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I. INTRODUCTION

Over the past decade, the health care industry in the United States underwent significant changes in its quest to reduce rising health care costs while continuing to provide quality service. Historically, health care services were provided by a physician in a solo practice, by a single unaffiliated hospital, and by a traditional indemnity insurer. The emergence of managed care organizations (MCOs), physician practice management companies (PPMs), hospital systems, and integrated delivery systems (IDS) changed the


2. MCOs seek to control health care costs while continuing to provide quality care. They accomplish this by controlling the cost, volume, and type of health care services their enrollees—individuals enrolled in their health care plan—receive. There are many types of MCOs—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service plans (POS). First, HMOs are the most cost effective and the most restrictive to enrollees, essentially requiring enrollees to receive all of their health care services within the plan. Enrollees must choose a primary care physician from among those participating in the plan. Then, the primary care physician will control their use of medical services within the plan. Second, PPOs are less restrictive, since they allow enrollees to seek health care outside of the plan for a higher cost and do not require a physician to control the use of services by a patient. Overall, however, PPOs cost more than HMOs. Third, POSs are essentially HMOs that cover out-of-plan health services. POSs require a primary care physician, but they still provide reduced coverage when an enrollee seeks specific health services outside of the plan. See Thomas C. Fox et al., *Health Care Financial Transactions Manual* § 11.02 (1996). When this Comment refers to MCOs, the statement applies to all forms of MCOs. When this Comment refers to HMOs, the statement specifically addresses HMOs. This Comment will focus on HMOs, since they are the most controversial and the most mature type of MCO.

3. A PPM provides various types of services to physicians within its network. Some PPMs are more sophisticated in the services they provide than others. Services include, but are not limited to, billing, access to sophisticated information systems, and equipment provisions. See Andrew J. Demetriou, *Physician Practice Management Companies: Structures and Strategies*, in *Health Care M&A: Commercialization of the Medical Industry* 605, 609 (PLI Law & Practice Course Handbook Series No. A-741, 1996).

4. A hospital system involves the consolidation, through acquisition or joint venture, of for-profit and not-for-profit hospitals, thereby creating financial benefits through economies of scale, increased purchasing power, and stronger combined volumes. These benefits give large, for-profit hospital chains a strong competitive advantage over not-for-profit hospitals. See Nationsbank, N.A., *Health Care Industry Review &
delivery of health care in many areas of the country. These new health care organizations face business, industry, regulatory, and legal risks that may affect their profitability. Prudent lenders will be concerned about these risks and will incorporate an analysis of them in their evaluation of potential borrowers. Since part of the lender’s analysis should include an assessment of legal and regulatory risks, the involvement of attorneys is essential.

This Comment provides a broad overview of the health care industry with a focus on the business, industry, legal, and regulatory risks that effect the profitability of HMOs and PPMs. Lenders who understand these risks will be prepared to analyze a potential health care company borrower and to decide, based upon that analysis, whether or not to extend a loan. With a better understanding of the industry and its associated risks, attorneys will be more effective negotiators, contract drafters, and advisors for their clients, whether those clients are lenders, health care companies, or physicians.

With a view towards providing information to lenders and lawyers, this Comment will explore the health care industry and the risks associated with lending to two specific types of health care companies. First, this Comment will focus on the evolution of HMOs and PPMs within the health care industry. Next, this Comment will focus on the strategic and financial risks of HMOs and PPMs that must be

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5. An IDS is created in the health care industry when hospitals, physician practices, individual physicians, and MCOs combine or affiliate. Together these entities become more competitive, achieve greater financial viability, and improve the quality of services to patients. See Douglas A. Hastings, Physician-Hospital Integration: Beyond Contracting Models, in HEALTH LAW HANDBOOK 3, 3-4 (Alice G. Gosfield ed., 1995) [hereinafter Hastings, Integration].

6. Health care is delivered through several complex segments. The following is a broad overview of the various segments and where HMOs and PPMs fit in. Health care providers include: acute care hospitals, rural health clinics, and physician groups—including PPMs. Post acute care providers include: long-term care, home health care, rehabilitation, outpatient facilities, and psychiatric care. Third-party payers include: insurance companies, Medicaid, Medicare, and MCOs—including HMOs. Suppliers include: clinical labs, drug makers, pharmacies, and medical supplies. See FOX, supra note 2, § 16.01-.07. MCOs, such as HMOs, are a hybrid of providers and third-party payers that are positioned to play multiple roles in health care. They currently dominate health services in many areas of the country. See id. at § 11.01-.02.

7. Some areas of the country responded to the emergence of managed care more quickly than others; subsequently, the penetration of MCOs tends to be higher in those areas. In 1994, North Carolina ranked 37th in terms of HMO penetration by state. See STANDARD & POOR’S, INDUSTRY SURVEYS HEALTHCARE: MANAGED CARE 6 (Oct. 17, 1996).

8. See infra notes 14-86 and accompanying text.
Both HMOs and PPMs are important to banks, because they need significant amounts of capital to fuel their acquisition strategies, to build sufficient information system networks, and to meet their working capital requirements. This Comment will then consider the industry, legal, and regulatory risks that may also affect the profitability of HMOs and PPMs. Finally, this Comment will consider lessons that might be learned from Coastal Physician Group in light of the risk assessments discussed in this Comment.

II. PPMs AND HMOs IN THE HEALTH CARE INDUSTRY

In order to fully assess the risks that may affect the profitability of HMOs and PPMs, it is important to understand the development of the current health care system. In that regard, a detailed review of HMOs and PPMs, which are considered to be two primary components of today's health care system, is in order. First, HMOs emerged in response to the demand by employers and individuals for lower health care costs. In many states, HMOs successfully penetrated the health care market, reaching over twenty percent of the

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9. See infra notes 87-178 and accompanying text.
10. Traditionally, lenders provide capital through credit vehicles such as term loans or lines of credit. It is important to note, however, that many HMOs and PPMs turn to the capital markets for additional forms of financing. The capital markets provide HMOs and PPMs with access to investors through the public debt and equity markets. Lenders such as NationsBank can also provide their clients with access to the capital markets through their Section 20 subsidiaries—NationsBanc Capital Markets, Inc. See, e.g., MEDPARTNERS, INC., 1996 QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934 FOR THE QUARTERLY PERIOD ENDED SEPTEMBER 30, 1996 (1996) (describing the use of capital markets financing vehicles). Both investment bankers and lenders need to understand the business, industry, legal, and regulatory risks of HMOs and PPMs. This Comment focuses specifically on the risks that need to be understood by lenders.
11. See infra notes 179-331 and accompanying text.
12. Coastal Physician Group (Coastal) is a PPM that ran into financial trouble in 1995. In 1997, Coastal's financial problems still exist.
13. See infra notes 332-73 and accompanying text.
14. See NATIONS BANK, N.A., HEALTH CARE INDUSTRY REVIEW & OUTLOOK 3RD QUARTER 1996, at 19 [hereinafter NATIONS_BANK 3RD QUARTER]. Hospital Systems are the third major component within the health care industry. See id. A discussion of this complex area is beyond the scope of this Comment.
15. Employers have been the primary driving force behind the growth of managed care. In the past, many employers paid all of the healthcare premiums of their employees to insurance companies and MCOs. Presently, many employers require employees to pay as much as twenty to forty percent of their health insurance premiums. In addition, employees make co-payments on items such as drugs and office visits, which reduce the costs to the HMOs and physicians. In the past the average co-payment was five dollars, but recently it has been increased in many instances to ten dollars. Telephone Interview with Andy Bressler, Healthcare Analyst, NationsBank, N.A. (Jan. 30, 1997).
United States by 1994. Then, PPMs emerged in response to the penetration and the power of HMOs and other MCOs. PPMs allow physicians to band together under professional corporate management in order to create efficiencies, increase bargaining power relative to MCOs, and increase physician profits.

A. Emergence of HMOs and PPMs

In the traditional doctor-patient relationship, employers and employees paid a premium to insurance companies who, in turn, paid physicians and hospitals on a fee-for-service basis. Therefore, those physicians who maintained a strong recurring relationship with their patients by providing quality health care obtained a loyal patient base that generated strong profits. Each patient was allowed to select his or her physician; thus, a physician had an incentive to provide quality services in order to foster a strong relationship with each patient. In this traditional system, physicians determined health care utilization and prices, and, by so doing, they collectively proceeded to charge hundreds of billions of dollars for health services. Health care costs grew from about six percent of gross domestic product in 1967 to approximately fourteen percent in 1995. Believing health insurance premiums were too high, employers and unions pushed the health care industry towards managed care.

MCOs emerged as a way to reduce health care costs by reducing the price and volume of health care services. They gained direct access to patients and shifted profits away from physicians. Cost-conscious employers, who saw health benefits reducing their bottom

16. See STANDARD & POOR'S, supra note 7, at 5-6. MCOs cover more than seventy percent of all employees nationwide. See Leigh Page, Employers Look to Managed Care to Rein in Benefit Costs, AM. MED. NEWS, Feb. 19, 1996, at 5.
18. See id. at 6.
19. See FOX, supra note 2, § 19.02.
23. See FOX, supra note 2, § 11.02.
line, fueled the growth of cost-saving MCOs.24 In an MCO structure, fee-for-service billing is replaced by pre-arranged fee structures and utilization review procedures.25 Employers pay a lower premium to the MCO than they would to an indemnity insurance company.26 MCOs then pay physicians and hospitals a lower fee for health services or a fixed capitated payment.27

Unlike the relationship between traditional indemnity insurance companies and physicians, in which the patient selected any doctor and the insurance company paid the bill, the MCOs' and patients' relationship with physicians is filled with restrictions. MCOs contract directly with physicians individually or through Independent Practice Associations (IPAs), and pay them a reduced fee-for-service.28 A physician's pool of potential patients decreases significantly if the physician is not a member of a managed care provider network.29 Patients who are covered by an MCO are limited to selecting among physicians with whom the MCO contracts in order to receive maximum coverage under their health care plan.30

In the case of HMOs, for example, enrollees receive services from a group of physicians with whom the HMO contracts. The physician that a patient selects is known as the primary care physician or "gatekeeper."31 In essence, a patient is "locked in" to the HMO.32 In

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24. See Bill Alpert, Getting Doctors to Work for You: Physicians are Selling their Practices; Should We be Buying?, BARRON'S, Aug. 26, 1996, at 15. As of 1995, seventy-one percent of all workers with employer-provided insurance were enrolled in MCOs. See STANDARD & POOR'S, supra note 7, at 12.

25. Utilization review is a process by which a third-party payer, purchaser, health care organization, or utilization review contractor evaluates the necessity or appropriateness of medical care on a case by case basis either before or after the treatment. See BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 364 (1991).


27. A capitated payment is a flat fee paid per patient per month to cover specified health services without regard to the actual number of services provided. See HENRY H. PERRITT, JR., HEALTH CARE LEGISLATION UPDATE AND ANALYSIS, § 3.10 (1996). Global capitation from HMOs places physicians or physician groups at risk for all health services including those provided by subcontractors. See Sage, supra note 26, at 18.

28. See Alpert, supra note 24, at 24. An IPA is similar to a PPM, but the practice managers merely assist the physicians in their dealings with MCOs and do not acquire the physician practice. See id.

29. The problem of patient decline looms large for non-affiliated physicians, since a significant portion of the U.S. population is enrolled in managed care plans. See FOX, supra note 2, § 11.01.

30. In fact, in order for an employee to receive maximum coverage, the employee may be required to make co-payments or deductible payments or both for some items.

31. See FOX, supra note 2, § 11.02.
other words, "if the enrollee chooses to go outside the HMO system for medical care, he or she typically will be responsible for the full cost of the service." Therefore, a patient will almost always choose a physician from among the HMO's provider network. Thus, pressure has been placed on physicians to contract with MCOs and to be placed on their preferred provider lists in order for physicians to retain patients and have access to a larger pool of new patients.

However, revenues received by physicians for services rendered to MCO patients are, in general, significantly lower than traditional fee-for-service revenues, thereby reducing a physicians' per patient profitability. As a result of reducing revenues per patient, physicians realized that they needed to focus on cost containment. Many sole practitioners found cost containment difficult in light of the high costs associated with running a medical practice. Clearly, a physician practice must receive fees adequate to cover operating expenses in order to be profitable. Few physicians, however, had the bargaining power necessary to obtain higher fees for services from MCOs. Thus, physicians were forced to accept lower fees in order to gain access to patients. These factors illustrate that the physician market was ripe for integration and consolidation, which led to the emergence of PPMs.

Physicians and physician groups are responding to the power of managed care organizations by affiliating with PPMs. The PPM segment of the health care industry is poised for rapid growth. There are close to 650,000 physicians in the United States, and less than five percent are affiliated with PPMs. In addition, it is estimated

32. See id.
33. Id. In contrast, if the MCO is a PPO, then the patient simply pays more for the out of plan service. See id.
34. See Julie Johnsson, Solo Practice: Down Not Out, AM. MED. NEWS, Feb. 19, 1996, at 7 [hereinafter Johnsson, Solo Practice].
35. See id.
36. Physicians are fragmented, with seventy-five percent practicing in groups of ten or fewer; therefore, physicians have limited or no power against MCOs. See MedPartners (visited Feb. 4, 1996) <http://www.researchmag.com/company/profile/cpmptr.htm>.
37. See McDowell & Brown, supra note 17, at 3. Affiliation with physician practice management companies is just one of four primary options. The other options are affiliation with hospitals, affiliation with HMOs, affiliation with insurers, or the "development of physician-controlled managed care strategies, such as the consolidation of group practices or the development of physician-governed IPAs and networks." Id.
38. Since approximately twenty percent of physicians work for medical schools and universities, the actual number of patient care physicians is lower. See American Medical Association (visited Feb. 5, 1996) <http://www.ama-assn.org/meetings/public/i96/reports/cms9i96.htm>.
that physicians generate $200 billion in revenues each year and influence up to $800 billion. The goal of PPMs is to put doctors back in charge of medicine by freeing them from the more complex business concerns. PPMs purchase the assets and liabilities of the physicians and, in-turn, provide management services in exchange for a management fee. The physician practice continues to exist as a separate legal entity. The PPM acts as a middleman between the MCO and physicians. A PPM will have experience with managed care markets and access to volume contracts. As a result, physicians have greater access to MCOs and greater bargaining power with them.

PPMs provide several key resources to physicians, thereby enabling physicians to increase competitiveness and achieve success in today’s health care environment. First, PPMs provide increased access to investment capital necessary to maintain and grow a practice. Second, the business and management expertise of PPMs reduces administrative hassles for physicians. Third, PPMs offer physicians economies of scale, which decreases operating costs and increases purchasing power with suppliers. Fourth, PPMs can provide physicians with access to the powerful information management systems that increasingly play a central role in the health care industry. Finally, through affiliation with PPMs, physicians are better able to capture new patients through access to national or regional managed care contracts and contracting support programs.

In general, PPMs provide a vehicle through which physicians can compete for profits against MCOs more equally. Their size empowers them with the economic strength to bargain with MCOs in order to be certain that the clinics are included on the MCOs’ provider lists.

40. See McDowell & Brown, supra note 17, at 3.
42. See McDowell & Brown, supra note 17, at 4-5. After the acquisition, the PPM serves as a management services organization for the physicians. Id. at 5.
43. See id. at 4.
44. See id. at 8.
45. See id. at 8-9.
46. See id. at 7. A solo or small group physician practice relies on bank debt for capital, but a PPM has access to the capital markets and is usually large enough to command more favorable rates on debt from banks.
47. See id.
48. See id.
49. See id. at 8.
50. See id. at 8-9.
and to allow them to negotiate better fees or capitation arrangements for the clinics. PPMs are positioned to be most effective in markets in which managed care dominates, especially those in which MCOs make capitated payments to physicians. Often the threshold for physician integration through the formation of a PPM is met when capitation reaches twenty percent of the market. Therefore, the growth of PPMs is tied to the growth of MCOs in many markets.

PPMs are effectively able to increase profitability when they are engaged in managed care arrangements through capitation. With increasing frequency, HMOs are shifting the risk of health care costs directly to the physicians through capitation, which increases physicians' exposure to the risk of increasing health care costs. As of 1995, seventy-six percent of primary care physicians, forty-six percent of specialists, and thirty-four percent of hospitals had some capitated contracts. PPMs benefit because they usually receive a percentage of their physicians' income, which may be higher due to their ability to negotiate better capitation arrangements.

HMOs and PPMs engage in power struggles for access to patients and increased profits. Many are for-profit corporate organizations which are publicly traded. As such, the management of these organizations must answer to shareholders and Wall Street analysts. HMOs replace the traditional indemnity insurers and take on insurance risk. Simply put, HMOs are profitable when their costs are less than their premium revenues, and their costs are driven by the type, volume, and cost of medical care received by their enrollees. These medical costs are influenced by physicians, but HMOs have controlled the costs by paying reduced fees-for-service or capitated payments. PPMs, when they receive global capitated payments also take on insurance risk. If the type, volume, and cost of the

51. See id. at 7-9.
52. See Jaklevic, supra note 20, at 27.
53. See id.
54. See NATIONS BANK 3RD QUARTER, supra note 14, at 19.
55. By passing the risk of increased health care costs to the PPM, the MCOs also pass the ability to increase profits to the PPM. In that situation, the PPM is essentially acting as an insurance company receiving a capitated premium. For a detailed explanation of capitation and its consequences, see infra notes 208-19 and accompanying text.
56. See Physician Reimbursement, 1995 HMO-PPO DIG. at 12.
57. In general, capitation arrangements can be particularly profitable for physicians when a PPM is involved, since the PPM assists the physicians in managing their costs, which is the key to profitability in a capitation arrangement.
58. However, many indemnity insurance companies are adding HMOs as a product line.
59. See Sage, supra note 27, at 18.
health care given to the patients are higher than the capitated payment, the physician will lose money. Therefore, the organization which has access to more patients has the potential to be less risky and more profitable since those patients with higher costs will be offset by those with lower costs. In order to gain access to more patients and increase their efficiencies, power, and profits, these health care organizations need to grow, and, therefore, they often turn to consolidation as their primary growth vehicle.

B. Other Important Current Developments in the Health Care Industry

The health care industry is moving towards the integration of health care financing and delivery through IDSs. An IDS may include physicians, hospitals, HMOs, indemnity insurance, and other additional services. There are at least four different categories of integration occurring simultaneously: (1) hospital collaborations and affiliations; (2) physician practice integration; (3) physician-hospital integration; and (4) provider-payer integration.

Financial integration indicates the sharing of profits and losses. If segments are financially integrated they are usually operationally integrated, but the reverse is not necessarily true. PPMs provide an example of financial and operational integration. They organize physician practices into larger groups and share in the profits and losses through contractual arrangements with other health care entities and patients.

Health care providers integrate for strategic, economic, service, and legal reasons. Strategically, providers seek to become owners, to increase their competitiveness, to strengthen their negotiating position with payers, to improve the future value of their practice, and to "strengthen their primary care referral channels." From an eco-

63. See Campbell, supra note 60, at 3.
64. See id.
66. Id.
nomic standpoint, providers seek to reduce costs through economies of scale, to gain better access to capital for expansion and information systems, and to increase their profitability. Providers attempt to improve their service to patients by enhancing their facilities, gaining freedom from the administrative burdens of the current payment system, and improving their information systems. Legal exposure is reduced regarding some issues, but integration may actually increase exposure to anti-kickback or self-referral laws.

In response to eroding income brought about by the power of managed care, physicians are increasingly pursuing the following integration strategies: the development of IPAs and other physician contracting organizations and networks; PPMs; primary care groups; specialist groups; multi-specialty groups; hospital affiliations through Physician-hospital organizations (PHOs); and managed care company affiliations. Some physician affiliations have not been successful. For instance, many hospitals did not have the management expertise to successfully operate physician practices, which resulted in a widespread lack of success of PHOs over the last several years. In addition, IPAs have not achieved the level of success at winning MCO contracts due to lack of management expertise, capital, and information systems. Due to this lack of success, many HMOs that had acquired integrated physician practices and hospitals began selling them off in 1996.

Another important phenomenon that has occurred in response to the increased cost of indemnity health insurance and rising health care costs is the emergence of self-insured employers. Today, many employers are self-funded, giving them greater ability to engage in direct negotiating and contracting for health services with MCOs, rather than traditional indemnity insurance companies. The cost of health care coverage for employees is borne by self-insured employers. In order to minimize the costs of self-insurance, the employer contracts with a third party administrator (TPA), which may be an MCO, insurance company, or free-standing utilization review company, to perform utilization reviews. The TPA also provides many

67. See id.
68. See id.
69. See NATIONS BANK 2ND QUARTER, supra note 4, at 17.
70. See Jaklevic, supra note 20, at 27.
71. See NATIONS BANK 2ND QUARTER, supra note 4, at 17.
72. See FURROW, supra note 25, at 363.
73. See id.
74. See Mark E. Lutes & Ann Leopold, ERISA Perspectives on Managed Care, in
of the other services such as claims processing typically provided by insurers, but TPAs assume no insurance risk. The employer compensates the TPA to administer the employer's health plan. The contractual structure of agreements between the TPA and the employer along with the compensation creates ERISA issues. In a utilization review, a TPA prescreens the medical necessity and cost-effectiveness of specific medical, usually surgical, procedures to be performed and suggests alternative procedures in appropriate cases.

C. The Uniqueness of the Health Care Industry

The health care industry is one of the largest segments in the US economy, accounting for about one-seventh of the annual gross domestic product. The CBO estimated that total national health care expenditures reached $1 trillion in 1996, and is expected to exceed $2 trillion by 2007. Federal and state government spending on Medicare and Medicaid in 1995 was approximately $350 billion. The government has a huge stake in the industry, for financial and social policy reasons. However, health care service providers are highly fragmented, and this fragmentation causes inefficiencies, leads to the increase of health care costs, and, subsequently, is a financial drain on the federal government. HMOs are the driving force in the health care industry's attempt to reduce this escalation of health care costs. When PPMs band physicians together, they reduce physician fragmentation and encourage consolidation, which creates economies of scale and reduces overall health care costs.

Regulation of the health care industry occurs at the federal and state level. The federal government commits federal funds to health care through Medicare and Medicaid, and it has exclusive authority

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75. See FURROW, supra note 25, at 363.

76. See Lutes & Leopold, supra note 74, at 361.

77. See id. A critical area of law related to self-insured employer plans is ERISA. For a discussion of ERISA, see infra notes 247-69 and accompanying text.

78. See FURROW, supra note 25, at 364.

79. Health care costs make up fourteen percent of the Gross Domestic Product. See Health Costs, supra note 22, at 2. That is about one-seventh of the total GDP. See id.


82. It is the large percentage of solo practitioners and small group practices that create the fragmented physician market.
over self-insured employers through the Employee Retirement Income Security Act of 1974 (ERISA). In addition, states regulate health care insurance. States also license or certify health care facilities and professionals, but their financial welfare is influenced by federal reimbursement policies such as Medicaid. For the most part, the regulation that currently exists was enacted before the push for more IDSs and the expansion of managed care. Therefore, existing regulations will most likely change in order to accommodate the emerging health care system. HMOs and PPMs need to be able to navigate through these regulations and understand when and how they may affect their future cash flows.

III. BUSINESS LENDING RISKS OF HMOs AND PPMs

A. Reasons HMOs and PPMs Borrow Money

HMOs and PPMs are likely to seek capital in order to grow through acquisitions, to enhance their information technology infrastructure, and to meet working capital needs. When a lender analyzes a company to determine whether or not to provide financing—cash is king. Cash flow is especially important for HMOs and PPMs, because cash is central to their business. They do not invest cash in machinery to manufacture products, rather they manage cash flows within the health care system between employers and physicians. Broadly, lenders must focus on operating cash flows. In addition, lenders must consider the corporate strategy of the potential borrower along with other factors, depending upon the purpose and size of the loan.

One of the more likely purposes of a loan to an HMO or PPM is for an acquisition. Currently, the most prevalent trend in the health care industry is mergers and acquisitions (M&A) including, specifically, horizontal consolidation and vertical integration. Horizontal consolidation occurs when "two entities providing the same product

84. See Perritt, supra note 27, at § 4.11.
85. See Sage, supra note 27, at 10-11. See also Fox, supra note 2, § 2.01-.03.
86. See Sage, supra note 27, at 11.
87. HMOs and PPMs provide value through information management, which requires that the HMOs and PPMs operate large, complex information systems.
88. Commonly referred to as EBITDA—earnings before interest, taxes, depreciation, and amortization.
89. See Sage, supra note 27, at 10.
... merge in order to create utilization and cost efficiencies through volume growth. For example, HMOs often seek additional enrollment through acquisitions in an attempt to become national, regional, or niche product players. "Vertical integration occurs when two entities at different levels merge," so they can integrate delivery of health services and/or payment functions. This may be riskier than horizontal consolidation since it requires management expertise in more than one of the complex health care segments. In addition to M&A, health care companies seek and finance joint ventures as a way to integrate services between hospitals, physicians, and HMOs.

As a result of the current M&A trend, lenders are often called upon to value acquisition targets and finance the transactions. Overvaluation is one of the most common reasons for post-merger integration failure. The acquiring company is unable to achieve the cost efficiencies sought from the merger because it paid too much. With regard to HMOs and PPMs, overvaluation results from the assumption that physician productivity will not be adversely affected by industry conditions and that the new entity could correctly address its underwriting risks. An attorney can add value to his or her service to lenders and to acquiring companies by understanding the business and industry risks and identifying any legal risks that can hurt the target company's cash flows. In doing so, the attorney helps to ensure that the target company is not overvalued.

B. Health Maintenance Organizations

When a lender considers making a loan to an HMO, it must consider the business risks of HMOs and incorporate an analysis of those risks in their due diligence of the specific company seeking capital. An analysis of an HMO should include a look at the following areas: what type of HMO it is, its corporate strategy, its source of revenues, its expenses, its cost-control systems, and the key industry drivers that will effect management decisions. During the course of running the business, management makes decisions which affect one or more

90. Kornreich, supra note 1, at 333.
91. See NationsBank 3rd Quarter, supra note 14, at 7.
92. Kornreich, supra note 1, at 333.
93. See Hastings, Integration, supra note 5, at 3.
94. See generally McDowell & Brown, supra note 17, at 28-40 (discussing the business and financial analysis of PPMs and offering a detailed look at valuation along with opportunity and termination costs). Some of these concepts are also applicable to valuing HMOs.
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of the areas listed above and can reduce the profitability of the company.

Enrollment in HMOs was projected to approach sixty-five million Americans by the end of 1996, which is twenty-five percent higher than the fifty million enrolled at the beginning of 1995.\(^\text{95}\) It is important to note, however, that the penetration of HMOs is stronger in some states—Massachusetts, California, and Minnesota, for example—than others.\(^\text{96}\)

In order for HMOs to be successful in the future, they must define the parameters of their corporate strategy and determine whether they want to be “[n]ational [p]layers, [d]ominant [r]egional [p]layers, or [n]iche [p]roduct [p]layers.”\(^\text{97}\) Players without such strategies risk being acquired by focused players seeking enrollment growth. A key growth segment within HMOs is Medicare.\(^\text{98}\) As the federal government seeks to decrease Medicare’s growth, it has turned to managed care programs.\(^\text{99}\) The HCFA estimated that as of October 1, 1996, four million Medicare beneficiaries were enrolled in HMOs, which accounted for only ten percent of total beneficiaries.\(^\text{100}\)

Before an analysis can be made of the HMO, the lender must identify the type since it may influence the analysis. There are essentially four types of HMOs outlined in federal regulations.\(^\text{101}\) The first is a staff model HMO, in which the HMO employs its own staff of physicians and other health care providers and pays them a salary.\(^\text{102}\) Next is a group practice model HMO, in which the HMO contracts with a medical group practice and pays a fixed, capitated fee for the health services provided to the HMO’s enrollees.\(^\text{103}\) The medical group practice employs the physicians and pays them a salary.\(^\text{104}\) As with the staff HMO, the group practice model HMO’s enrollees seek

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96. See STANDARD & POOR'S, supra note 7, at 5.
97. NATIONS BANK 3RD QUARTER, supra note 14, at 7.
98. See STANDARD & POOR'S, supra note 7, at 1.
99. See id. at 1-2.
100. See For the Record, MOD. HEALTHCARE, Nov. 11, 1996, at 16.
101. See 42 C.F.R. § 417.103(a)(1). There are also state regulations that apply to HMOs. For instance, an HMO must be licensed by the state in which it operates. While a discussion of state regulations is beyond the scope of this Comment, it is important to note that they may need to be reviewed when considering a transaction.
102. See FOX, supra note 2, at § 11.02.
103. See id.
104. See id.
most of their health services from one location. The third model is called the IPA model HMO, in which the HMO contracts with an IPA or a group of IPAs. In the IPA model, physicians maintain their own practices, and the HMO pays the IPA a reduced fixed fee; in turn, the IPA pays its physicians on a fee-for-service basis. The fourth model is the Contract Model HMO, in which the HMO contracts with individual physicians who maintain their own offices and private practices. The HMO pays the individual physicians on a reduced fee-for-service basis or on a capitated fee basis. In addition, an HMO can operate any combination of the models.

HMO earnings are driven by several different factors. Revenues for HMOs are driven by three groups: large commercial customers with more than fifty employees, small commercial customers with fewer than fifty employees, and government sponsored Medicare and Medicaid recipients. Competitive pricing pressures have reduced the premiums received by large commercial customers. At the same time, HMOs have more flexibility to receive higher pricing from small commercial customers who are highly fragmented and geographically diverse. Revenues are driven by the premiums paid to HMOs per enrollee and the number of enrollees in the HMO. In the near future, enrollment growth will be the primary factor in earnings increases for HMOs.

In addition, in order for an HMO to be profitable, it must be able to control expenses. An HMO's expenses are composed of medical costs incurred, the rate of medical cost inflation, and administrative costs. The key indicator of profitability in the managed care sector is referred to as the medical loss ratio (MLR). The

105. See id.
106. See id.
107. See id.
108. See id. It is also commonly known as the “Network” model.
110. See FOX, supra note 2, at § 11.02.
111. See STANDARD & POOR’S, supra note 7, at 1.
112. See id.
113. See id.
114. See id. at 21.
115. See id. at 1. Most of these enrollment gains are expected to come from Medicare. Id.
116. See id. at 21-22.
117. See id. at 21. The MLR involves the utilization of health care services. Utilization is determined by cost and volume. If the utilization is too high, then the MLR could increase to eighty-five percent to ninety-five percent, thereby making it almost impossible
MLR is determined by dividing the total amount of direct medical costs—such as pharmaceuticals, doctors, and hospital-related costs—by the HMO’s premium revenues. On average, a well-run HMO should have an MLR of around eighty percent, in which case eighty cents of every premium dollar is spent on medical costs. This indicates that the HMO has managed its patient base well and accurately forecasted the medical service usage of its enrollees. Remaining expenses include administrative costs such as marketing, billings and collections, database management, and customer service. The “administrative cost ratio” is determined by dividing the selling, general, and administrative expenses by total revenues. This ratio should not exceed ten percent, but depends on the HMO’s operating and corporate strategies.

A well-run HMO incorporates cost-control systems throughout its organization. Cost controls must be established internally in several key areas of the HMO. First, there must be an “ongoing utilization review process for each physician.” Second, “reports comparing actual service usage and forecast utilization” must be generated systematically. Third, “hospital usage for individual patients” must be monitored. Finally, HMOs must control the number of times “HMO physicians refer their patients to other specialists and health care facilities.”

There are other parts of an HMO’s financial statements that warrant mentioning. First, net profit margins for the HMO sector of MCOs currently fall in the tight range of two percent to three percent, with several companies reporting net losses. Those HMOs with “large and diverse membership bases” will most likely be more stable than “smaller HMOs with more focused membership profiles.” Second, an HMO’s earnings can also be overstated by

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118. See id. at 21-22.
119. See id. at 22.
120. See id.
121. See id.
122. See id.
123. See id.
124. See id. at 15.
125. Id.
126. Id.
127. Id.
128. Id.
129. See id. at 22.
130. Id.
inadequate balance sheet "reserves for claims, losses, loss adjustment expenses, and healthcare services expenses." Finaly, HMOs generally do not carry large amounts of debt on their balance sheets. Although managed care does not rely on debt financing to the extent that other industries do and acquisitions are usually financed with cash or stock, debt is still an option for many HMOs and may become a greater source of financing in the future.

HMOs are expected to rebound from a weak year in 1996, but the long term outlook is uncertain. HMOs performed poorly in 1996 due to the underwriting cycle, flat premiums, increased competition, and the coverage of less healthy populations as HMOs increased their penetration. There is a positive outlook for 1997 in light of an estimated increase in premiums of two to five percent. Over the long term, the merger frenzy should decrease competition in the HMO market, resulting in weaker competitive pricing pressures and higher profits. At the same time, however, the government will most likely reduce HMO reimbursements on Medicare as a way to trim the budget. Also, providers continue to strengthen their position in the industry, diffusing the HMOs' ability to realize profits at the expense of others. In the meantime, HMOs need to concentrate on reducing sales and administrative costs.

In sum, the financial viability of an HMO can be determined by looking at several factors. First, the quality of top management is indicative of the success of an HMO, since they are the decision makers who influence all other business risks. Second, an analyst needs to identify the breakdown of HMO enrollees by segment, either commercial or Medicare/Medicaid, in order to properly examine

131. Id at 22-23.
132. See id. at 22.
134. See NATIONSBank 3RD QUARTER, supra note 14, at 6-7.
135. See Hammonds, supra note 133, at 114.
136. On January 21, 1997, President Clinton announced that his budget would include $138 billion in Medicare savings over a six year period. His proposal includes a $46 billion reduction in reimbursements to MCOs over a six year period. See Medicare: Clinton to Propose $138 billion in Program Savings Over Six Years, Health Care Daily (BNA), Jan. 22, 1997, available in LEXIS, Health Library, BNAHLT File. Notably, on January 27, 1997, Senate Majority Leader Trent Lott stated that he favors increasing payments to HMOs as a way to give beneficiaries the option of enrolling in an HMO and as a way to continue to increase innovation in health care. See Medicare: Lott Says Medicare HMO Payments Could be Increased, Health Care Daily (BNA), Jan. 28, 1997, available in LEXIS, Health Library, BNAHLT File.
137. See Hammonds, supra note 133, at 114.
the associated risks. Third, the HMO should ensure that contractual agreements with providers and other health care entities enable it to sufficiently control costs. Fourth, the geographic areas in which the HMO currently operates, along with plans for expansion, affect profitability since some areas of the country have experienced more HMO penetration than others. Fifth, the medical loss ratios and administrative costs must be analyzed since they represent the largest expenses. Sixth, the amount of income generated from administrative fees, interest income, and other sources besides premium revenues can boost revenues, enabling the HMO to experience higher profits while taking some of the pressure off of cost-control initiatives. Seventh, understanding the types of services provided to enrollees assists the analyst in understanding the potential magnitude of the health care costs. Finally, the determination of whether the MCO is able to meet earnings per share (EPS) estimates in relation to total earnings and the number of shares outstanding is a key factor in determining profitability.

C. Physician Practice Management Companies

When a lender considers making a loan to a PPM, it must consider the business risks of PPMs and incorporate an analysis of those risks in its due diligence of the specific company seeking capital. An analysis of a PPM should include a look at the following areas: its corporate strategy, the terms of the Asset Purchase Agreement and Management Services Agreement, sources of revenue, and expenses. The decisions management makes regarding these areas affect the profitability of the company and determine whether the lender is repaid.

Before engaging in a detailed analysis of PPMs, it is important to discuss four critical success factors which should drive management’s decisions. First, the PPM must have the management expertise to make strategic decisions concerning physician groups within the

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138. See STANDARD & POOR’S, supra note 7, at 20.
139. See id.
140. See id. When there is a significant amount of competition for enrollees among HMOs, the premiums charged to employers may be reduced or remain artificially stable, thereby reducing the profitability of the HMOs.
141. See id.
142. See id.
143. See id.
144. See id. If an HMO grows too fast by issuing stock, it can dilute the value of its stock and EPS.
managed care system. This includes managing costs through the use of information systems and managing its relationship with managed care payers. Second, the PPM must develop a positive physician-driven structure and culture. Doctors want to deal with a company that understands their duties and concerns. The PPM should not tell physicians how to practice medicine. Third, PPMs must maximize profits for shareholders. The second and third factors may conflict since payers, physicians, and shareholders each have their own objectives. Finally, the overall growth strategy of the PPM will impact its profitability in the future. Issues such as whether to diversify, how fast to grow, and how to finance that growth will impact the future revenues and expenses of the PPM.

In considering what types of physician practices to integrate and manage, corporate strategy decisions vary widely among PPMs, but essentially these strategies fall into three broad categories: multi-specialty, single-specialty, and primary-care physician based. First, some PPMs, like PhyCor, focus on multi-specialty practices and add primary care physicians. Second, other PPMs seek to integrate single specialty practices such as Physician Reliance Network, which focuses on oncologists, OccuSystems, which focuses on occupational health, and Physicians Resource Group, with a focus towards eye care. Third, other PPMs, such as InPhyNet and Pacific Physician Services, assemble a core of primary-care physicians, which is difficult since many practice in small groups or as solo-practitioners. In addition, hospital-affiliated PPMs such as EmCare organize doctors within hospitals. It is important to note that some PPMs will seek a strategic position in more than one segment.

Structuring a PPM-physician relationship generally involves two principal agreements, the Asset Purchase Agreement and the Management Services Agreement. Under the Asset Purchase Agreement, the PPM purchases the assets of the physicians group

145. See McDowell & Brown, supra note 17, at 10.
146. See id.
147. See id.
148. See id.
149. See id.
150. See Jaklevic, supra note 20, at 27-30.
151. See id. at 27.
152. See id.
153. See id.
154. See id. at 30-31.
155. See McDowell & Brown, supra note 17, at 4-5.
Payment will be made in cash, PPM stock, debentures, or a combination of these. After the acquisition, the PPM enters into a Service Agreement with the clinic, which maintains a separate legal identity. Typically, management agreements are long term, ranging from twenty year terms to forty year terms.

Under the Management Services Agreement, the PPM provides not only all of the assets necessary for the clinic to operate, but also all of the administrative, financial, and management functions for the clinic. The PPM furnishes equipment, furniture, offices, "billing and collection services," "general financial and administrative services," "managed care contracting services," and the nonprofessional personnel working at each clinic. For purposes of comparison, physicians pay their own salaries, the salaries for professional services, and practice insurance premiums. In exchange for these services, the PPM receives a management fee of approximately eight to ten percent of physician income.

The issue of accounts receivables is an especially sensitive one for PPMs. The management fee received by the PPM is ultimately paid from the collection of physicians' accounts receivables. In order to secure payment of the management fee, the clinic will usually either assign the receivables to the PPM or give the PPM a security interest in the receivables. However, a significant liquidity problem for PPMs is the buildup of accounts receivables. Because PPMs are growing so rapidly, factors such as the length of time it takes to convert the receivables to the proper billing system and the build up of receivables due to new contracts cause the overall accounts receivable balances to accumulate, which reduces the speed in which cash is received by the company. This is one of the reasons PPMs rely so heavily on working capital lines of credit. Many PPMs suffer from high receivable balances that turn over into cash slowly.

156. See id. at 4.
157. See id. at 11.
158. See id. at 5.
159. See id.
160. See id.
161. Id.
162. See id. at 16.
163. See Campbell, supra note 60, at 20.
164. See McDowell & Brown, supra note 17, at 17-18.
165. See id.
166. See MEDPARTNERS, supra note 10, at 18.
Revenues for PPMs are primarily driven by management fees. Management fees can be structured in different ways, but they are usually related to physician productivity. Some PPMs receive a percentage of gross revenues of the clinic, while others receive a percentage of net income before distribution to the physicians. In addition, in states where global capitation arrangements are utilized by MCOs to pay physicians, the PPM retains a portion of the capitated payment from the MCOs. In such instances, the capitation fee from MCOs can represent a more significant portion of a PPM's revenues than the management fee from physicians. The relationship between the PPM and the clinics will be friendlier if the clinic's incentives and the PPM's incentives parallel one another; otherwise, one party may seek profits to the detriment of the other party.

Expenses for a PPM are related to the clinics and the cost of operating the PPM itself. Clinic expenses include salaries and benefits, supplies, contracted medical services, and other operating expenses. PPM corporate expenses include salaries and benefits, the cost of maintaining adequate information systems, and other general corporate expenses. The main objective for the PPM is to control the expenses incurred by the clinics through management expertise, utilization reviews, and the efficient use of information systems to centralize the administrative functions of the clinics.

In sum, the financial viability of a PPM can be determined by looking at many factors. First, the ability of the PPM to manage cash flows and convert accounts receivables into cash quickly is critical for success. Second, the size of the market share held by a PPM in each region in relation to competitors is indicative of success. Third, a quality management team with a strong record and physician leaders who understand the industry and its risks is essential. In fact, since acquisitions will continue to fuel growth, it is important for management to have demonstrated the ability to identify and bring value to

167. Physician productivity is tied to the number of patients with whom a physician works. In a fee-for-service system, if the physician sees more patients, then the physician is more productive. Under capitation, the physician is more productive when patients require fewer services. Essentially, if the PPM is able to run the physicians' practice more efficiently, then the physicians and the PPM will be more profitable.

168. See McDowell & Brown, supra note 17, at 5.


170. See McDowell & Brown, supra note 17, at 16.

171. See id. at 5.

172. See NATIONSBANK 2ND QUARTER, supra note 4, at 17.

173. See id.
transactions. Fourth, management must not overvalue its acquisitions if efficiencies are to be achieved.174 Fifth, the PPM must have strong information systems and administrative expertise.175 Sixth, leadership in developing a market is necessary for success.176 Seventh, strong and favorable relations with MCOs and other payers such as employers is essential for the success of the PPM and its physicians.177 Finally, the PPM needs to be able to manage capitation.178

IV. INDUSTRY, LEGAL, AND REGULATORY RISKS OF HMOs AND PPMs

The purpose of this section is to provide a broad overview of the various industry, legal, and regulatory issues that may have an important impact on the future cash flows of HMOs and PPMs. Due to the complexity and magnitude of each issue, a full in-depth analysis is beyond the scope of this Comment; instead this Comment will review the most relevant parts of each risk.

A. Utilization

Controlling utilization within managed care involves controlling health care costs by evaluating the necessity and appropriateness of medical care on a case by case basis, which may hurt the quality of health care services.179 Controlling utilization means controlling the demand for services by patients.180 HMOs need to maintain a strong medical cost management program in order to be profitable. When payments are pre-paid, such as through capitation,181 HMOs will increase their revenues by reducing their costs, which in this industry

174. See McDowell & Brown, supra note 17, at 11-14.
175. See NATIONS BANK 2ND QUARTER, supra note 4, at 17.
176. See id.
177. See id.
178. See id.
179. See FURROW, supra note 25, at 364.
180. See id. In short, in light of the fact that there are many medical services available to meet the needs of patients, utilization attempts to find the most cost-effective method for delivering service, thereby eliminating waste in the health care system and reducing costs to patients and employers. See id.
181. See Alice G. Gosfield, Is Less Really More? Utilization Management in the 1990s, in HEALTH LAW HANDBOOK 89, 94 (Alice G. Gosfield, 1996). Primary care capitation is an incentive offered to physicians to control utilization of health services by placing the risk of increased costs on those performing the services. See id. Another method of controlling utilization pays physicians bonuses to encourage them to use one procedure over another. See id. More methods are likely to appear in the future; nevertheless, the risk that these methods will not effectively control costs exists. See id.
means reducing the cost and volume of the medical services. The risk lies in the fact that HMOs must control costs in order to be profitable, but if they cut them too much there may be a backlash from the public, resulting in large jury verdicts against HMOs and PPMs or in requirements that HMOs provide certain mandatory benefits.

Utilization reviews and compensation arrangements are used by HMOs and other MCOs to control the cost and volume of health care services. First, HMOs can monitor care directly on a case-by-case basis through utilization reviews. In general, utilization reviews involve the submission of a request for approval of certain services by the physician to the plan—a doctor working for the plan makes the decision. Frequently used reviews include “pre-admission review of non-emergency admission [to a hospital]; concurrent review of hospital stays; discharge planning; ambulatory care review and retrospective claims review.”

Second, compensation is used by HMOs to control utilization. In compensation arrangements, the health care decision regarding services a patient should receive is made solely by the physician. The main method of compensation as a way to control utilization is capitation.

There are several factors in the health care industry that will have an impact on the ability of HMOs and PPMs to control utilization in the future. First, HMOs are covering less healthy populations. When HMOs first began, they attracted young, healthy enrollees interested in preventive care and prenatal benefits. As HMO penetration increases, they add enrollees who require more medical services, thereby increasing utilization and decreasing profits. Second, many large HMOs took on large indemnity populations intending to convert them to managed care, but the conversion has been difficult to implement and HMOs have been left with enrollees who have higher utilization costs. Third, it is difficult for HMOs to maintain a strong medical cost management

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182. Utilization also refers to the MLR. See supra note 117 and accompanying text.
183. See Gosfield, supra note 181, at 95.
184. Id. at 96.
185. See id. at 101.
186. See id. at 102. The revenues are fixed in a capitation arrangement, so physicians are profitable if they control costs by controlling the utilization of health care services by patients.
187. See NATIONSBANK 2ND QUARTER, supra note 4, at 7.
188. See id.
189. See id.
190. See id.
program when the rate of enrollee growth is high. Average HMO enrollment growth from January 1995 to January 1996 was approximately seventeen percent, with some companies growing at faster rates as high as eighty percent. Fourth, pharmaceutical costs may increase further in the future. Finally, the use of POS products by HMOs is growing, and with these products, HMOs will not have as much control over utilization and medical costs. Each of these factors may result in decreased future cash flows for HMOs.

An issue surrounding utilization is its effect on the quality of health care. If the public believes HMOs have cut back utilization too much, then regulators and the courts may intervene, resulting in increased costs for HMOs and PPMs. State regulators have intervened in many areas including, among others, maternity benefits, OB/GYN access, anti-gag rules, emergency benefits, and any-willing provider laws. In addition, many states require utilization review organizations (URO) to obtain Utilization Review Accreditation Commission (URAC) accreditation, while other states at least hold UROs to the URAC's standards.

The courts have also played a role in monitoring the effect of utilization management on the quality of health care. The success of plaintiffs in this area has been slow. For example, in Dunn v. Praiss, an HMO was held liable for a bad outcome due to a late diagnosis of testicular cancer by a urology practice, which had contracted with an HMO that received capitated payments for its

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192. See id. at 8.
193. See Standard & Poor's, supra note 7, at 10.
194. See NationsBank 2nd Quarter, supra note 4, at 7.
195. See Gosfield, supra note 181, at 94.
196. See NationsBank 3rd Quarter, supra note 14, at 10.
197. See Gosfield, supra note 181, at 107.
198. See id. at 109-11. A detailed discussion of current case law is beyond the scope of this Comment. The purpose of addressing this issue is to alert the lender or lawyer that such case law exists. In considering utilization management, a review of the leading cases relating to the liability of MCOs in this regard would be important. See Wickline v. California, 228 Cal. Rptr. 661, appeal granted, 231 Cal. Rptr. 560, 727 P.2d 753 (1986); Wilson v. Blue Cross of Southern California, 222 Cal. Rptr. 3d Supp. 660, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990); Hughes v. Blue Cross of Northern California, 245 Cal. Rptr. 273, 199 Cal. App. 3d 958 (1988); Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir.), cert. denied, 113 S. Ct. 812 (1992); Kuhl v. Lincoln National Health Plan, 999 F.2d 298 (8th Cir. 1993). However, it is important to note that cases involving ERISA plans are difficult to win. Significantly, ERISA may preempt claims dealing with utilization review issues in addition to other issues. See infra notes 247-69 and accompanying text.

specialty health services. The court held that the HMO was responsible for the harmful outcome based on the theories of respondeat superior or agency as a result of its payment relationship and its control over the physician. In situations like the one in Dunn, physicians are caught in the middle as they try to fulfill their duty to treat the patient, receive payment for the treatment, and maintain a positive, profitable relationship with the managed care plan. In Hand v. Tavera, the court held that an on-call primary care physician who contracts with an HMO owes a prepaid enrollee in the HMO medical plan a duty of care when the enrollee shows up in a participating hospital emergency room because a physician-patient relationship does exist. Moreover, in Fox v. HealthNet of California, which was a non-ERISA case, an HMO contracted to provide comprehensive health services, but then denied coverage for an experimental treatment. The claim filed was a denial of "medically necessary" benefits as a bad-faith breach of contract, and the suit yielded the plaintiff an $89 million verdict against the HMO.

B. Capitation and HMOs

HMOs receive prepaid per-person charges for health care services from employers, commonly referred to as capitated payments. HMOs assume the financial risk of capitated payments, but they are also able to reap financial gains by controlling clinical and administrative responsibilities. Like traditional insurance companies, HMOs have experience handling capitated payments and insurance risk.

200. See id. at 866, 868-69.
201. See id. at 869.
202. See Gosfield, supra note 181, at 118.
203. 864 S.W.2d 678 (Tex. App. 1993).
204. See id. at 678-79. The physician owed the patient a duty of care even though he never before saw the patient, because it was in the physician's contract with the HMO to serve as a gatekeeper for the patient and to arrange for covered health services for the patient. See id.; see also Gosfield, supra note 181, at 118.
206. See id.; see also Gosfield, supra note 181, at 111.
207. See Fox, No. 219692; see also Sage, supra note 27, at 12. The contract promised to render comprehensive services for a pre-paid premium. See Fox, No. 219692.
208. See Findlay, supra note 109, at 45. Essentially, the HMO is accepting insurance premiums from employers and taking on insurance risk. If the health care costs incurred by enrollees are less than the premiums received, then the HMO makes money; however, if costs are greater, then they lose money. Thus, it is critical for HMOs to control their costs. The most significant ways by which the HMOs control costs is through reduced payments to providers and utilization reviews that control the volume and type of health services.
HMOs receive premiums from employers and, in turn, pay providers on a discounted fee-for-service basis. However, HMOs are increasingly paying providers on a capitated basis.209 This method seems to transfer the potential for financial gain and control over medical decisions and costs to providers. Large provider groups and PPMs are in a position to demand the shift while possessing the capabilities to handle the risk. On the other hand, solo practitioners and small groups are hesitant to take on the financial risks of capitation.210 As physicians continue to consolidate, HMOs will most likely replace more fee-for-service payments with capitated payments. While this will reduce the financial risk HMOs assume, it may also reduce future revenues of HMOs.211

C. Capitation and PPMs

Global capitation is a risky proposition for physicians and PPMs that cannot control their costs. Under a fee-for-service system, the physician assumes little risk and merely charges a fee which includes the costs incurred and a profit margin. In contrast, under capitation, the physician assumes financial risk. If patient costs exceed the capitation amount, the physician must absorb those additional costs, which may result in losses, and therein lies the risk. Capitation can also lead to profits, but only if the costs are tightly managed without impeding the patient’s quality of care.

Through their management expertise and information systems, PPMs are able to manage costs more effectively than solo-practitioner physicians or physician groups, but the risk of loss still exists. A report released in 1996 found that more than fifty percent of physicians receive no income from capitated contracts in recognition of the financial risks.212 Therefore, as the use of capitation becomes more widespread throughout the United States, the desire

209. See id. A study of 108 MCOs found that only thirty-seven percent of HMOs use capitation as the primary payment method, whereas sixty percent had partial risk-sharing arrangements. See id. In contrast, 100% of PPOs had risk-sharing arrangements, but only seven percent of PPOs engaged in capitated contracts with physicians. See id.

210. See id.

211. When HMOs pay providers on a discounted fee-for-service basis, they have the opportunity to make money if they can control the services used by their enrollees. However, under capitation the HMO receives a fixed premium and pays a fixed per person capitated payment to the provider. Therefore, the HMO only makes money on the spread, which means the HMO’s survival is partially based on how well it negotiates its premiums received and fees paid.

212. See id. at 48. Solo practitioners and small physician groups usually prefer to receive discounted fees-for-service over capitation in recognition of the financial risk capitation presents. See id.
of physicians to join PPMs will most likely increase. This will increase the number of capitation arrangements the PPM has to manage for physicians and increase the risk of loss. For example, lenders should be on the alert when a provider group's capitated revenues increase significantly in one year.

Ultimately, the effectiveness of capitation will depend on how well management and attorneys negotiate individual contracts between the HMO and PPM. There are several key issues to consider. First, setting the appropriate capitation rates is critical. The rates should be in line with the location, age, and health of the enrollee population. Second, it is also important to ensure that the primary care providers are not obligated to perform health services for which they are inadequately trained or that result in too strenuous a caseload. Finally, look at the size of the PPM to ensure that it is capable of managing the capitated arrangement. On average the PPM should strive for 250 capitated lives per physician, but no lower than 100 lives. Keeping these issues in mind will help mitigate the risk of capitation.

D. Direct Contracting

In an attempt to further reduce health care costs, large corporations such as Xerox are creating their own HMOs to provide health care coverage for their employees. Buyer's Health Care Action Group, a coalition of twenty-four large employers in Minnesota, will be contracting directly with provider groups in 1997. This group will function the same as other HMOs in the market, contracting with

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213. In the Western United States, fifty-five percent received no capitated income. See id. In the Midwestern United States, sixty-one percent received no capitated income. See id. In the Eastern United States, sixty-six percent received no capitated income. See id. Finally, in the Southern United States, seventy-one percent received no capitated income. See id. Physicians with little or no current exposure to capitation will be vulnerable to the risks and may find joining a PPM to be an attractive way to mitigate his or her financial risks in a capitated arrangement.

214. See id. at 51. A physician group may find a sudden large increase, as little as fifteen percent, in capitated revenues difficult to manage resulting in poor health care decisions in order to remain profitable. See id.

215. See id. at 55.

216. See id. at 50.

217. See id.

218. See id.

219. See id.

220. See STANDARD & POOR'S, supra note 7, at 3.

221. See Findlay, supra note 109, at 55.
physicians, hospitals, and other healthcare segments. In addition, employers may be able to contract directly with fully integrated hospital chains such as Columbia/HCA HealthCare for their health care services. Both of these trends will likely reduce the number of employees enrolled in HMOs, and, therefore, reduce the profitability of HMOs.

E. Medicare and Medicaid Reimbursement Risk

Federal Medicare and Medicaid reimbursements are determined by the Health Care Financing Administration (the HCFA). In an effort to encourage more managed care providers to include Medicare recipients, the HCFA began setting what it considers to be attractive rates. Medicare-risk HMOs are reimbursed for each beneficiary at ninety-five percent of the average fee-for-service cost of a Medicare beneficiary in the same geographic region. However, a recent HCFA study shows that Medicare HMOs may have, in the past, been over-reimbursed by as much as seven percent.

With respect to Medicare and Medicaid reimbursement, there are two primary risks for HMOs. First, there is the risk that the HCFA could reduce the reimbursement rate to HMOs, thereby placing more pressure on them to control costs or increase premiums for commercial clients. As a result of the HCFA study, reimbursement rates may be reduced to eighty-eight percent of fee-for-service benefits. The second risk focuses on the Medicare enrollees.

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222. See id.
223. See id.
226. See STANDARD & POOR'S, supra note 7, at 1. The HCFA has been trying to increase Medicare recipient enrollment in HMOs since 1982. The goal is to decrease health care costs while providing an additional option for health care. See id. at 2.
227. See id. The rates are also adjusted for gender, age, reason for entitlement, and institutional status. See id.
228. See id.
229. In fact, the current version of the 1998 budget proposal contains such reductions. See supra note 136 and accompanying text.
230. This is the difference between the current ninety-five percent reimbursement less the suggested seven percent overcompensation. See supra notes 226 and 227 and accompanying text.
231. Not only is the federal government seeking to increase enrollees, but in addition,
Even if the reimbursement rate remains steady, the HMOs will quickly exhaust the supply of healthy Medicare recipients. Therefore, HMOs will be compelled to enroll less healthy recipients which will increase their utilization and decrease their profitability.

F. Mandatory Benefits and Anti-managed Care Laws

HMOs achieve cost efficiencies by controlling the utilization of health care services. However, recently there has been a backlash by the states and the federal government against some utilization control efforts. Such efforts are perceived by many to result in a reduced quality of health care services for HMO patients. Thus, state governments are increasing mandates on all health plans to provide for additional services. In addition, in 1996 the federal government took on a larger role when President Clinton established a new commission to examine issues related to the quality and the growth of managed care. These state and federal governmental actions are a result of public perceptions about managed care systems. Whether or not these perceptions are true, the end result is increased costs for HMOs and reduced cash flows.

Currently, two issues seem particularly important to the public—maternity benefits and mental health provisions. For instance, in 1995 and 1996, twenty-nine states passed legislation that mandated coverage for extended stays in the hospital for women after giving birth. In addition, in 1996 the federal government expanded that coverage to all fifty states. Prior to these government mandates, HMOs provided coverage for only short hospital stays, as little as twenty-four hours, which the public labeled “drive-through deliveries.” The new mandatory coverage for mothers and newborns requires HMOs to pay for at least forty-eight hours in the hospital for a normal delivery and ninety-six hours for a cesarean. The result of these laws is increased costs for HMOs, which will decrease their profitability unless they raise the premium rates charged to employ-

the American Association of Retired People will begin marketing Medicare HMO coverage to its members in 1997. See NationsBank 3rd Quarter, supra note 14, at 12.
232. See Standard & Poor’s, supra note 7, at 2.
233. See NationsBank 3rd Quarter, supra note 14, at 10.
234. See id. at 9.
235. See id. at 8.
237. See Gosfield, supra note 181, at 93.
238. See Newborn Act at 110 Stat. 2936.
ERS.

The quality of care surrounding mental health services and managed care is also a growing issue of concern. In recent years, most employers have moved their employees to managed health plans for mental health services. Thus, these plans, which are essentially HMOs, decide both the amount of care and the provider of that care. This has resulted in more drug treatments and shorter inpatient and outpatient care. As of November 1996, two states had passed mental health benefits legislation mandating that health plans pay for additional services. Once again, state regulations are increasing the health care costs of HMOs.

Many states are contemplating anti-managed care legislation. In the November 1996 election, California and Oregon placed anti-managed care initiatives on their ballots. Although these initiatives failed, the propositions were able to garner between thirty-five and forty percent of the popular vote. These propositions included provisions concerning utilization reviews, health plan fees, justification for increased premiums, provider termination, and health care provider compensation. Interestingly, the Texas legislature is also considering a proposal to hold managed care plans liable for medical malpractice, and Massachusetts may require new health plans to be not-for-profit.

G. ERISA

In many cases, an HMO is able to escape potential liability from state tort and health reform laws due to ERISA. However, the safety that ERISA afforded HMOs in the past may not be as secure in the future as Congress imposes substantive requirements and the courts narrow the focus of ERISA with respect to state laws that "relate to" ERISA health plans. Therefore, in the future, HMOs may find

239. Realistically, when costs are passed on to employers, they will merely shift the cost to employees requiring them to pay a larger percentage of their health care premiums or higher co-payments.


241. See id.

242. See NATIONSBANK 3RD QUARTER, supra note 14, at 8.

243. See id. at 9.

244. See id. at 9-10.

245. See id.

246. See id.

themselves open to increased liability and damage awards. Administrative costs may also increase as HMOs seek to tighten utilization review procedures.

ERISA is a federal law that applies when employee welfare benefit plans, including health coverage, are self-insured by employers. Any state laws which "relate to" any employee benefit plan, such as state-mandated benefit laws or restrictions on policy exclusions, are preempted by ERISA. Many state legal remedies such as bad-faith breach-of-contract claims and emotional distress claims cannot be brought against ERISA plans or the MCOs with whom employers contract. Plaintiffs can only proceed with an action against a wrongly denied benefit, and, in those cases, punitive damages cannot be awarded.

The purpose of ERISA is to provide uniform administration of employee benefit plans across the nation and to free employers from the administrative hassle of ensuring compliance with conflicting state laws. Employers are not required to provide any substantive health coverage under ERISA. In fact they are given great latitude with respect to health benefits.

Many of the state laws preempted by ERISA are not replaced with equivalent federal laws, creating an "ERISA vacuum." This "vacuum" reduced regulations of health benefit plans that were self-insured and helped fuel the growth of managed care. Congress has not taken steps to close the "vacuum," but courts have addressed this issue. As a result of the 1995 Supreme Court decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company, MCOs, including HMOs, may be open to

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248. See Sage, supra note 26, at 11-12.
250. See Sage, supra note 26, at 12.
251. See id.
252. See Roth, supra note 247, at 191.
253. See Sage, supra note 26, at 12.
254. See id.
255. See id.
256. See id.
257. 115 S. Ct. 1671 (1995). The court held that New York State's hospital surcharges collected from patients, whose health plans were governed by ERISA and whose HMO membership fees were paid by an ERISA plan that was designed to fund uncompensated care, did not "relate to" employee benefit plans as described in ERISA and therefore were not preempted. The surcharges only indirectly affected the prices of insurance policies. See id. at 1672, 1683. The significance of this case is that it narrows the circumstances under which a state law may relate to a plan, thereby freeing many state laws from preemption and allowing a violation of state laws to be litigated against an ERISA plan violator.
increased liability in the future. In addition, Dukes v. U.S. HealthCare, Inc. appeared to open the door, at least in the Third Circuit, for increased state court litigation where the quality, not quantity, of health care is at issue with respect to HMO-induced provider behavior regarding services. In essence, ERISA MCOs may be liable under state tort laws for their role as arrangers for medical care. Plaintiffs will also seek to hold MCOs liable for corporate negligence and vicariously liable for the acts or omissions of physicians contracting with them.

The tort liability to which an HMO may be subject depends on the role that the HMO plays with respect to the employer. An HMO can play two important roles with respect to ERISA plans: health plan administrator and URO. ERISA usually protects an HMO in its role as a plan administrator. Another challenge involves claims against administrators of plan benefits. An HMO may also be liable as a utilization review agent. The case law regarding the preemption of state tort law claims is unsettled, but so is the case law relating to the preemption of state health reform initiatives. It seems that state attempts to regulate insured plans as part of general state regulation of insurance will be ‘saved’ from preemption under certain circumstances. However, attempts to regulate both insured and self-insured ERISA plans by broadening the scope of insurance-type laws to self-insured plans have not been saved from preemption.

In general, ERISA will almost always preempt state law, but this area of the law opened up in 1995, leaving practitioners with less

258. The main issue of contention between state laws and ERISA preemption generally involves state laws that do not directly regulate ERISA plans, but that do, nonetheless, effect the plan. See Roth, supra note 247, at 191.
261. See Roth, supra note 247, at 200. The Supreme Court addressed whether or not state tort actions against ERISA plans were preempted by ERISA in Macky v. Lamier Collection Agency & Service, Inc. 486 U.S. at 833.
262. See id. at 202.
263. See id. at 203-05.
264. See id. at 203. See also Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993).
265. See Roth, supra note 247, at 204. The circuit courts are split on this issue. See id.
266. See id. However, most courts follow the holding of Corcoran v. United HealthCare, Inc. 965 F. 2d 1321 (5th Cir. 1992). The court held that ERISA preempted a claim for injury allegedly caused when a plan’s utilization review agent refused to certify a hospital stay. See Corcoran, 965 F.2d at 1321. The court recognized that this decision essentially left the plaintiff without a remedy. See id. at 1338.
267. See Roth, supra note 247, at 206.
268. Id. at 206-07.
H. Fraud and Abuse

Fraud and Abuse in the Medicare and Medicaid arena is a very serious matter. The HCFA, through the Office of Inspector General, actively seeks out fraud, and, in 1996, it increased the number of enforcement officers and the amount of money committed to detecting fraud. The penalties issued by the HCFA can be severe, as shown by the two largest health fraud cases: National Medical Enterprises, which had to pay $379 million in 1994, and Caremark, Inc., which had to pay $161 million in 1995. There are two specific types of health related fraud that lenders and attorneys need to be aware of—anti-kickback rules and self-referral bans—in addition to a more general type of fraud—false claims. In order to prevent fraud and abuse, companies should implement corporate compliance programs. The Health Insurance Portability and Accountability Act of 1996 greatly affected health fraud and abuse issues, so it warrants a

269. See id. at 205.
270. The Department of Justice is involved in many of these cases.
273. See NME to Pay $379 Million in Penalties under Settlement with Federal Agencies, 3 Health Law Rep. (BNA) No. 27, at 917 (July 7, 1994). NME settled with the Justice Department for criminal fines, civil damages, and penalties. Fraudulent practices at NME's psychiatric and substance abuse facilities included unnecessary patient admissions, extended hospital stays to increase insurance coverage, billing insurance companies for the same service multiple times, and billing Medicare for payments to doctors to induce referrals of patients to its facilities. See id.
274. See id.
275. See Caremark to Pay $161 Million to Settle Fraud, Kickback Cases, 4 Health Law Rep. (BNA) No. 25, at 953 (June 22, 1995) [hereinafter Caremark]. Caremark settled civil and criminal claims for kickback and fraud charges after the company made payments to physicians in order to have business referred to it. They also submitted false Medicare claims. See id. Caremark is an especially good example for this Comment since it was a PPM before it was acquired by MedPartners in 1994.
276. See id.
brief discussion. Lenders are vulnerable to the financial consequences of fraud and abuse their borrowers, but a thorough due diligence investigation and candid discussions with attorneys and management can mitigate this risk.

Congress enacted the anti-kickback statute as part of the Medicare and Medicaid Patient and Program Protection Act of 1987. It essentially prohibits payments or the solicitation of payments related to the delivery of health care services covered by certain federal and state health care programs made willfully or knowingly in exchange for patient referrals. The case law under the anti-kickback statute demonstrates that this law is applied broadly and is very fact-specific. However, the statute also includes five statutory exceptions to the anti-kickback prohibitions, such as payments to bona fide employees. Safe-harbors are also available under the statute. If a transaction does not fall within one of the exceptions or safe-harbors, the company could be subject to criminal and civil penalties and exclusion from Medicare, Medicaid, and other federally funded health care programs. Therefore, attorneys should carefully review relevant transaction documents, and lenders should obtain specific representations from the management of the borrower that addresses these issues.

The federal self-referral bans began under the Ethics and Patient Referrals Act within the Omnibus Budget Reconciliation Act of 1989. It prohibited the referral of Medicare patients to a clinical lab in which the physician or a family member had a financial interest. The ban was extended to cover ten additional health care

279. See id.
280. See FOX, supra note 2, §§ 4.01, 4.03-.04. One of the leading cases in this area that illustrates a broad interpretation of the statute is Hanlester Network v. Shalala. 51 F.3d 1390, 1400 (9th Cir. 1995) (holding that “knowing and willful” under the anti-kickback statute requires the defendant to “(1) know that § 1128B prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to disobey the law”).
282. See FOX, supra note 2, § 6.01.
283. See id. § 4.03.
284. See id. § 4.06. In addition, abusive marketing practices such as high pressure sales tactics can result in kickbacks or false claims. See id. § 4.01.
286. See id.
services under the Omnibus Budget Reconciliation Act of 1993. In addition, the Social Security Amendments of 1994 amended the list of designated health services covered under Stark II. The statute also contains exceptions as to when a physician can refer a patient for services to an entity in which he holds a financial interest. Penalties include denial of payment, the return of any moneys received, civil penalties of up to $15,000 per referral, and exclusion from the Medicare and Medicaid programs.

The False Claims Act (the FCA) makes it illegal to fraudulently claim payment from the U.S. government. The FCA applies in civil and criminal actions. Private persons can bring suit under the act on behalf of the United States. The plaintiff must plead the allegation of fraud distinctively, and he must also present sufficient facts to create a reasonable inference of fraud. However, the FCA prevents qui tam actions in two instances. The first instance occurs when the action is based on conduct currently in litigation and the government is a party. A qui tam action is also prevented when the action is based on the "public disclosure" of conduct. In this case no action can be brought unless the Attorney General brings the action or the individual in the qui tam suit is the "original source."

A private plaintiff is called a "qui tam" plaintiff and is also referred to as the "relator," since the government has the real party interest. The rules for a private plaintiff are contained in section 3730 of title 31 of the United States Code, and were first included in the 1986 amendments. A


See id. The original source is an individual possessing "direct and independent knowledge" of the claim who has provided the information to the government voluntarily.
health care company may commit a false claims violation in conjunction with an anti-kickback or self-referral violation.\textsuperscript{298}

Organizations can mitigate the severity of any sanctions by complying with the Guidelines for Organizations.\textsuperscript{299} The most significant mitigating factor outlined in the guidelines is the maintenance of a corporate compliance program which is designed to prevent and detect fraud.\textsuperscript{300} A corporate compliance program reduces possible criminal activity and economic losses due to criminal activity in the organization.\textsuperscript{301} An effective compliance program includes the items listed in the U.S. Sentencing Guidelines Manual.\textsuperscript{302}

First, the organization must designate a group of individuals to establish compliance standards and procedures which conform to industry practices.\textsuperscript{303} The second guideline that must be met is to designate a corporate executive to oversee the compliance program as a compliance coordinator. This person must report to the Board of Directors on a regular basis.\textsuperscript{304} Third, the organization must meet its duty of care obligation not to delegate decision-making authority to employees likely to commit criminal acts.\textsuperscript{305} Fourth, the compliance standards must be written, disseminated to employees, and used as the basis for ongoing compliance training programs.\textsuperscript{306} Fifth, the organization must strive to achieve actual compliance by utilizing, monitoring, and auditing the systems.\textsuperscript{307} In addition, employees must know how and where they can report fraud violations anony-

\textsuperscript{298} See id.

\textsuperscript{299} Caremark, Inc. plead guilty to criminal kickback and fraud charges, and also settled in order to resolve civil claims for the submission of false Medicaid claims among other fraudulent practices. See Caremark, supra note 275, at 953.

\textsuperscript{299} See Tillman & McGuan, supra note 271, at 256. The U.S. Sentencing Commission, which created the U.S. Sentencing Guidelines, was established by Congress as part of the Comprehensive Crime Control Act of 1984. 18 U.S.C. §§ 3551-3742 (1994). The U.S. Sentencing Guidelines originally applied to individuals, but the guidelines were amended in 1991 to include the Guidelines for Organizations, which applies to all business entities including, but not limited to, corporations, partnerships, and pension funds. See id.; U.S. SENTENCING GUIDELINES MANUAL §§ 8A1.1-8E1.3 (1996) (setting forth the guidelines for sentencing organizations).

\textsuperscript{300} See Tillman & McGuan, supra note 271, at 256.

\textsuperscript{301} See id. In the settlement between the government and NME Psychiatric Hospitals, Inc., the government imposed the establishment of a compliance plan. See id. at 258.

\textsuperscript{302} See U.S. SENTENCING GUIDELINES MANUAL § 8C2.5.

\textsuperscript{303} See Tillman & McGuan, supra note 271, at 260-61.

\textsuperscript{304} See id. at 261.

\textsuperscript{305} See id. at 262. The organization must perform due diligence to determine who such likely individuals are by screening applicants and asking them about past criminal activities. See id.

\textsuperscript{306} See id. at 263.

\textsuperscript{307} See id. at 264.
Sixth, the standards must be consistently enforced throughout the organization. This enforcement includes adequate discipline of individuals who commit a violation and also punishment for those who fail to detect a violation. Seventh, the organization must be able to respond appropriately when a violation occurs. Finally, the organization must ensure that it retains all necessary documents relating to the compliance program.

The federal government continues to directly address fraud and abuse issues even though it provides incentives for companies to implement compliance programs as a way to reduce fraud and abuse. The Health Insurance Portability and Accountability Act of 1996 contained many new fraud and abuse provisions. The first provision, the Fraud and Abuse Control Program, attempts to eliminate fraud and abuse through such vehicles as audits, investigations, and the creation of new safe harbors. Second, the Medicare Integrity Program provision of the Act enhances and centralizes Medicare program functions. Third, the Act expands the coverage of fraud and abuse laws. Not only are Medicare and Medicaid covered, but all federal health plans and some private health plans are also covered. Fourth, the Anti-Kickback provision includes an additional exception for “entities that have ‘risk sharing’ arrangements that place the other party at ‘substantial financial risk’ in utilizing items or services.” Finally, the Act adds a new category to the Federal Health Care Offenses. The crimes which make up this new category include: health care fraud, health care theft or embezzlement, false statements made in a health care context, obstruction of an investigation, and money laundering.

308. See id.
309. See id. at 266.
310. See id.
311. See id. at 267.
312. See id. at 269.
313. See Crane, supra note 271, at 1399.
314. See id.
315. See id. at 1400.
316. See id.
317. Id.
318. See id. at 1401.
319. See id.
I. **Antitrust**

Attorneys and lenders also need to be familiar with antitrust laws. Antitrust will be a crucial issue as the health care industry consolidation trend continues. A key development in the area of health care antitrust laws occurred on August 28, 1996, when the U.S. Department of Justice and the Federal Trade Commission released their new guidelines entitled "Statements of Antitrust Enforcement Policy in Health Care" (Guidelines). The most significant changes in the new release related to physician networks and multi-provider networks, both of which contract with MCOs to provide physician and other health services.

A meaningful change involved the extension of the "rule of reason" analysis to non-financially integrated provider networks. This change took place because groups like the American Medical Association (AMA) argued that antitrust laws discouraged providers from forming networks that would improve quality assurance and utilization reviews. The AMA pointed out that if non-financial networks do not have programs designed to achieve quality assurance and utilization reviews, the network will be illegal *per se* for price fixing.

These new antitrust guidelines will most likely result in structural changes to the health care industry which will create opportunities for attorneys and lenders. For example, many health attorneys believe that this legislation will increase the formation of provider networks because physicians will be more confident as to their legal position under the new antitrust laws. Physicians can now engage in additional activities such as competing against HMOs...

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322. See id. A "rule of reason" analysis looks at an agreement and weighs the pro-competitive effects against the anti-competitive effects and disallows agreements that are anti-competitive in nature. Under the prior rules many of these agreements would have been illegal *per se*. See id.

323. See id. Non-financial integration refers to clinics that are operationally integrated.

324. See id.

325. See id.

for managed care contracts. In addition, the new guidelines expand the types of financial integration allowed to physicians in rural, less-competitive areas, and they allow networks to contract directly with self-insured employers without facing regulation as insurers.

J. Corporate Practice of Medicine

The corporate practice of medicine doctrine prevents corporate organizations from offering medical services through licensed physicians. This doctrine may become an issue when physician practices are acquired or when an HMO contracts with a physician or physician group for health services. A violation of this doctrine can result in professional discipline of the physicians, and it may even subject the officers or directors of the corporation to criminal penalties. Therefore, when drafting a contract between physicians and corporations, attorneys should review the specific state laws which address this issue.

V. A Lesson for Bankers and Attorneys: Coastal Physician Group

Coastal Physician Group, a North Carolina-based PPM, was extremely successful as of 1994. However, as a result of management's strategic decisions and other market factors, the company has not been profitable since the first quarter of 1995, and it is currently seeking a buyer or merger partner. In fact, throughout 1996 Coastal sold assets in order to repay lenders $40 million due on January 2, 1997. Coastal is a victim of an uncertain and volatile health care industry which currently believes that growth through

327. See id.
328. See id. at 1335-36.
329. See FOX, supra note 2, § 10.01. The doctrine states that corporations and other unlicensed persons or entities may not practice medicine through licensed employees. See id. § 10.02.
330. See id. § 10.01.
331. See id.
333. See David Ranii, Coastal Losses 2nd—Largest Ever, NEWS & OBSERVER, Nov. 15, 1996, at 9C. Coastal hired Smith Barney to seek a buyer for its core physician contract business for emergency rooms in order to raise cash to meet its near-term cash needs and its 1997 debt payment of $78 million. See Kyle Marshall, Coastal says it is in Cash Crisis, NEWS & OBSERVER, Feb. 6, 1997, at 8C-9C [hereinafter Marshall, Cash Crisis].
334. See Marshall, Cash Crisis, supra note 333 at 9C. Coastal met this debt obligation on time. See id. The assets sold included clinics, physician practices, and HMOs. See id.
acquisition and integration are necessary for survival. This acquisition frenzy and push towards integration of health services creates opportunities for companies, but also increases their financial and legal risks. For example, companies can grow within their core strategic segments or they can diversify by entering into new segments of the industry. Diversification can be a risky strategy since each segment of the health care industry is extremely complex and the interaction between each segment is changing rapidly every year. For Coastal, a diversified acquisition strategy contributed to the company’s bleak financial situation. Coastal illustrates the potential vulnerability in PPMs and the potential danger a PPM faces when it diversifies quickly into HMOs.

Coastal was founded in 1977, and went public in 1991. In the early 1990s Coastal was a leader in the PPM industry and built a network of physician practices. However, Coastal’s successful original corporate strategy, which is still its core business, was managing and staffing hospital emergency rooms with specialists such as obstetricians. As it diversified, Coastal added a medical malpractice insurance company and began providing services such as billing and bill collections. From 1986 to 1990, Coastal’s net operating revenue increased thirty percent annually.

In 1991, Coastal embarked on a new strategy in recognition of the fact that the number of hospitals, Coastal’s major clients, were decreasing as a result of consolidation. This new strategy was the acquisition and management of physician practices. Coastal believed that physicians could only control access to patients by consolidating against MCOs, insurers, and hospitals. In addition, Coastal thought that the physician practices benefited from professional management skills, economies of scale, and centralized billing. Because of this belief, Coastal established a relationship with Humana, an HMO, and acquired up to one hundred physician practices.

335. See id. at 8C.
337. See id. at A1, A6.
338. See id. at A1.
339. See id.
340. See Lowes, supra note 332, at 32.
342. See id. at A6.
343. See id.
344. See id.
practices which serviced Humana’s enrollees. Coastal’s new strategy seemed to be extremely successful—by 1994 Coastal’s revenues increased to $749 million from $161 million in 1990.

However, in 1994, there were signs that Coastal’s PPM strategy was failing to achieve all of the efficiencies it sought, in part because of the power of HMOs. Thus, Coastal acquired HMOs as part of its new diversification strategy. The company purchased several HMOs, including an HMO in Southern Florida, where Humana had a strong presence. By choosing to go head to head with its most significant PPM client, Coastal isolated Humana and became its competitor. At this time, Humana accounted for twenty-six percent of Coastal’s revenues. The deterioration of this relationship resulted in a flood of red ink at Coastal.

Coastal made many mistakes in its attempt to lead physicians into a health care revolution against managed care. These mistakes can serve as lessons for PPMs, bankers, and attorneys.

First, Coastal’s acquisition strategy created a complex company which lacked integration. Coastal grew too fast, which resulted in the inability to integrate its physician practices into the company’s systems. Coastal also failed to adequately integrate its diversified divisions into a comprehensive corporate strategy. Furthermore, in attempting to grow, Coastal gave too much away in its contracts. For example, it agreed to accept payments based on the amount of business in the emergency business versus the low-risk traditional flat rate per physician method. The company also did not anticipate

345. See id. at A6.
346. See Lowes, supra note 332, at 31. Coastal’s market value peaked at $900 million, which was six times its market value three years earlier. The stock traded as high as $42 a share in 1994, but by September 25, 1996 the value collapsed to $6.25 a share. See Deogun, supra note 336, at A6. In early February 1997, Coastal’s stock closed at $2.75 a share. See Marshall, Cash Crisis, supra note 333, at 8C.
347. See Deogun, supra note 336, at A6.
348. See Heather Harreld, Tracking Coastal Hospital Deaths add to woes of Durham firm that once wowed Wall Street Investors, TRIANGLE BUS. J., Apr. 26, 1996, at 47.
349. See id.
350. See Lowes, supra note 332, at 34.
351. See id. at 31.
352. See id. at 33. In addition, the absence of a single computer system caused Coastal to lose track of its receivables and payables, so they were not able to react to slow collections. See Kyle Marshall, Winning Control of Coastal, NEWS & OBSERVER, Aug. 25, 1996, at 2F [hereinafter Marshall, Control]. This can result in cash flow problems.
353. See Marshall, Cash Crisis, supra note 333, at 8C.
354. See Marshall, Control, supra note 352, at 2F.
355. See id.
lost its original business of supplying emergency-room doctors to hospitals.\footnote{356}

The second mistake that Coastal made was that it underestimated the power of HMOs in light of the fact that it is cost and not quality that drives most employer health care decisions.\footnote{357} HMOs wield the power since they control the direct access to patients through their relationship with employers. Coastal believed in the underlying philosophy of most PPMs, that groups of doctors could match the power of HMOs.\footnote{358} The company began to diversify its strategy, which led them into the HMO business from which Coastal suffered heavy losses.\footnote{359}

Coastal's third mistake involved the arrangement of capitated contracts with HMOs to care for enrolled patients, which meant that Coastal bore the risk if the costs for care rose above the fixed, capitated rate.\footnote{360} Coastal’s profits were squeezed by Humana, the physician practices’ most significant client, after Coastal purchased an HMO which was a direct competitor of Humana in Southern Florida.\footnote{361} Humana increased the services it offered to its plan members in order to make their HMO more attractive.\footnote{362} Humana also decided to no longer charge its patients a five dollar per drug prescription co-payment, and Coastal had to pick up the tab.\footnote{363} Humana then increased the number of physicians in its network which reduced the number of patients that Coastal’s PPM physicians had access to for treatment.\footnote{364} It appears that Coastal’s contracts with Humana were not drawn up to protect it from these practices, and, furthermore, that in negotiations neither Humana nor Coastal had specified the rights of either party with respect to non-compete stipulations.

Coastal's fourth mistake involved problems in its operations. The company lacked basic financial controls and had inadequate information systems, which led to the insufficient integration of physician practices.\footnote{365} Individual physician practices used different financial systems which resulted in de-centralized control of spending.

\footnote{356. See id.}
\footnote{357. See Deogun, supra note 336, at A6.}
\footnote{358. See id.}
\footnote{359. See Lowes, supra note 332, at 32.}
\footnote{360. See Harrel, supra note 348, at 47.}
\footnote{361. See Deogun, supra note 336, at A6.}
\footnote{362. See Harrel, supra note 348, at 47.}
\footnote{363. See Deogun, supra note 336, at A6.}
\footnote{364. See id.}
\footnote{365. See id.}
and increased costs. Inadequate systems also led to slow access to information by physicians. Coastal was not able to execute its management expertise in the various physician practices, since many doctors wanted to "run the show," causing many of them to be poorly run. For instance, physicians that were put on salary no longer had the incentive to pull in business. In addition, the management team was slow to react to its financial problems, and at one point waited ten months after their financial problems were made public to engage turnaround specialists.

Finally, Coastal maintained a very high price earnings (P/E) multiple while experiencing operating cash flow problems, which enabled them to buy cash flow with stock versus cash. When Coastal acquired a physician practice and its associated cash flows, they were then able to include Coastal stock as part of the purchase price. The physicians received attractive stock, and Coastal did not need to go to lenders for acquisition financing. Therefore, the financial plans that lenders typically require may not have been developed, since Coastal did not need to seek debt acquisition financing. However, Wall Street expected even greater earnings to avoid dilution of the issued stock and justify the high P/E. Many PPMs currently carry high P/E multiples, which should make lenders wary that the bottom may fall out of this segment.

366. See id.
367. See Lowes, supra note 332, at 33. Access to information took as long as three months at times. See id.
368. See Deogun, supra note 336, at A6. This was a key issue since one of the reasons physicians join PPMs is access to management expertise, and management expertise enables the PPM to achieve efficiencies at the physician practice level.
369. See Marshall, Control, supra note 352, at 2F.
370. As of 1994, Coastal's P/E ratio was 29.2. COASTAL HEALTHCARE GROUP, INC., COMPANY REPORT (1994). When Coastal bought its physician practices, the doctor received cash or a combination of cash and stock. The amount of stock offered ranged from fifty percent to eighty percent of the purchase price. Generally, the doctor had to wait two years to sell the stock. See Lowes, supra note 332, at 34-36. When Coastal stock was trading at a high price, with a high price to earnings multiple, their stock gave them great purchasing power.
372. Lenders may benefit from this scenario since physicians may be more hesitant to accept stock compensation for their practices, resulting in the need for more cash and stock combinations in the purchase price.
373. As of the third quarter 1996, the trailing price to earnings industry average for PPMs was fifty-five as compared to twenty for the Standard & Poor 500. See NATIONSBANK 3RD QUARTER, supra note 14, at 21.
VI. CONCLUSION

Health care is an evolving industry in which participants seek ways to control costs while concurrently providing high quality and accessible health care to the American people. The uncertainty of the future in light of the volatility of the past makes the health care industry risky. However, the uncertainty may be thought of as an opportunity to those companies that engage in thoughtful analysis and proceed with caution. Lenders and attorneys need to maintain awareness of the health care industry's business, industry, legal, and regulatory risks, especially the HMO and PPM segments, which may reduce the profitability of health care companies.

When assessing a health care company, lenders should consider legal and regulatory areas of risk in addition to industry and financial risks. Medicare and Medicaid reform is just around the corner as the federal government seeks to balance the budget, and the outcome is highly uncertain. Since Medicare and Medicaid receivables usually account for a significant portion of health care receivables, the outcome of this reform will have a significant impact on HMOs and PPMs. Furthermore, the law continues to evolve in areas such as ERISA, Antitrust, and Fraud and Abuse. Each of these areas must be monitored closely in order to determine the ultimate impact on the financial viability of HMOs and PPMs in the health care industry.

Moreover, as attorneys counsel their clients and draft agreements, they should not only consider the legal and regulatory risks, but also the financial drivers and industry trends. HMOs contract with employers and providers, while PPMs contract with HMOs and physicians. These contracts result in obligations for each party. If these obligations cost too much or allow the incoming revenue of an organization to be reduced, the profitability of the HMO or PPM can be jeopardized. Therefore, attorneys should understand management's strategy and concerns so that all contracts will afford management the necessary protections needed in a volatile and uncertain future.

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