RECORD, Volume 23, No. 1*

Palm Desert Spring Meeting
May 21–23, 1997

Session 37PD
The Business of Medicine 101

Track: Health
Key words: Health Maintenance Organizations, Finance

Moderator: JAMES N. ROBERTS
Panelists: JOSEPH O'HEHIR†
JEFFREY WINTER‡
Recorder: JAMES N. ROBERTS

Summary: This session provides an overview of the business of medicine from both a hospital and a physician viewpoint. This overview focuses on factors critical to the process of a hospital or physician group, including:

- *Definition of mission,*
- *Impact of uncompensated care,*
- *Impact of Medicare and Medicaid,*
- *Typical fixed and variable expense structure,*
- *Definition of services covered/size of operation,*
- *Contracting issues and relationships with commercial carriers and managed care organizations, and*
- *Scheduling and capacity management.*

Mr. James N. Roberts: As actuaries, many of us are involved in either implementing or creating exotic schemes for reimbursing providers in unique ways, and our goal is generally to try to get the most economically efficient payment mechanisms in place that we can, generally looking at them from the point of view of the payers because they tend to be our clients. In this session we attempt to reverse that perspective and look at it from the point of view of the providers of health care services—to learn how they function as a business. The health care delivery system businesses are very complex, obviously, and there are many

*Copyright © 1998, Society of Actuaries

†Mr. O'Hehir, not a member of the sponsoring organization, is Chief Executive Officer of California Pacific Medical Services in San Francisco, California.

‡Mr. Winter, not a member of the sponsoring organization, is Assistant Vice President, Mergers and Acquisitions, of Columbia/HCA Health Care in San Diego, California.

business aspects that we could explore, ranging from merger and acquisition to operations issues.

We're very fortunate to have two people who represent the two biggest segments of the health care delivery system, at least in terms of dollars: the physician side and the hospital side. I'll do this introduction in two parts. The first presenter is Joe O'Hehir. Joe is the CEO of the California Pacific Medical Services organization, which provides services to a very large multispecialty physician practice.

Let me make a couple comments about the organization. It is a nonprofit, mutual benefit corporation currently representing partnerships between the physicians who make up the California Pacific Medical Group and the California Pacific Medical Center in San Francisco. That organization serves 172,000 HMO enrollees and manages over $200 million in capitated or at-risk payments. So as you can see, they already function in many ways as an insurance company and are probably larger than some of the insurance companies that we ourselves may represent. California Pacific Medical Services provides administrative services to the Brown & Toland Medical Group. I will let Joe describe anything else about his background that may be important. He has been in the health care management business for 24 years and has been involved in many aspects of that as a business.

Mr. Joseph O'Hehir: Many of you may deal with organizations like ours, and what I would like to do is give you sort of an inside look, a peeling back of what a physician services organization looks like and how we try to help what you do—those who work with medical groups—which is try to explain to physicians what clinical and financial responsibility really means. Are there any physicians in the audience? Good, because when you talk on these subjects you have to qualify who's sitting in the audience, and so we don't have any doctors. How many work with medical groups? Have you worked with medical groups as actuaries? And how many have worked with hospitals? It's about 50/50.

I'm going to try to also give you a glimpse of what Jeff and I have been talking about, the risk-sharing arrangements that go on between hospitals and medical groups. I'll try to give you the physician's perspective, but many times when you work with hospitals and medical groups that are looking to assign risk, you play a very key role, the way we do. We're referees on how the physicians and the hospitals have to split the capitated premium payment coming in. In many cases when we write these risk-share agreements we usually put in some type of dispute resolution by an expert, and that usually means an actuary. So you do play a key role, as you'll see, in our organization. I'd like to give you a snapshot of the business side of what it takes to run a physician Individual Practice Association (IPA).

One of the things I really want to impress on you is that my role and our organization's role is to be a background management company for the physicians. We truly want physicians and the providers of care to focus on what they do well, which is practice medicine. Certainly with the complexities of managed care and their signing risk to providers it has become very complex, very confusing. What we try to do in a management structure representing the medical group is to take care of all that. We're sort of the background production company so that most of their time and effort as physicians is spent doing what they want to do which is practicing and providing care. That's really why they chose their profession. This business side has really been complex to them, and what organizations like ours try to do is help them understand this risk management that they are taking on.

There's a full bowl of alphabet soup in health care. We are what's called a management services organization (MSO). Some are fairly well known, mainly the publicly held companies, the management companies, such as Mulliken, Med Partners, Fycor, and it really depends on an MSO as to who started it and who owns it. What I'm going to describe to you is more the private side of this, which is really why we're there—by and for those local physicians as a provider organization, as a provider network, for the provision of care in that local health care community. We're in business, first and foremost, to make sure high-quality care gets provided by this physician or provider network. There are other companies that have become publicly held, large companies looking to do this regionally and nationally. I'm going to give you a glimpse of what a local and a regional system looks like.

There are several players in this equation. Again, this may be fairly basic for some people, but it always helps me describe how complex the movement of money and premiums is in our field. In our case we really look at our customers as being the employers. In the city and county of San Francisco there are about 600 employers. We certainly have Medicare and Medical; so, we have government. Those are sort of the ultimate payers. As Jim mentioned, we manage about 170,000 enrollees. These are the contracted health plans, of which we manage about 14; therefore, we manage the enrollees, and we take a premium. We take the premium from the health plan basically to manage all the health care needs and services of that particular population we're assigned, which is in this case about $200 million worth of health care premium.

Our MSO is the management structure. We're sort of the administrator; we're the business arm for running this provider network. We have about 225 employees, and as I'll show you, it looks very similar to many of the companies and some of the health plans that you may work with. We have a medical group that has 1,250 physicians. It's an IPA, and I'll give you a glimpse of that. We also have a unique situation: this past year we have integrated the University of California–San

Francisco Medical Center and their medical group into our provider network, along with Cal Pacific Medical Center, which is an affiliate of Sutter Health. We were one of the first that sort of combined community hospital-based physicians with faculty-practice-based physicians in a particular provider network. So this is kind of the schematic, if you will, of what really goes on in the health care network that we manage in the city and county of San Francisco.

As merger mania hits in all expanding or rapidly changing markets, this one is very similar. To show you what a small world it is: Jeff worked at Children's Hospital years ago when he was starting in his profession. This, in fact, is one of the foundations of the network that I work with now, because Children's Hospital merged with Pacific Presbyterian Hospital back in the early 1990s, and at the same time the complementary smaller IPA or medical groups merged. In San Francisco, as I'll show you, I think we're now up to almost calling them Stage 6 and Stage 7 managed care markets, where the market is really matured in the sense of who the provider and deliveries are. There are only a couple of major networks in the city and county of San Francisco. We and Kaiser really control almost 96% of all the HMO business that flows through the city, and it's really these types of mergers that are continuing. So as the health plans have merged, the same critical mass has been occurring both on the hospital system side that Jeff will show you from Columbia and on the physician side which is really what I'm talking about here. You have setting up and getting doctors involved in running businesses.

I'm not sure what your particular market segment looks like, but San Francisco, as Jeff would comment on, is a pretty mature, growing, managed care market. About 50% of the estimated six million lives in the San Francisco Bay area are in an HMO program, and usually most of these, because of the sophistication of the providers that we represent, are in full-risk health plans (Table 1). So the health plan is taking in the premium from the employer and the administrative fee—anywhere between 15–22%—and the rest is going to groups like ours. They basically assign all of that risk, both clinical and financial responsibility, to us as providers. I'll give you a glimpse of how that works, but that gives you a feel for the market. So it's a fairly mature—if you looked across the country—managed care market but one that many people feel much of the country will be moving to because prepaid health plans are certainly working in San Francisco.

TABLE 1
SAN FRANCISCO BAY AREA ESTIMATED MARKET SEGMENT

	1994–1995	1996
HMO	2,881,700 (45%)	49%
Other Insured	1,462,300 (23%)	19
Uninsured	1,266,000 (20%)	19
Medi-Cal	723,000 (12%)	13
Total Population	6,333,000 (100%)	100%

Much transformation is going on in northern California. What we're trying to do is help physicians—I'm going to talk mainly about physicians—really taking them as the little mom and pop businesses that they were, and putting them into organizations so that they are thinking now about economy of scale and an economy of skill; but we still want them treating their individual patient. Now they're part of an organization that takes responsibility for serving a population, obviously very similar to the populations that many of you analyze and provide as the data that help them understand what taking risk is all about. So we really moved, and health care is still a local business. However, it is going through a process or a transformation that is looking more at managing the population, not just individual lives.

What's the impact? What does this type of driver of managed care really mean to a market like San Francisco? Well, it's become competitive. You have a high level of consumer expectation when you're in a developing market, and many of the citizens in San Francisco, one out of every four, is in an HMO plan. They really understand HMOs; they understand the product much more. We have an educated consumer. The risk arrangements, though, are really just settling out, but we're sort of an advanced risk model where the health plan is still the intermediary. Of course, the other model out there is more of what I call a direct market. We're still in an indirect or a wholesale market on the provider side, but yet, nonetheless, we're seeing most of the trends that are occurring in managed care. Ninety percent of the care occurs outside of a hospital, yet one of the most expensive portions of the delivery system is the hospital portion. In managed care the whole idea is to keep that population healthy, not even get them in to use the demand for services, but at the same time there's a suspicion of profit-driven denial of care.

A point is reached where people are saying, “Great, but it's gone way too far,” and here was fee-for-service, here's where full risk has gone or, if you will, where capitation has gone. Somewhere in between really is where it will ferret out, we hope. But this is the type of impact that managed care and full-risk capitation has had on a marketplace, and as an advancing market, I think this is what we're finding from the employers. We began to see in San Francisco a decrease in premiums,

and now they're starting to go up slightly. As we talk to the employers, they're saying, "You know, we've had a really good cost reduction right here, but we're getting a little tired of the employees complaining about denial of care." Now, that really isn't occurring, but it's the market perception that drives how you have to manage your business.

So, where cost has been king in managed care in San Francisco, in the advanced stage quality is now the crown prince that's really going to take over the monarchy. We're hearing many things looking at outcomes, health status. We have Kaiser as the major player in northern California driving outcomes, but outcomes are really more based on how customers, meaning the patients or the enrollees, are served in a customer satisfaction way on the convenience and access to physician services and health care services. Obviously a very important message when you deal with organizations like ours is that information is the power behind the throne. In managed care, as in any type of business of this nature, the person who controls the information controls the marketplace, and what we try to do is get physician organizations to understand this. If they're going to take risk, they have to understand the population. Just as you analyze the population, they have to understand the risks they take. There is a belief that many things that have worked in other businesses are now being applied to health care. It's a $1 trillion industry, and, unfortunately, it has not used good, sound business principles and good service principles, and that is what the success of managed care can bring to health care. If you focus on quality of care, the cost in savings and efficiency will come. This is just basic good business sense.

Just a word about the organizations. I'm a tennis player; I took this job as CEO about two years ago, and I have two corporate partners, the hospital and the medical group. I never knew what it was like to be the tennis ball going back and forth between those two organizations. You have two organizations that usually have to partner together either economically or strategically but really run under two different missions. Governance and control are things that are more—sometimes much more—important than economics because a good deal of struggle is going on for who controls the delivery of care. It has led to evolutions of organizations and structures that you, as actuaries, will deal with, and these are just some of the basic, natural occurrences.

The mission of a physician is to keep people out of hospitals. The mission of a hospital is to increase their admissions because they have to pay for the bricks and mortar and the structure. You have just the basic, natural competitive nature. Many of you probably have to deal like I do in cases where you try to work out a risk-share agreement between these two. It's very difficult, because each sees only their own side. They can't seem to walk in each other's shoes. So, I empathize with

actuaries who have to do what we do in the sense of trying to describe the economic partnership when it's mainly about emotional control and governance issues. It’s very difficult to do. Jeff and I were talking about that at lunch. These are some of the things that really drive risk-share agreements. They really come down to why there usually are dispute resolution mechanisms between the two parties.

Just a word about management structure. You do need to start an MSO fresh for a doctor group. It takes about $5–6 million. Most physicians don't have that type of money. Remember, they're small mom and pop business owners. They look and need a franchisee or a franchiser to have the capital structure to build the business structure they're looking for. In many cases it is the hospital or it is a major player such as Columbia. In our case the local hospital said, Yes, we're going to put money and capital and an information system together because we want these doctors locked in and hopefully remembering us to refer the patients to.

Our hospital is a 501(c)(3) not-for-profit, and the medical group is a for-profit medical professional corporation, but they've had a pretty good partnership. They've had a five-year exclusive risk-share arrangement between them, and they did management services agreements so that we have an economic flow of operations to run the MSO. So many times the hospital is the capital partner or the seed capital player, and what we do is start building the administrative services that you need depending upon how much risk you're taking as a medical group. You obviously have to go out and contract with health plans. You must have an information technology system. You have to adjudicate and pay claims. So basically you start to replicate what a health plan offers, but when you're going to take on risk these are the types of departments and services you need. We mirror what a health plan does. As we started to take more risk on, we had to add many of the things that you see with the health plans—eligibility, credentialing. We've been delegated by the health plan to perform all functions. Basically, the health plan says you have the market figured out from a provider standpoint. You get the premium. We'll give you everything but our marketing and administrative fee, and you guys manage it, and, in fact, we negotiate quality incentives.

Basically, when National Committee for Quality Assurance (NCQA) comes in to audit a health plan they don't go to the health plan. They come to our medical group because we're, in fact, fully delegated for those responsibilities. We do pharmacy management, outcomes assessment, and so on, and what you start to see in a management company for a physician group that's taking full risk is a structure very similar to the companies that maybe many of you work in. You have a marketing arm, an operation—in our case medical management is where we have to do oversight—and we're responsible for ensuring the quality of care for every

enrollee. You have a finance department managing, as I mentioned, over $200 million. We become the payer. All the money comes in, and we disburse the money and administer the money out to the providers, and you're running about a $20 million cost supporting this.

You start to look at other business opportunities within a group. We have what we call a macro-strategy in which we manage the IPA and try to get the contract and get all those revenues for the doctors. The IPA or the medical group can only be successful if the individual doctors' offices, as franchisees, are successful, so we offer practice management services. We also have people that go in and help organize the doctors because their practice is no longer really run the same way in a risk environment. It's cost efficiency, and we go in and help them with practice management because we have to have every one of those physicians, particularly the primary care ones who are the care managers, be successful in this IPA. You must have the most successful primary care physicians. In fact, we've been able to have our physicians make more money under capitation than they did under fee-for-service. Then we had to prove it. You have to invest in the infrastructure of the business to show them that, in fact, prepaid capitation is a better way for them to manage their business and their professions, but you can't just hand it to them because they don't know what to do with it. You have got to provide the services and the support mechanism in an organization like that.

Next, I'd like to share some numbers with you, how could I not show numbers, right? Table 2 gives you a profile of HMO enrollment. Remember, we were a startup. We're a not-for-profit. Our mission in the MSO is to maximize the provider revenues and minimize the administrative costs. We started out with about 60,000 lives at the beginning of 1993. The hospital Jeff started with had its own health plan. It was sold out to a health plan that later became Health Net. So there was a base of business, around 60,000 lives. It has grown very significantly, and this jump was the result of adding the integration of UCSF; which I'll show you what that strategy meant from a market share standpoint, but first I'll talk about critical success factors. You have to have the market share, the number of enrollees in a market to be able to drive a good, high premium obviously with the health plans. We take about 10% of the premium spent on administering when the physicians take full risk. I think that is very important to note.

I love it when health plans talk about medical loss ratios. I hope that nobody's from a health plan—I should have probably qualified that. But, I think, in our case a health plan takes 15%, 18%, 20%. It still costs the medical group another 10%. So the true medical care cost from that premium is in the 60% range because we have to replicate many of the functions when we take on risk, and that's really the way things are going to be in the city, in San Francisco. The employers are saying, Now,

if we divide this money up, who's doing what, and why are we replicating some of these things? This is what we're trying to work out, but it's being driven by the employer. These are the resources required to run an organization like that. As I mentioned, we try to minimize our administrative structure so that most of the money stays with the providers of care.

TABLE 2
CPMG/BTMG HMO ENROLLMENT

	Actual	**Budget**
Jan '93	60,921	60,875
Mar '93	65,956	60,875
Jun '93	75,664	60,875
Sep '93	79,883	60,875
Dec '93	83,520	60,875
Mar '94	93,038	85,489
Jun '94	97,610	87,120
Sep '94	100,322	90,878
Dec '94	103,135	92,957
Mar '95	114,734	106,000
Jun '95	119,590	109,000
Sep '95	122,865	112,000
Dec '95	125,478	115,000
Mar '96	131,011	137,872
Jun '96	131,969	143,801
Sep '96	133,835	132,376
Jan '97	169,143	166,693

I just want to briefly mention from our experience—and we're in our fifth year of operation—what we have learned: what are critical success factors for provider organizations—physician provider organizations—to succeed and thrive in a managed care marketplace. As I mentioned, market share is very critical. Managed care is a zero-sum game. Either you have the membership or somebody else has it, and you have to retain that and grow that enrollment. I'll show you what that has meant: you have to differentiate yourself. In our case it's access and convenience. Many people now want direct access to specialists. So you have to be able to manage that. As I mentioned, information services is really what it's all about. If you have the information on that population, and very much of it comes from your profession, it helps the provider understand when they manage risk. They have to understand the economic analysis and impact as they make their care decisions. Our job is to constantly use information technology to automate for efficiency. That's where the money can be shifted. We want to pull it out of administrative expense, not the cost of care.

As I mentioned, when you're managing a population you want each individual physician to take care of his or her patients, but you have to look at population trends. You have to look at certain needs. In our case we look at special care needs of populations. Almost 1.5% of our population has the human immunodeficiency virus (HIV). That's a very significant risk factor for us. We look at asthma, at seniors, and at congestive heart failures. You have to really understand what your population need is from a medical perspective. One of the things that we're trying to struggle over with physicians is the satisfaction surveys that we send back to them. Kaiser really drove this. The physicians went to school, they received degrees, and they think they're being judged on their technical merits and their ability to treat and diagnose people, but really the consumer judges them on the level of service. You look at how quickly it takes you to get an appointment. What does it take to park there? How do I get my results back? What's the paperwork hassle like? That's how consumers pick health care, and what we're trying to do is educate physicians that, yes, you have to be the top medical care provider, but you also have to recognize you're in a service business, just like an airline is, just like a hotel is. They hate to hear this, but this is a basic fact of what is going to drive health care toward the future. Of course, in this business you have to have sufficient funding to run an organization like this, and you have to get the providers to commit to have it.

Now, some examples of what we've been able to do. A key figure we look at is the enrollment growth. How is it maintaining? This is behind UCSF integration, why we went ahead and did it. We found that people in the city said they want both Cal Pacific and San Francisco. We want them within the same network. We don't want to have to go out of network. So we were able to combine in the city the managed care network that was Cal Pacific and UCSF, ending up with four hospital campuses and over 1200 physicians. So, basically in the city in every zip code you have doctors and you have hospitals, and that's what consumers want for convenience and access.

What does that mean from a business strategy? The HMO population is a two-horse town when it comes to providers. You have Kaiser representing their plan, our major competitor, and, the employers will pick three or four of their health plans. Chances are they're going to have Brown & Toland as one of their providers. So this is the type of consolidation that happens, and you're really up at a 50+% HMO market penetration.

Information technology is the most expensive side of our business, as I'm sure it is for yours, but of course many of you work for companies that understand that. Doctors don't. They still use little ledger journal books in their practices, and we're trying to put PCs in and make them come on to the Internet. This is a real challenge

for us, making them understand the importance of information, taking it from all those charts and X-rays and trying to automate it for efficiency. Just think, it is such an advanced profession, but it is so archaic in the area of computers. It's just amazing. I don't want even to have been in health care. It's better if they come from some of the other industries that have had very good experiences in point-of-service information gathering.

So this is the way the system used to traditionally look. You had a central system. But now we have an Ethernet set up in which we have both an Internet and an Intranet. We have all 250 primaries on-line to the management services company, and we have the hospitals on-line. This is what it is about, but I have to be very candid with you. It is an imposing educational process to people who traditionally took a profession and just want to take care of patients. You have to help them through this, and you have to convince them that this will make their profession better.

Much work is being done around NCQA and quality measurements. Employers want to know the health status and how we're taking care of them. What preemptive work is being done? Preventive care is very important now. Most of health care money is shifting more toward preventive care—immunizations, breast screens, cervical cancer. These are the rates, the benchmarks, that employers are saying they want to know before they choose you as a provider. We're seeing a good deal of continuous quality improvement and total quality management. These are new to medical groups and the medical profession, but they have to learn what the business of medicine is about. This is very important as you build these types of physicians' networks so that they understand when they're accepting risk. They have to have quality improvement programs. They're very receptive to it, but you have to realize most of them have never really done this before.

Just a word on contracts because I know that you get involved in this aspect of it many times with some of the provider groups. Our goal is to maximize the provider revenue while minimizing expense and maximizing the market share. We look at enrollment marketing, selective product decisions, and the shared risk contract between the primary two players, the hospital, and the medical group. In the contract negotiations, we sit as the facilitator between the hospital and the medical group. That's usually where you're called in for your actuarial analysis. How to split up the capitation premium. We're trying to create a contract that promotes the quality of care and cost savings, but they're big items. In the case of our hospital and Cal Pacific, 40% comes from the full-risk premium revenue, and it's always interesting.

Many of you are probably familiar with this, but this is the basic economic partnership we try to really look at. The HMO cap dollars come into the MSO. We split it according to the way the risk share is set up between the hospital and medical group. Dollars go into a hospital fund. They pay for the administrative fee. Then basically you have a responsibility matrix of services: what the hospital is responsible for. In this case, in our hospital system, they also have the ancillary services. They do much more than just the inpatient or acute care. On the physician side they have all the physician services—in this case, outpatient, and ancillary—and they set up risk pools. They try to reduce cost because the big reward in this business is to reduce inpatient days and length of stay, by the use of economic risk pools. This is really what it's all about, getting the incentives lined up because the physicians are the ones who control 80 cents of each dollar that's spent. They make every decision. The hospital is a site of care, a very critical site of care and a very cost-impacted site of care, but the physician is the one who decides where the patient is treated and how they're being treated. So you want to make sure the incentives are lined up so that the physician and the hospital actually have their risk protected by having the physician understand their responsibility, and that usually goes through incentives.

We try to build an interdependent team approach with our physicians. Mike Abel is the president of our medical group. He's a colorectal surgeon, one of the best in the country. He's a very dynamic physician executive leader, and I don't go in and tell him how to do colorectal surgery. My responsibility is to try to run the business side of his profession, and teamwork allows us to do it. The more physicians realize this, the more they're going to understand when they accept risk, and they understand the financial and clinical responsibility of their profession. So, you always have to set up trust and communication, and in my case my biggest job is to educate physicians on the business of medicine. If you can do that, you can build market leadership in a county such as ours. It takes time, but it's possible.

Jeff and I were talking about what our profession is all about. I'm a believer in quotes, and there are two that to me always describe life in a management services company. One is Churchill's definition of history, which was "one damn thing after another." The minute we think we can take a breather, some other issue comes up. Then, of course, in the case of us being the background production company, the physicians are on center stage. They do nothing wrong. Therefore, for us, our security on earth is the MSO. There's just opportunity.

I just want to part with a statement that I think describes what a physician is really about in this country. This is a quote from a famous American who really, I think, defined managed care. This famous person said the doctor of the future will give no medicine but will interest his patient in the care of the human frame, diet, and the

cause and prevention of disease. That's what managed care's all about. I found it very interesting that this was said by Thomas Edison a long time ago. But that's what we're trying to do in the business of medicine, to get physicians to take care of the patients and the population. I think managed care is one of the most important aspects and elements of the history of this industry.

Mr. Roberts: Our next presenter is Jeff Winter. Jeff is an assistant vice president, mergers and acquisitions, for Columbia Hospital Organization. Jeff is a Californian. He's been in the hospital industry here for his career, primarily hospital administrator and then for the last few years in a mergers and acquisitions capacity.

Mr. Jeff Winter: I assume I don't have to do much introduction, although I will do some about Columbia. Jim asked me to present to you all, and I took a look at the predetermined topic, the business of medicine. There are probably few organizations that focus more on the business of medicine than Columbia. If you look at how health care in general has been transformed over the past 25 years, since diagnostic-related groups (DRGs), risk contracting, the emergence of HMOs, and physician group consolidations, and how it has intensified even further over the past ten years, at least, and maybe I'm biased, but my sense is that Columbia has had a fair amount to do with pushing health care and markets along the change curve.

I want to talk to you about Columbia, who Columbia is, some of the frames of reference and paradigms that I think make us an unique in the industry, the kind of things that we look for some critical factors of success going forward for our organization, and what we believe it's going to take to survive in the industry. You probably all know already that Columbia is the largest health care organization in the world today. That's not chest-beating. It's just a matter of fact. We're a $20 billion organization. We have in excess of 350 hospitals now around the country, and that's a particular paradigm that I'd like to dismiss. Columbia is actually far more than just a hospital company, although clearly that's where the majority of our revenues come from today, although I think that's changing going forward and certainly the most tangible part of our asset base. If you look at what we are across the country, we're actually the largest provider of home health care now in the southeast with acquisitions in California such as, the recent purchase of Value Health and a couple years ago Preferred Provider Organization (PPO) Alliance. We just made a major investment in a cable TV health education channel. So we're looking at all aspects of the continuum with the idea of creating a continuum to allow us to go into markets and serve all of the needs for a defined population under one contract stream of revenue.

As I mentioned, we have in excess of 350 hospitals, and in excess of 150 outpatient centers now. Columbia is the tenth largest employer in the U.S. Surgical procedures are in excess of two million. We have $20 billion in annualized revenues and supply cost in excess of $2.6 billion. One of the things we've been very good at is utilizing these numbers to the advantages of the affiliates within the system. You can imagine that the ability to purchase $2.6 billion a year in supplies gives us considerable leverage in terms of pricing and ability to ultimately pass through that cost to the payers and the physician groups we have to work with in order to be more competitive than the people we're competing against for market share.

There are a couple of basic tenets. The status quo is clearly unacceptable in every market. We even have a hospital, a large tertiary facility in eastern Idaho, where there is no managed care. Physician consolidation has not occurred yet. Frankly, the hospital's doing extremely well, but even there we know that market won't stay stable. It won't stay static. At some point managed care will penetrate that market. Physicians will start to consolidate. We will have the same types of struggles for market position that we have in markets like California. So the status quo is clearly unacceptable going forward.

We need to continue to be consumer driven and customer driven in all of our markets. We need to organize our continuum of services. For example, in the current marketplace Kaiser, you may know, is looking to change their paradigm of care into contract for institutional care rather than provide it all under one umbrella. They're doing that with the concept that they're also marketing $75 and $80 individual premiums out on the street, and they can't continue to provide the infrastructure to serve those enrollees at that price with what they have. So they're looking to buy it cheaper. Clearly, where they can purchase those services from an organization like Columbia or Brown & Toland or whoever, with added value to their enrollees, that is what's going to drive those decisions. To the extent that an organization like Columbia can bring both quality as well as cost-yielding value to organizations like Kaiser, and the ultimate purchasers of care, that's where market shift is going to go, and we want to clearly be positioned to take advantage of that.

Let's discuss superior performance and core competencies. What do I mean by core competencies for an organization like Columbia? The ability to deliver low-cost care, the ability to have sustainable systems of care in the community, those kinds of systems that are not going to be at risk in the market because of low capitalization, and that's very much not the issue with us. If you look at California, 50–70% of the health care systems in California are on narrow ground in terms of stability on their balance sheets. All of our organizations in California or those that

partner with us, because of our capital resources, are debt free from an individual provider standpoint.

Our ability to create pricing within the market to move market share and for those arrangements to be sustainable is far greater than that of an individual stand-alone organization, and, ultimately, the ability to measure everything. Joe talked about that. Probably nothing is more crucial today in health care than—and we're still very new at this, the industry is in general—the ability to put in place information systems that are very expensive, to be able to monitor quality, outcomes, and cost. This is absolutely critical and, again, is something that few individual organizations can do on their own. This is really where we get much of the advantage of having a large system.

Those of you who work for large companies know there are disadvantages of working for large organizations, the fight for bureaucracy and all the rest of it, but we do everything we can to bring the advantages to the fore for Columbia and obviously focus on management, focus on being disciplined, and following a low-cost, high-quality vision sustainable across all markets, with strict adherence to our vision using skills developed in one market to build an advantage in the other market. For example, if we have an emergency room that does a great job in serving the customer, serving the health plans in Illinois, turning those patients around in less than an hour, we can use those skills on another one here in Orange County that's taking two-and-a-half hours for the patient to get in and out. Those are the things, like Joe said, that we're going to be judged on in the market, judged on by the health plan, judged on by the consumer, and judged on by the physicians who are utilizing our service.

Again, one of the advantages of a large system in trying to take that down to the individual facility level and raising the bar for all participants involved is executing in a disciplined and focused way, although some people have said that Columbia's sort of the Pac Man of the industry. It's really quite untrue in a sense that we have very disciplined investment parameters, disciplined strategic focus in particular markets on the kinds of affiliates that we want to partner with or bring into our system. Particularly in advanced markets like California the last thing in the world that we're looking to do, and I think the last thing, frankly, that most people are looking to do, is just take on willy-nilly a set of bricks and sticks that isn't going to get us where we need to be in terms of positioning ourselves in a defined market at the end of the day. I've seen many organizations that have done that over the past 10–15 years, but that's always been the mind-set of hospitals and health care systems. In the past, the more you build, somehow or another the better your system is going to be, and that's clearly not the case in today's market. In fact, if anything, it's shifted just the other way.

Systems to document quality and efficiency couldn't be more critical. At the end of the day, as markets continue to consolidate, as hospitals continue to close, as physician groups amalgamate, as larger players emerge, and now instead of a market like Orange County and its two million people where they probably have 30 hospitals and who knows how many physician groups, at the end of the day all that will be left is probably eight or ten hospitals and maybe 15 or so large physician groups. At the end of the day everyone's going to be able to take only a certain amount of the premium dollar. We're all fighting now for different pieces of the dollar, and a hospital here in particular moves from one organization to another sometimes by maybe the difference of $50 in a per diem price. That can't continue forever. Ultimately, the providers are going to increase their leverage through consolidation. There's going to be a balancing between the plans and the providers, and there'll be fewer abilities for the payers to negotiate one against the other. Most important then, as the pricing pressure evens out in the marketplace, what is going to create the differentiation?

If you're fortunate enough to position yourself in a market where you can be one of the end-stream players, then you have to say, What am I going to do at that point to get that Pacific Care contract or Kaiser contract or whoever from the competitors that are still going to be there? That's going to be quality, and not only the ability to give lip service to quality, because everyone does that today, but the ability to actually prove quality through definable, measurable, statistical presentation of outcomes, and that's why the investment in that infrastructure is so critical today. Those who are doing it today are going to position themselves for ten years out.

It is a challenge to operate effectively in the uncertain environment, making the most of our industry position, again, leveraging size, using skill, keeping strategies on course, taking advantage of momentum, although I have to admit that in the past year our momentum has waned slightly in light of all the stuff everyone reads in *The New York Times* and *The Wall Street Journal,* although if you read *The Wall Street Journal*, I think we're starting to turn that corner.

Local management needs to drive development from operations, a critical factor for focus within Columbia. Although development from mergers, and acquisitions and operations are two distinct recording structures within the company, we don't buy a hospital. We don't partner with an organization. We don't do any of that—building to our continuum—unless operations is in sync with it and knows what their performance requirements are for that organization going forward because their feet will be held to the fire. So it does create within our organization a joint decision making between the two different sides of the company that says this acquisition or this partnership is strategic, it makes sense, it amplifies our other assets in the market, and we can hit the return on investments criteria for the investment we're

making in this new piece of our organization, and that the value that we pay for it clearly accrues to the rest of the organization.

One of the most fascinating things about Columbia is that it's grown so quickly; of course, it's always an ongoing struggle, and we're still maturing as an organization, clearly, but for the most part we need the ability to manage the diversity of the different cultures. You can imagine the kinds of management styles that a company we may have acquired brought to the table versus a company like Columbia, and the challenge of ultimately bringing all of those different pieces together into one organization that has a similar mind-set in the 36-some-odd states and hundreds of markets that we operate within that arena. As I mentioned before, one of the key advantages of working with an organization like a Columbia is shared resources. Why would some nonprofit organization in Oklahoma join a system like Columbia other than the capital resources, the ability to take out debt, the ability to position themselves, to be part of a large information base, and so on? One of the key reasons is that we take a look throughout the whole company in terms of what works best within hospital operations, within both the hospital and the physician side of the component, in terms of leveraging our PPO and HMO relationships around the country. Even though California is quite advanced in some ways, I think we're very insular in the way we think that the world ends at the Arizona/Nevada border. The reality is that the payers are often multistate payers now, and the ability to develop those long-term relationships and leverage our position from one state to the other is something that helps all affiliates in the system. Again, we benefit from the ability to measure and to export around the company best practice examples within the organization.

Of course, we encourage active involvement of constituencies and employees in the legislative process. This is because we’re the tenth largest employer in the state and the fact that not-for-profit and for-profit mergers, acquisitions, and conversions are clearly up against considerable legislative scrutiny now. That we have those positions, that we have the resources to be active in the lobbying agendas of those individuals shaping health care policy throughout the country does, we believe, give us a leg up.

When you put it all together this is really what it comes down to for us. First, there are no home runs in health care today. It's a complex, convoluted industry. Joining an organization like Columbia and saying that we have a magic pill to make it all better is absolutely false. No one has that, and we tell folks that all the time. But it's a whole series of efforts and tactics that hopefully will take you to the position in the marketplace you want to be. What works in San Francisco, what works in L.A. or in Chicago, is different in each instance. I think most of you know that. We start on the foundation with quality of patient services. We absolutely believe that is

what's going to create market differentiation and success. We spend $200 million a year on information systems within Columbia, and that's just the ongoing evolution of our system, not all of the dollars that have been invested to create the foundation.

When we took over, for example, the Good Samaritan system in San Jose, they were lauded in *Information Systems* magazine for putting this new $35 million information system in their four hospitals. That system was going to attempt to create some of what we have developed in information technology. We went in and for under $10 million were able to export all of the proprietary systems that we've been able to develop, and the systems that we put in are not only focusing on cost containment or financial accountability, they're also focusing on clinical data and clinical outcomes in terms of all the kinds of things that Joe was talking about as well that are so critical to be able to communicate value. You lay on top of that comprehensive services, that is, when we go to talk to Pacific Care or Kaiser or Health Net or Blue Cross, we want to be able to bargain at that same contracting table for all the things that we can reasonably provide to one defined group of enrollees in order to gain ultimate leverage and continuity within the system and to serve the health plan well.

I can tell you that today, as operators in health care, that physician integration is where it's at. It's figuring out how the relationship should work between the physicians, the hospitals, and the health plans. Everything else is fairly easy when you get right down to it. Going forward, the organizations who do that the best are going to be the ones that are in the best positions in their marketplace.

Geographic accessibility is important. Honestly, the more portals of access that we can provide to the community, the better. Competitive pricing, and in many cases the pricing that we've had to look at, may have actually been below our cost. Now, that's not unique to Columbia. I guarantee you that any hospital, at least in the state of California, that's taking a $700 per diem is operating below its cost. Every hospital out there in order to survive, at least in the short term, believes they have to price themselves in that arena. Well, that's fine when you have 10% of your business at that level. What happens when it starts becoming 50%, 60%, 70%, and 80%? Now you have a tough time of it. What happens next? Markets consolidate. Hospitals close, merge into one another. Physician groups consolidate and come together. And ultimately pricing pressures are allowed to creep back up, and you have more of a balance. It's no different from what happens in every other industry. Using science to our advantage, and ultimately we believe if we do all of these things, do them well and do them in the right order, that will—we will—be the strategy of choice for health plans in the market.

Some key points that we believe in terms of what successful organizations need to be about. You have to keep your eye on the ball, to stay customer-focused. What does it take to partner or be a good provider for an IBM, for a Shell Oil, for a Pacific Care, for a Health Net, or for Dr. Smith? Provide for market-based decision making. Act fast and stick to the vision. This is probably one of the key assets that Columbia has going for it in defined markets. We don't have a huge bureaucracy. We can make large decisions with basically one phone call when it exceeds a certain manager's limit. There aren't committees. There aren't many constituencies that we need to get involved for every key decision that needs to be made quickly in a market. So our ability to move quickly in markets and make decisions and act on deals quicker than many others has enabled us to grow much quicker.

You must successfully manage the quality cost equation. I think that will be truly the difference between success and failure going forward in the market. Fight bureaucracy every day and, again, have a bias toward action and taking risk.

The issue always comes down to fish or cut bait, but you can't just sit there in the boat and ponder that decision for 10 or 12 months. The market is moving very rapidly, you know that what's going on now between providers and health plans, physician groups, is to create longer-term relationships. It's no longer the situation where you just put a contract in place for 12 months, and then if no one cancels it with 90-day notice, it just rolls over. Now, Pacific Cares and Health Nets are forming ten-year agreements, and they're very serious, long-term relationships where they're wedded—parties are wed to each other over time. So, again, decisions have to be made quickly when the windows of opportunity present themselves.

I'm going to go very quickly here on a couple of key things just to try and blow away some paradigms that may be in your minds. One of the things that we always hear and I encounter all the time is that Columbia's owned by Wall Street, or organizations like ours are owned by Wall Street, and so that means when we go into a community, and we attempt to facilitate a relationship with a St. Joseph's or another nonprofit organization, one of the things we're always told is, well, the money gets all sucked out of our community, goes back to Wall Street, and you rape and pillage our hospital. Now, there's nothing further from the truth. Clearly, these are not aggressive takeovers. They're all relationships that are built based on mutual consent. If you look at all the partnerships, we have 25 partnerships now across the country where we've brought really the best of the nonprofit world and the for-profit world together in these partnerships, maintaining the missions, maintaining the charity care policies, doing all of those things, and yet wiping out the debt, creating debt-free organizations that are competitive in their marketplace, and every single one of those partnerships, the oldest one being, I think, about six

years old now, is still sustainable, still doing well, and excelling in their market. The reality is, of course, that our company is owned by many of the people that you all deal with, retirement plans, mutual fund organizations, probably many of you in this room.

Another myth that we always deal with is that we're pulling all this money out of the hospital. Again, that doesn't happen, and we pay two cents per share per quarter or eight cents per share from Columbia to dividends. Frankly, the only reason we do that is if we didn't, we wouldn't be able to have many of the mutual funds that invest in Columbia stock participate because of their own rules and regulations. Everything else, every other dollar of cash flow that we produce, is reinvested back into the hospitals and the health systems that we operate.

Let's look at facts about mergers. In 1996, there were 705 hospital mergers and acquisitions between nontax-paying hospitals. Only 63 were involved in publicly held hospitals. So although we often get the handle that Columbia is the one creating these trends and making much of this happen. The reality is we're just responding to the market, and we're trying to find opportunities to make sense of it for our organization where we can. The reality is all this is happening in the market because of all of the trends and dynamics that Joe and I have been talking about.

Facts about quality are always an interesting area, too, because I always hear that we're responsible to Wall Street. We're not responsible to the local community. We don't care about quality. All we care about is profits. The reality is you don't have profits without quality. It's as simple as that. It works that way in every other industry; it's no different in health care. If we don't provide good services to the physicians, guess what? There's another hospital system down the street. If we don't provide good service to the payers so that your premiums can be competitive to consumers, we don't get that business. And if the patients aren't satisfied, they're not going to come back to the hospital. They're going to be upset with their physician. Quality is absolutely and clearly a basis under which we have to operate, and our surveys show that. Ninety-four percent of the people who come to Columbia hospitals are extremely satisfied with the level of quality.

Let's look at facts about capital. This is always an interesting one, too, because if we're pulling all the money out of our hospitals and our health care systems, how is it that when compared on a national basis, we're actually providing 41% more annually back into the hospitals, nonprofit community hospitals in the marketplace?

Moving in to facts about price: again, just in general, we work very hard to get our costs in a position to form economic relationships with the physicians so we can

drive cost per patient or per unit of service to a lower level than the cost of our competitors in order to build market share and to serve our constituents better.

You figure uncompensated care and the issue of charity care in, I'm assuming, when you look at risk premiums and help hospitals and physician groups figure out what they can do and what they can't do in terms of risk. Do you all understand the issue about charity care in hospitals and physician groups? I'm not sure everyone does, because what I always hear is that people think that somehow we have the ability to manage that, that we can put a policy in place that says, well, we're just not going to take any charity care. We won't deal with people who don't have the resources. First, that's protected by federal law. Under the Consolidated Omnibus Budget Reconciliation Act of 1986 law, all hospitals that operate emergency rooms, if a patient shows up and requests to see a doctor, have no choice under federal law and would be subject to penalty and fines. Second, I would guarantee anyone in this room that Sharpley/Staly Health Care, the nonprofit health care system we were involved with earlier last year, has a hospital in La Jolla. The hospital in La Jolla, I guarantee you, takes significantly less charity care than a for-profit hospital does in National City, or in San Diego. It's very much a function of location, and that's what drives charity care by and large. Again, back to the uncompensated care. It's really the same issue, but basically it just goes to show what we've actually experienced, at least in our system, after a not-for-profit organization becomes part of Columbia, that charity care goes up just slightly in terms of a percent of net revenues.

Overall, I hope I did give you a bit of a feel for Columbia's organization and some of the trends and facets that are going on in health care and what we're doing as part of an organization to try and drive forward some sensibility in the industry and position ourselves for the long term.

Mr. Thomas D. Burgess: I think I heard you say that the keystone for business success is to actually affect medical outcomes and to document that improvement. My question is, What is your strategy for achieving that?

Mr. Winter: The investment that we're making today is really twofold. Our ability to manage costs in the health care system as managers goes only so far. In fact, I would say that if 100% is the optimum for managing costs, we're probably only 20–25% there. All the rest of the ability to manage cost, which ultimately get to identifying and measuring outcomes, will come from our ability to partner with physician groups. The physicians, just by virtue of their role, control 75–80% of the cost in health care. Cost is one part of the equation. The other part of the equation clearly is clinical outcomes and measurement. The investment that we're making in information systems and technology is being made in the hospital, in the home

health agencies, in the rehab centers, and in the physician offices. The concept within Columbia is ultimately to create an on-line medical record that would be one seamless medical record both for the physician office and for the hospital and from that extract standards of clinical performance that allow physicians and hospitals to measure each other—to measure themselves against each other and then ultimately to document that for the public, for payers, for anyone else to see, and compare that data against our competitors.

From the Floor: Does that pre-assume that the problem with not already having good, positive medical outcomes is just that doctors don't know what to do, and if they had more information on what to do, there would be better medical outcomes?

Mr. Winter: I think there's probably much good information for physicians to have that's focused on clinical outcomes and success factors, for example, in diabetes. I don't think there's much good information yet out there on creating value-oriented health outcomes where physicians have the ability to look at clinical outcomes both from a clinical perspective as well as a cost perspective, ultimately translating that to value for the consumers.

From the Floor: Also, when I said earlier that I heard you say that improving outcomes was of paramount importance, it is really cost-effective, positive, medical outcomes that you're talking about.

Mr. Winter: I think that's a much better way to say it, yes.

From the Floor: It's taken for granted that if we put an infinite number of resources into it, I suppose to the resources that are already being input, medical outcomes would already improve. So what you're looking for by way of being a business success is to have better outcomes for less cost.

Mr. Winter: Yes.

From the Floor: Or maybe the same outcomes for less cost.

Mr. Winter: Yes.

From the Floor: Less cost seems to be more important than the medical outcome now.

Mr. Winter: I think they're both equally important, and I think also that what's often been shown is that if you compare the two, you may well end up having

better clinical outcomes as a result because often more resources or more cost connected to those resources does not necessarily improve outcomes.

Mr. Hau T. Doan: My question is directed to both speakers. I thought I heard from both of you that a critical aspect of health care today is how to properly align incentives for the physician and the hospital partners. Given that there's only a finite amount of money involved, would you give us some guidance about how to develop some good criteria for determining what should be the fair share in a risk-sharing arrangement, how you can appropriately divide up the money?

Mr. O'Hehir: We're in our fifth year of a risk-share agreement, so I could at least speak to our experiences. One of the elements of success is you have to do a bottom-up as well as a top-down analysis. My personal experience is that the bottom-up approach is important because that's when you determine the responsibility of the services, and I think that's really what we have found factually. Who is providing the care? Who is responsible for the care? What is that site of care, whether it's the physician's office or a hospital? Who has the most direct impact on the decision making? What we try to do when we work is to build a bottom-up responsibility service matrix, and you then are analyzing the cost information you'd have over the past years of experience on that population. We assign a cost for each one of those responsibility services boxes. Fortunately for us, with 170,000 lives in our fifth year, we have millions of bits of data from claims information and cost experience on our population. So what we try to do is look at the trends over the last two or three years, identify the responsibility matrix, put it under the physicians, put it under the hospital, and basically try to do a matrix buildup from the bottom up, and then you're taking a top-down in the sense of what premium you are taking into the group. In our case there are two contracts. There's a full-risk agreement, but two checks come in from the health plan. In California you have to separate the hospital services and have a contract with a hospital. So the two checks come in, and then what we really end up hassling over is the difference—the spread, if you will—between the premium coming in and what actually the cost of care is in these two responsibility areas, each of the major organizations being the physician and the hospital. That's usually where we go for independent assessment of what are fair market rates for the services, and that's where many times we use actuaries such as Ernst & Young or some of the other companies that come in and help us determine fair market value or fair market rates so we can do the split of what would be left over from the top-down versus the bottom-up.

From the Floor: If I may have a follow-up question, you said that you would do a bottom-up cost analysis, for example, once the responsibilities are clearly delineated. That cost obviously is historical cost, however defined, I assume that

between the hospital and physician side there must be some agreement about an acceptable level that you could recognize as valid in terms of determining the risk share. So would that be a critical element of the analysis? For instance, let's say there's a dispute from the physician side, objecting to the historical hospital cost, and even if it's managed, it could be managed down, but the cost-per-day is part of that cost and physicians think it's too high—but an amount is necessary in order to determine what the fair share is. I assume you have an agreement on that, right?

Mr. O'Hehir: We do, and the way it usually works out, to be very candid with you, is that we get down to that one box that is usually the per diem rate or the actual per diem rates, and that's usually when we look for independent advice. Usually the agreements are set up, if the two parties can't reach an agreement, an independent third party comes in and presents—and, in fact, it's binding—a decision on what those rates are. It comes down to those critical couple of boxes, and, of course, usually it's the inpatient hospital costs because traditionally some of the hospitals don't have as much of the data that, say, a physician group does in the sense of tracking their actual service costs.

Mr. Winter: I would just add one more comment to that. When Joe spoke earlier about the forging of those relationships and the agreements or disagreements that are involved and how most of that is based on ego, emotion, and desire for control, he really hit the nail on the head, because too often as providers we focus on splitting up the piece of the pie that the health plans are allowing us to argue about among ourselves, and that's all—that's where the focus is. There are health plans in the state of California that are operating at 72% medical loss ratios. Now, no one can convince me that it takes 28% of the premium for the health plan to do what a health plan should do, and obviously built into that is profit for the health plan. Built into that is redundancy of services in terms of quality management, utilization oversight, and all the rest of it, and there are really very few organizations even in a market as advanced as California that have been able to come together between the hospital and the physician side effectively enough to where they've balanced those dynamics and to have a sustainable long-term relationship to where they can then go back and leverage the health plan for what I call that 9% or 10% or possibly even more percent of arbitrage that's available between what really should be a medical loss ratio and what everyone claims is there. I think going forward that's where the real opportunity will be.

From the Floor: This is just a quick follow-up to his question. In your paradigm where you go to third-party negotiation, essentially, are you willing to share how often you do that? And then my follow-up question to that would be, if you're willing to share that information, from your perspective as the CEO of your

company, how many of those third-party outcomes are satisfactory from your point of view?

Mr. O'Hehir: I'll be very candid. Every time we used to go to a third party it usually was not an economic issue, but it came down to, as I was mentioning, control or governance. We're usually very satisfied because we are trying to sit in the middle as the administrator. Usually what happens is we're somewhere between two and five points apart on what we call the premium split. The actuary usually can come in and help at least define where each party is. Usually what we try to do is get the parties to take the difference, and it usually comes down to about two or three points, and put it in a risk pool. Then, if the budgets run the way they are, there are ways that either side can recover. So we usually agree up front that whatever the third party comes up with is a binding resolution. I think that's very important. And yet they still want to continue to debate, of course, the binding resolution, but we usually are very pleased with it, and it's usually a verification of where we are. It's such a volatile issue that it's that independent sort of third party, unbiased—and I really think that is true—that allows us to finally get these deals done. It really comes down to that almost every time because of the nature of the competitive environment and these one or two points. When you're up around $200 million of premium it's quite a good deal of money to both sides.

From the Floor: To continue to follow up on the same issue, based on the way you explained the split being done based on the expected split of the cost of providing service, which, in turn, is based on historical cost of service, it would seem then that either the split is not at all based on the risk that the parties each incur or it's just assumed that the risk is exactly proportional to the expected cost. Certainly a dollar shortfall is not going to affect a doctor the same way it's going to affect a hospital. It's not going to affect two hospitals the same way depending on their fixed versus variable cost and the way they're structured and so forth, right? So, you just don't bother to look at risk because it can't be quantified?

Mr. O'Hehir: No. We try to look at risk, and I think that's where the risk pools come in. In fact, the hospitals realize that when they do put these risk pools together that they're taking the risk for the inpatient care, if you will, and receiving the premium, but, as Jeff was just saying, the doctor makes the decision. So by aligning the incentive with a risk-share agreement to protect their downside risk or to protect their risk, then most of these incentives are aligned so that if there is a surplus in the pool, it goes to the physicians. It's a way that the hospitals actually have to protect their risk.

Mr. Winter: I would agree. From the hospital's standpoint it's sort of a reverse paradigm, but in one way the more dollars that are given back to the physicians in

the risk pool, theoretically, the more successful everyone will be because the physicians are the only ones who can drive down hospital utilization and resource intensity. Those are costs then that are taken out of the hospital side of the equation, and the physician should be rewarded for that.

Mr. Roberts: I'd like to ask Joe a question. You made a comment that I found somewhat intriguing, that under your firm's management the physician's business became more profitable under capitation than under fee-for-service, which is kind of counterintuitive since you're taking a layer off the available dollars, and presumably the volume of services may be somewhat constrained on the physician side. So I wonder if you could give us a little discussion on why that particular dynamic happens or what you do to make that happen.

Mr. O'Hehir: Jeff and I were talking about this before the session. One of the more critical success factors is the physician leadership role and their enthusiasm for embracing managed care. As an example, our belief and philosophy is that physicians lost control of their profession to the insurance carriers because they weren't managing or providing information that allowed people to understand what the cost of care was about. So we and our board, in a leadership role, were able to convince the physicians that to take back clinical and financial responsibility they really had to manage their business. They put together and invested in information systems, quality review committees, and utilization management committees. We put together hospitals that help manage more efficiently inpatient care. The physicians set a discipline among themselves. They also were very prudent financially. They put together incurred but not reported tables and accrual type of accounting mechanisms. They were just very financially prudent, and what they did is they managed themselves very tightly, but then they had surplus at the end of the year that they distributed to those that performed very well on providing the top quality care. So they ran under budgets. They ran very well-disciplined financially, they had large surpluses at the end of the year, and they put the money back in the physicians' hands. When you take on risk one of the critical success factors is to get the risk down to the level of the person who really is making the decision on what's provision of care. They capped their primary care physicians very early on. They've done budgets and risk pool budgets for each specialty. So I think what they really did was take some ability to realize that if they managed their profession well, that actually increased their pay. As an example, they achieved almost 150% of resource-based relative value schedule equivalency for their capitation because they've been able to successfully negotiate very high premiums with the health plans and manage their business that well. These guys are actually the highest-paid physicians, and their success is due mainly because they put their own good management disciplines in and then really sort of did a peer-type review and peer performance.