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From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs / COOs / CFOs

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R. Lewis Dark

Founder & Publisher

Do You Want To Follow Or Lead?

How many of our clients are ready to lead the industry? This issue of THE DARK REPORT provides you with an opportunity to move ahead of your competitors and gain a critical advantage. I am referring to the emergence of physician practice management (PPM) companies.

As you will read on pages 9-14, we predict these PPMs will become important players in most regional markets. Their control of a sizeable number of physicians will give them tremendous influence on how clinical laboratory services are purchased and utilized. Once again, THE DARK REPORT is first to identify a major industry trend and offer pathologists and laboratory executives insights on how to profit.

But where we can only offer valuable advice and insight, it is up to you to act decisively upon this information. This is why I ask whether you want to be a follower or a leader. Leaders will study the phenomenon of physician practice management companies. As they learn more, they will begin contacting the right executives at these companies to build relationships. Leaders will find out how these PPMs want to purchase and use laboratory testing. They will use this knowledge to create "value-added" services which best meet the needs and expectations of PPM customers.

Those clinical laboratories first to the PPM table with good pricing, good services and a personal relationship will be the laboratories which earn the business. That is the reward for leadership.

What about those laboratory executives who decide to follow? "Wait and see" is an attitude that will put their laboratories at a competitive disadvantage with PPMs. If **MedPartners, Inc.**, the largest PPM, now controls 10,000 physicians and $6.4 billion in sales, do you think that the three national laboratories are "waiting to see what happens?" No sir! I'll guarantee you that each of the three laboratories has people now contacting MedPartners and other rapidly growing PPMs. They are already pressing for the business.

That means regional commercial laboratories and hospital-based labs with outreach programs will be forced to come from behind if they fail to take action now. On the other hand, assertive marketing to PPMs this early in the game will permit shrewd laboratory executives to claim a place at the table. If they do, they will earn every dollar of business that the PPM sends to their laboratory. TDR

Legislators May Repeal New York Lab Surcharge

Six months of hearing from unhappy constituents stimulates state lawmakers to consider repeal

CEO SUMMARY: On January 1, New York State began to tax lab tests performed by free-standing laboratories with an 8.18% surcharge. The New York State Clinical Laboratory Association took its message directly to the public. Laboratories in New York State created enough consumer protest that legislators introduced bills in both chambers to exempt free-standing laboratories from this surcharge.

INDEPENDENT LABORATORIES in New York continue to press the state legislature for repeal of the 8.18% surcharge currently assessed on tests performed by "free-standing" laboratories within the state.

"I'm optimistic that we have turned a corner on this issue," stated Tom Rafalsky, President of the **New York State Clinical Laboratory Association** (NYSCLA). "Bills were introduced in both the Senate and the Assembly that would remove this surcharge on laboratory tests. As final budget legislation is enacted during the next 30 days, we believe that independent laboratories will be removed from the surcharge pool."

Legislation creating the surcharge was passed last summer. The laboratory industry was not aware of provisions in the bill which included independent laboratories in the taxing scheme until after the bill had been enacted into law. In the fall of 1996, lab industry representatives met with lawmakers to present their arguments as to why independent laboratories should be excluded from a hospital financing plan. *(See sidebar on page 3.)* Lawmakers were both unsympathetic and unresponsive during these meetings.

"We have a variety of constitutional and regulatory objections to this legislation and how the **Department of Health** is interpreting its implementation," noted Rafalsky. "This caused us to pursue two remedies. We filed a lawsuit seeking injunctive relief. We also began a campaign to educate both voters and state legislators about the negative consequences this surcharge has on independent laboratories." *(See TDR, February 17, 1997.)*

First rounds of the lawsuit did not favor NYSCLA's position. Lawyers for the trade group filed a notice of appeal with the judge in May and intend to move the lawsuit to the next level in the judicial process.

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NY's Lab Surcharge A Result Of Reforms To Hospital Financing

NEW YORK'S LABORATORY TEST SURCHARGE is part of a comprehensive effort to reform hospital reimbursement practices in New York. For many years New York regulated reimbursement under a system known as the New York Prospective Hospital Reimbursement Methodology (NYPHRM).

The advent of managed care caused hospital finances to deteriorate. These developments made NYPHRM out-of-date and ineffective. With hospitals in the state suffering severe losses, New York was forced to revamp hospital reimbursement through the use of market-based reforms.

"The Health Care Reform Act attempts to fund three basic healthcare activities in the state," explained Larry Siedlick, Chairman and CEO of Sunrise Medical Laboratories. "They are Indigent Care, Health Care Initiatives and Graduate Medical Education (GME). Legislators estimate that HCRA will raise $2.9 billion per year to fund these efforts.

"In simplest terms, hospitals pay a 1% surcharge on inpatient/outpatient revenues. The second category is called 'Patient Services Payments.' For services covered in this category, Medicaid and Workers' Compensation/No Fault surcharges will be 5.98%. Third party and private pay surcharges will be 8.18%."

Apparently the New York legislature recognized that hospitals were increasingly active in "non-traditional" activities, such as comprehensive clinics, and ambulatory surgicenters. The "Patient Services Payments" category was created to include those hospital business activities in the revenues subject to the surcharge.

"Regardless of what the legislature intended, independent laboratories fall into this second category," explained Siedlick. "This occurred despite the fact that independent laboratories were never part of the old NYPHRM system. They neither contributed to the revenue pools nor received any benefits from them."

NYSCLA's educational campaign proved to be the big winner. "Our member laboratories began printing notices on laboratory test bills sent to patients beginning January 1," said Rafalsky. "The response from the public was immediate.

"In the early months of this campaign, upwards of 1,000 calls per day were received by the Department of Health alone," he added. "Similar volumes of constituent phone calls and letters were received by senators, assemblymen and the governor's office.

100,000 Patient Bills Daily

"When passing the law, legislators overlooked the fact that 100,000 laboratory bills are mailed daily to their constituents," noted Rafalsky. "Six months later, this effort continues. We know that calls and letters concerning this laboratory test surcharge still flow daily into the state house."

Independent laboratories in New York State are suffering from the effects of this surcharge. The most immediate consequence has been a reduction in laboratory reimbursement schedules by private payers. Insurance companies are responsible for paying the surcharge. "Some insurance companies are blatantly passing the surcharge on to laboratories in the form of lower reimbursement," observed Rafalsky. "This was never the intent of the legislation."

Additional Costs

Laboratories incur additional costs when collecting, reporting and remitting the surcharge for patients with no insurance. Administrative requirements of the surcharge are difficult to fulfill. The Department of Health interprets the legislation as making the laboratory the guarantor of this surcharge. This is a policy to which NYSCLA vigorously objects.

Laboratories outside New York should understand that they are also threatened by this surcharge. In an inter-

view last February, Rafalsky told THE DARK REPORT that other states in the East were studying New York's laboratory test surcharge with the intent of adopting it.

"I know of several states which seriously looked at how to establish a similar taxing scheme," explained Rafalsky. "New York showed them a new source of revenue. Laboratories should keep a watchful eye on their state legislatures."

Massachusetts is one state which quickly noticed the new tax, but dropped the idea. In committee meetings held during February, attempts to introduce a tax on laboratory testing were met with objections that "the nightmare in New York" was not something elected officials in Massachusetts wanted to repeat.

Surcharge Created Chaos

"This surcharge has created chaos for many laboratories," said Pat Lanza, President of **Sunrise Medical Laboratories** in Hauppauge. "Despite the fact that the surcharge took effect over six months ago, there are laboratories which still do not collect the tax. Some laboratories don't have a method to track collections and remit payment. For such labs, the potential problems from non-compliance represent a ticking time bomb."

"The administrative burdens and costs are only part of the story," added Lawrence Siedlick, Chairman and CEO at Sunrise. "Insurance companies are required to pay the surcharge on laboratory tests. Since the surcharge took effect on January 1, more than half the insurance companies in the state have arbitrarily reduced their reimbursement schedules for laboratory testing."

According to Siedlick, Sunrise Medical Laboratories saw declines in laboratory test reimbursement schedules ranging from 4% to 10% during the last six months. "Insurance companies are passing the surcharge down to the laboratories. Obviously the financial impact of this is painful, because independent laboratories already struggle with revenue erosion caused by managed care and changes to Medicare and Medicaid."

Rafalsky, Lanza and Siedlick all agree that the battle to exclude independent laboratories from the surcharge is still not over. "Public outcry on the laboratory surcharge issue not only surprised our legislature and governor," explained Siedlick, "but it also created widespread recognition among lawmakers of the need to revisit the surcharge on laboratory testing. For example, all 35 Republican Senators sponsored the Senate's bill. That is certainly evidence that these Senators know their constituent's position on the laboratory test surcharge issue."

"From a practical standpoint," added Rafalsky, "there are differences in the Senate bill and the Assembly bill. These will need to be worked out and a common bill passed by both houses before we can claim success. People familiar with the legislative process know that many unexpected things can happen before any bill earns final approval."

NYSCLA's member laboratories earned the respect of senators, representatives and the governor's office for the educational program on the surcharge. "In meetings with legislative and executive leaders, all agree on one point," said Rafalsky. "They say we did a good job of educating the public!

"It demonstrates the power of the public to create action by the government," he continued. "It also demonstrates that clinical laboratories have the power to educate and motivate the public, if they can act as a united group on industry issues of common concern." **TDR**

(For further information, contact Tom Rafalsky at 212-245-3555; Pat Lanza and Larry Siedlick at 516-435-1515.)

3 Blood Brothers Differ On Surcharge Strategies

National labs take different approaches toward repeal of New York's laboratory test surcharge

CEO SUMMARY: United we stand, divided we fall. On the issue of laboratory test surcharge repeal in New York, the three national labs took independent positions. Was the clinical industry served by this lack of unanimity? More importantly, do the actions of two of these national laboratories reveal a possible predatory attitude toward independent commercial labs and hospital laboratory outreach programs?

SHOULD THE LABORATORY INDUSTRY show a united front in efforts to repeal New York's 8.18% surcharge on laboratory testing? Most laboratory executives would probably say yes.

After all, here's an unprecedented, unwarranted tax on a single category of healthcare provider: independent licensed clinical laboratories. No other class of non-hospital healthcare provider is required to pay the surcharge.

Further, every impact of the surcharge would be negative to clinical laboratories, while money from the surcharge was earmarked to benefit hospitals. Given this basic analysis, it should be a simple decision for any licensed laboratory in New York State: oppose implementation of the surcharge and seek repeal of the enabling legislation.

When the **New York State Clinical Laboratory Association** (NYSCLA) convened meetings to discuss this issue, it found general agreement among independent laboratories. However, there was neither consensus nor support by all three of the blood brothers, **Laboratory Corporation of America**, **Quest Diagnostics Incorporated** and **SmithKline Beecham Clinical Laboratories**. Of the three, only SmithKline has supported and participated in the programs organized by NYSCLA member laboratories.

...there was neither consensus nor support by all three of the blood brothers, Laboratory Corporation of America, Quest Diagnostics, Inc. and SmithKline Beecham Clinical Laboratories.

"Both LabCorp and Quest had already quit NYSCLA about one and a half years ago," stated Marvin Numeroff, who was president of NYSCLA at that time. "When this surcharge issue popped up, both labs reacted independently from NYSCLA. Each hired a lobbyist and is pursuing their own strategy in Albany."

As noted in earlier issues of THE DARK REPORT, NYSCLA's strategy focused on two areas: a lawsuit to

obtain injunctive relief and a campaign to repeal the legislation.

The linchpin strategy of the surcharge repeal effort was to alert the public that New York State was taxing laboratory healthcare services for the first time. This was accomplished by including a notice in every laboratory test bill sent to patients.

Regular Meetings

"During the fall of 1996 we met repeatedly with lawmakers and regulators over this laboratory test surcharge," stated Kirby Hannan, who represents NYSCLA in legislative matters. "On one hand, it was made clear to us that any publicity would create unfavorable consequences with legislators. On the other hand, after four months of meetings it became obvious to us that they considered the deed a 'fait accompli.' There would be no satisfactory response to our request for reconsideration."

Educating the public exposed the lab industry to risk and controversy with some lawmakers. However, it proved to be the one strategy which produced results.

"Obviously, delivering 100,000 patient bills per day to constituents with notice of a new tax scheme hit a sensitive nerve with the overtaxed public," said Hannan. "Lawmakers were not pleased, but this sustained public outpouring caused them to respond to the surcharge issue. Bills to repeal the laboratory test surcharge have been sponsored and entered in both the Senate and the Assembly."

Would this have occurred without public pressure? "I think not," replied Hannan. "Constituent response really made the difference on this issue. The educational campaign to the public turned out to be our most effective strategy in the campaign to repeal the surcharge."

Neither Quest nor LabCorp supported the public education campaign. Both companies declined to send information on the surcharge with their patient bills.

Our Opinion...

Inter-Lab Competition Affects Cooperation

IN THE ROUGH-AND-TUMBLE WORLD *of the free market, every laboratory views its self interest differently. No one should be surprised to see the three national laboratories act in opposition to the common interests of independent labs and hospital laboratories.*

For example, just three years ago, independent commercial laboratories in California were banding together to discuss forming what is now called the ***Preferred Laboratory Access Network*** *(PLAN) Their goal was to create a statewide managed care contracting consortium. This would permit them to bid for contracts exclusively held by the national labs. Managers from* ***National Health Laboratories*** *(NHL) showed up at early meetings and threatened to sue PLAN for anti-trust violations if they proceeded. NHL's intimidation did not succeed. PLAN obtained a favorable ruling letter on the network from the Department of Justice and proceeded with organization.*

We observe that most national laboratory industry meetings take place without either the regular participation or attendance of a significant number of the general managers from the larger regional laboratory sites operated by the three blood brothers. In that respect, they are isolating themselves from changes in the mainstream thinking within our industry.

Because of the intense competition within the laboratory industry, lack of unanimity in supporting the repeal of the New York laboratory test surcharge should not be surprising. But is there middle ground? As the clinical laboratory marketplace evolves in new directions, many laboratory executives are watching the three national laboratories to see if they have reformed their ways from past patterns of below-cost bids for managed care work. The low-ball price levels which resulted are what now threaten the financial health of the entire industry, themselves included.

—Editor

That was not the case with SmithKline, which actively supported this effort.

SmithKline also helped in funding the NYSCLA lawsuit, which went forward without money and support from LabCorp and Quest. Both laboratories are not participating in the NYSCLA lobbying initiatives to repeal the surcharge.

"Whether or not the laboratory test surcharge is repealed this summer, the process sure revealed a lot about the corporate attitudes of all three national laboratories," stated a president of one independent laboratory in New York. "Among my peers, there is definitely a feeling that LabCorp and Quest are getting a free ride should the lawsuit prevail and the surcharge get repealed. We've been doing all the work and putting up all the money. Success benefits all laboratories, including those two."

Different Attitudes

"During the past several years, I've noticed different attitudes by the three national laboratories in how they supported New York's clinical laboratory association," he continued. "SmithKline seems to appreciate the value to local communities of both hospital-based and free-standing laboratories. Certainly SmithKline recognized the value of patient bills in educating the public. It is my opinion that one reason SmithKline joined independent laboratories in sending notices with patient bills was was also to show a subtle sign of support to the smaller community-based laboratories."

Hannan had interesting opinions as to the motives of LabCorp and Quest. "After watching their actions in recent years on a variety of issues affecting clinical laboratories in New York, I believe that both LabCorp and Quest see the surcharge as encouraging further consolidation among smaller laboratories. Such consolidation would serve their long-established goals of increasing market share."

Further evidence that Hannan's opinion has merit comes from a knowledgeable observer. "Both Quest and LabCorp retained lobbyists of their own to work the surcharge issue. There is evidence that someone representing LabCorp is working to prevent the repeal of the surcharge, for reasons which I do not know."

LabCorp's Position

LabCorp Investor Relations Director Pam Sherry explained the company's position. "Our corporate counsel confirms that LabCorp has never been part of an industry coalition in New York. All lobbying on the surcharge supported by LabCorp has been done through the **American Clinical Laboratory Association** (ACLA). I can also definitely confirm that we are not trying to maintain the surcharge."

Marvin Numeroff offered another reason why Quest and LabCorp probably view issues like the surcharge differently than NYSCLA members. "For the most part, members of NYSCLA own and operate their own laboratories. An owner of a business certainly thinks about issues differently than an employee who represents a large company."

Surcharge Vote Approaches

As the time to vote on repealing the laboratory test surcharge approaches, laboratories in New York State will maintain efforts to educate lawmakers about its negative impact upon clinical laboratories. Another consequence of the repeal effort is that differences in how the three national laboratories seek to position themselves within the industry have surfaced. It demonstrates how difficult it will be for the laboratory industry to address similar concerns in the future behind a united front. TDR

(For further information, contact Marvin Numeroff at 718-859-4777, Kirby Hannan at 518-465-6550 and Pam Sherry at 910-584-5171.)

Legislative Watch

Proposed Monthly Test Limit Defeated By United Lab Action

PROPOSALS TO CAP laboratory tests at no more than six per month for MediCal patients in California alarmed clinical laboratories throughout the state. The **California Clinical Laboratory Association** (CCLA) took immediate steps to counter the proposals.

"This was a budget issue initiated by state bureaucrats," stated Michael Arnold, legislative advocate for CCLA. We were very much opposed to this. We testified in subcommittee hearings held by both the assembly and senate. Further, all CCLA member laboratories sent letters to subcommittee members outlining the reasons why this proposal should not be enacted.

"I think we did a pretty good job of educating lawmakers about our position," he continued. "Both budget committees listened to what we had to say and rejected the proposals. The lab test cap was also not included in the overall budget debate taking place at this time in the joint budget conference committee.

"This leads us to believe we have defeated the laboratory test cap for this year," added Arnold. "However, it is probably going to rear its ugly head again in coming years, because there is already a MediCal cap on prescriptions. The administration argues that laboratory tests should be capped in a similar fashion as prescriptions."

According to Arnold, lawmakers learned that the proposed laboratory test cap would restrict patients from necessary laboratory tests, because physicians would tend to avoid filing the burdensome "Treatment Authorization Request" forms (TAR) required for MediCal officials to approve exceptions to the monthly test cap. Further, the administrative cost to comply with this proposal would exceed any cost benefits to the state. It would also create disproportionate burdens for laboratories.

New York enacted a similar cap on Medicare testing several years ago. "At the time this was proposed, laboratories were concerned," stated Tom Rafalsky, president of the **New York State Clinical Laboratory Association** (NYSCLA). "Over our objections, the lab test cap was implemented.

"Unlike the proposal in California, our Medical lab test cap is 18 tests per year," said Rafalsky. "Certain classes of patients with chronic disease are exempted from the cap. Medicare officials claim the threshold of 18 tests per year only affects a small number of exceptions.

"Laboratories in New York have learned to live with this regulation," he explained. "It is the doctor who must get override authorization, but the laboratory has to do the billing. Laboratories find it is a problem getting doctors to cooperate."

Laboratories in other states should be alert to legislative proposals to cap Medicaid lab testing. Things that happen first in California and New York tend to be copied by other state legislatures. A trend to cap laboratory testing under Medicaid could even spread to the Medicare program. **TDR**

(For further information, contact Michael Arnold at 916-446-2646 and Tom Rafalsky at 212-245-3555.)

Affecting Pathology & Clinical Laboratories

Physician Management Companies Exploding, Will Transform Healthcare

By Robert L. Michel

CEO SUMMARY: Consolidation and integration of healthcare services will be the dominant trend during the next five years. It happened to commercial laboratories from 1985-95. Widespread hospital consolidation began around 1990 and continues today. Now consolidation is coming to physicians. As physician practices consolidate and come under the management of multi-billion dollar national corporations, both pathologists and clinical laboratories will need to respond with appropriate market strategies if they are to retain and expand business relationships with these physician practice management companies.

PHYSICIAN PRACTICE MANAGEMENT COMPANIES (PPMs) are probably the fastest growing consolidators of healthcare in today's marketplace. Yet few pathologists and clinical laboratory executives appreciate the profound changes to be triggered by PPMs during the next five years.

Pathologists will be impacted in two ways. First, pathology-based PPMs are already in the marketplace seeking to purchase pathology practices. Pathologists now find themselves asking: "Should I sell my practice to a PPM? To which PPM should I sell? At what price?"

Readers of THE DARK REPORT are already familiar with the business strategies of such emerging pathology-based PPMs as **AmeriPath**, **Physician Solutions** and **American Pathology Resources**. *(See TDR, November 4, 1996 and April 21, 1997.)* These companies are the first wave of physician practice management companies to enter the pathology market/place.

Changes To Contracting

Second, just as pathology-based PPMs will change the structure and business organization of pathology practices, so also will family practice and specialty PPMs impact the way pathology services are contracted and delivered. Clinical laboratories can expect to experience similar changes. This will occur as PPMs participate in new forms of healthcare service organizations. (*See sidebar on page 12.*)

Pathologists and clinical laboratory executives should anticipate the needs of PPMs and prepare effective strategies to partner with them in profitable ways. The development of PPMs is a major trend. As PPMs increase their market clout in certain cities, they will seek to control costs and enhance clinical effectiveness by cutting innovative deals with responsive pathologists and clinical laboratories.

In the fee-for-service healthcare world of the past, the great majority of physicians practiced medicine as individuals, in small groups or regional clinics. This fragmented marketplace is inappropriate to serve managed healthcare.

Physician practice management companies became the way to consolidate fragmented physician practices into national chains. These PPMs start by purchasing clinics and group practices. They attempt to generate short term cost reductions by centralizing administration, billing, purchasing, managed care contracting and similar functions.

PPMs are not the only group seeking to acquire and consolidate physician practices. Hospitals and integrated delivery systems comprise the other physician practice consolidator in the marketplace Because they are local, hospitals and integrated systems will not have national influence in the same way as national PPMs.

Fast-Growing Segment

Physician practice management companies represent a fast-growing segment of healthcare. To better understand the phenomenon, a close look at the leading industry PPM explains why investors are willing to pour tens of millions of dollars into these companies. Just as **Columbia/HCA** dominates the for-profit hospital marketplace, **MedPartners, Inc.** of Birmingham, Alabama is the major player among physician practice management companies.

Founded just four years ago, MedPartners manages over 10,000 physicians and will finish 1997 with projected revenues of $6.4 billion! That performance makes it one of the fastest-growing corporations in the nation's history.

Whereas most PPMs are looking to gain economic benefits through the consolidation of administration, billing, purchasing and similar internal cost containment measures, MedPartners has an expansive view for the future. It wants to become an integrated, comprehensive provider of clinical services. Like Columbia/HCA, MedPartners wants to create a national, brand-name, profit-driven delivery system.

To make that vision a reality, MedPartners is carefully acquiring compa-

nies with unique expertise. MedPartners recently purchased **InPhyNet Medical Management**, which is the nation's largest manager of hospital-based physicians practices. MedPartners also acquired one of the five largest pharmacy benefit managers in the country when it purchased **Caremark International** in September 1996. Besides pharmacy benefit management, Caremark brought a rapidly developing disease management capability to MedPartners.

In order to take advantage of these comprehensive resources, MedPartners wants to become a national, branded healthcare service. The company is pursuing two strategies to make this happen. The first is to build physician networks in the top 55 markets within the United States. Coincidentally, this is the same goal for the national HMOs. MedPartners seeks to position itself as a single, national solution for such HMOs.

In fact, MedPartners already has an agreement with one such HMO to provide services on a national scale. In March 1997 it was announced that **Aetna U.S. Healthcare** would utilize MedPartner physicians in any city where both Aetna and MedPartners do business.

Global Capitation Next

MedPartners' second strategy is to convert its physicians to global capitation. Such arrangements would include hospital and pharmacy services. "This is not about acquiring a lot of practices and trying to squeeze profits out of them," stated Larry House, President and CEO of MedPartners. "It's about fundamental change in the healthcare delivery system."

Unlike most of his PPM competitors, House intends for MedPartners to become a full-fledged competitor for the healthcare dollar. By striving toward global capitation, MedPartners becomes a competitor with some hospitals. For HMOs, there may be reluctance to allow physicians to manage pharmacy benefits. It could prove difficult for MedPartners to establish a market presence if these players choose not to cooperate. However, MedPartners' $6.4 billion in annual revenues gives it the clout necessary to compete for this business.

How much business does this represent? MedPartners wants to develop a 10%-15% market share in each of the 55 largest markets. To date, it has only achieved 15% market share in Southern California. In MedPartners' other regions, market share does not exceed 5%.

Sizeable Laboratory Volume

MedPartners' goal of 15% market share in the top 55 markets gives clinical laboratories an indication that MedPartners will control a sizeable amount of laboratory test volume. For the three blood brothers, Laboratory Corporation of America, Quest Diagnostics, Inc. and SmithKline Beecham Clinical Laboratories, MedPartners represents an important chunk of business. It should not surprise anyone if MedPartners announced a national laboratory testing agreement with one or more of these three laboratories during the next 24 months.

In the meantime, Southern California is the market to watch. MedPartners will use Southern California as the test bed for its business strategies. That process is already under way. In March, MedPartners inked an agreement with **Tenet Healthcare Corp.** to create a single contracting network between MedPartners' 4,000 physicians and Tenet's 33 hospitals. (*See sidebar on next page.*) The MedPartners name is also beginning to appear on its Southern California offices. This is the first move to implement the national branding strategy.

Physician practice management companies are not without their detractors. Many physicians point out the loss of control that results when a corporation purchases a physician's practice.

Tenet And MedPartners Team Up To Create "Regional Network" In Southern California

NEW PURCHASING RELATIONSHIPS triggered by physician practice management companies such as MedPartners are perfectly illustrated by Tenet Healthcare Corp.'s activities in Southern California.

Tenet is cutting deals with one PPM and one clinical laboratory to provide services to their 33 hospitals in Southern California. Tenet chose MedPartners to be its PPM partner. In April, Tenet announced that it was forming a provider network with MedPartners. In a clever win-win strategy for both firms, Tenet's 33 hospitals and MedPartner's 4,000 physicians form the backbone for a single contracting network.

MedPartners has 1.4 million patients who can now access Tenet's hospitals in Southern California. Further, MedPartners' managed care plan, Pioneer HMO, with 100,000 enrollees, will obtain inpatient hospital care from 13 Tenet hospitals under a full-risk capitation agreement. Just this part of the agreement is valued at $80 million per year in revenues.

Simultaneous with this, Tenet is selecting one laboratory to provide reference and other testing for its hospitals. Obviously the winning laboratory would have the inside track to service physicians in the MedPartner offices as well. Quest Diagnostics Inc. is believed to be Tenet's first choice to serve their 33 hospitals.

Tenet is creating a critical mass of 33 hospitals and 4,000 physicians. If a single laboratory can provide services and integrate laboratory test data across the information systems of hospitals and physician offices, it becomes an essential partner in this clinically integrated alliance.

Tenet's Southern California project illustrates how PPMs create new business models that can be served by laboratories and pathology groups with regional capability. It demonstrates the need for pathologists and clinical laboratories to anticipate how they can best serve these newly evolving forms of healthcare providers. It will also require new sales and marketing strategies.

There is also the perception that corporate executives are more inclined to compromise the quality of healthcare in favor of cost management.

Continued PPM Growth

While examples may exist to justify these criticisms, healthcare industry analysts predict continued rapid growth among PPMs. According to **Sherlock Co.** of Gwynedd, Pennsylvania, during 1996, publicly traded PPMs closed 368 acquisitions. This was up from 1995 and 1994, when acquisitions totalled 250 and 141, respectively.

For pathologists, the arrival of PPMs on the healthcare scene triggers important decisions. Should the pathologist sell to a pathology-based PPM? If the decision is not to sell, what kind of market strategies are necessary to protect existing contracts and revenues? Are colleagues in the pathologist's practice ready to compete against whatever PPM pathology services might be offered in their local market?

These are difficult questions. They require skills in market assessment, business planning and financial analysis which most pathologists have yet to develop. Even organizers of the early pathology PPMs are not 100% confident that these infant companies can find success in today's rapidly evolving healthcare marketplace. The financial exposure from making the wrong decisions can propel some pathology PPMs and individual pathology practices into bankruptcy.

An entirely different issue which confronts both pathologists and clinical laboratories is the market impact of PPMs on contracting and service

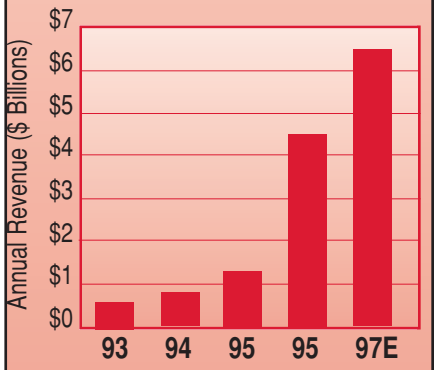
MedPartners, Inc.

Key Facts

Number of States with Physician Offices: 36
Physician Affiliations: 10,753
Group Practices: 2,646 physicians
IPA Relationships: 5,699 physicians
Hospital-based: 2,408 physicians
Pharmacy Benefits Management: 15 million people in all 50 states.
Physician Practices: 253
Practice Locations: 580
Emergency Room Contracts: 145
Radiology Contracts: 22
Number of Enrollees: 1,686,982
Revenue from Prepaid Care: 52.2%.

As illustrated by the graph below, MedPartners has enjoyed phenomenal growth since its founding in January 1993. Estimated revenues for 1997 are $6.4 billion.

ANNUAL REVENUE



Source: MedPartners, Morningside Financial.

issues. Will PPMs buy anatomic pathology and laboratory testing in different ways? Will PPMs develop sufficient market clout to radically transform current industry practices for contracting, for pricing and for bundling of pathology and laboratory testing services?

If PPMs continue their growth and influence in local markets, then the answer will be yes. As the largest PPMs achieve national capability, it will make them logical partners for the national HMOs, self-insuring corporations and similar healthcare service purchasers.

The Tenet-MedPartners agreement in Southern California should be carefully watched by pathologists and clinical laboratory executives. It is an early, if not the first, model of how a large PPM, in combination with a strong regional hospital system, can create a healthcare service consortium unlike anything existing today in the United States. Arrangements between MedPartners and Aetna will provide further insights into how PPMs and national HMOs will transact business.

Important Clues

For clinical laboratories, the Tenet-MedPartners consortium may provide important clues about future opportunities. Which labs will be winners, which labs will be losers if the consortium goes to either an exclusive or limited laboratory provider panel? Will Tenet insist that, where feasible, MedPartners' doctors send their outreach testing to the nearest Tenet hospital laboratory?

For pathologists at the Tenet hospitals, does the MedPartner agreement give them an advantage to pursue AP work originating in the physician's offices? What if the tables were turned? Could MedPartners convince Tenet that it makes economic sense to have all of Tenet's hospital-based physicians affiliated with, and be managed by, MedPartners?

These are fascinating questions. Unfortunately, answers will not be forthcoming until Tenet, MedPartners and the marketplace provide answers. In the meantime, perceptive observers can gain early insights into how national PPMs may alter current healthcare practices by watching the progress of MedPartners' first regional agreements. TDR

(For further information, contact Robert Michel at 503-699-0616.)

Pathologists Beware...

Proposed Changes to PPM Accounting May Impact Pathology Practice Roll-Ups

MANY PATHOLOGISTS wonder whether they should consider selling their practice to one of the emerging pathology practice management (PPM) companies.

One appeal of these PPMs is the potential of their stock to become publicly traded. Were that to happen, and the pathology PPM generated ample profits, share prices could soar, enriching its pathologist stockholders. Indeed, this is precisely what occurred to some of the earliest public PPMs.

AmeriPath, Inc. is the first pathology-based PPM to flirt with an initial public offering (IPO). It acquired 12 pathology practices in five states, generating annual revenues of $82 million. In THE DARK REPORT'S analysis of the economic justification and business design of Ameripath's proposed IPO last January, it was noted that much of upside potential in the short term depended on the stock market giving AmeriPath the same earnings multiple as existing PPMs. Eventually AmeriPath's IPO was cancelled and the company is revamping its business plan in preparation for another attempt at an IPO later this year. *(See January 17, 1997, pages 2-7.)*

It is important for pathologists to understand what types of accounting practices support some public PPMs. Typically, a PPM can purchase a physician's practice for up to six times annual earnings, including goodwill. If Wall Street bids the stock price to a multiple of 25 times earnings, the difference between the price paid to the physician and the stock's value is profit to the shareholders. Most PPMs currently trade at a multiple of 25-27 times earnings, so this is a realistic strategy in today's stock market.

What makes this game possible is that the PPMs pay the physician a large amount of goodwill. (Goodwill is the difference between the value of tangible assets and the purchase price for the business.) In some cases, up to 80% of the purchase price may involve goodwill. This pumps up the purchase price the physician can get for selling his practice. Because the PPM can pay more, the physician has a motivation to sell to a PPM as opposed to another physician.

PPMs will pay an "overmarket" price because current SEC rules permit companies to amortize goodwill costs over an unspecified period of time. Many PPMs choose to amortize goodwill over a 40-year period. This reduces the annual charge from writing down goodwill.

What makes this questionable from an investor perspective is the fact that a PPM is really purchasing the physician's services. Will the physician work for the PPM for 40 more years? What happens when the physician's non-compete runs out?

The SEC is proposing that goodwill be amortized over ten years. Compromise proposals would cap it at 20 or 25 years. Should the SEC succeed in changing the way goodwill is written off, then the formulas Wall Street uses to value new PPMs could change dramatically for the worse.

For pathologists nearing the retirement age, selling to a PPM may be a good way to maximize the value of their practice. For pathologists with many years of career ahead, the motives of the PPM organizers should be carefully scrutinized. Once the pathologist sells his practice, he loses significant control over how the practice is managed.

Savvy pathologists realize that the goal of a pathology PPM should be to add value in the marketplace, not to pump share prices upwards through accounting tricks. The first is a formula for long-term success. The second is a short-term profit gambit.

Dismal Hospital Finances Behind Lab Joint Venture

Columbia/HCA's motivation was to restore profits at their three Louisville hospitals

CEO SUMMARY: 1995 marked a pace-setting agreement between Columbia and LabCorp. LabCorp would consolidate and manage the laboratories at three Columbia Hospitals. All participants agree that the project has met expectations. But Columbia has yet to clone this model elsewhere. Here's why.

COMMENTATOR Paul Harvey is famous for his trademark radio programs which end with the tag line "... and now you know the rest of the story."

THE DARK REPORT has finally ferreted out the secrets of the joint venture in Louisville between **Columbia/HCA** and **Laboratory Corporation of America.** Now "the rest of the story" can be told about this ground-breaking alliance.

When the Columbia/LabCorp joint venture was first announced in the fall of 1995, many lab industry executives wondered how this would change the competitive marketplace for laboratory services. The reason was simple.

Ideal Test Of Consolidation

Columbia was taking three local hospitals, representing over 1,100 beds, and consolidating those laboratories with LabCorp's large regional laboratory in Louisville. It would be an ideal test of how to successfully marry the strengths of a large commercial lab with the local needs of three nearby hospitals. It might even put to rest that oft-quoted fear that "commercial laboratories can't run hospital labs because they don't understand the different way a hospital lab operates."

For the three national laboratories, a successful Columbia/commercial lab joint venture in Louisville could become the model for similar deals throughout the country. Because Columbia operated over 300 hospitals at the time, LabCorp, **Quest Diagnostics Inc.** and **SmithKline Beecham Clinical Laboratories** had reason to believe that Columbia's success with this joint venture might trigger a cascade of similar arrangements. This was potentially a major business opportunity.

Hospital-based laboratories and regional commercial labs viewed this differently. If Columbia were to move this model outside Louisville and partner with a national lab in their particular community, it would mean one more tough competitor to battle. This would not be welcome news for regional laboratories already struggling to maintain financial stability.

To the surprise of many, however, Columbia has yet to clone this joint venture model with any of the three national labs in any other city. Given

Columbia's reputation for innovation, experimentation and a willingness to change traditional practices if it boosted profits, this was puzzling.

The secret behind how the Louisville deal came about is also the reason why Columbia has yet to duplicate this model in other cities. The secret is both simple and logical.

Through a quirk of circumstance, all three Columbia Hospitals in Louisville were losing money. They are **Columbia Suburban Hospital, Audubon Regional Medical Center** and **Columbia Southwest Hospital.** They were losing so much money that two of the three Louisville hospitals ranked in the bottom 10 worst-performing hospitals owned by Columbia in 1995!

Instead of innovation, Columbia's joint venture with LabCorp was done from desperation. Local Columbia executives were willing to take any steps necessary to restore their three hospitals to profitability.

This also explains why Columbia executives in other regions have not copied the Columbia/commercial lab joint venture model. If the Louisville hospitals continue to lose money, why would another Columbia executive want to copy the consolidated laboratory model from that city?

Both Parties Satisfied

Indications are that Columbia and LabCorp are satisfied with the performance of the lab joint venture, both in terms of finances and service. But until the Louisville hospitals return to profitability, no other Columbia executive appears eager to copy the model.

During the last two years, the only other reported Columbia/commercial lab joint venture is the Atlanta reference lab project. This is a partnership between Columbia/HCA and **MDS Healthcare** of Ontario, Canada. Unlike the Louisville joint venture, which utilized existing laboratory resources, the Columbia/MDS venture is constructing

Columbia's Bottom Ten Hospitals

Ranked by Net Losses ($000's)

This table shows how Columbia's three Louisville hospitals rank among the worst financial performers in 1995, the year that the laboratory joint venture with Laboratory Corporation of America was created. Rankings involve 317 hospitals owned by Columbia/HCA

Rank	Hospital	Reporting Year	Net Income
317.	Columbia Doctor's Hospital, Tulsa	1995	-$11,698
316.	Columbia Michael Reese Hospital, Chicago	1995	-$11,194
315.	Columbia Grant Hospital, Chicago	1995	-$8,471
314.	Columbia Medical Center At Terrell, Terrell, TX	1995	-$5,867
313.	Beaumont Medical Surgical Center, Beaumont, TX	1995	-$5,629
312.	Columbia Independence Regional Health Center, Independence, MO	1995	-$5,274
311.	Columbia Montgomery Regional Medical Center, Montgomery, AL	1995	-$5,093
310.	Columbia Medical Arts Hospital, Dallas	1995	-$4,115
309.	**Columbia Suburban Hospital, Louisville, KY**	**1995**	**-$3,604**
308.	**Audubon Regional Medical Center, Louisville, KY**	**1995**	**-$3,085**
289.	**Columbia Southwest Hospital, Louisville, KY**	**1995**	**-$1,201**

Source: HCIA, Baltimore, Maryland.

a state of-the-art reference laboratory from scratch. It will include the automated laboratory equipment which MDS designed and markets under the **Autolab** name. MDS will also manage the laboratory.

Columbia's contribution to the partnership is cash and reference testing from its 18 hospitals located in Georgia. To supplement the reference testing volume from the Columbia hospitals, the partnership intends to pursue outreach testing in competition with other laboratories in Atlanta and throughout the state.

This means Columbia provides two interesting case studies for the laboratory industry to watch. In Louisville, the joint venture utilizes existing laboratory capacity. It took excess capacity off line while reducing costs to the joint venture partners.

The outcomes will teach laboratory executives which strategy is wiser: to build new, highly efficient laboratories or to take existing laboratory resources and make them as productive as possible.

This is in keeping with THE DARK REPORT's prediction of regional laboratory systems which evolve by using existing laboratory resources in that area for their highest and best use. It avoids the construction of new laboratory capacity at a time when managed care is squeezing excess hospital beds and laboratory resources out of existence.

Atlanta represents exactly the opposite approach to excess capacity and laboratory regionalization. The construction of a new laboratory in a crowded metropolitan marketplace adds capacity. It sets up the same kind of scenario which was played out in California.

With lots of excess lab capacity and high fixed costs, the temptation is to bid incremental specimen volume at marginal cost. This is what occurred in California. There each laboratory hoped that increased volume, even priced at marginal cost, would lower the average cost per test going through their laboratory.

Strategic Folly

As a result, competitive pricing in California became the lowest in the nation. During 1996, a rash of laboratory bankruptcies demonstrated the folly of that strategy, even as the bankruptcies themselves removed excess laboratory capacity from the California marketplace.

Could the same thing happen in Atlanta? SmithKline and Quest both operate regional laboratories in that area. The additional lab capacity available to the Columbia/MDS partnership may encourage them to discount testing in order to attract outreach specimen volume. Further, were Columbia/MDS to discount to attract volume, would SmithKline and Quest demonstrate pricing discipline? Or would they discount to match Columbia/MDS in order to protect existing market share?

There will be many interesting lessons to learn from the experience of Columbia in both Louisville and Atlanta. With managed care continuing to squeeze costs out of the system, knowledge gained from these two markets will be invaluable. The outcomes will teach laboratory executives which strategy is wiser: to build new, highly efficient laboratories or to take existing laboratory resources and make them as productive as possible.

As to the Louisville joint venture, it remains the one recent example of a commercial lab consolidating and managing multiple hospital laboratories. The Louisville concept works and was born of financial desperation. And now you know... *the rest of the story!* TDR

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

Neuromedical Systems, Inc.'s (NSI) President and CEO, Mark Rutenberg, is probably the first victim of the Pap smear technology wars. It was announced on June 30 that Rutenberg had resigned. Apparently investors are unhappy with his company's performance. Despite widespread promotion of Neuromedical's PapNet™ technology, the company's stock price dropped precipitously in recent months. Rutenberg is the visionary who founded NSI and spent almost ten years bringing the technology to market. In fact, just last year Rutenberg was honored as Entrepreneur Of The Year by **Ernst & Young**.

ADD TO...
PAP SMEAR WARS

For **Cytyc, Inc.**, news from the battlefront was good. **Quest Diagnostics Inc.** agreed to offer Cytyc's ThinPrep™ Pap Test throughout its national system of laboratories. Reimbursement remains an obstacle, and Quest's Chief Medical and Science Officer, Dr. Gregory Critchfield, noted that fact in Cytyc's press release.

HMO DOCTOR VISITS

In a study partially funded by the **R.J. Wood Foundation**, it was determined that HMO enrollees see their doctor more than PPO or indemnity enrollees. HMO medical visits averaged 4.8 per person per year. The number for PPO and indemnity enrollees was 4.5 and 4.0, respectively. Researchers attribute this increased number of visits to their belief that HMO enrollees have easier access to primary care providers.

Columbia/HCA may be picking up an image of a media "bad boy." In the last month, both the *Wall Street Journal* and *Modern Healthcare Weekly* ran large stories built around interviews with ex-Columbia executives. Both stories referenced the stress and conflict managers experience in attempting to meet Columbia's rigorous financial goals.

Healthcare consolidation continues, and **Kaiser Permanente** is on the move. Voting members of **Group Health of Puget Sound** in Seattle voted to approve an unusual merger with Kaiser's Northwest Division. Although both plans retain their name, assets and operations, a newly formed, not-for-profit company in Portland, Oregon will oversee the combined operations. This partnership creates a plan with 1.1 million enrollees, 1,912 physicians and $1.9 billion in revenue. Kaiser would like to create similar partnerships in other parts of the United States.

Physician Office Laboratories (POL) may be on the decline. According to the **Center for Laboratories at HCFA**, the number of POLs decreased by 3,000 between 1995 and 1996. POLs represent 55.2% of all labs registered or certified in HCFA's database under the CLIA amendments. This is a decline from 57.9% in 1995.

That's all the insider intelligence for this report. Look for the next briefing on Monday, August 4, 1997

THE DARK REPORT

UPCOMING...

- *Midyear Review: "State Of Pathology" And "State Of The Clinical Laboratory."*
- *Update On Laboratory Automation Investigates Technology's Performance.*
- *Selling Your Pathology Practice: Strategies To Develop The Highest Price.*
- *Capitation Pricing For Laboratory Services Takes Surprising Direction.*