior CPA partners conducted by Prince & Associates of Shelton, Conn., revealed that more than 60 percent were "highly interested" in offering investment management services, and three-quarters of those said they were evaluating the best approach for their firms.

Meanwhile, more than 260,000 of the nation's brokers are moving into the investment advisory and financial planning business because securities sales and transactions are being commoditized by the Internet's World Wide Web. A recent survey conducted for the International Association for Financial Planning clearly demonstrated the dominance of registered investment advisors, over stockbrokers, among clients 35-49 years old. With the average Merrill Lynch private client well over 60, it's easy to spot the future vulnerability of this business model. When asked to determine the added value of key industry players, baby boomers in a recent Dalbar study ranked financial planners first, followed by stockbrokers, CPAs, mutual fund companies, insurance agents, and commercial bankers, respectively. Even if you are a CFP™ or investment advisor and despite the proliferation of investment advisors, evidence suggests that your individual impact is still narrow.

Furthermore, a Prince & Associates study of 778 affluent individuals, each with more than 5 million dollars to invest, examined the relationship between clients and their providers of five key financial services: retirement planning, estate planning, investment management, executive benefits, and health-disability insurance. Prince found that 59 percent of the clients had been serviced in only one area by a particular advisor. Despite the significant assets of each client, the advisers have been unsuccessful at broadening these relationships—a key indicator that many affluent clients do not have a primary financial adviser.

Among the challenges you face to broaden your influence is to offer your clients value-added services, perhaps by establishing your expertise in the medical niche and capitalize on being different. You must not be just another of the more than 250,000 or so individuals who claim to be financial planners, with a collective uni-

verse of an additional 700,000 or so who purport to be financial advisors, in some fashion or another. You must begin to develop the strategic competitive advantage of practice management knowledge to synergize with your existing financial service and product line.

Integrated practice management and financial planning will also become much more competitive among physicians because of the above professional fusion. No one is suggesting therefore that you abandon your core financial advisory business for business management. It is merely a fact that medicine has drastically changed during the past decade, and the knowledge that you used yesterday will no longer be enough for you to get by on in the future. Medical practice management is the natural outgrowth of traditional financial planning services, and investment advice, in turn, is central to the implementation of a contemporary medical office business plan. The most successful financial planners therefore, will be those who incorporate practice management services into their practices.

[D] Insurance Agents and Counselors

As a registered health underwriter, insurance counselor, long-term care or life insurance agent, it seems that almost every insurance agent is also acquiring a general securities license, or CFP™, in addition to the CLU or ChFC after their name. Currently, about 240,000 life insurance agents, down from more than one million in 1965, are being pressured to move toward financial planning, as distribution of insurance products over the Internet spreads like wildfire. Meanwhile, the same insurance and investment companies that are knocking on your door are also courting the medical professionals with their practice enhancement programs. Even if you are not interested in going into the financial planning business, you have seen the status of the American College erode of late, even as your own business has declined because of the World Wide Web and various discounted insurance companies. And, in the eyes of your former golden goose doctor-clients, you may have become a charlatan and everyone is clamoring for a piece of your insurance business and cloaking it in the guise of the contemporary topic of the day; medical practice management and financial planning. Think this is an exaggerated statement? An October 1997 survey conducted by Deloitte & Touche Consulting Group of New York, found insurance agents ranked last in having the trust of a wide selection of the public!

But, how do you regain this lost trust, and what about this new entity known as managed care. How do you learn about it at this stage in your career? What ever happened to the traditional indemnity health insurance, with its deductibles, co-payments and 80/20 patient responsibility? It was so easy to sell, provided good coverage, and the agent made a nice profit. As an insurance agent, all you want to know is, can I still sell insurance and make a living? Like the struggling collateral advisors above, you find yourself asking, how do I talk the talk, and walk the walk, in this new era of insurance turmoil? Slowly, as you read, you become empowered with knowledge and ideas for new insurance product derivatives that actually provide value to your physician clients. You are no longer just an insurance salesman, but a trusted risk management advisor. You have avoided the managed care ripple effect.