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The four-part Aventis Pharmaceuticals **Managed Care Digest Series™** is part of our continuing commitment to provide you with key data on the evolution of health care. Our goal is to help you remain on the leading edge of health care changes in America, and we hope that this information enables you to identify the trends that can result in positive outcomes for your organization. This series contains information that can help you develop strategies, control costs, and assess value by providing real-world applications for information management coupled with the latest health economics data.

Aventis Pharmaceuticals (see insert) is pleased to provide you with your copy of the *Medical Group Practice Digest*. This Digest profiles medical group practices, which are the focal point for delivery of the highest quality, most cost-effective care in managed care settings. The participation and performance of medical groups are extremely important factors in the process of improving the quality of care and patient satisfaction within local care systems.

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Sincerely,

Dave Pickhardt
Vice President, Managed Care

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Aventis Pharmaceuticals
399 Interpace Parkway
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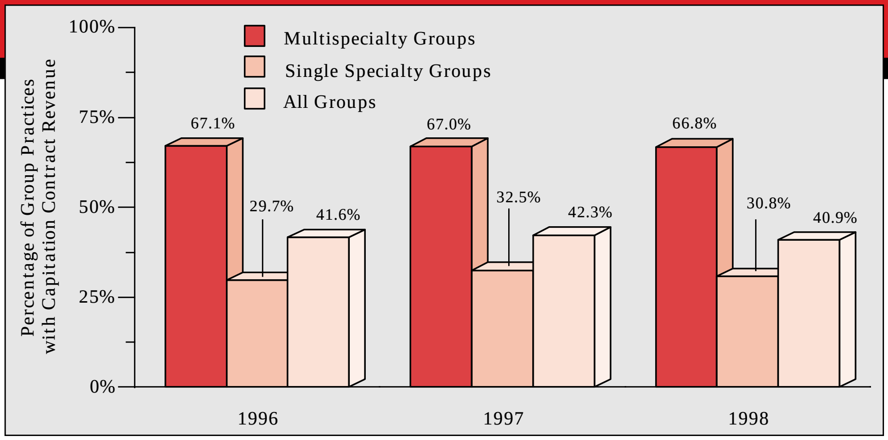
SHARE OF GROUPS WITH CAPITATION REVENUE DECLINES
The percentage of MGMA group practices deriving revenue from capitation contracts dropped in 1998, to 40.9% from 42.3% in 1997. The share of multi-specialty groups generating capitation contract revenue (66.8%) was 36 percentage points more than that of single specialty groups (30.8%).



Data sources: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999, 1998 Report Based on 1997 Data © 1998 and 1997 Report Based on 1996 Data © 1997

Introduction

Aventis Pharmaceuticals is pleased to present the **Medical Group Practice Digest** of the Aventis Pharmaceuticals **Managed Care Digest Series™** for 2000. This annual series of Digests sponsored by Aventis Pharmaceuticals includes the **HMO-PPO/ Medicare-Medicaid Digest,** the **Institutional Highlights Digest** and the **Managed Care Trends Digest 2000**. The series also provides information about all the major components of health care delivery.

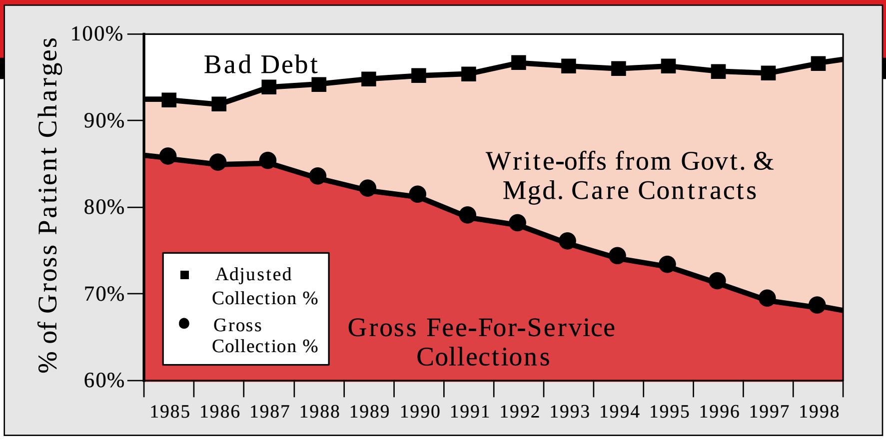
The **Medical Group Practice Digest** is designed to provide a useful set of statistics about medical group practices, which are a critical factor in the delivery of the highest quality, most cost-effective care in managed care settings. The participation and performance of medical groups are extremely important factors in the process of improving the quality of care within local care systems.

We leave it to you to interpret the data. We hope you will refer often to this Digest and to the others in our series on managed care.

USES FOR THE DIGESTS

These Digests are used by health care providers, associations, insurers, consultants, strategists, employers and policy analysts. Feel free to use this publication's contents in any way you like, provided that you credit the Aventis Pharmaceuticals **Managed Care Digest Series™ Medical Group Practice Digest** *and* all sources listed for the particular data presented in the Digest. Digest statistics are often used for:

- Speeches and presentations
- Health care organization planning and budgeting
- Health care strategic forecasting
- Comparisons of industry segments with an individual organization's results
- Benchmarking for quality analysis and improvement
- Marketing projections
- Product development.



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

MEDICAL GROUPS COLLECT 68.4% OF PATIENT CHARGES

Groups collected 68.4% of patient charges in 1998, down from 69.2% in 1997. The remaining charges were written off either as contractual adjustments and government charge restrictions (28.2%) or as bad debt (3.4%).

Data Sources and Methodology

This Digest was developed in cooperation with the Medical Group Management Association (MGMA), Englewood, Colo., the American Medical Group Association (AMGA), Alexandria, Va., and, for the first time, the California Association of Physician Organizations (CAPO), Los Angeles, Calif.

This Digest includes data published for the first time ever from the Specialty Cost and Capitation Survey and the Pharmacy Risk Survey conducted by CAPO, an affiliate of the Healthcare Association of Southern California (HASC). HASC represents more than 300 health care organizations in Southern California, including hospitals and health facilities, physician groups and integrated systems. CAPO data derive from 19 of more than 65 CAPO member groups.

The MGMA is the national professional and trade association representing medical group practice administrators, with 7,204 group practices that include 185,154 physicians. The MGMA and its Center for Research maintain the nation's largest collection of medical group practice management materials and databases about medical group practices.

This Digest contains data from four MGMA and Center for Research survey reports:

- *MGMA Cost Survey: 1999 Report Based on 1998 Data, 1998 Report Based on 1997 Data* and *1997 Report Based on 1996 Data*
- *MGMA Physician Compensation and Production Survey: 1999 Report Based on 1998 Data* and *1998 Report Based on 1997 Data*
- *CRAHCA Performance Efficiency Evaluation Report (PEER): 1998, 1997* and *1996 Annual Reports*
- *CRAHCA Physician Services Practice Analysis (PSPA) Comparison: January–June 1999 Medians.*

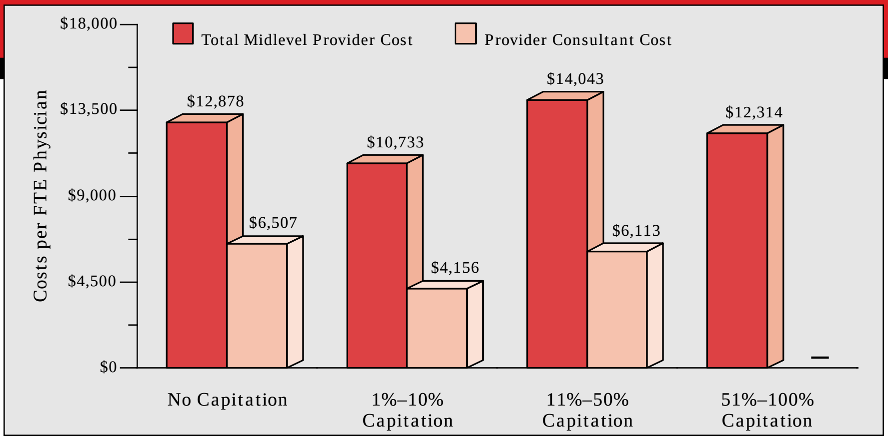
The MGMA data presented in this Digest are not based on random sampling, and the sample size and other characteristics of the data presented may vary from year to year.

The AMGA provides members with various products and services, including legislative representation and participation in outcomes measurement, managed care and education programs.

This Digest contains data on AMGA group practices as of December 31, 1999 or earlier. At year-end 1999, membership in the AMGA included 211 medical group practices with a reported 41,327 physicians nationwide.

AMGA data are compiled from AMGA's statistical database and pharmacy risk survey of member groups. Information on patient satisfaction and best practice benchmarks is from *Patient Satisfaction Specialty Benchmarks*, a continuing survey by AMGA's Outcomes Measurement Consortia.

This Digest also features highlights of a telephone focus group discussion, during which medical group leaders shared their views on current medical group issues.



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

MIDLEVEL PROVIDER EXPENSES DECLINE AT GROUPS WITH HIGH CAPITATION
Group practices with more than 50% capitation revenue recorded total midlevel provider costs of $12,314 per FTE physician in 1998, down 14.2% from $14,353 per FTE physician in 1997, and 4.4% lower than the $12,878 at groups with no capitation revenue.

MEDICAL GROUP PRACTICES DEFINED
A medical group practice is a formal and legally recognized organization that consists of three or more physicians who are engaged in the practice of medicine, sharing business management, facilities, records and personnel.

AN EXPLANATION OF FTE PHYSICIANS
Full-time-equivalent (FTE) clinical care physicians work at least the minimum number of hours that the group practice considers to be a normal work week (or 1.0 full-time-equivalency). Within this formula, a clinical care physician working half of this minimum number of hours would account for 0.5 FTEs, etc.

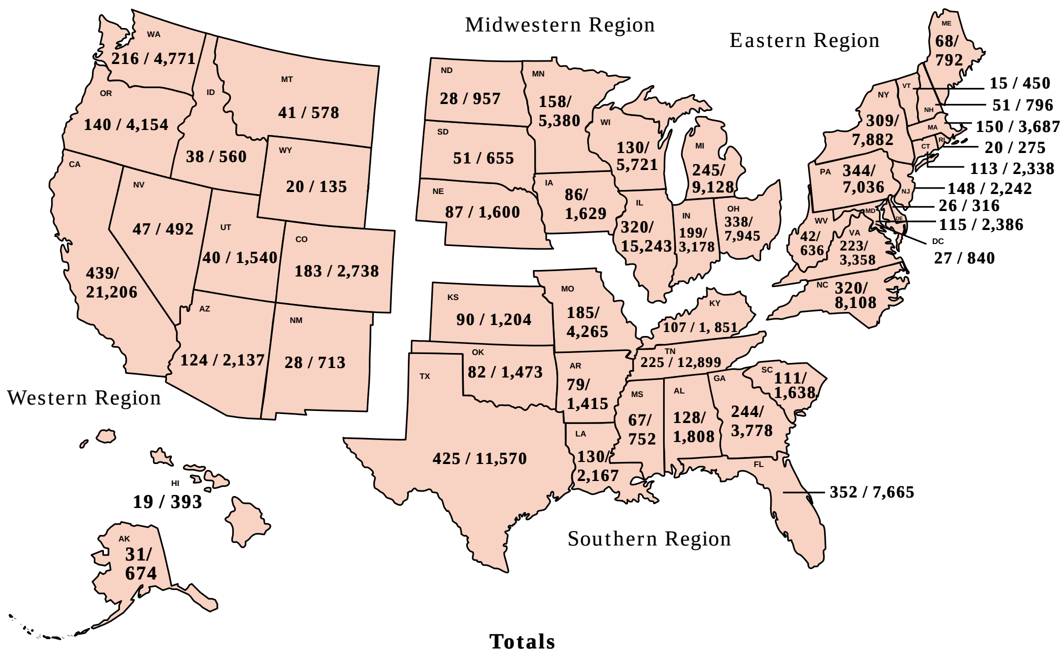
Summary of Key Findings

- The number of Medical Group Management Association group practice memberships declined 5.8% in 1999, to 7,204 from 7,648 in 1998, while the number of physicians practicing in MGMA groups fell 1.1%, to 185,154 from 187,159 in 1998.
- The number of group practices owned by physicians fell 11.6% in 1999, to 4,486 from 5,075 in 1998. These groups accounted for 62.3% of all MGMA groups, down from 66.3% the previous year. The number of physicians in these groups declined 8.2%, to 71,443 from 77,798 in 1998.
- MGMA multispecialty groups with more than 50% capitation revenue had higher median total medical revenue per FTE physician than did other groups in 1998, at $559,769, or 3.6% higher than the $540,275 reported for groups with no revenue from capitation.
- The overall share of MGMA groups with revenue from capitation contracts dropped overall (to 40.9% from 42.3% in 1997) and in four of six size categories profiled in 1998.
- The ratio of FTE support staff to FTE physicians was 6.20 for MGMA multispecialty groups with more than half of revenue from capitation in 1998, 21.6% higher than the 5.10 for groups with no capitation revenue, and 3.3% higher than the 6.00 ratio reported for groups with high capitation revenue in 1997.
- The actual Medicare + Choice pharmacy expense at reporting CAPO physician organizations was $53.27, significantly above the $31.14 target for expected claims. The result was a net deficit of $9.70 PMPM in 1999.
- Of 41,327 total FTE physicians in AMGA groups in 1999, 32,230 (78.0%) were in groups with 151 or more FTE physicians. These large groups accounted for 27.0% of all AMGA groups, whereas groups with 10 or fewer FTE physicians made up only 4.7%.
- Whereas more than 75% of AMGA groups with 100,000 or more capitated lives derived more than half of revenue from capitated contracts in 1999, no such groups with fewer than 15,000 capitated lives did so.

MGMA membership reflects practice consolidation

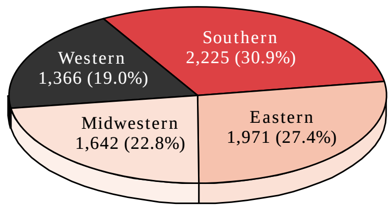
The number of MGMA group practice memberships declined 5.8% in 1999, to 7,204 from 7,648 in 1998, while the number of physicians in MGMA member groups fell 1.1%, to 185,154 from 187,159.[1] In 1999, member groups of the MGMA accounted for 37.0% of all 19,478 groups in the nation, and MGMA group physicians made up 89.6% of the 206,557 physicians in medical group practices.[2]

DISTRIBUTION OF MGMA GROUPS AND PHYSICIANS

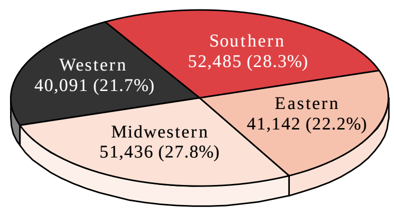


Totals
7,204 Medical Group Practices
185,154 Medical Group Physicians

DISTRIBUTION OF MGMA GROUP PRACTICES[3, 4]



DISTRIBUTION OF MGMA GROUP PRACTICE PHYSICIANS[3, 4]



Data source: Medical Group Management Association Member Database, 1999 © 2000

[1] MGMA data on the number of physicians in MGMA member groups were compiled 3/8/00.

[2] American Medical Association data on national totals are the most recent available (early 1997).

[3] **Eastern Region** consists of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia and West Virginia.
Southern Region consists of Alabama, Arkansas, Florida, Georgia, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee and Texas.
Midwestern Region consists of Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin.
Western Region consists of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming.

[4] Percentages are calculated using group practices located only in the 50 states and the District of Columbia.

KEY TO MAP

This map depicts the locations of MGMA group practices and the total number of MGMA group physicians. The first number represents the number of medical group practices in that state; the second number represents the number of physicians in those group practices in that state. For example, there were 352 group practices in Florida in 1999, with 7,665 physicians practicing in them.

CALIFORNIA LEADS IN NUMBER OF MGMA GROUP PRACTICES

California had more group practices that were part of MGMA than any other state, with 439, accounting for 6.1% of all MGMA groups and 32.1% of MGMA groups in the Western region. By comparison, Texas was home to 425 group practices, representing 5.9% of all MGMA groups and 19.1% of all MGMA groups in the Southern region. California practices also had the highest number of MGMA group physicians, with 21,206, accounting for 11.5% of all physicians in MGMA groups and 52.9% of all MGMA physicians in the Western region.

Share of MGMA groups owned by physicians declines

The number of medical group practices owned by physicians dropped 11.6% in 1999, to 4,486 from 5,075 in 1998. These groups accounted for 62.3% of all MGMA groups, down from 66.3% the previous year. Similarly, the number of physicians in physician-owned groups fell 8.2%, to 71,443 from 77,798 in 1998. Meanwhile, the number of groups owned by hospitals dropped 12.3%, to 533 from 608 in 1998.

LARGEST MEMBER GROUPS OF MGMA GROW IN NUMBER

The number of MGMA group practices with 151 or more FTE physicians increased 56.2% in 1999, to 203 from 130 in 1998. Conversely, the number of group practices with 10 or fewer FTE physicians declined 27.8%, to 3,990 from 5,529 in 1998.

IN 1999, ORTHOPEDIC SURGERY GROUPS ARE MOST COMMON

The most common type of MGMA single specialty group practice continued to be orthopedic surgery groups, with 446. These groups represented 12.9% of all MGMA single specialty groups, and had more physicians (4,439) than any other kind of MGMA single specialty group. By comparison, cardiology groups accounted for 9.1% of single specialty groups in 1999, with 316.

[1] A medical group practice in this category is owned by a commercial business that provides medical services to the business's employees and their families as a means of controlling health care costs.

[2] The percentages in the two far right columns in this data grouping are percentages of all single specialty medical group practices.

[3] "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

MEDICAL GROUP PRACTICES

	Number of Medical Group Practices		Number of Physicians in Medical Group Practices		Percentage of Medical Group Practices	
	1998	1999	1998	1999	1998	1999
TYPE OF OWNER						
Government	31	34	1,547	2,229	0.4%	0.5%
Hospital	608	533	21,657	16,631	7.9	7.4
Industry[1]	18	22	318	321	0.2	0.3
Integrated Health System	250	224	21,925	16,517	3.3	3.1
MSO/For-Profit Investor	213	228	6,691	13,842	2.8	3.2
Physician	5,075	4,486	77,798	71,443	66.3	62.3
University/Medical School	142	121	33,196	29,153	1.9	1.7
Other	267	329	13,379	13,760	3.5	4.6
Unknown/NA	1,044	1,227	10,649	21,257	13.6	17.0
TOTAL	**7,648**	**7,204**	**187,159**	**185,154**	**100.0%**	**100.0%**
SIZE (# of FTE Physicians)						
No Physicians	—	—	—	—	—	—
10 or fewer	5,529	3,990	23,667	20,232	72.3%	55.4%
11–25	1,226	1,123	20,400	18,042	16.0	15.6
26–50	458	438	17,746	15,793	6.0	6.1
51–75	145	143	9,778	8,833	1.9	2.0
76–150	160	151	19,193	16,419	2.1	2.1
151 or more	130	203	96,375	105,835	1.7	2.8
Unknown/NA	—	1,156	—	—	—	16.0
TOTAL	**7,648**	**7,204**	**187,159**	**185,154**	**100.0%**	**100.0%**
SINGLE SPECIALTY[2]						
Allergy/Immunology	34	31	259	269	0.4%	0.4%
Anesthesiology	247	215	4,656	4,293	3.2	3.0
Cardiology	361	316	5,736	4,352	4.7	4.4
Family Practice	410	303	2,719	2,204	5.4	4.2
Gastroenterology	122	99	694	590	1.6	1.4
General Surgery	131	105	694	633	1.7	1.5
Hematology/Oncology	135	90	1,413	677	1.8	1.2
Internal Medicine	120	86	1,199	834	1.6	1.2
Obstetrics/Gynecology	391	307	2,511	2,086	5.1	4.3
Ophthalmology	278	190	1,626	1,237	3.6	2.6
Orthopedic Surgery	583	446	7,307	4,439	7.6	6.2
Otorhinolaryngology	107	81	465	372	1.4	1.1
Pathology	53	47	654	597	0.7	0.7
Pediatrics[3]	130	99	1,839	1,005	1.7	1.4
Radiology	204	171	2,592	2,337	2.7	2.4
Urology	182	151	929	884	2.4	2.1
All Other Single Specialties	367	719	4,346	15,613	4.8	10.0
Total Single Specialty	**3,855**	**3,456**	**39,636**	**42,422**	**50.4%**	**48.0%**
Total Multispecialty	**1,794**	**1,717**	**120,810**	**111,123**	**23.5%**	**23.8%**
Unknown/NA	1,999	2,031	26,713	31,609	26.1%	28.2%
TOTAL	**7,648**	**7,204**	**187,159**	**185,154**	**100.0%**	**100.0%**

Data source: Medical Group Management Association Member Database, 1999 © 2000

Invasive cardiologists have many inpatient encounters

Of the single specialty group practice specialties profiled, cardiologists performing invasive procedures averaged the most encounters with hospital inpatients, at 1,482 in 1998, up 5.6% from 1,404 in 1997. By comparison, OB/gyns in single specialty group practices reported the fewest encounters with hospital inpatients per FTE physician, at 150 in 1998, down 6.8% from 161 the previous year.

NUMBER OF ENCOUNTERS WITH HOSPITAL INPATIENTS PER FTE PHYSICIAN

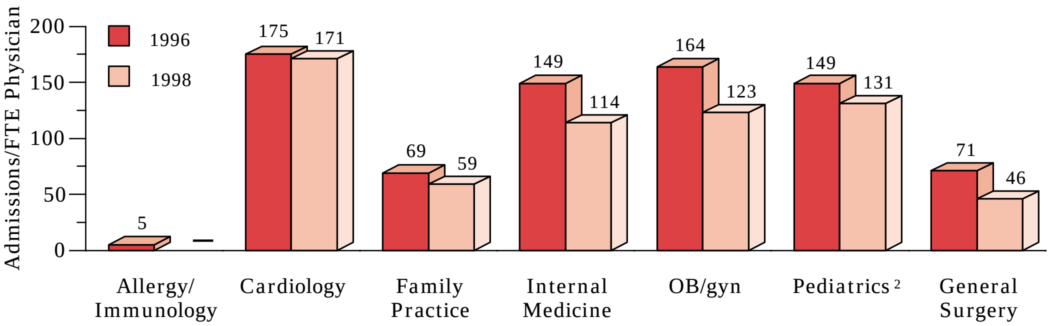
SPECIALTY	Single Specialty 1996	Single Specialty 1997	Single Specialty 1998	Multispecialty 1996	Multispecialty 1997	Multispecialty 1998
Allergy/Immunology[1]	—	—	—	26	33	—
Cardiology: Invasive	1,493	1,404	1,482	1,106	1,189	1,252
Cardiology: Noninvasive[1]	1,550	1,375	1,390	898	1,067	1,314
Family Practice (without OB)	401	465	441	279	270	314
Internal Medicine	544	654	666	628	599	672
Obstetrics/Gynecology	123	161	150	190	177	156
Pediatrics[1, 2]	389	298	388	271	306	330
General Surgery[1]	474	429	401	409	387	411

Data sources: Medical Group Management Association Physician Compensation and Production Survey: 1999 Report Based on 1998 Data © 1999, 1998 Report Based on 1997 Data © 1998 and 1997 Report Based on 1996 Data © 1997

NUMBER OF HOSPITAL ADMISSIONS PER FTE PHYSICIAN[3]

SPECIALTY	1996	1997	1998
Allergy/Immunology	5	21	—
Cardiology	175	136	171
Family Practice	69	68	59
Internal Medicine	149	123	114
Obstetrics/Gynecology	164	140	123
Pediatrics[2]	149	151	131
General Surgery	71	70	46

NUMBER OF HOSPITAL ADMISSIONS PER FTE PHYSICIAN[3]



Data sources: CRAHCA Performance Efficiency Evaluation Reports: 1998 Annual Report © 1999, 1997 Annual Report © 1998 and 1996 Annual Report © 1997

ENCOUNTERS JUMP FOR CARDIOLOGISTS IN MULTISPECIALTY GROUP PRACTICES

The number of encounters with hospital inpatients per FTE physician increased 23.1% for noninvasive cardiologists in multispecialty group practices in 1998, to 1,314 from 1,067 in 1997. Multispecialty group OB/gyns averaged 156 encounters with inpatients in 1998, down 11.9% from 177 in 1997.

GROUPS RECORD LOWER HOSPITAL ADMISSION RATES

From 1996 to 1998, hospital admissions per FTE physician dropped in six of seven group specialities shown. General surgeons in groups had 46 hospital admissions per FTE physician in 1998, down 35.2% from 71 in 1996. OB/gyns in group practices had 123 hospital admissions per FTE physician in 1998, a 25.0% decline from 164 in 1996.

[1] Some data for 1997 are restated and, therefore, differ from the *Medical Group Practice Digest*, 1999.

[2] "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

[3] All practice types (single specialty and multispecialty) are included.

NOTE: An encounter is a visit where there is an identifiable contact between a patient and a physician or mid-level provider.

In-house lab use rises in most single specialty groups

The average number of in-house laboratory procedures ordered by FTE physicians rose between 1996 and 1998 in five of seven selected specialist categories profiled. In-house laboratory procedures per FTE physician increased most, by percentage, during this period for general surgeons (139.1%). However, these procedures decreased for allergists/immunologists (5.5%) and for family practioners (4.3%).

INTERNISTS SURPASS 6,500 IN-HOUSE LAB PROCEDURES IN 1998

Internists ordered 6,570 in-house laboratory procedures per FTE physician in 1998, the largest average number of the single specialists profiled and 23.7% more than in 1996. By comparison, allergists/immunologists ordered 503 procedures per FTE physician, the fewest of the specialist categories shown.

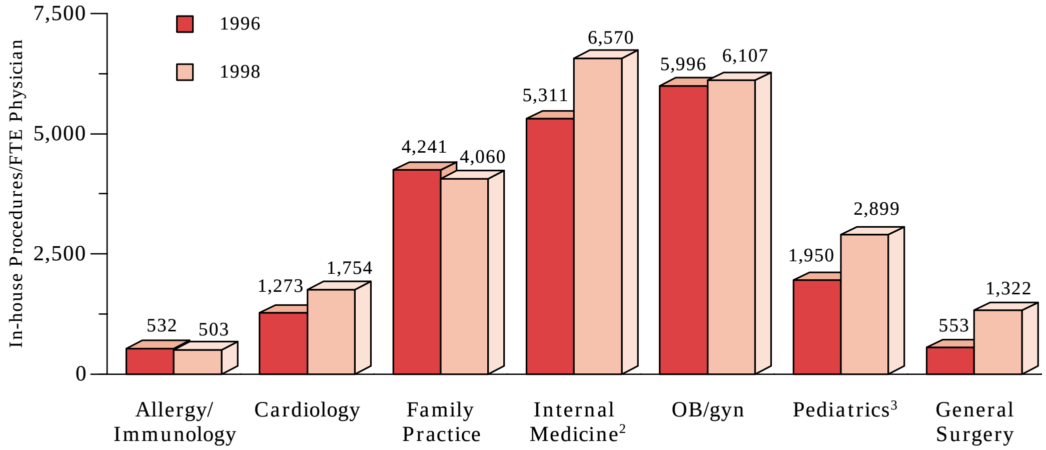
OB/GYN MDs REPORT HIGHEST IN-HOUSE RADIOLOGY RATE

Among MGMA specialists, obstetricians/gynecologists recorded the highest number of in-house radiology procedures per FTE physician, at 755, followed by 709 for internists and 533 for family practitioners. By comparison, cardiologists reported the lowest number of in-house radiology procedures of the specialists profiled, at 189 per FTE physician.

IN-HOUSE LABORATORY PROCEDURES BY SPECIALTY[1]

SINGLE SPECIALTY	Number of In-house Laboratory Procedures per FTE Physician		
	1996	1997	1998
Allergy/Immunology	532	617	503
Cardiology	1,273	1,269	1,754
Family Practice	4,241	4,567	4,060
Internal Medicine[2]	5,311	5,639	6,570
Obstetrics/Gynecology	5,996	3,570	6,107
Pediatrics[3]	1,950	1,843	2,899
General Surgery	553	665	1,322

IN-HOUSE LABORATORY PROCEDURES BY SPECIALTY[1]



IN-HOUSE RADIOLOGY PROCEDURES BY SPECIALTY[1]

SINGLE SPECIALTY	Number of In-house Radiology Procedures per FTE Physician		
	1996	1997	1998
Allergy/Immunology	219	205	205
Cardiology	—	149	189
Family Practice	585	564	533
Internal Medicine[2]	673	515	709
Obstetrics/Gynecology	658	368	755
Pediatrics[3]	245	310	357
General Surgery	150	299	366

Data sources: CRAHCA Performance Efficiency Evaluation Reports: 1998 Annual Report © 1999, 1997 Annual Report © 1998 and 1996 Annual Report © 1997

[1] These data refer only to orders by physicians in multispecialty groups having in-house clinical laboratories and imaging capabilities. Data were unavailable on the total number of procedures ordered if outside services were used.

[2] For in-house procedures data, "internal medicine" comprises an entire department that may include various subspecialists.

[3] "Pediatrics" excludes subspecialty pediatrics, such as pulmonology, neurology, gastroenterology and endocrinology.

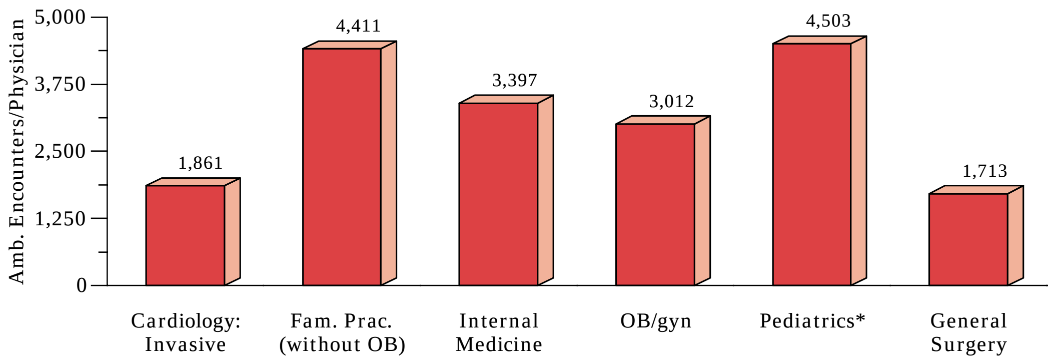
Pediatric groups have most ambulatory encounters

Pediatric group practices averaged more ambulatory encounters per physician in 1998 than did any other single specialty group, with 5,067, a 4.6% drop from 5,312 encounters in 1997. Among multispecialty group practices, pediatricians also recorded the most ambulatory encounters, with 4,503 per physician, a 0.9% drop in average ambulatory patient volume from 4,546 the previous year.

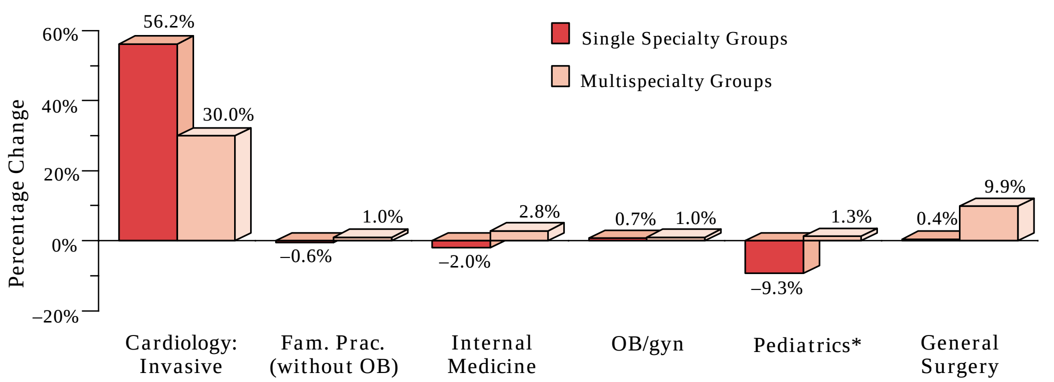
NUMBER OF AMBULATORY ENCOUNTERS PER PHYSICIAN

	Single Specialty Groups			Multispecialty Groups		
SPECIALTY	1996	1997	1998	1996	1997	1998
Allergy/Immunology	2,000	2,700	2,140	2,979	2,992	2,878
Cardiology: Invasive	1,121	1,352	1,751	1,431	1,624	1,861
Cardiology: Noninvasive	1,575	1,369	1,828	1,578	2,049	2,048
Family Practice (without OB)	4,410	4,719	4,382	4,366	4,415	4,411
Internal Medicine	3,059	3,309	2,998	3,305	3,310	3,397
Obstetrics/Gynecology	3,179	2,992	3,201	2,983	2,853	3,012
Pediatrics*	5,589	5,312	5,067	4,446	4,546	4,503
General Surgery	1,492	1,586	1,498	1,558	1,616	1,713

1998 MULTISPECIALTY GROUP AMBULATORY ENCOUNTERS PER PHYSICIAN



1996–1998 PERCENTAGE CHANGE IN AMBULATORY ENCOUNTERS PER PHYSICIAN



Data sources: Medical Group Management Association Physician Compensation and Production Survey: 1999 Report Based on 1998 Data © 1999, 1998 Report Based on 1997 Data © 1998 and 1997 Report Based on 1996 Data © 1997

FAMILY PRACTICE PHYSICIANS RANK SECOND IN VISITS

In 1998, family practitioners in both single specialty and multispecialty groups ranked second to pediatricians in number of ambulatory encounters, with 4,382 and 4,411 per physician, respectively. Four of the eight profiled specialties in multispecialty groups averaged more ambulatory encounters in 1998 than in 1997, while in single specialty groups, only three of the eight shown registered more encounters. Meanwhile, from 1997 to 1998 allergists/immunologists recorded the largest decrease, by percentage, in ambulatory encounters per single specialty group physician (down 20.7%, to 2,140 from 2,700 in 1997) and per multispecialty group physician (down 3.8%, to 2,878 from 2,992).

* "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

NOTE: An ambulatory encounter is an identifiable contact between a patient and a group practice physician, at the time of which advice, a procedure, service or treatment is provided. An ambulatory encounter can occur at the medical practice's clinical facilities, a patient's residence, an ambulatory care center, an emergency department, a long-term care facility, etc. Ambulatory encounters exclude patient encounters with group practice midlevel providers and physician extenders.

General surgeons in group practices have more cases

General surgeons in MGMA group practices recorded a median of 719 surgical/anesthesia cases in 1998, up 5.3% from 683 cases in 1997. In multispecialty groups, the number of surgeries increased 5.1%, to 655 cases per surgeon from 623 the previous year. By comparison, in single specialty group practices the median number of surgeries decreased 4.5%, to 772 cases from 808 in 1997.

SINGLE SPECIALTY OB/GYNs PERFORM FEWER SURGERIES
Obstetricians/gynecologists in single specialty groups had 29.3% fewer surgical/anesthesia cases (244) in 1998 than did OB/gyns in multispecialty group practices (345). Meanwhile, the median number of surgical/anesthesia cases involving invasive cardiologists in multispecialty groups (247) was more than 2.5 times that of invasive cardiologists in single specialty groups (96).

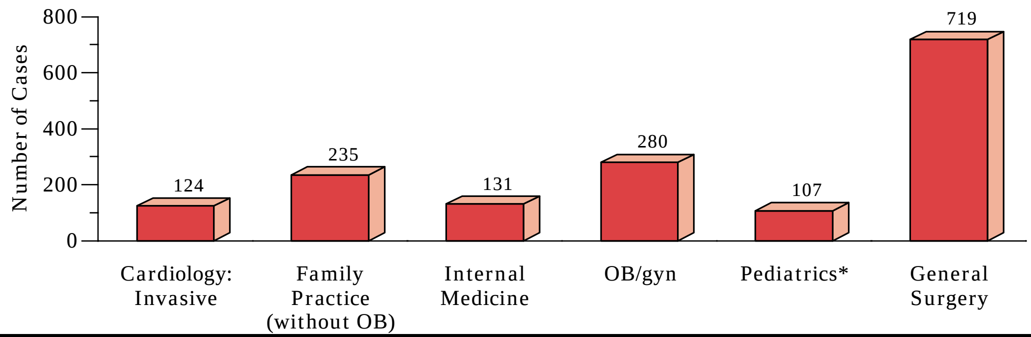
MDs IN CAPITATED GROUPS PERFORM FEWER SURGERIES
In three of five categories for which data were available, physicians in multispeciality groups with more than half of revenue from capitation had a lower number of surgical/anesthesia cases than did physicians in groups with no capitation revenue. Family practitioners in such groups with more than 50% capitation revenue had nearly 2.5 times more of these cases than physicians in groups with no capitation revenue.

* "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

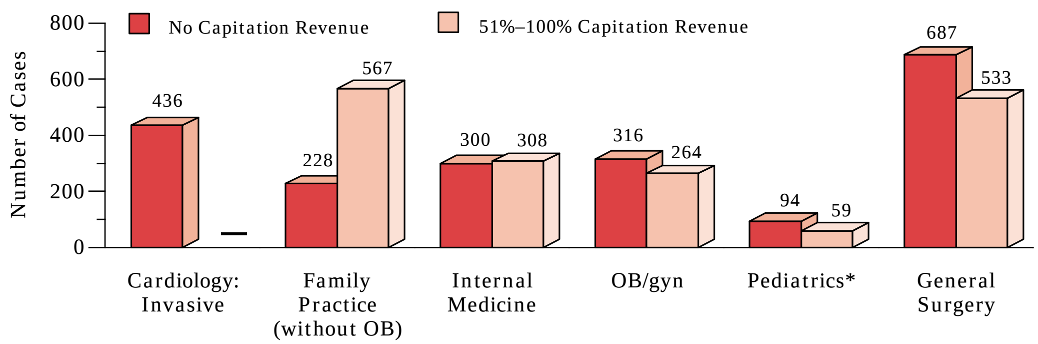
MEDIAN NUMBER OF PHYSICIAN SURGICAL/ANESTHESIA CASES

SPECIALTY	Single Specialty Group Practices	Multispecialty Group Practices	All Group Practices
Allergy/Immunology	—	—	—
Cardiology: Invasive	96	247	124
Cardiology: Noninvasive	—	51	61
Family Practice (without OB)	265	226	235
Internal Medicine	111	132	131
Obstetrics/Gynecology	244	345	280
Pediatrics*	175	81	107
General Surgery	772	655	719

MEDIAN NUMBER OF PHYSICIAN SURGICAL/ANESTHESIA CASES



MEDIAN NUMBER OF PHYSICIAN SURGICAL/ANESTHESIA CASES: MULTISPECIALTY GROUPS



Data source: Medical Group Management Association Physician Compensation and Production Survey: 1999 Report Based on 1998 Data © 1999

RVUs are measures of medical procedure complexity

Physician work RVUs per physician per year are indicative of the complexity of procedures and cases for different medical specialities. RVUs per physician per year in MGMA single specialty group practices were higher for obstetrical/gynecological procedures and cases (at 9,135 in 1998) than for the other specialties profiled, for instance, because these procedures and cases can be comparatively complex.

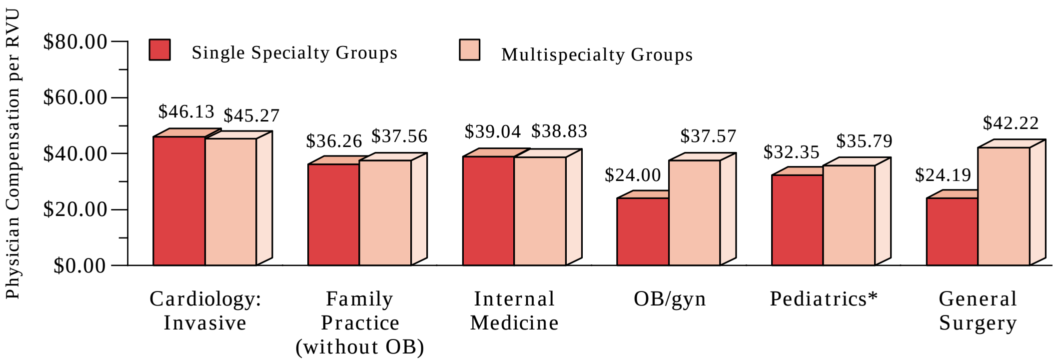
PHYSICIAN WORK RVUs PER PHYSICIAN BY SPECIALTY

SPECIALTY	Single Specialty Group Practices	Multispecialty Group Practices
Allergy/Immunology	—	3,099
Cardiology: Invasive	8,069	6,411
Cardiology: Noninvasive	5,407	5,556
Family Practice (without OB)	3,786	3,747
Internal Medicine	3,350	3,707
Obstetrics/Gynecology	9,135	6,055
Pediatrics*	4,386	3,783
General Surgery	7,375	5,181

PHYSICIAN COMPENSATION PER PHYSICIAN WORK RVU BY SPECIALTY

SPECIALTY	Single Specialty Group Practices	Multispecialty Group Practices
Allergy/Immunology	—	$55.86
Cardiology: Invasive	$46.13	45.27
Cardiology: Noninvasive	60.25	47.94
Family Practice (without OB)	36.26	37.56
Internal Medicine	39.04	38.83
Obstetrics/Gynecology	24.00	37.57
Pediatrics*	32.35	35.79
General Surgery	24.19	42.22

PHYSICIAN COMPENSATION PER PHYSICIAN WORK RVU BY SPECIALTY



Data source: Medical Group Management Association Physician Compensation and Production Survey: 1999 Report Based on 1998 Data © 1999

RVUs GIVE RELATIVE COST INFORMATION

Relative value units (RVUs) are federal government measures that provide weighted amounts to be paid for medical services. They are used to develop the Medicare Fee Schedule and have physician work, physician expense and malpractice expense components.

COMPENSATION PER RVU IS HIGH FOR SINGLE SPECIALTY CARDIOLOGISTS

Of the single specialties listed, physician compensation per physician work RVU per year in single specialty groups was highest in 1998 for noninvasive cardiologists ($60.25) and for invasive cardiologists ($46.13) and lowest for general surgeons ($24.19). Meanwhile, the physician compensation per physician work RVU per year rate in multispecialty group practices was highest in 1998 for allergists/immunologists ($55.86) and lowest for pediatricians ($35.79).

* "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

CPT-4 codes describe common medical procedures

The tables below present the median percentages of total procedures (denoted by CPT-4 codes) performed at MGMA groups in the first six months of 1999. The various codes denote differences in the complexity of the case and in the time required to perform the procedure successfully. Of the five procedures listed for pediatric groups, for instance, 64.5% were Level 3 office/outpatient visits by established patients.

ESTABLISHED PATIENT, LEVEL 3 VISITS ARE COMMON

In four of the seven specialties profiled, Level 3 office/outpatient visits by established patients (CPT-4 99213) occurred more often than did other such visits. Of these four, internal medicine groups had the highest median percentage of these visits, at 70.7% of total procedures. Level 3 office/outpatient visits by new patients (CPT-4 99203) were most common in three of the seven specialities. Level 3 office/outpatient visits by new patients accounted for more than half (56.3%) of all office visits by new patients at MGMA pediatric group practices.

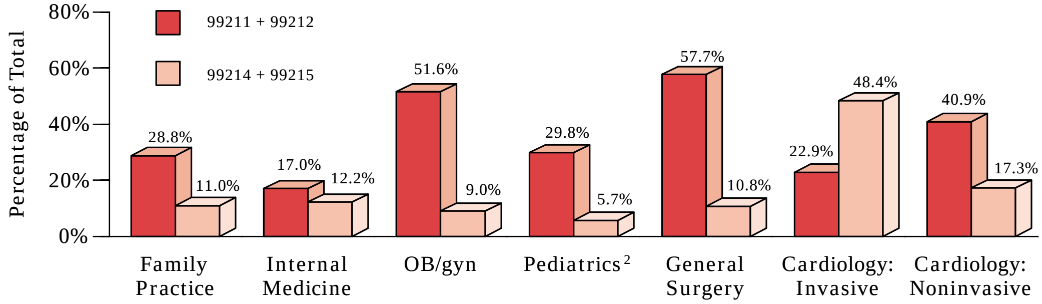
DISTRIBUTION OF SELECTED CPT CODES BY SPECIALTY: NEW PATIENTS[1]

CPT-4 CODES	Percentage of Total Office/Outpatient Visits						
	Family Practice (150.64 FTEs)	Pediatrics[2] (99.01 FTEs)	Internal Medicine (119.68 FTEs)	Obstetrics/ Gynecology (44.66 FTEs)	General Surgery (54.45 FTEs)	Cardiology: Invasive (45.86 FTEs)	Cardiology: Noninvasive (42.32 FTEs)
99201	13.1%	3.6%	4.0%	6.8%	13.2%	—	—
99202	55.4	25.7	19.1	29.3	47.4	28.6%	17.6%
99203	25.0	56.3	44.6	35.4	14.5	25.4	—
99204	3.5	10.4	21.8	25.8	18.4	38.1	73.5
99205	2.9	4.1	10.5	2.7	6.6	7.9	8.8

DISTRIBUTION OF SELECTED CPT CODES BY SPECIALTY: ESTABLISHED PATIENTS[3]

CPT-4 CODES	Percentage of Total Office/Outpatient Visits						
	Family Practice	Pediatrics[2]	Internal Medicine	Obstetrics/ Gynecology	General Surgery	Cardiology: Invasive	Cardiology: Noninvasive
99211	3.1%	0.9%	2.4%	4.8%	4.9%	12.4%	24.3%
99212	25.7	28.9	14.7	46.8	52.8	10.6	16.6
99213	60.2	64.5	70.7	39.4	31.5	28.6	41.8
99214	10.3	5.0	9.6	7.2	8.7	44.5	15.9
99215	0.7	0.7	2.7	1.8	2.1	3.9	1.4

DISTRIBUTION OF SELECTED CPT CODES BY SPECIALTY: ESTABLISHED PATIENTS[3]



Data source: CRAHCA Physician Services Practice Analysis Comparison: January–June 1999 Medians © 1999

[1] A patient who is new to the physician and whose medical records need to be established.
[2] "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.
[3] A patient whose medical and administrative records are available to the physician.

DEFINITIONS OF CPT-4 CODES

- 99201: Office/outpatient visit, new patient, Minimal
- 99202: Office outpatient visit, new patient, Straightforward
- 99203: Office outpatient visit, new patient, Low Complexity
- 99204: Office/outpatient visit, new patient, Moderate Complexity
- 99205: Office/outpatient visit, new patient, High Complexity
- 99211: Office/outpatient visit, established patient, Minimal
- 99212: Office/outpatient visit, established patient, Straightforward
- 99213: Office/outpatient visit, established patient, Low Complexity
- 99214: Office/outpatient visit, established patient, Moderate Complexity
- 99215: Office/outpatient visit, established patient, High Complexity

Highly capitated groups garner highest total revenue

Multispecialty group practices deriving more than half of revenue from capitation had higher median annual total medical revenue per FTE physician than did other groups in 1998, at $559,769, or 3.6% higher than the $540,275 reported for groups with no capitation revenue. Total net medical revenue per FTE physician was lowest for groups with 11% to 50% capitation revenue, at $491,617.

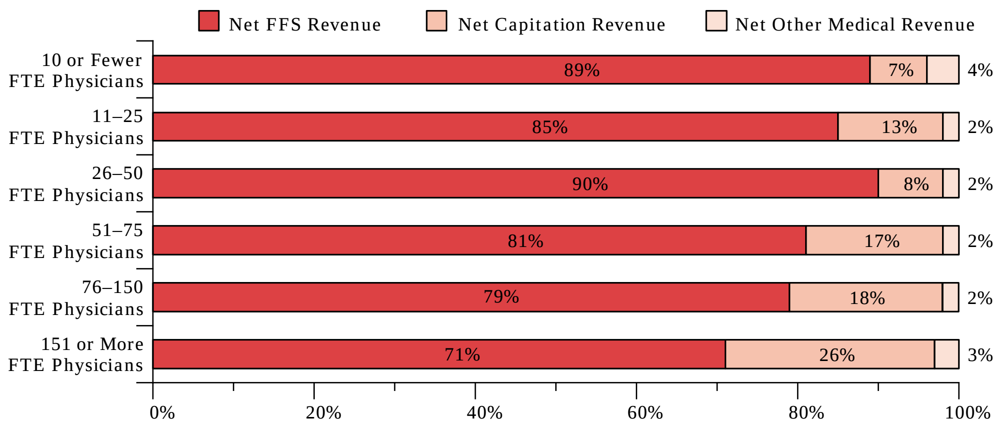
CHARGES AND REVENUE PER FTE PHYSICIAN FOR MULTISPECIALTY GROUPS

	1998 Median Annual Charges and Revenue per FTE Physician			
CHARGES SOURCE	Groups With No Capitation Revenue	Groups With 1% to 10% Capitation Rev.	Groups With 11% to 50% Capitation Rev.	Groups With 51% to 100% Capitation Rev.
Gross Fee-For-Service Charges	$701,079	$696,075	$514,521	$293,413
Gross Capitation Charges	—	28,736	136,364	317,104
GROSS PATIENT CHARGES	**$701,079**	**$671,810**	**$710,338**	**$600,592**
REVENUE SOURCE				
Net Fee-For-Service Revenue	$531,786	$446,055	$343,718	$185,681
Net Capitation Revenue	—	28,736	136,364	317,104
Net Other Medical Revenue	10,277	18,489	10,056	—
TOTAL MED. REVENUE	**$540,275**	**$495,207**	**$491,617**	**$559,769**

REVENUE PER FTE PHYSICIAN FOR MULTISPECIALTY GROUPS

	1998 Median Annual Revenue per FTE Physician					
REVENUE SOURCE	10 or Fewer FTE Physicians	11–25 FTE Physicians	26–50 FTE Physicians	51–75 FTE Physicians	76–150 FTE Physicians	151 or More FTE Physicians
Net Fee-For-Service Revenue	$394,855	$399,300	$474,000	$470,529	$426,478	$470,455
Net Capitation Revenue	30,922	61,927	42,503	98,763	99,544	175,738
Net Other Medical Revenue	17,704	10,277	12,326	14,487	13,143	17,283
TOTAL MED. REVENUE	**$428,957**	**$463,338**	**$548,354**	**$556,924**	**$563,465**	**$607,500**

MEDIAN ANNUAL REVENUE PER FTE PHYSICIAN FOR MULTISPECIALTY GROUPS*



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

MEDICAL REVENUE INCREASES ALONG WITH GROUP SIZE

In 1998, the total medical revenue per FTE physician for multispecialty groups increased in relation to group size. Whereas groups with 151 or more FTE physicians had a total net medical revenue of $607,500, groups with 10 or fewer FTE physicians recorded revenue of $428,957. Meanwhile, median net capitation revenue at groups with 151 or more FTE physicians ($175,738) was more than five times that of group practices with 10 or fewer FTE physicians ($30,922).

LARGEST GROUPS GET 26% OF REVENUE FROM CAPITATION

Multispecialty group practices with 151 or more physicians garnered a median of 26% of total net medical revenue from capitation in 1998, down 1% from 27% in 1997. By comparison, groups with 10 or fewer FTE physicians reported that a median of 7% of total net medical revenue derived from capitation, a moderate decline from 9% the previous year.

* Percentages are medians and may not sum to 100%.

Internal medicine groups show rise in Medicare share

In 1998, internal medicine group practices had a higher Medicare median share of total gross charges than the other single specialty group types profiled, at 49.0%, up from 46.0% in 1997. The Medicare share of charges fell in the other single specialty group types shown. Just 3.0% of total gross charges at obstetrics/gynecology groups in 1998 were Medicare charges, for instance, down slightly from 3.2% in 1997.

OB/GYN GROUPS HAVE HIGH COMMERCIAL AND SELF-PAY SHARE

Of the group practice single specialties profiled, the commercial and self-pay share of total gross charges was highest for obstetrics/gynecology groups, at 87.9%, and lowest for internal medicine groups, at 39.0%. Similarly, Medicaid charges accounted for 5.9% of total gross charges for OB/gyn groups in 1998, the highest such charge among the selected single specialty groups.

SMALLEST GROUPS HAVE HIGHEST MEDICARE SHARE

The Medicare portion of total gross charges was highest, at 30.0%, in 1998 for multispecialty groups with 10 or fewer FTE physicians, up from 29.5% in 1997. Between 1997 and 1998, the Medicare share of total gross charges rose in three of the six profiled categories of multispecialty groups.

* Percentages are medians and may not sum to 100%.

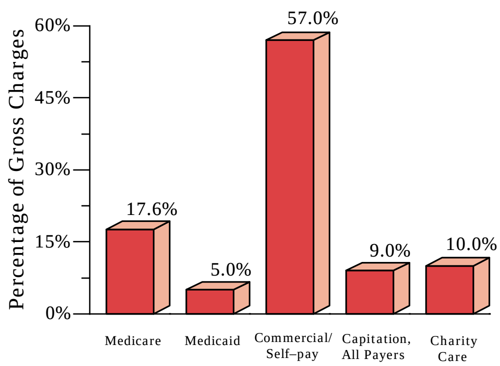
PAYER BREAKOUT OF TOTAL GROSS CHARGES FOR SINGLE SPECIALTY GROUPS*

SINGLE SPECIALTY	Medicare	Medicaid	Commercial And Self-Pay	Capitation, All Payers	Charity Care
Cardiology	43.3%	3.0%	49.0%	0.0%	1.0%
Family Practice	17.6	5.0	57.0	9.0	10.0
Internal Medicine	49.0	2.0	39.0	1.0	0.0
Obstetrics/Gynecology	3.0	5.9	87.9	0.0	1.0
General Surgery	30.0	3.4	57.4	0.0	1.0

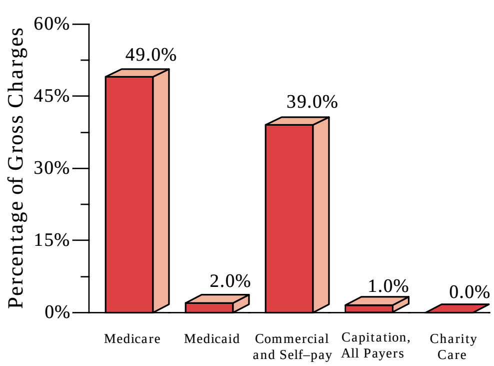
PAYER BREAKOUT OF TOTAL GROSS CHARGES FOR MULTISPECIALTY GROUPS*

SIZE (# of FTE Phys.)	Medicare	Medicaid	Commercial And Self-Pay	Capitation, All Payers	Charity Care
10 or fewer	30.0%	8.7%	48.0%	0.3%	1.0%
11–25	29.0	6.0	47.7	2.0	1.0
26–50	26.6	5.1	60.5	2.5	0.0
51–75	23.0	4.0	50.4	3.0	0.0
76–150	23.0	3.5	53.0	18.7	0.0
151 or more	23.6	5.0	35.0	4.3	0.0

TOTAL GROSS CHARGES FOR FAMILY PRACTICE GROUP PRACTICES*



TOTAL GROSS CHARGES FOR INTERNAL MEDICINE GROUP PRACTICES*



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

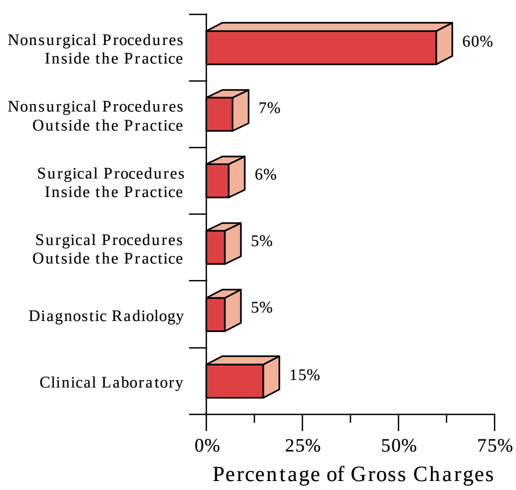
On-site nonsurgical procedures generate 42% of charges

Of the physician procedures profiled, the median percentage of total gross charges among multispecialty groups was highest for nonsurgical procedures conducted inside the practice itself in 1998, at 42%, down from 44% in 1997. By comparison, charges for surgical procedures conducted inside the practice itself accounted for just 5% of total gross charges among these groups, unchanged from the previous year.

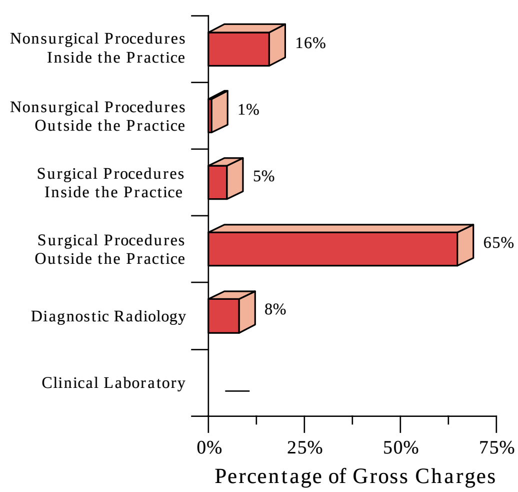
MEDIAN PERCENTAGES OF TOTAL GROSS CHARGES: MULTISPECIALTY GROUPS*

	Nonsurgical Procedures		Surgical Procedures		Other Procedures	
	Inside the Practice	Outside the Practice	Inside the Practice	Outside the Practice	Diagnostic Radiology	Clinical Laboratory
SIZE (# of FTE physicians)						
10 or fewer	47%	13%	2%	16%	4%	11%
11–25	42	11	3	16	6	12
26–50	34	10	6	20	8	11
51–75	39	15	4	22	7	11
76 or more	39	7	6	—	9	10
PERCENTAGE OF CAPITATION REVENUE						
No Capitation Revenue	34%	12%	5%	22%	5%	12%
1%–10%	36	11	3	18	8	10
11%–50%	48	9	5	13	7	11
51%–100%	—	—	—	—	—	—
REGION						
Eastern	44%	18%	3%	12%	6%	10%
Southern	39	10	5	20	7	12
Midwestern	31	11	3	18	9	10
Western	45	8	6	21	8	11
ALL GROUPS	**42%**	**11%**	**5%**	**18%**	**6%**	**11%**

MEDIAN PERCENTAGES OF TOTAL GROSS CHARGES FOR FAMILY PRACTICE GROUP PRACTICES*



MEDIAN PERCENTAGES OF TOTAL GROSS CHARGES FOR ORTHOPEDIC SURGERY GROUP PRACTICES*



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

CAPITATION BOOSTS SHARE OF ON-SITE NONSURGICAL WORK

Charges associated with nonsurgical procedures conducted inside the practice represented 48% of total gross charges in multispecialty groups deriving 11% to 50% of revenue from capitation, compared with just 34% in groups with no reported capitation revenue. The share of total gross charges for these procedures was highest, by region, at groups in the West (45%) and lowest at groups in the Midwest (31%).

OFF-SITE SURGICAL PORTION IS HIGH AT ORTHOPEDIC SURGERY GROUPS

Charges for surgical procedures performed outside the practice accounted for 65% of total gross charges at orthopedic surgery group practices, compared with 5% at family practice groups. Charges for nonsurgical procedures conducted inside the practice at family practice groups represented 60% of total gross charges, compared with just 16% at orthopedic surgery groups.

* Percentages are medians and may not sum to 100%.

Operating costs rise again at highly capitated groups

Median total operating costs per FTE physician rose 2.4% at multispecialty groups with more than half of revenue from capitation, to $359,975 in 1998, from $351,521 in 1997. By comparison, operating costs climbed 17.2% at groups with no capitation revenue, to $280,990 from 239,695 the year before. These costs rose 12.8% at groups with 11% to 50% capitation revenue, to $295,330 from $261,722.

BUILDING COSTS ARE GREATER FOR CAPITATED GROUPS

Multispecialty group practices that derived more than half of income from capitation had median building and occupancy costs per FTE physician of $41,308, 49.0% higher than the $27,728 recorded by groups with no capitation revenue. Highly capitated groups, which tend to be larger institutions than groups with no capitation revenue, had relatively higher costs in most expense categories in 1998, including administrative supplies/services, furniture/equipment and information services.

GROUPS WITH HIGH CAPITATION HAVE HIGH STAFF COSTS

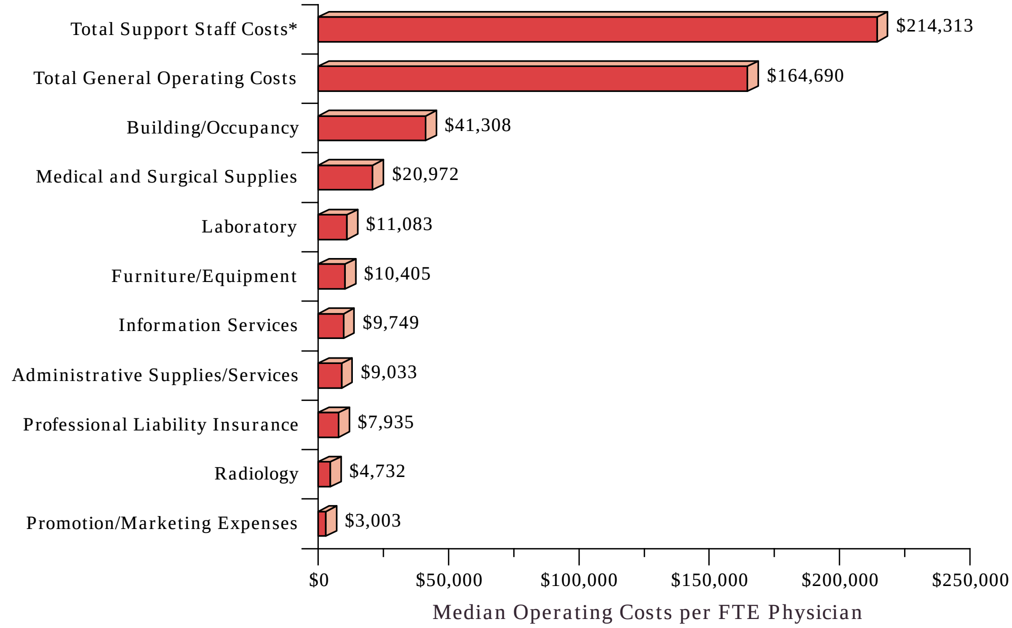
Multispecialty groups with more than 50% capitation revenue had a median of $214,313 in support staff costs per FTE physician in 1998, 46.9% higher than the $145,876 reported for such groups with no capitation revenue. Costs associated with support staffs were higher in 1998 than in 1997 for groups, regardless of capitation revenue percentage category.

* No data on midlevel providers or physicians are included in support staff costs data.

MEDIAN OPERATING COSTS PER FTE PHYSICIAN: MULTISPECIALTY GROUPS

EXPENSE CATEGORY	Groups With No Capitation Revenue	Groups With 1% to 10% Capitation Rev.	Groups With 11% to 50% Capitation Rev.	Groups With 51% to 100% Capitation Rev.
Administrative Supplies/Services	$7,483	$8,655	$8,208	$9,033
Building/Occupancy	27,728	30,567	30,835	41,308
Furniture/Equipment	5,265	7,711	6,283	10,405
Information Services	8,610	8,228	11,532	9,749
Laboratory	17,013	11,634	10,794	11,083
Medical and Surgical Supplies	23,236	22,473	17,843	20,972
Professional Liability Insurance	8,154	6,944	8,635	7,935
Promotion/Marketing Expenses	2,302	2,083	1,641	3,003
Radiology	3,958	4,173	8,584	4,732
Total General Operating Costs	132,698	138,642	134,235	164,690
Total Support Staff Costs*	145,876	141,200	161,370	214,313
TOTAL OPERATING COSTS	**$280,990**	**$280,417**	**$295,330**	**$359,975**
SAMPLE SIZE	**73**	**56**	**49**	**12**

MEDIAN OPERATING COSTS PER FTE PHYSICIAN: MULTISPECIALTY GROUPS WITH 51%–100% CAPITATION REVENUE



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

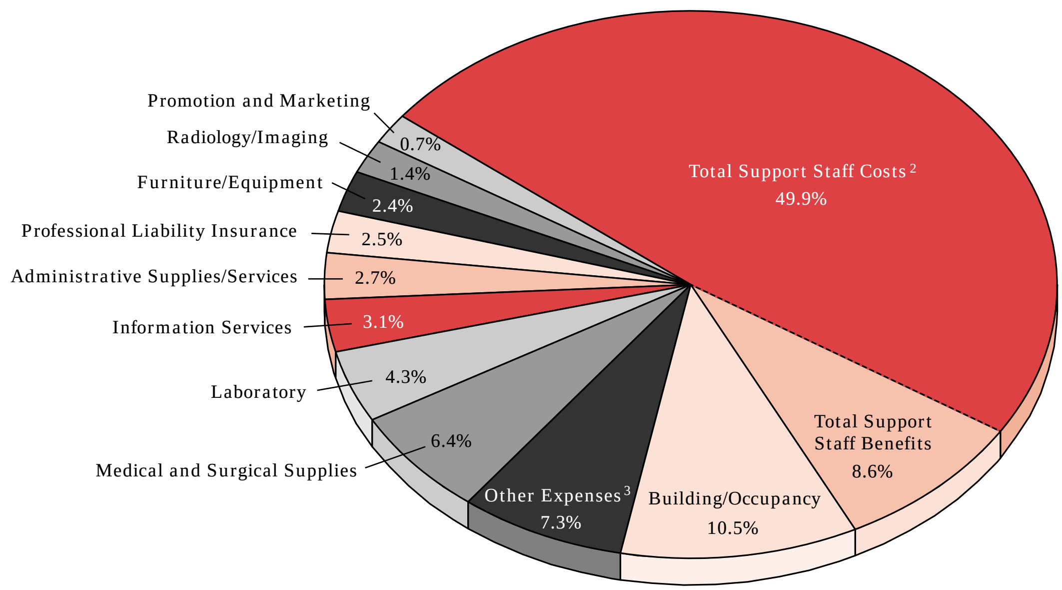
Support staff compensation is half of operating costs

Support staff compensation was 49.9% of median operating expenses per FTE physician in multispecialty groups in 1998, up significantly from 43.8% in 1997. The percentages of total operating expenses declined in nine other categories, increased in one and was unchanged in the remaining category. Other nonprovider expenses decreased, to 7.3% from 10.3% the previous year.

MEDIAN OPERATING COSTS PER FTE PHYSICIAN: MULTISPECIALTY GROUPS[1]

EXPENSE CATEGORY	Percentage of Total 1996	1997	1998
Total Support Staff Costs[2]	44.1%	43.8%	49.9%
Building/Occupancy	11.0	11.0	10.5
Total Support Staff Benefits	10.0	9.6	8.6
Medical and Surgical Supplies	7.0	6.7	6.4
Other Expenses[3]	9.1	10.3	7.3
Laboratory	4.9	4.7	4.3
Professional Liability Insurance	3.0	2.9	2.5
Administrative Supplies/Services	3.3	3.0	2.7
Information Services	3.0	3.0	3.1
Furniture/Equipment	2.9	2.7	2.4
Radiology/Imaging	1.9	1.5	1.4
Promotion and Marketing[4]	—	0.7	0.7
SAMPLE SIZE	**353**	**334**	**291**

1998 DISTRIBUTION OF OPERATING COSTS: MULTISPECIALTY GROUPS[1]



Data sources: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999, 1998 Report Based on 1997 Data © 1998 and 1997 Report Based on 1996 Data © 1997

1998 SUPPORT STAFF COSTS REPRESENT 58.5% OF OPERATING EXPENSES IN 1998

Total support staff costs per FTE physician (compensation plus benefits) as a percent of total operating costs rose among multispecialty group practices in 1998, to 58.5% from 53.4% in 1997. Support staff benefits, accounting for 8.6% of total operating expenses per FTE physician, may include retirement plans, travel and training allowances, professional dues and health, life and disability insurance. Building and occupancy expenses in multispecialty group practices made up 10.5% of operating costs per FTE physician in 1998.

1 Percentages were calculated by using a computed sum of medians totaling $282,834 for 1998 total operating costs per FTE physician, $249,300 for 1997 and $240,471 for 1996.

2 "Support staff costs" includes employed support staff compensation and contracted support staff costs. No data on midlevel providers or physicians are included in support staff costs data.

3 "Other expenses" includes the following: physical therapy costs; fees for outside professionals; ambulatory surgery promotion and marketing; interest; health, business and property taxes; other nonprovider expenses; and the "Ambulatory Surgery Center" category from prior years.

4 This cost category was combined under "Other Expenses" in 1996.

Operating costs per MD rise for multispecialty groups

Median operating costs per FTE physician for multispecialty group practices increased 5.9% in 1998, to $274,159 from $258,959 in 1997.* This 1998 amount accounted for 57.1% of total operating costs, which were $480,108. Total provider costs were $211,198, or 44.0% of total costs. At 35.2%, physician compensation accounted for the greatest share of total provider costs for these groups.

TOTAL COSTS FOR FAMILY PRACTICE GROUPS INCREASE

Median total costs were $433,496 per FTE physician at family practice single specialty group practices, up 2.7% from $422,118 in 1997. Total operating costs and total provider costs represented 56.5% and 42.2% of median total costs, respectively. Of the provider costs shown, physician compensation, at 30.0%, accounted for the largest share of median total costs per FTE physician.

PROVIDER COSTS RISE AT ORTHOPEDIC SURGERY GROUPS

Single specialty orthopedic surgery groups reported median total costs per FTE physician of $759,186 in 1998, up 7.0% from $709,229 in 1997. By comparison with multispecialty and family practice groups, physician compensation, at 45.2%, continued to account for a significantly higher share of median total costs per FTE physician in these single specialty groups.

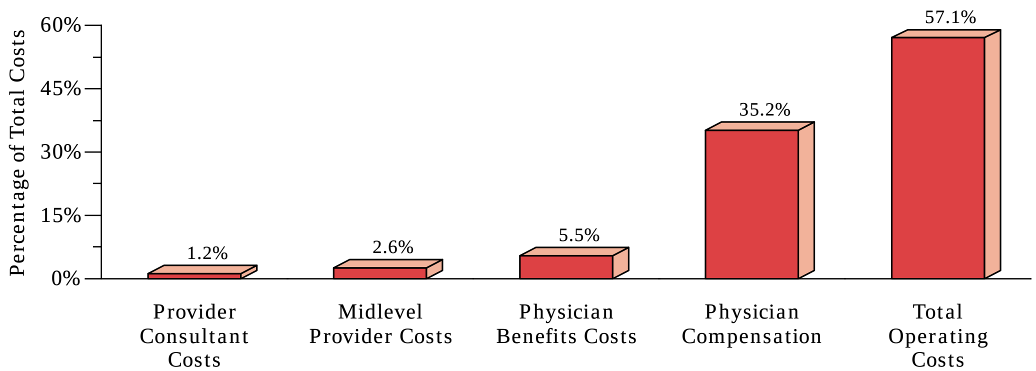
* Data for 1997 are restated and, therefore, differ from the *Medical Group Practice Digest*, 1999.

** Percentages are calculated from median total costs and may not sum to 100%.

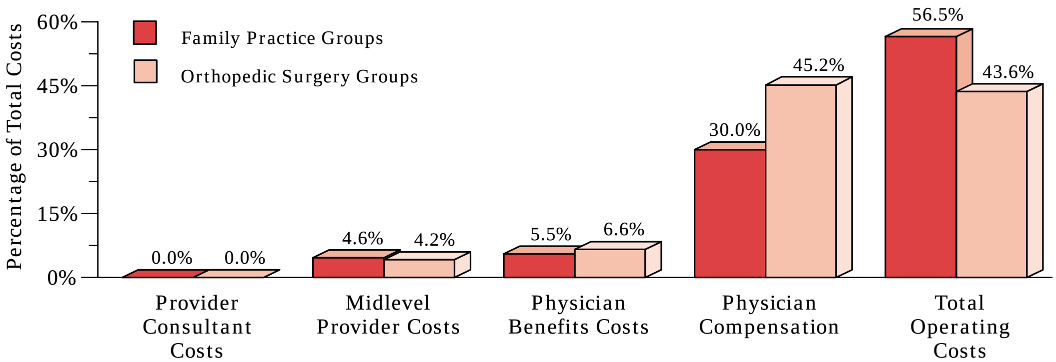
MEDIAN PROVIDER AND OPERATING COSTS PER FTE PHYSICIAN**

	Multispecialty Groups		Family Practice Single Specialty Groups		Orthopedic Surgery Single Specialty Groups	
PROVIDER COSTS	Median Costs	Percentage of Total Costs	Median Costs	Percentage of Total Costs	Median Costs	Percentage of Total Costs
Midlevel Provider Costs	$12,269	2.6%	$20,000	4.6%	$31,474	4.2%
Provider Consultant Costs	5,778	1.2	—	0.0	—	0.0
Physician Compensation	169,036	35.2	130,328	30.0	343,335	45.2
Physician Benefits Costs	26,213	5.5	24,034	5.5	49,714	6.6
Total Provider Costs	**$211,198**	**44.0%**	**$183,008**	**42.2%**	**$406,470**	**53.5%**
Total Operating Costs	**$274,159**	**57.1%**	**$244,716**	**56.5%**	**$331,020**	**43.6%**
TOTAL COSTS	**$480,108**		**$433,496**		**$759,186**	

MEDIAN PROVIDER AND OPERATING COSTS AS A PERCENTAGE OF TOTAL COSTS: MULTISPECIALTY GROUPS**



MEDIAN PROVIDER AND OPERATING COSTS AS A PERCENTAGE OF TOTAL COSTS**



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

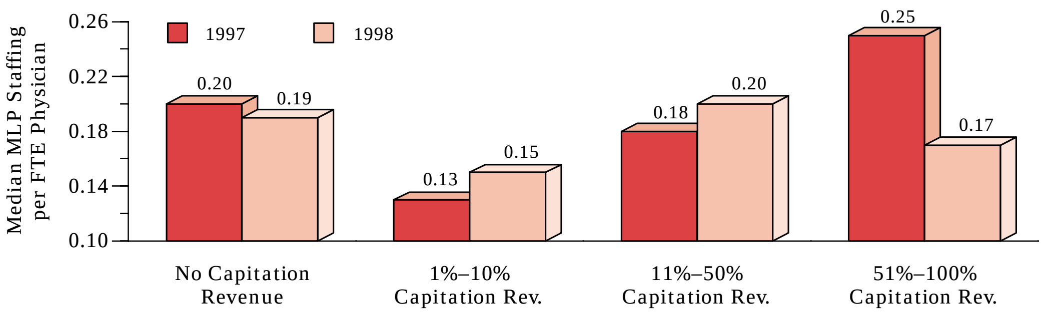
More multispecialty groups use midlevel providers

Midlevel providers (MLPs) were employed by 83.5% of multispecialty groups in 1998, up from 80.7% in 1997. For the first time in four years, the median MLP ratio per FTE physician among groups with MLPs on staff rose, to 0.20. Groups with 10 or fewer and 151 or more FTE physicians had a higher median MLP staff ratio than did all other group practice size categories, at 0.33 MLPs per FTE physician.

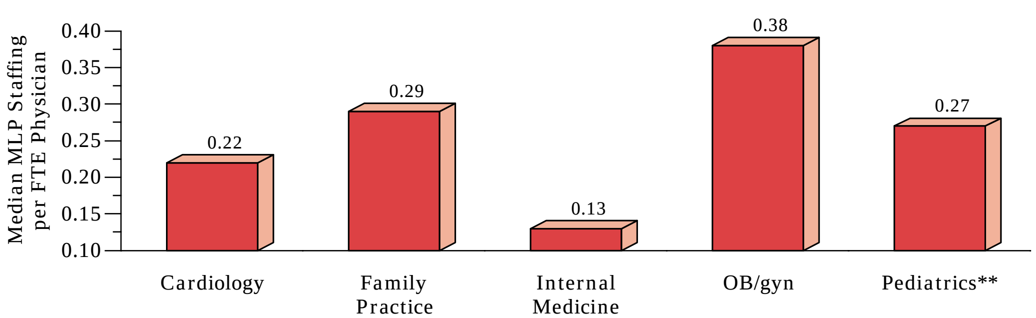
STAFFING OF MIDLEVEL PROVIDERS: MULTISPECIALTY GROUPS*

	Median MLP Staffing per FTE Physician	% of Groups With MLPs
SIZE (# of FTE physicians)		
10 or fewer	0.33	78.0%
11–25	0.15	71.0
26–50	0.13	90.4
51–75	0.12	90.5
76–150	0.20	100.0
151 or more	0.33	100.0
PERCENTAGE OF CAPITATION REVENUE		
No Capitation Revenue	0.19	76.7%
1%–10%	0.15	92.9
11%–50%	0.20	98.0
51%–100%	0.17	100.0
ALL GROUPS	**0.20**	**83.5%**

STAFFING OF MIDLEVEL PROVIDERS: MULTISPECIALTY GROUPS*



STAFFING OF MIDLEVEL PROVIDERS: SELECTED SINGLE SPECIALTY GROUPS*



Data sources: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999 and 1998 Report Based on 1997 Data © 1998

SHARE OF MIDLEVEL PROVIDER USE RISES WITH GROUP SIZE

In general, the percentage of multispecialty groups that had MLPs on staff rose along with group size. Whereas 78.0% of groups with 10 or fewer FTE physicians hired midlevel providers in 1998, 100.0% of groups with 76 or more FTE physicians used MLPs.

MLP STAFF RATIO IS HIGHEST AT OB/GYN GROUP PRACTICES

OB/gyn groups recorded a higher median staff ratio than other selected single specialty groups, at 0.38 MLPs per FTE physician, up 35.7% from 0.28 in 1997. By comparison, the MLP staff ratio for internal medicine groups remained unchanged at 0.13, the lowest such ratio of the single specialty group practices profiled.

* Midlevel providers are specially trained and licensed nonphysician providers who can provide medical care and billable services. Examples of midlevel providers include audiologists, certified registered nurse anesthetists (CRNAs), dietitians/nutritionists, midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, podiatrists, psychologists, social workers, speech therapists and surgical technicians.

** "Pediatrics" excludes subspecialty pediatrics such as pulmonology, neurology, gastroenterology and endocrinology.

Multispecialty groups show slight staffing ratio rise

The median ratio of FTE support staff to FTE physicians for multispecialty groups increased slightly in 1998, to 4.79 from 4.78 in 1997. This ratio was highest for groups with 51 to 75 physicians, up 9.8% to 5.50 from 5.01, and lowest for groups with 10 or fewer FTE physicians, up fractionally to 4.72 from 4.69. The median ratio for groups with 151 or more FTE physicians rose 21.3%, to 5.36 from 4.42 in 1997.

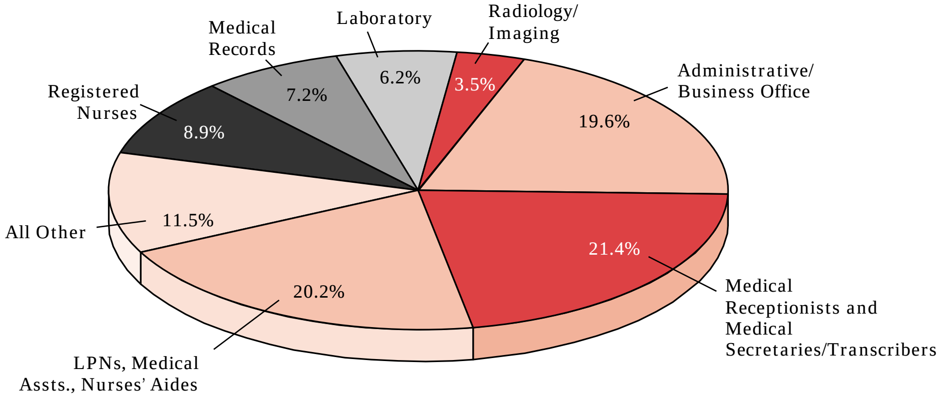
LARGEST GROUPS INCREASED STAFF SUPPORT RATIOS
Multispecialty groups with 151 or more FTE physicians reported increases in the median ratio of FTE support staff to FTE physicians in 10 staff categories, including clinical laboratory (to 0.47 in 1998 from 0.29 in 1997), business office (to 0.63 from 0.46) and licensed practical nurses (to 0.68 from 0.56). These large multispecialty groups had the highest overall median staff ratio in five of the 16 support staff categories profiled.

THREE CATEGORIES ACCOUNT FOR 61.2% OF SUPPORT STAFF
More than one-fifth each of median support staff per FTE physician in multispecialty group practices in 1998 were medical receptionists, secretaries and transcribers (21.4%) and LPNs, medical assistants and nurses' aides (20.2%), while just under one-fifth (19.6%) were administrative and business office employees.

MEDIAN FTE SUPPORT STAFF PER FTE PHYSICIAN: MULTISPECIALTY GROUPS*

STAFF CATEGORY	10 or Fewer FTE Physicians	11–25 FTE Physicians	26–50 FTE Physicians	51–75 FTE Physicians	76–150 FTE Physicians	151 or More FTE Physicians	All Groups
General Administrative	0.25	0.25	0.25	0.26	0.24	0.33	**0.25**
Business Office	0.76	0.69	0.68	0.72	0.68	0.63	**0.67**
Managed Care Administrative	—	0.10	0.09	0.06	0.14	0.05	**0.09**
Information Services	0.12	0.11	0.09	0.11	0.16	0.21	**0.11**
Housekeeping/Maint./Security	0.13	0.12	0.09	0.13	0.13	—	**0.11**
Other Admin. Support	—	0.08	0.08	0.05	0.05	—	**0.07**
Registered Nurses	0.62	0.44	0.47	0.49	0.50	0.32	**0.46**
Licensed Practical Nurses	0.67	0.50	0.54	0.31	0.29	0.68	**0.48**
Med. Assistants, Nurses' Aides	0.67	0.43	0.46	0.59	0.44	—	**0.56**
Medical Receptionists	0.94	0.70	0.80	0.85	0.82	—	**0.84**
Med. Secretaries/Transcribers	0.25	0.33	0.25	0.31	0.32	0.31	**0.26**
Medical Records	0.36	0.46	0.41	0.52	0.41	0.24	**0.37**
Clinical Laboratory	0.38	0.39	0.34	0.30	0.32	0.47	**0.32**
Radiology/Imaging	0.15	0.17	0.23	0.23	0.22	0.30	**0.18**
Other Med. Support Services	0.24	0.15	0.20	0.36	0.29	0.32	**0.22**
Contract/Temp. Support Staff	0.20	0.13	0.11	—	—	—	**0.15**
TOTAL FTE SUPPORT STAFF/FTE PHYSICIAN	**4.72**	**4.91**	**5.06**	**5.50**	**5.23**	**5.36**	**4.79**

DISTRIBUTION OF FTE SUPPORT STAFF: MULTISPECIALTY GROUPS*



* No data on midlevel providers or physicians are included in support staff or nonprovider data.

Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

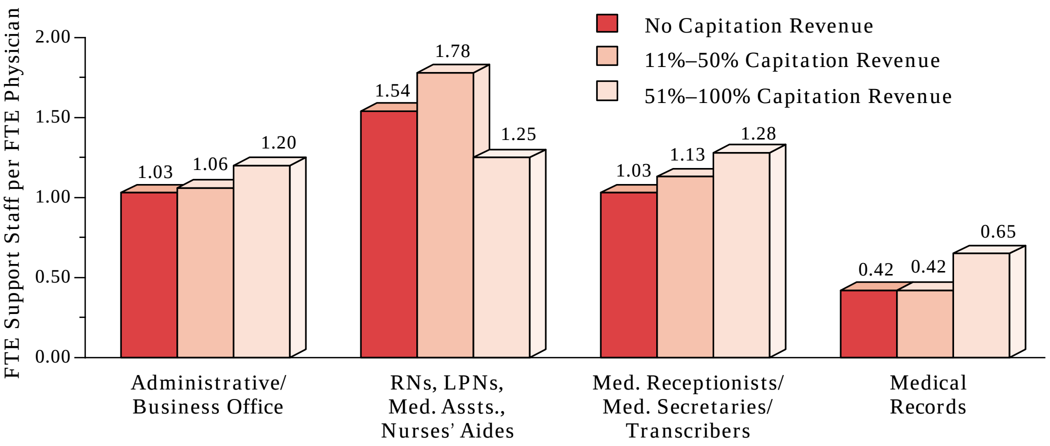
Highly capitated groups have highest staff ratio again

MGMA multispecialty groups deriving more than half of revenue from capitation had a higher staff ratio of FTE support staff to FTE physicians than did other groups in 1998, at a median of 6.20, 21.6% higher than the 5.10 recorded by groups with no revenue from capitation. The ratio of support staff to FTE physicians was lowest for groups with 1% to 10% of revenue from capitation, at 4.86.

MEDIAN FTE SUPPORT STAFF PER FTE PHYSICIAN: MULTISPECIALTY GROUPS*

STAFF CATEGORY	Groups With No Capitation Revenue	Groups With 1% to 10% Capitation Revenue	Groups With 11% to 50% Capitation Revenue	Groups With 51% to 100% Capitation Revenue
General Administrative	0.23	0.25	0.25	0.29
Business Office	0.76	0.66	0.68	0.56
Managed Care Administrative	0.04	0.07	0.13	0.35
Information Services	0.12	0.12	0.15	0.09
Housekeeping/Maint./Security	0.12	0.11	0.11	0.09
Other Admin. Support	0.08	0.05	0.08	—
Registered Nurses	0.50	0.33	0.63	0.53
Licensed Practical Nurses	0.61	0.35	0.32	—
Medical Assts., Nurses' Aides	0.43	0.45	0.83	0.72
Medical Receptionists	0.71	0.77	0.86	0.94
Med. Secretaries/Transcribers	0.32	0.25	0.27	0.34
Medical Records	0.42	0.32	0.42	0.65
Clinical Laboratory	0.34	0.37	0.32	0.47
Radiology/Imaging	0.19	0.17	0.23	0.31
Other Med. Support Services	0.22	0.29	0.15	0.09
Contract/Temp. Support Staff	0.12	0.11	0.13	—
TOTAL FTE SUPPORT STAFF PER FTE PHYSICIAN	**5.10**	**4.86**	**5.05**	**6.20**

MEDIAN FTE SUPPORT STAFF PER FTE PHYSICIAN: MULTISPECIALTY GROUPS*



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

MOST STAFF RATIOS ARE HIGHEST IN CAPITATED GROUPS
The ratio of FTE support staff to FTE physicians for multispecialty groups that derived more than half of revenue from capitation was highest in 1998 in 7 of the 16 staff categories listed. However, these groups also recorded the lowest staff ratio in four of the categories profiled. By comparison, groups with no capitation revenue reported the highest staff ratio in just three of the categories profiled and the lowest staff ratio in four of the staff categories.

CAPITATED GROUPS HAVE MORE STAFF PER FTE PHYSICIAN
In three of the four general staff categories profiled, multispecialty groups with more than half of revenue from capitation had higher support staff ratios than did other groups. Staff ratios were highest for registered nurses (RNs), LPNs, medical assistants and nurses' aides, regardless of capitation share, in three of the four general staff categories profiled.

* No data on midlevel providers or physicians are included in support staff or nonprovider data.

Share of groups with revenue from capitation drops

The percentage of MGMA group practices that derived revenue from capitation contracts declined overall (to 40.9% from 42.3% in 1997) and in four of six size categories profiled in 1998. The percentage for reporting groups with 151 or more FTE physicians, for instance, fell to 81.3% from 93.3% in 1997, while the percentage for groups with 76 to 150 FTE physicians rose to 91.4% from 90.2%.

SHARE OF SINGLE SPECIALTY GROUPS WITH CAPITATION REVENUE FALLS

The share of single specialty groups with revenue from capitation declined in 1998, to 30.8% from 32.5% in 1997. Of the single specialty groups profiled, the capitation revenue share was highest for pediatric groups, at 70.8%. Although the share of multispecialty groups with revenue from capitation was more than twice that of single specialty groups, it dropped slightly in 1998, to 66.8% from 67.0% the previous year.

SINGLE SPECIALTY GROUPS RARELY GET MOST OF INCOME FROM CAPITATION

The median percentage of single specialty groups with more than half of revenue from capitated contracts was only 0.3%, compared with 5.8% for multispecialty groups. Conversely, the share of single specialty groups deriving no revenue from capitated contracts (71.7%) was nearly double that of multispecialty groups (36.2%) in 1998.

* Data for 1996 and 1997 have been restated and, therefore, differ from the *Medical Group Practice Digest*, 1999.

PERCENTAGE OF GROUP PRACTICES DERIVING REVENUE FROM CAPITATION CONTRACTS

	1996*	1997*	1998
SIZE (# of FTE physicians)			
10 or fewer	27.6%	32.3%	28.7%
11–25	50.0	45.2	45.2
26–50	63.8	60.7	58.3
51–75	81.6	76.5	72.2
76–150	85.0	90.2	91.4
151 or more	94.4	93.3	81.3
SPECIALTY COMPOSITION			
Single Specialty	29.7%	32.5%	30.8%
Multispecialty	67.1	67.0	66.8
ALL GROUPS	**41.6%**	**42.3%**	**40.9%**
SAMPLE SIZE	**1,123**	**1,195**	**1,047**

MEDIAN PERCENTAGE OF SINGLE SPECIALTY GROUP PRACTICES WITH CAPITATION REVENUE BY SPECIALTY

	Percentage of Groups with Capitation Revenue		
	1996	1997	1998
SINGLE SPECIALTY			
Anesthesiology	15.2%	18.4%	9.6%
Cardiology	31.3	33.7	35.1
Family Practice	63.4	61.8	61.6
Internal Medicine	45.7	58.8	64.7
Pediatrics	73.3%	75.0%	70.8%
General Surgery	18.2	37.8	44.1
Orthopedic Surgery	21.1	20.9	17.6
Urology	25.9	24.1	20.7

MEDIAN PERCENTAGE OF GROUP PRACTICES BY CAPITATION CONTRACT REVENUE PERCENTAGE

	Groups With No Capitation Revenue	Groups With 1% to 10% Capitation Rev.	Groups With 11% to 50% Capitation Rev.	Groups With 51% to 100% Capitation Rev.
SPECIALTY COMPOSITION				
Single Specialty	71.7%	17.4%	10.6%	0.3%
Multispecialty	36.2	25.8	32.3	5.8
ALL GROUPS	**62.2%**	**19.7%**	**16.4%**	**1.8%**

Data sources: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999, 1998 Report Based on 1997 Data © 1998 and 1997 Report Based on 1996 Data © 1997

Compensation of PCPs is based more on productivity

The share of multispecialty group primary care physicians (PCPs) whose compensation was based half or more on productivity in 1998 was 54.1%, compared with 45.2% for single specialty group specialists. Meanwhile, the share of PCPs who had a guaranteed salary as 51% to 99% of their compensation was 28.4%, signficantly greater than the 18.0% recorded for single specialty group specialists.

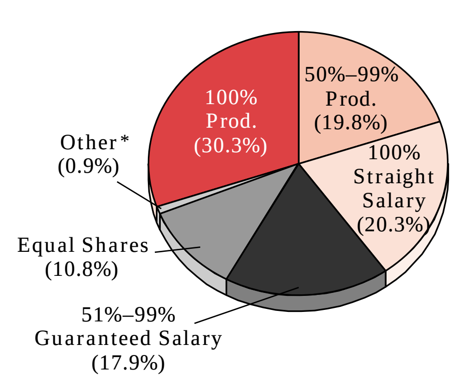
PERCENTAGE OF ESTABLISHED PRIMARY CARE PHYSICIANS, BY COMPENSATION METHOD: MULTISPECIALTY GROUPS

	Productivity		51%–99% Guaranteed Salary	Straight Salary	Equal Shares	Other*
SIZE (# of FTE physicians)	100%	50%–99%				
10 or fewer	24.9%	16.1%	27.0%	29.2%	2.8%	—
11–25	38.6	20.6	23.2	15.1	2.5	—
26–50	36.5	25.0	20.1	16.1	1.1	1.2%
51–75	47.1	14.1	22.4	16.3	—	—
76–150	44.0	18.9	27.0	10.1	—	—
151 or more	20.8	22.9	41.3	13.9	—	—
ALL GROUPS	**33.7%**	**20.4%**	**28.4%**	**16.2%**	**1.0%**	**0.5%**
SAMPLE SIZE: 7,628 providers/592 groups						

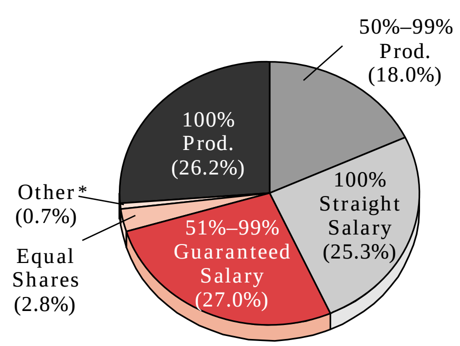
PERCENTAGE OF ESTABLISHED SPECIALISTS, BY COMPENSATION METHOD: SINGLE SPECIALTY GROUPS

	Productivity		51%–99% Guaranteed Salary	Straight Salary	Equal Shares	Other*
SINGLE SPECIALTY**	100%	50%–99%				
Allergy/Immunology	22.9%	7.1%	32.9%	18.6%	18.6%	—
Anesthesiology	19.0	21.6	14.7	16.0	21.8	6.9%
Cardiology	12.3	19.8	22.0	19.2	24.7	2.0
General Surgery	15.0	36.4	9.5	10.9	28.2	—
Hematology/Oncology	15.7	31.4	13.7	24.5	14.7	—
Obstetrics/Gynecology	27.9	13.2	24.7	24.5	9.1	0.6
Ophthalmology	49.6	29.4	10.7	8.9	1.5	—
Orthopedic Surgery	39.6	29.2	12.9	11.9	5.8	0.6
Radiology/Diagnostics	2.0	10.4	17.3	12.4	48.8	9.2
ALL GROUPS	**25.2%**	**20.0%**	**18.0%**	**18.8%**	**15.8%**	**1.8%**
SAMPLE SIZE: 7,164 providers/1,062 groups						

COMPENSATION FOR GROUPS WITHOUT MANAGED CARE



COMPENSATION FOR GROUPS WITH MANAGED CARE



GROUPS WITH MC PATIENTS OFTEN USE SALARY GUARANTEES

The percentage of MGMA member group physicians with managed care patients who had a guaranteed salary as at least half of their compensation was 27.0% in 1998, considerably higher than the 17.9% reported for physicians in those MGMA groups without managed care patients.

Compensation Methods:

- 100% Productivity: 100% of physician pay is based on individual physician productivity.
- 50% to 99% Productivity: 50% to 99% of physician pay is based on individual physician productivity; remainder is based on other factors.
- 51% to 99% Guaranteed Salary: 51% to 99% of physician pay is a guaranteed base salary; the balance is determined through other measures, such as productivity and profit sharing.
- Straight Salary: 100% of physician compensation is attributable to fixed salaries.
- Equal Shares: All physicians in the medical group are paid equal amounts based on the group's performance.

* "Other" methods of determining compensation levels involve evaluations of patient satisfaction and physician leadership roles, seniority and involvement in community services.

** These data were compiled on established specialists in single specialty groups only. No specialists from multispecialty groups were included.

Data source: Medical Group Management Association Physician Compensation and Production Survey: 1999 Report Based on 1998 Data © 1999

Share of groups using two or fewer satellite offices dips

The share of reporting groups that made use of two or fewer satellite branch offices per group fell in 1999, to 59.1% from 60.9% in 1998. Meanwhile, the share of these groups that made use of three to four satellite offices per group rose, to 17.6% from 15.5% the previous year. The share of such groups that made use of seven or more satellite clinics per group was 16.1%, up from 14.5% in 1998.

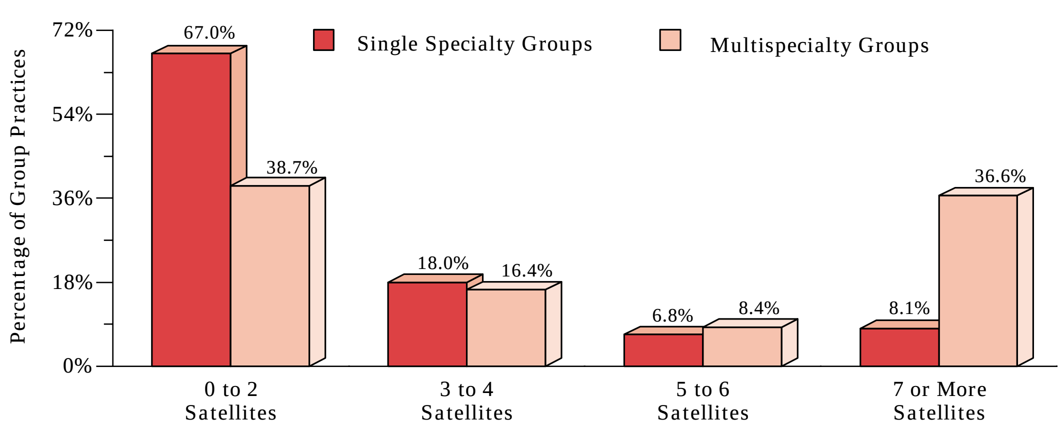
CAPITATION BOOSTS AVERAGE NUMBER OF SATELLITE OFFICES
The share of groups using seven or more satellite branch offices per group was highest among groups with more than 50% of revenue from capitation (64.7%) and lowest among groups with no capitation revenue (7.7%). The share of groups with two or fewer branch offices was highest among groups with no capitation revenue (67.7%) and lowest among groups with more than 50% of revenue from capitation (23.5%).

MANY GROUPS USE TWO OR FEWER SATELLITE OFFICES
With the exception of ophthalmology groups, which were more likely to average three to four satellite branch clinics, groups in every single specialty category were more likely to make use of two or fewer satellite branch offices per group than any other branch office number. Of these single specialty groups, otorhinolaryngology groups had the highest share of groups with seven or more branch offices per group (17.6%).

USE OF SATELLITE CLINICS

	Percentage of Groups With 0–2 Satellites	Percentage of Groups With 3–4 Satellites	Percentage of Groups With 5–6 Satellites	Percentage of Groups With 7+ Satellites
SINGLE SPECIALTY				
Anesthesiology	94.0%	––	—	6.0%
Cardiology	44.8	29.2%	10.4%	15.6
Family Practice	80.2	5.3	7.9	6.6
General Surgery	67.6	23.5	—	8.8
Internal Medicine	82.4	8.8	5.9	2.9
Obstetrics/Gynecology	74.3	17.1	5.7	2.9
Ophthalmology	25.9	35.5	22.6	16.1
Orthopedic Surgery	65.6	23.0	7.4	4.1
Otorhinolaryngology	58.8	23.5	—	17.6
Pediatrics	75.0	12.5	4.2	8.3
Radiology	76.7	6.7	6.7	10.0
Urology	65.5	13.8	10.3	10.3
PERCENTAGE OF CAPITATION REVENUE				
No Capitation Revenue	67.7%	18.1%	6.4%	7.7%
1%–10%	49.5	18.2	11.5	20.8
11%–50%	42.3	14.7	7.1	35.9
51%–100%	23.5	11.8	—	64.7
SPECIALTY COMPOSITION				
Single Specialty	67.0%	18.0%	6.8%	8.1%
Multispecialty	38.7	16.4	8.4	36.6
ALL GROUPS	**59.1%**	**17.6%**	**7.2%**	**16.1%**

USE OF SATELLITE CLINICS



Data source: Medical Group Management Association Cost Survey: 1999 Report Based on 1998 Data © 1999

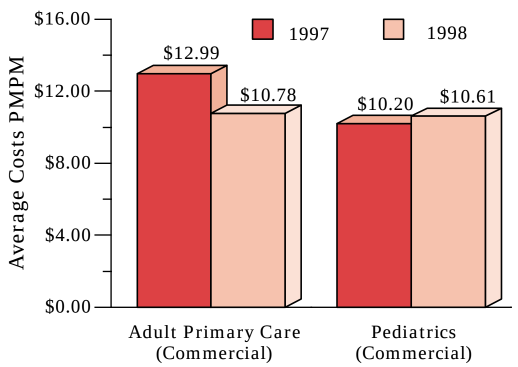
Primary care costs decline for commercial members

Primary care specialty costs among large California physician organizations dropped 17.0% in 1998, to $10.78 per member per month (PMPM) from $12.99 in 1997. By comparison, the pediatric care cost rose 4.0% in 1998, to $10.61 PMPM from $10.20. Overall, costs increased between 1997 and 1998 in five specialty care categories—in most cases only slightly—and decreased in one category.

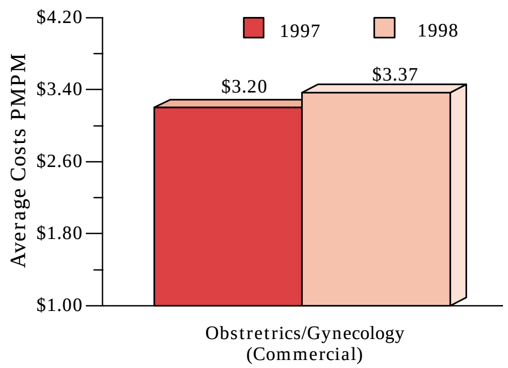
PHYSICIAN ORGANIZATION SPECIALTY COSTS FOR COMMERCIAL HMO MEMBERS

	Commercial HMO Members				
	PMPM 1997	PMPM 1998	High	Low	% Capitated
PRIMARY CARE					
Adult Primary Care	$12.99	$10.78	$16.00	$8.00	—
Pediatrics	10.20	10.61	17.14	8.00	—
SPECIALTY CARE					
Allergy/Immunology	$0.19	$0.23	$0.47	$0.10	41.0%
Anesthesiology	1.99	2.02	3.84	0.65	43.0
Cardiology	0.67	0.66	0.91	0.42	—
Gastroenterology	0.46	0.49	1.11	0.15	89.0
Hematology/Oncology	0.80	1.10	2.40	0.47	50.0
Obstetrics/Gynecology	3.20	3.37	4.57	2.03	67.0

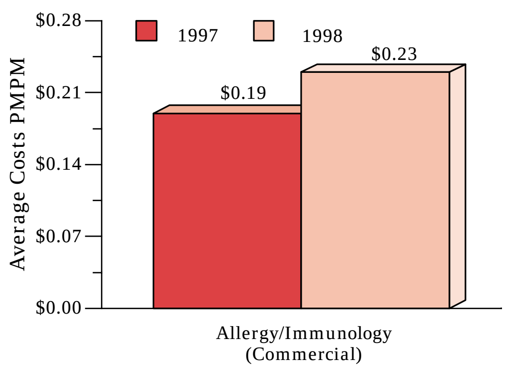
PRIMARY CARE



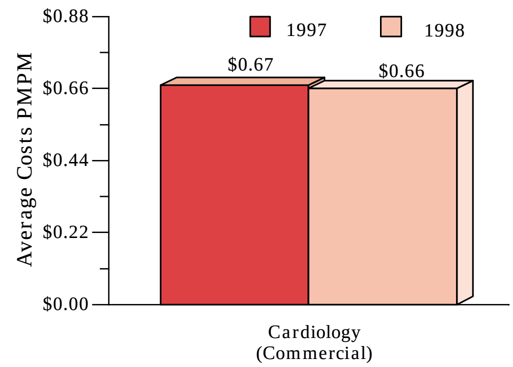
OBSTETRICS/GYNECOLOGY



ALLERGY/IMMUNOLOGY



CARDIOLOGY



Data source: California Association of Physician Organizations and Reden & Anders, Ltd., Specialty Cost/Capitation Survey: 1999 Survey Based on 1998 Data © 2000, 1998 Survey Based on 1997 Data © 1999

SPECIALTY COSTS ARE REVEALED FOR FIRST TIME BY CAPO

The data on pages 25 through 28 represent specialty cost information available for the first time in any publication. These data are important because California has long been a bellwether state for the health care industry. Managed care and capitation are more extensive in California, and the state's medical rates and costs are leading indicators of what the future might look like elsewhere in the country. California Association of Physician Organizations (CAPO) member physician organizations are among the largest in the state.

SPECIALTY COSTS REFLECT REAL AND EXPECTED EXPENSES

Specialty costs are based on actuarial calculations which incorporate actual experience (past history of medical claims costs) and are based on historical trends. Specialty costs represent significant benchmarks for physician organizations in pricing their services under managed care contracts.

Organizations have lower Medicare primary care costs

The average primary care specialty cost per member per month (PMPM) for Medicare + Choice members fell 10.6% in 1998, to $29.56 from $33.08 in 1997. By comparison, average costs PMPM for these Medicare members increased in all five specialty care categories profiled, including for allergy/immunology medical care, in which costs climbed by one-third, to $0.20 from $0.15 in 1997.

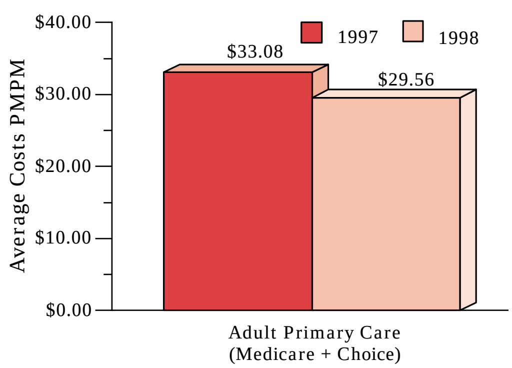
COSTS PMPM RISE FOR HEMATOLOGY/ ONCOLOGY SERVICES
Average specialty costs PMPM for Medicare + Choice members increased 49.1% for hematology/ oncology services, to $5.25 from $3.52 in 1997, the largest increase among the specialty care categories. Hematology and oncology specialty costs for services provided to commercial members also rose, by 37.5% (see page 25). Meanwhile, Medicare + Choice specialty costs climbed 18.8% for anesthesiology services, to $6.63 from $5.58 the year before, while average Medicare + Choice costs increased 11.6% for gastroenterologists, to $3.17 PMPM from $2.84.

ORGANIZATIONS CAPITATE MEDICARE + CHOICE MEMBERS FOR CARDIOLOGY
In 1998, 80.0% of Medicare + Choice enrollees being treated at CAPO organizations paid for cardiology services under capitated contracts. By comparison, only 40.0% of Medicare + Choice members in these organizations paid for anethesiology services under capitated contracts.

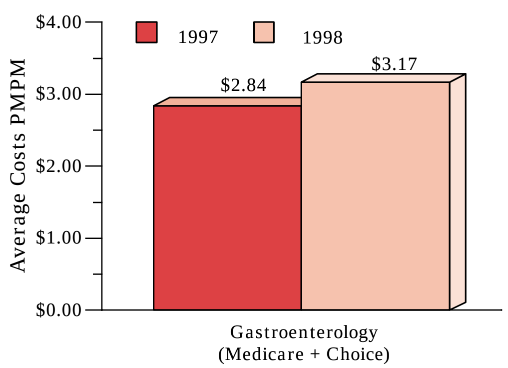
PHYSICIAN ORGANIZATION SPECIALTY COSTS FOR MEDICARE + CHOICE HMO MEMBERS

	Medicare + Choice HMO Members				
	PMPM 1997	PMPM 1998	High	Low	% Capitated
PRIMARY CARE					
Adult Primary Care	$33.08	$29.56	$50.00	$12.00	—
Pediatrics	—	—	—	—	—
SPECIALTY CARE					
Allergy/Immunology	$0.15	$0.20	$0.51	$0.04	44.0%
Anesthesiology	5.58	6.63	10.55	2.34	40.0
Cardiology	6.29	6.48	8.18	4.81	80.0
Gastroenterology	2.84	3.17	8.16	0.90	80.0
Hematology/Oncology	3.52	5.25	11.00	1.59	54.0
Obstetrics/Gynecology	—	—	—	—	—

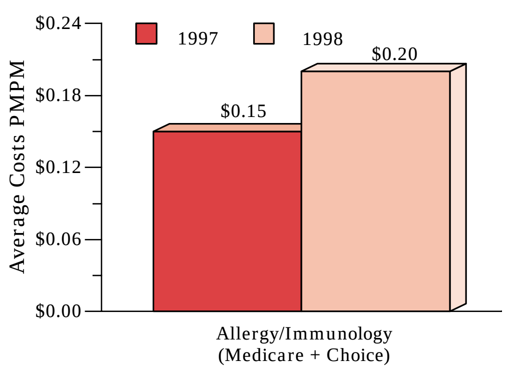
PRIMARY CARE



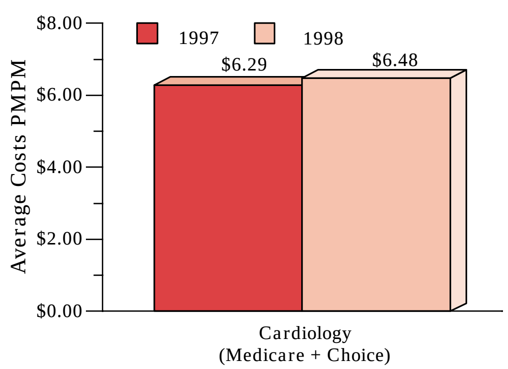
GASTROENTEROLOGY



ALLERGY/IMMUNOLOGY



CARDIOLOGY



Data source: California Association of Physician Organizations and Reden & Anders, Ltd., Specialty Cost/Capitation Survey: 1999 Survey Based on 1998 Data © 2000, 1998 Survey Based on 1997 Data © 1999

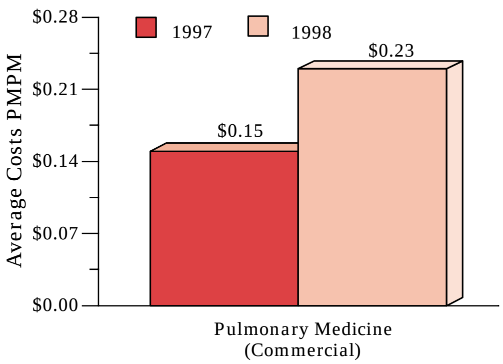
1998 specialty costs PMPM rise on commercial side

Average specialty costs PMPM for commercial HMO members increased between 1997 and 1998 in six of nine specialty care categories profiled. For example, pulmonary care costs for commercial HMO members jumped 53.3%, to $0.23 PMPM from $0.15 in 1997. Costs rose 17.6% for radiology services, to $2.27 PMPM from $1.93 in 1997, and 20.0% for endocrinology care, to $0.06 from $0.05.

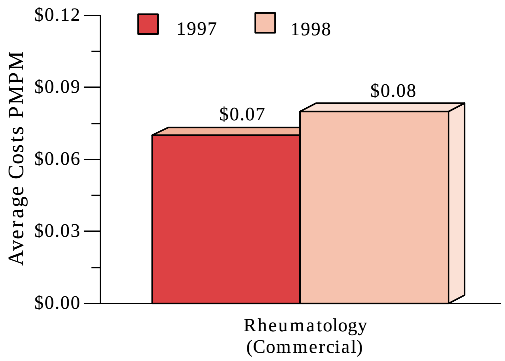
PHYSICIAN ORGANIZATION SPECIALTY COSTS FOR COMMERCIAL HMO MEMBERS

	Commercial HMO Members				
SPECIALTY CARE	PMPM 1997	PMPM 1998	High	Low	% Capitated
Endocrinology	$0.05	$0.06	$0.15	$0.02	35.0%
Ophthalmology	0.56	0.63	1.06	0.25	84.0
Otorhinolaryngology	0.57	0.55	0.77	0.24	76.0
Pulmonary Medicine	0.15	0.23	0.51	0.05	53.0
Radiology	1.93	2.27	3.63	0.75	67.0
Rheumatology	0.07	0.08	0.35	0.01	25.0
General Surgery	0.93	1.03	2.09	0.45	71.0
Orthopedic Surgery	1.32	1.22	2.12	0.62	80.0
Urology	0.47	0.45	0.97	0.20	85.0

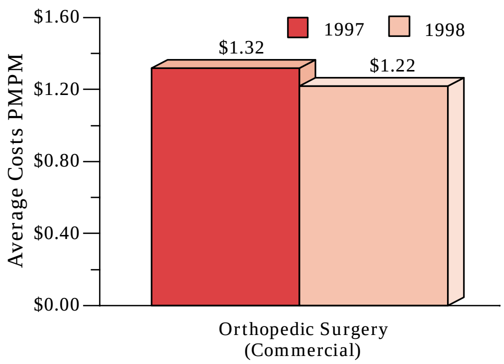
PULMONARY MEDICINE



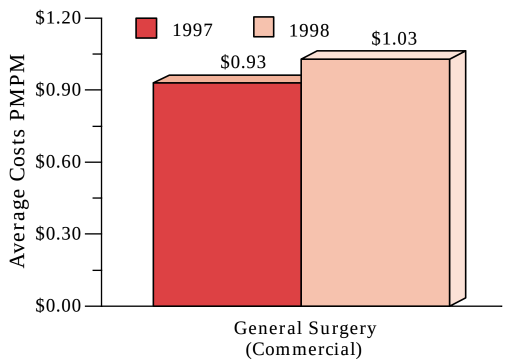
RHEUMATOLOGY



ORTHOPEDIC SURGERY



GENERAL SURGERY



Data source: California Association of Physician Organizations and Reden & Anders, Ltd., Specialty Cost/Capitation Survey: 1999 Survey Based on 1998 Data © 2000, 1998 Survey Based on 1997 Data © 1999

COSTS PMPM DIP FOR ORTHOPEDIC SURGERY SERVICES

Orthopedic surgery specialty costs per commercial HMO member per month dropped 7.6% in 1998, to an average of $1.22 from $1.32 in 1997. By comparison, average specialty costs PMPM for commercial HMO members declined 4.3% for urology care, to $0.45 from $0.47 the year before, and 3.5% for otorhinolaryngology services, to $0.55 from $0.57.

ORGANIZATIONS CAPITATE 85% FOR UROLOGY CARE

Commercial members receiving care at CAPO physician organizations, were most likely to be covered under capitated contracts for urology services (85.0%), ophthalmology services (84.0%) and orthopedic surgery services (80.0%). These members were also highly likely to be covered under capitation agreements for otorhinolaryngology services (76.0%) and general surgery (71.0%). By comparison, these members were least likely (25.0%) to be covered for rheumatology services under capitated contracts.

Specialty care costs rise for Medicare + Choice members

Average specialty costs per member per month (PMPM) increased for Medicare + Choice members between 1997 and 1998 in eight of the nine specialty care categories shown. For instance, endocrinology specialty costs for Medicare members jumped 72.7%, to $0.38 from $0.22 the previous year. Similarly, urology costs for Medicare + Choice members rose 41.3%, to $3.97 from $2.81 in 1997.

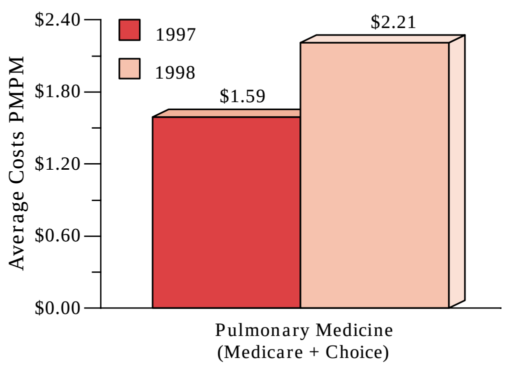
COSTS PMPM CLIMB FOR PULMONARY MEDICINE SERVICES
Specialty costs for services provided by pulmonary physicians jumped 39.0% for Medicare + Choice members, to $2.21 PMPM in 1998 from $1.59 in 1997. In this same period, average monthly costs for these members increased 13.0% for ophthalmology services, to $7.15 from $6.33 the previous year. However, orthopedic surgery specialty costs fell 6.0% PMPM for Medicare enrollees, to $5.01 in 1998 from $5.33 in 1997.

ORGANIZATIONS CAPITATE OFTEN FOR UROLOGY SERVICES
In 1998, 83.0% of Medicare + Choice members served by CAPO physician organizations were covered for urology care under capitated managed care contracts, the highest share of the specialty care categories shown. That same year, by comparison, only 24.0% of Medicare + Choice members were covered for endocrinology services under capitated contracts, the smallest share of the specialty care categories profiled.

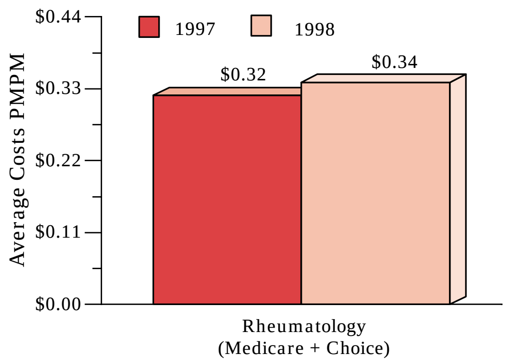
PHYSICIAN ORGANIZATION SPECIALTY COSTS FOR MEDICARE + CHOICE HMO MEMBERS

	Medicare + Choice HMO Members				
SPECIALTY CARE	PMPM 1997	PMPM 1998	High	Low	% Capitated
Endocrinology	$0.22	$0.38	$3.13	$0.01	24.0%
Ophthalmology	6.33	7.15	11.81	2.13	76.0
Otorhinolaryngology	1.03	1.16	2.04	0.51	75.0
Pulmonary Medicine	1.59	2.21	5.70	0.60	50.0
Radiology	8.80	8.85	17.70	2.05	55.0
Rheumatology	0.32	0.34	0.88	0.11	31.0
General Surgery	4.26	4.31	6.75	1.25	68.0
Orthopedic Surgery	5.33	5.01	9.11	1.42	74.0
Urology	2.81	3.97	7.71	2.15	83.0

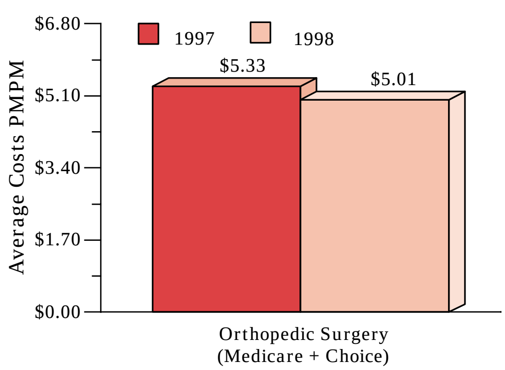
PULMONARY MEDICINE



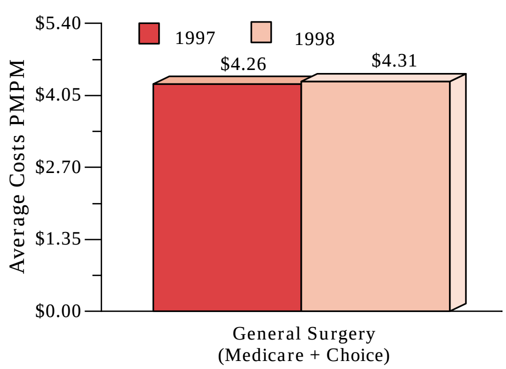
RHEUMATOLOGY



ORTHOPEDIC SURGERY



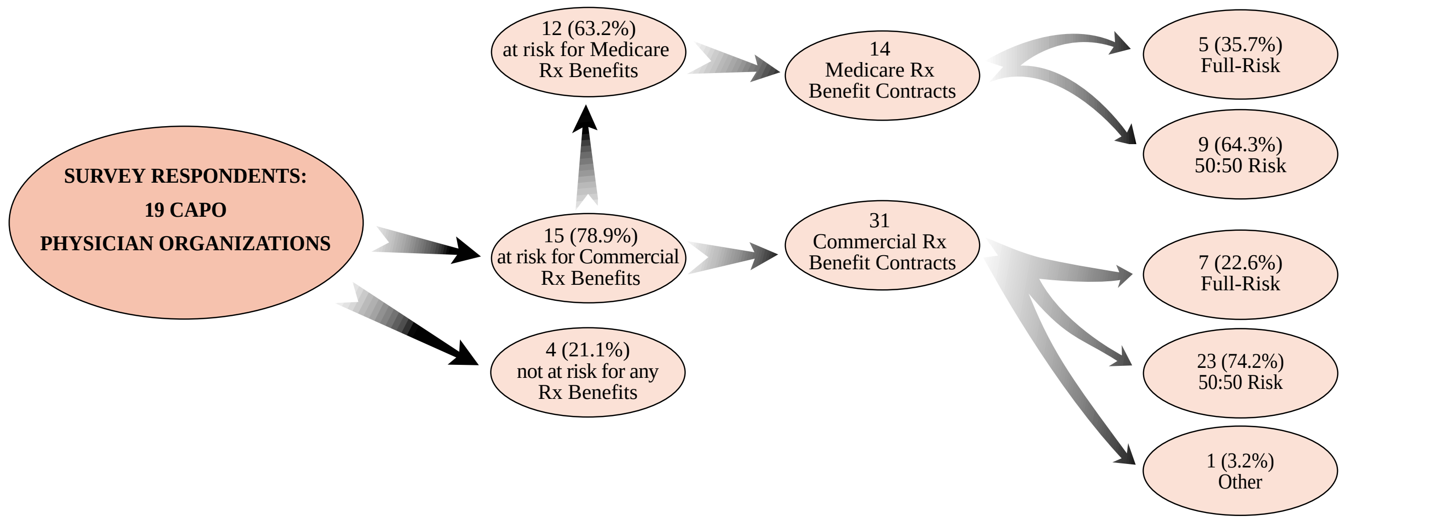
GENERAL SURGERY



Data source: California Association of Physician Organizations and Reden & Anders, Ltd., Specialty Cost/Capitation Survey: 1999 Survey Based on 1998 Data © 2000, 1998 Survey Based on 1997 Data © 1999

Organizations are often at risk for pharmacy benefit

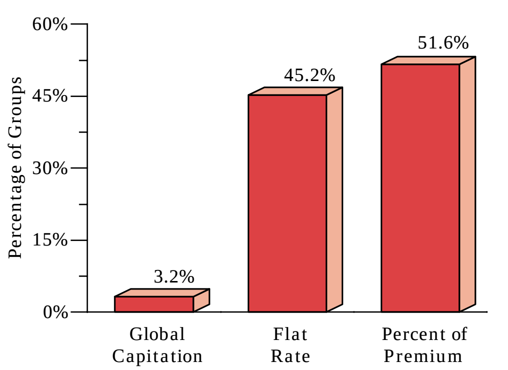
Of 19 reporting physician organizations in the California Association of Physician Organizations (CAPO), 15 (78.9%) assumed financial risk for commercial pharmacy benefits in 1999 under their contracts with health plans. By comparison, 12 (63.2%) of the 19 organizations accepted risk for the Medicare + Choice pharmacy benefit. Only four (21.1%) were not at risk for any of the pharmacy benefit.



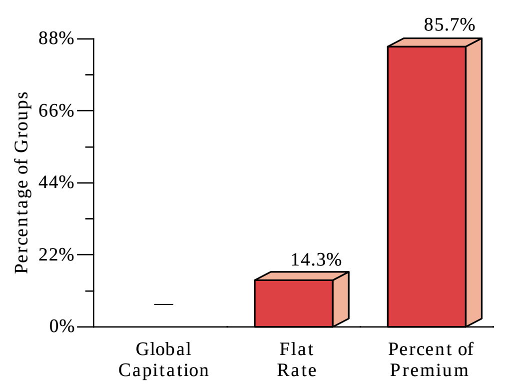
DEGREE OF FINANCIAL RISK FOR PHARMACY BENEFITS

SETTLEMENT SHARE	Commercial	Medicare + Choice
Full-Risk	7	5
50:50 Risk	23	9
Other	1	0

FUNDING METHOD FOR Rx BENEFITS: COMMERCIAL



FUNDING METHOD FOR Rx BENEFITS: MEDICARE + CHOICE



Data source: California Association of Physician Organizations Pharmacy Risk Survey, 1999 © 2000

NOTE: Data are derived from 19 of the more than 65 CAPO member physician organizations.

FEW ORGANIZATIONS TAKE MEDICARE FLAT RATE FUNDING

The share of reporting CAPO-member physician organizations accepting a flat-rate financial risk-sharing arrangement for their Medicare + Choice pharmacy risk benefit in 1999 was 14.3%. By comparison, 45.2% of CAPO organizations accepting risk for their commercial pharmacy benefit entered into a flat-rate risk-sharing arrangement. However, the percent-of-premium method was the most common arrangement for organizations accepting commercial (51.6%) and Medicare (85.7%) risk.

Organizations incur Medicare + Choice Rx risk losses

The Medicare + Choice pharmacy expense at 12 CAPO physician organizations in 1999 was $53.27 PMPM, 71.1% above the $31.14 funding target for expected claims. The result was a net deficit of $9.70 PMPM, or $907,543 per group, twice the amount lost on Medicare pharmacy risk in 1998 (some data not shown). The gross loss was 53.4% higher ($14.88 PMPM), but was limited by contract caps on losses.

COMMERCIAL Rx RISK IS MANAGEABLE FOR ORGANIZATIONS
Improvements in actuarially based funding levels coupled with the judicious use of contractual limits on losses allowed CAPO physician organizations to turn losses into gains in 1999 in the commercial pharmacy risk business. The average organization realized a surplus per group of $31,774 for the commercial pharmacy risk it undertook that year. The funding target for pharmacy benefits covering commercial health plan members was $13.97 PMPM, significantly below the $15.47 PMPM average actual cost of pharmacy benefits under those contracts.

TSSs OFTEN LOWER PHARMACY COSTS
Therapeutic support systems resulted in lower costs PMPM and better results overall on commercial pharmacy risks in 1999. But these efforts appeared to have no effect on reducing overall costs or increasing manageability of Medicare pharmacy benefits.

* For the purposes of this survey, therapeutic support system consisted of a pharmacy and therapeutics or formulary committee, a staff or consultant clinical pharmacist, and a preferred drug list or formulary.

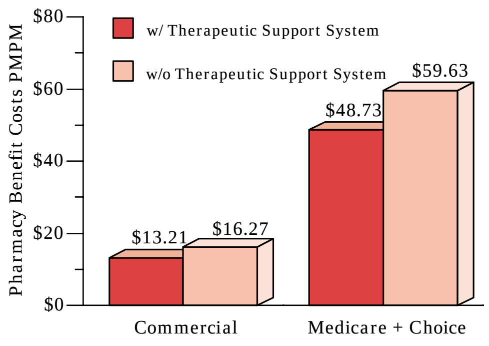
RESULTS OF PHARMACY RISK CONTRACTS FOR CAPO PHYSICIAN ORGANIZATIONS

	Commercial PMPM	Medicare + Choice PMPM
PHARMACY EXPENSE		
Funding Target (PMPM)	$13.97	$31.14
Expenses (PMPM)	$15.47	$53.27
Surplus/(Deficit) before limits	$(0.86)	$(14.88)
Actual Surplus/(Deficit)	$(0.36)	$(9.70)
Member Months per Organization	346,498	115,136
NET FINANCIAL IMPACT/GROUP	**$31,774**	**$(907,543)**

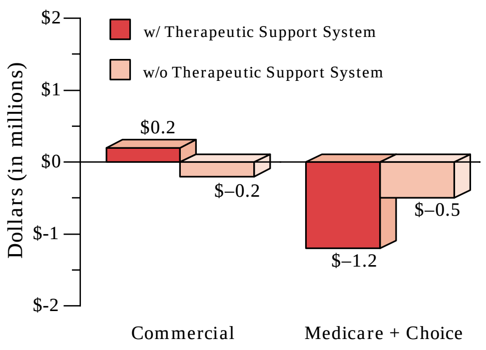
RESULTS OF PHARMACY RISK CONTRACTS FOR CAPO PHYSICIAN ORGANIZATIONS

	With Therapeutic Support System*		Without Therapeutic Support System*	
	Commercial	Medicare + Choice	Commercial	Medicare + Choice
Number of Orgs. Reporting	8	7	7	5
Pharmacy Expenses (PMPM)	$13.21	$48.73	$16.27	$59.63
Average Gain/(Loss)	$235,800	$(1,200,000)	$(201,000)	$(494,800)

IMPACT OF THERAPEUTIC SUPPORT SYSTEM (TSS) ON PHARMACY EXPENSES*



IMPACT OF THERAPEUTIC SUPPORT SYSTEM (TSS) ON PHARMACY EXPENSES*



Data source: California Association of Physician Organizations Pharmacy Risk Survey, 1999 © 2000

NOTE: One physician organization reported substantially higher member-months and year-end gains in commercial pharmacy risk, and significantly higher year-end losses in Medicare pharmacy than other respondents. The result was a significant difference between "mean" values and "median" values for several of the categories reported.

Contract limits on physician losses affect Rx risk results

Limitations on downside risks (losses) contained in 10 of 14 (71.4%) reporting Medicare + Choice pharmacy risk contracts in 1999 helped hold the average pharmacy risk deficit to $9.00 PMPM.

Loss caps were part of 61.3% of contracts covering commercial members, which held the 1999 loss to an average of $0.03 PMPM. Net results including the contractual limits showed some sizeable profits.

CAPO PHYSICIAN ORGANIZATION UTILIZATION MEASURES PER PHARMACY CONTRACT

UTILIZATION MEASURE	Commercial	Medicare + Choice
Average Cost per Prescription	$27.52	$29.77
Generic Utilization Rate	52.3%	54.8%
Formulary Compliance Rate	92.5%	94.2%
Avg. No. of Prescriptions PMPM	0.61	1.83

CAPO PHYSICIAN ORGANIZATION PHARMACY CONTRACT PROVISIONS

	Commercial	Medicare + Choice
Rebates Shared With Health Plans:		
Yes	51.6%	71.4%
No	22.6	14.3
Don't Know	25.8	14.3
Limits On Risk-Share Gain	32.3	28.6
Limits On Risk-Share Loss	61.3	71.4

CAPO PHYSICIAN ORGANIZATION FINANCIAL RESULTS ON PHARMACY CONTRACTS

FINANCIAL MEASURE	Commercial	Medicare + Choice
Funding Target (PMPM)	$13.61	$30.58
Expenses (PMPM)	$14.49	$51.58
Median Member-Months per Contract	441,156	185,365
Avg. Gain/(Loss) per Contract (before limits)	$(53,712)	$(1,900,000)
Net Avg. Dollar Gain/(Loss) per Contract (after limits)	$15,371	$777,894
Median Gain/(Loss) per Contract (before limits)	$231,658	$(2,510,000)
Net Median Dollar Gain/(Loss) per Contract (after limits)	$311,918	$(2,510,000)
Avg. Gain/(Loss) PMPM per Contract	$(0.03)	$(9.00)
Median Gain/(Loss) PMPM per Contract	$(0.71)	$(17.60)

Data source: California Association of Physician Organizations Pharmacy Risk Survey, 1999 © 2000

MEDICARE Rx COSTS FAR EXCEED RISK FUNDING TARGETS

The average Medicare + Choice pharmacy contract in 1999 resulted in costs of $51.58 PMPM, 68.7% greater than the funding target of $30.58 PMPM. This deficit resulted in an average loss per contract of $1.9 million, before any limitations were applied. Commercial pharmacy expenses were $14.49 PMPM, 6.5% higher than the funding target, resulting in an average loss before limits of $53,712 per contract.

NUMBER OF HEALTH PLANS SHARING REBATES IS HIGH

A large percentage of health plans with which CAPO physician organizations contracted in 1999 shared pharmaceutical rebates with contracting physician organizations. Of 14 Medicare + Choice pharmacy risk contracts, 10 (71.4%) provided for sharing of rebates between physician organizations and health plans. By comparison, 51.6% of CAPO physician organizations' commercial pharmacy contracts had rebate sharing provisions.

CAPO medical groups report pharmacy risk deficits

The average Medicare + Choice pharmacy risk cost at seven CAPO medical groups in 1999 was $54.71 PMPM, 65.3% above the $33.09 target for expected claims. The result was a net deficit of $11.95 PMPM, or $688,700 per group. The average commercial pharmacy risk cost at eight groups was $17.69 PMPM, 21.3% above the $14.58 funding target, for a net deficit of $0.98 PMPM, or $128,000 per group.

PLANS FUND IPA COMMERCIAL Rx RISK ADEQUATELY

The actual commercial pharmacy risk expense at four CAPO independent practice associations (IPAs) in 1999 was $13.25 PMPM, 1.2% less than the $13.41 funding target for expected claims. However, the actual Medicare + Choice risk cost at two IPAs was $56.32 PMPM, more than twice the $24.68 funding target. Although CAPO IPAs had commercial risk funding at adequate levels in 1999, they actually realized a net deficit for commercial and Medicare + Choice pharmacy risk benefits.

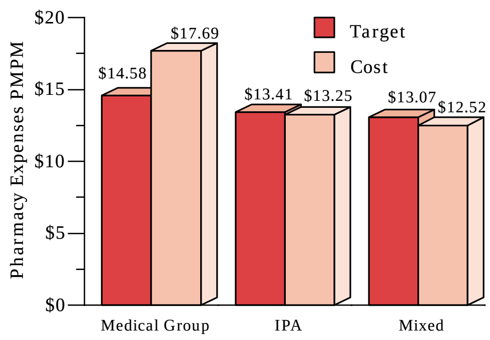
MIXED PHYSICIAN ORGANIZATIONS MANAGE Rx RISK

Mixed physician organizations realized an average net gain of $570,181 per organization in 1999 on the commercial pharmacy risk side but sustained an average net loss of $1.8 million on the Medicare + Choice pharmacy risk side. The mixed organizations' surplus on the pharmacy risk side for commercial business was the only net positive result among the three physician organization types in 1999.

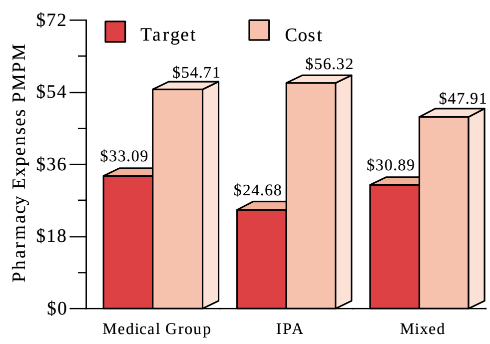
COMMERCIAL PHARMACY RISK BY TYPE OF ORGANIZATION

PHARMACY EXPENSE	Medical Group	IPA	Mixed
No. of Organizations Reporting	8	4	3
Funding Target (PMPM)	$14.58	$13.41	$13.07
Expenses (PMPM)	17.69	13.25	12.52
Surplus/(Deficit) before limits	(1.88)	0.25	0.36
Actual Surplus/(Deficit)	(0.98)	0.37	0.36
Avg. Annual Financial Impact	(128,000)	(52,470)	570,181

PHARMACY EXPENSES PMPM: COMMERCIAL



PHARMACY EXPENSES PMPM: MEDICARE + CHOICE



MEDICARE + CHOICE PHARMACY RISK BY TYPE OF ORGANIZATION

PHARMACY EXPENSE	Medical Group	IPA	Mixed
No. of Organizations Reporting	7	2	3
Funding Target (PMPM)	$33.09	$24.68	$30.89
Expenses (PMPM)	54.71	56.32	47.91
Surplus/(Deficit) before limits	(16.37)	(15.82)	(10.79)
Actual Surplus/(Deficit)	(11.95)	(2.49)	(9.24)
Avg. Annual Financial Impact	(688,700)	(309,500)	(1,820,000)

Data source: California Association of Physician Organizations Pharmacy Risk Survey, 1999 © 2000

NOTE: Sample sizes are very small for these data breakouts, therefore these data may not be conclusive. "Mixed" groups include combination medical group-IPAs that have both types of organizations under a single umbrella.

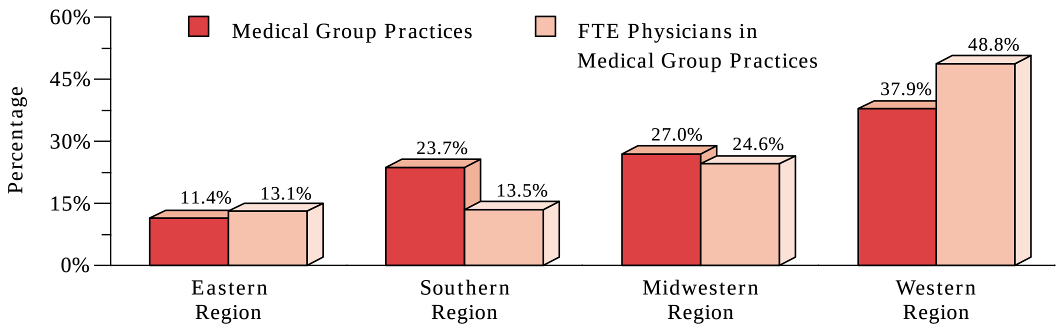
Largest member groups have 78% of AMGA physicians

Of the 41,327 total FTE physicians in AMGA groups in 1999, 32,230 (78.0%) were in groups with 151 or more FTE physicians. By comparison, only 71 (0.2%) were in groups with 10 or fewer FTE physicians. Groups with more than 150 FTE physicians accounted for the largest share, by size, of all AMGA groups (27.0%), whereas groups with 10 or fewer FTE physicians made up the smallest (4.7%).

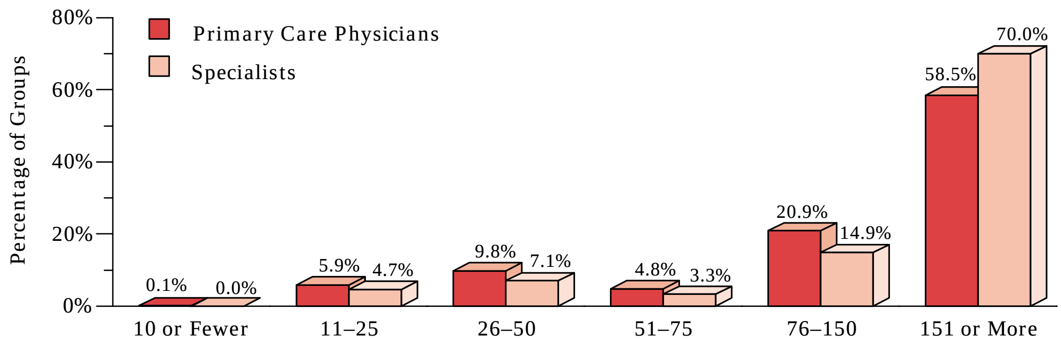
MEDICAL GROUP PRACTICES AND FTE PHYSICIANS*

SIZE (# of FTE physicians)	Medical Group Practices		FTE Physicians in Medical Group Practices	
	Number	Percentage	Number	Percentage
10 or fewer	10	4.7%	71	0.2%
11–25	23	10.9	451	1.1
26–50	51	24.2	1,942	4.7
51–75	21	10.0	1,354	3.3
76–150	49	23.2	5,279	12.8
151 or more	57	27.0	32,230	78.0
TOTAL	**211**	**100.0%**	**41,327**	**100.0%**

MEDICAL GROUP PRACTICES AND FTE PHYSICIANS, BY REGION**



PERCENTAGE OF MEDICAL GROUP PRACTICES, BY NUMBERS OF PCPs AND SPECIALISTS



Data source: American Medical Group Association Statistical Database, 1999 © 2000

* Demographic data do not include information from 66 IPA members representing 26,000 physicians and 1.6 million capitated lives. All demographic data is from the AMGA Membership Database 1999/2000.

** AMGA had groups in all states in the Eastern region, except Delaware, the District of Columbia, Maine, New Hampshire, Rhode Island, Vermont and West Virginia. AMGA had groups in all states in the Southern region, except Missouri. AMGA had groups in all states in the Midwestern region. (This region is called the Northern region by AMGA.) AMGA had groups in all states in the Western region, except Alaska, Idaho, Nevada and Wyoming. See page 5 for complete definitions of regions.

SHARE OF AMGA GROUPS IN THE WEST REGION FALLS

The West region served as headquarters for 37.9% of reporting AMGA member groups in 1999, down from 42.2% in 1998, but still the highest share of groups by region. This region also accounted for the largest share of physicians practicing in AMGA groups, at 48.8%. By comparison, AMGA member groups headquartered in the East region had just 11.4% of all AMGA groups in 1999 and only 13.1% of AMGA member group physicians.

MAJORITY OF AMGA GROUPS HAVE 151 OR MORE SPECIALISTS

In 1999, 70.0% of reporting AMGA groups (which, in general, are larger than MGMA group practices) employed more than 150 FTE specialists. Meanwhile, 58.5% of AMGA groups had more than 150 FTE primary care physicians (PCPs). By comparison, 0.1% of reporting AMGA groups employed fewer than 11 FTE PCPs, and an even lower percentage of these groups employed fewer than 11 FTE specialists.

Most groups with commercial lives are highly capitated

Of reporting AMGA groups with capitated commercial lives, 86.4% had more than half of total revenue from capitated contracts in 1999, up from 74.0% in 1998. Meanwhile, the share of groups with capitated Medicare beneficiaries that had half or more of revenue from capitation rose to 81.4% from 75.9%. Of groups with capitated Medicaid recipients, 73.7% had 51% to 100% of revenue from capitation.

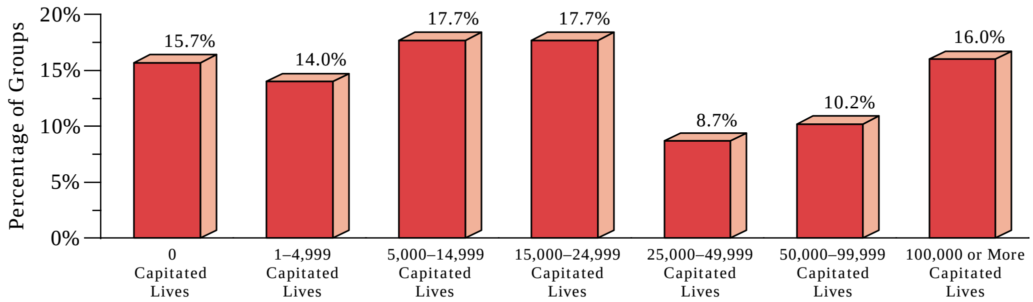
CAPITATION SHARE RISES WITH NUMBER OF CAPITATED LIVES
More than three-fourths (75.3%) of reporting AMGA group practices with 100,000 or more capitated lives derived more than 50% of revenue from capitated contracts in 1999. By comparison, no such reporting groups with fewer than 5,000 capitated lives derived more than 50% of revenue from capitated contracts.

MIDSIZED GROUPS HAVE LARGE SHARE OF CAPITATED LIVES
Of reporting AMGA group practices that derived revenue from capitated contracts, the largest shares by number of capitated lives provided services to 5,000 to 14,999 and 15,000 to 24,999 capitated lives (17.7% each). The share of these groups with 100,000 or more capitated lives (16.0%) and the share with no capitated lives (15.7%) were nearly as large. Meanwhile, the share of groups that derived 11% to 50% of revenue from capitation in 1999 was 36.1%, whereas just 14.7% of reporting groups had no capitation revenue.

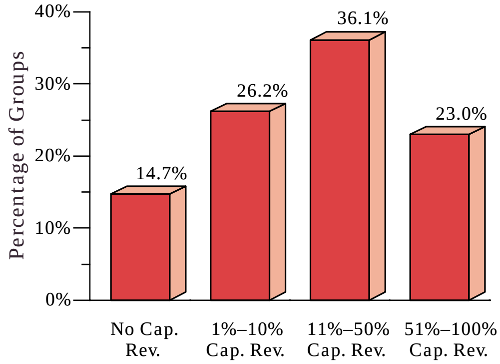
MEDICAL GROUP PRACTICES, BY PERCENTAGE OF CAPITATION REVENUE

CAPITATED LIVES	Groups With No Capitation Revenue	Groups With 1% to 10% Capitation Rev.	Groups With 11% to 50% Capitation Rev.	Groups With 51% to 100% Capitation Rev.
Commercial	0.0%	1.1%	12.5%	86.4%
Medicare	0.0	1.0	17.6	81.4
Medicaid	0.0	5.0	21.3	73.7
None	100.0	—	—	—
CAPITATED LIVES				
No Capitated Lives	100.0%	0.0%	0.0%	0.0%
1–4,999	0.0	87.5	12.5	0.0
5,000–14,999	0.0	22.0	78.0	0.0
15,000–24,999	0.0	33.3	55.5	11.2
25,000–49,999	0.0	4.9	40.7	54.4
50,000–99,999	0.0	5.8	51.3	42.9
100,000 or more	0.0	4.1	20.6	75.3
SAMPLE SIZE: —				

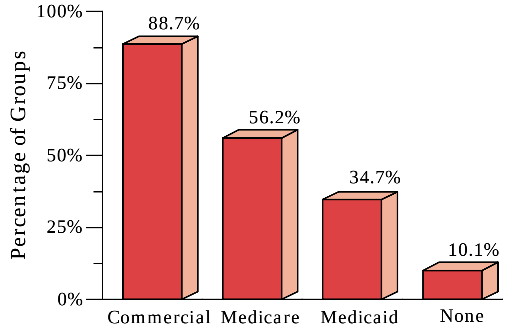
MEDICAL GROUP PRACTICES, BY NUMBER OF CAPITATED LIVES



MEDICAL GROUP PRACTICES, BY PERCENTAGE OF CAPITATION REVENUE



MEDICAL GROUP PRACTICES, BY TYPE OF PAYER



Data source: American Medical Group Association Statistical Database, 1999 © 2000

Groups in integrated systems average five components

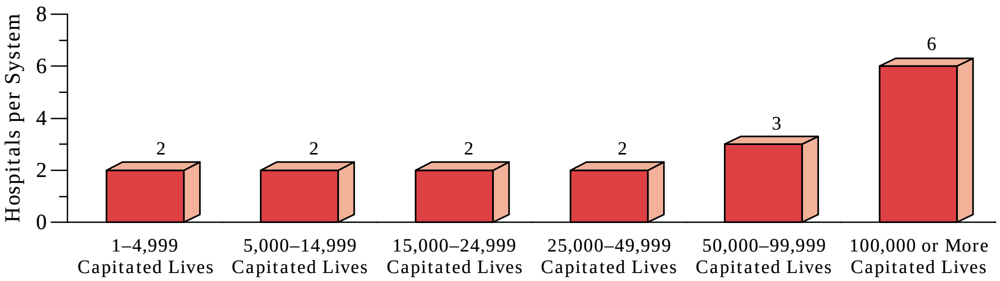
Reporting AMGA member respondents that classified themselves as being part of an integrated health care system had a per system average of three hospitals, one nursing home and one psychiatric facility.

Of the respondent types listed, independent practice associations (IPAs) and management service organizations (MSOs) averaged the highest number of integrated system components, with six.

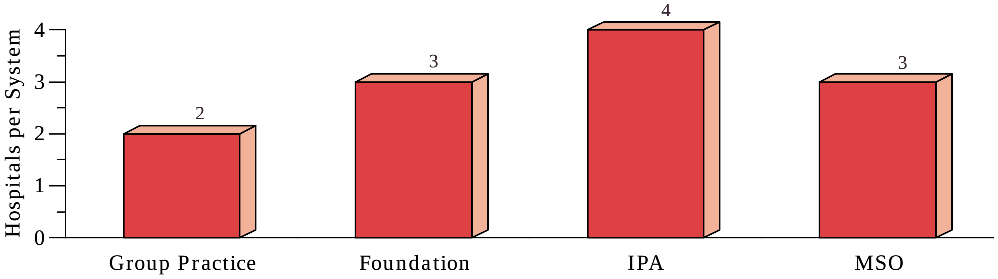
NUMBER OF COMPONENTS PER INTEGRATED SYSTEM*

	Avg. # of Hospitals	Avg. # of Nursing Homes	Avg. # of Psychiatric Facilities
TYPE OF RESPONDENT			
Group Practice	2	2	1
Foundation	3	0	1
IPA	4	1	1
MSO	3	2	1
Other	2	1	1
CAPITATED LIVES			
No Capitated Lives	4	2	1
1–4,999	2	1	1
5,000–14,999	2	1	1
15,000–24,999	2	0	1
25,000–49,999	2	2	1
50,000–99,999	3	1	1
100,000 or more	6	2	1
AVERAGE	**3**	**1**	**1**

HOSPITALS TIED TO INTEGRATED SYSTEMS, BY NUMBER OF CAPITATED LIVES*



HOSPITALS TIED TO INTEGRATED SYSTEMS, BY ORGANIZATION TYPE*



Data source: American Medical Group Association Statistical Database, 1999 © 2000

HIGHLY CAPITATED SYSTEMS AVERAGE FEWER HOSPITALS

Integrated health care systems that had 100,000 or more capitated lives and that were part of this reporting base had an average of six hospitals per system, down from eight hospitals the previous two years but still the highest such average among the size categories profiled. Meanwhile, an average of four hospitals were affiliated with integrated systems with no capitated lives, while systems with 1 to 49,999 capitated lives had an average of two hospitals per system.

IPA-TYPE SYSTEMS HAVE AN AVERAGE OF FOUR HOSPITALS

Integrated systems that had subsidiaries of the IPA-type that were part of this reporting base had the highest average number of hospitals per system, with four. By comparison, group practice-type integrated systems had an average of two hospitals per system.

* Without offering its own definition of an integrated health care system, AMGA allowed survey respondents to classify their own organizational structure.

Personal manner of physician receives top rating

Just over two-thirds (67%) of patients attended by physicians in reporting AMGA groups gave a rating of excellent to the personal manner of their provider. More than three-fifths (61%) gave this rating to the technical skills of the physician. For the third consecutive year, patients surveyed were least satisfied with the amount of time spent in the office waiting to see their physician (32%).

PEDIATRICIANS RECEIVE EXCELLENT RATING MOST OFTEN

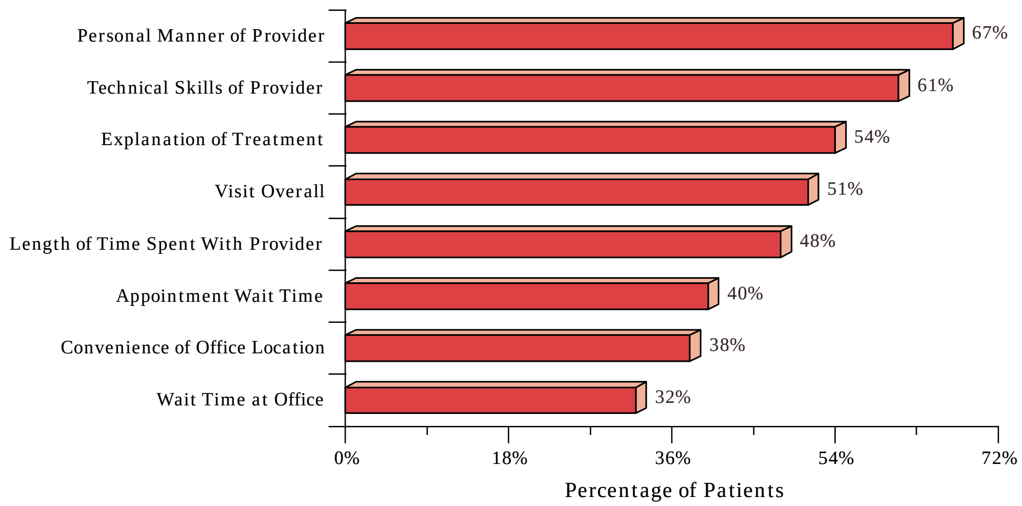
AMGA pediatricians received a rating of excellent from the highest or a share of the highest percentage of patients in six categories: personal manner of provider (71%), technical skills of the provider (66%), explanation of treatment (59%), length of time spent with the provider (53%), appointment wait time (48%) and the overall quality of the visit (56%). By comparison, urologists received a rating of excellent from the lowest or a share of the lowest percentage of patients in five categories, including personal manner of provider (60%), technical skills of provider (57%), length of time spent with physician (42%), appointment wait time (36%) and overall visit (45%).

PATIENTS GIVING GROUPS A RATING OF EXCELLENT (NORMS)*

SPECIALTY	Personal Manner of Provider	Technical Skills of Provider	Explanation of Treatment	Length of Time Spent With Provider
Allergy/Immunology	69%	64%	58%	52%
Cardiology	66	63	53	48
Family Practice	67	60	53	48
Internal Medicine	66	60	52	47
Ophthalmology	63	59	50	42
Pediatrics	71	66	59	53
Psychiatry	66	59	47	44
Urology	60	57	48	42
General Surgery	69	66	58	50

SPECIALTY	Appointment Wait Time	Convenience of Office Location	Wait Time at Office	Visit Overall
Allergy/Immunology	36%	28%	37%	53%
Cardiology	40	34	34	53
Family Practice	40	43	30	51
Internal Medicine	39	37	32	50
Ophthalmology	36	32	29	47
Pediatrics	48	40	35	56
Psychiatry	36	28	33	48
Urology	36	29	30	45
General Surgery	44	36	36	54

PATIENTS GIVING GROUPS A RATING OF EXCELLENT (NORMS): ALL GROUPS*



Data source: American Medical Group Association Patient Satisfaction Specialty Benchmarks © 2000

* Data on this page represent the results of a continuing project involving the benchmarking of patient satisfaction statistics through standardized measures and protocols developed by AMGA. Currently, 93 member group practices of AMGA have contributed data to the AMGA patient satisfaction database by periodically surveying patients using a standardized questionnaire. The specialty norm represents the average excellent score for providers in a particular specialty.

Top endocrinologists have highest rating in five areas

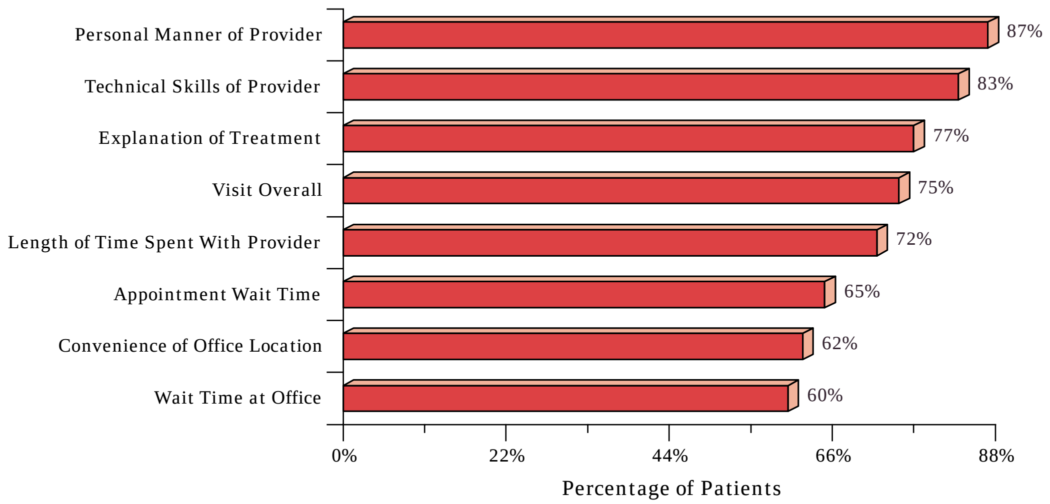
Endocrinologists received an excellent rating from the highest or a share of the highest percentage of patients in five survey areas, more than any other of the top 5% of specialists profiled. OB/gyns received a rating of excellent from the highest or a share of the highest percentage of patients in three areas. Radiologists received an excellent rating from the lowest share of patients in four areas.

PATIENTS GIVING THE TOP 5% OF PROVIDERS A RATING OF EXCELLENT*

SPECIALTY	Personal Manner of Provider	Technical Skills of Provider	Explanation of Treatment	Length of Time Spent With Provider
Anesthesiology	82%	79%	76%	68%
Gastroenterology	85	79	74	73
Hematology/Oncology	83	79	71	66
Obstetrics/Gynecology	91	89	86	78
Orthopedics	87	84	78	69
Otolaryngology	85	83	74	65
Endocrinology	95	91	86	73
Rheumatology	88	84	72	64
Diagnostic Radiology	82	69	66	63

SPECIALTY	Appointment Wait Time	Convenience of Office Location	Wait Time at Office	Visit Overall
Anesthesiology	44%	50%	53%	77%
Gastroenterology	55	53	67	78
Hematology/Oncology	66	58	56	66
Obstetrics/Gynecology	66	59	63	81
Orthopedics	56	56	63	79
Otolaryngology	43	56	58	70
Endocrinology	69	65	61	67
Rheumatology	55	47	55	65
Diagnostic Radiology	56	50	56	66

PATIENTS GIVING THE TOP 5% OF PROVIDERS A RATING OF EXCELLENT*



Data source: American Medical Group Association Patient Satisfaction Specialty Benchmarks © 2000

PERSONAL MANNER OF BEST PHYSICIANS GARNERS TOP SCORE

Nearly nine-tenths (87%) of patients receiving care from the top 5% of physicians in AMGA group practices over the last two years gave a rating of excellent to the personal manner of their physician. In that period, more than four-fifths (83%) of these patients gave a rating of excellent to the technical skills of their physician, while at least three-fourths granted an excellent rating to the explanation of treatment rendered by their providers (77%) and the overall quality of their visit (75%). During that same period, however, just three-fifths of patients (60%) gave an excellent rating to the amount of time spent waiting in the office for treatment by these top specialists.

* Data on this page represent the results of a continuing project involving the benchmarking of patient satisfaction statistics through standardized measures and protocols developed by AMGA. Currently, 93 member group practices of AMGA have contributed data to the AMGA patient satisfaction database by periodically surveying patients using a standardized questionnaire. The best practice benchmarks represent the average percent excellent score of physicians ranked in the 95th percentile (or top 5%) in each of the medical specialties in the database.

Personal manner of pediatricians receives highest score

More than nine out of every ten (92%) patients receiving care from the top 5% of pediatricians in AMGA group practices gave a rating of excellent to the personal manner of their providers, the highest such rating among the specialists profiled. By comparison, fewer than four of ten (37%) patients granted a rating of excellent to the amount of time waiting in the office to be treated by their internists.

GENERAL SURGEONS GET HIGH MARKS FROM PATIENTS

Over the course of the past two years, AMGA pediatricians received a rating of excellent from the highest percentage of patients in all eight survey categories profiled: personal manner of provider (92%), technical skills of provider (88%), explanation of treatment (85%), length of time spent with provider (82%), appointment wait time (78%), convenience of office location (72%), wait time at the office (68%) and overall visit (82%). By comparison, ophthalmologists ranked in the top 5% received an excellent rating from the lowest share of patients in three categories: technical skills of provider (73%), explanation of treatment (63%) and length of time spent with provider (58%).

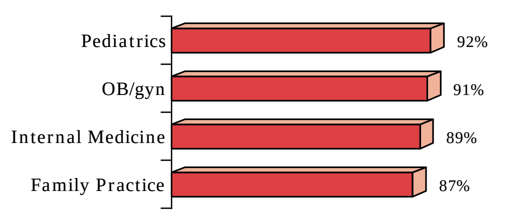
* Data on this page represent the results of a continuing project involving the benchmarking of patient satisfaction statistics through standardized measures and protocols developed by AMGA. Currently, 93 member group practices of AMGA have contributed data to the AMGA patient satisfaction database by periodically surveying patients using a standardized questionnaire. The best practice benchmarks represent the average percent excellent score of physicians ranked in the 95th percentile (or top 5%) in each of the medical specialties in the database.

PATIENTS GIVING THE TOP 5% OF PROVIDERS A RATING OF EXCELLENT*

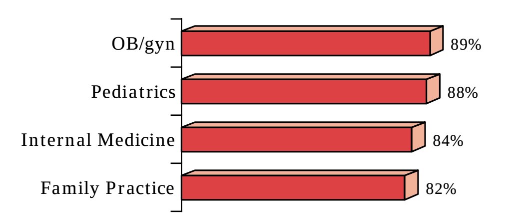
SPECIALTY	Personal Manner of Provider	Technical Skills of Provider	Explanation of Treatment	Length of Time Spent With Provider
Allergy/Immunology	85%	82%	77%	78%
Cardiology	75	85	78	78
Family Practice	87	82	76	73
Internal Medicine	89	84	75	65
Ophthalmology	82	73	63	58
Pediatrics	92	88	85	82
Psychiatry	83	77	64	63
Urology	82	80	83	72
General Surgery	89	86	84	76

SPECIALTY	Appointment Wait Time	Convenience of Office Location	Wait Time at Office	Visit Overall
Allergy/Immunology	62%	53%	57%	67%
Cardiology	59	47	66	73
Family Practice	66	70	59	76
Internal Medicine	67	65	37	75
Ophthalmology	65	53	44	71
Pediatrics	78	72	68	82
Psychiatry	59	51	56	66
Urology	55	46	57	80
General Surgery	72	65	68	79

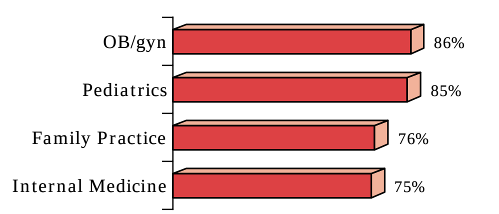
PERSONAL MANNER OF PROVIDER



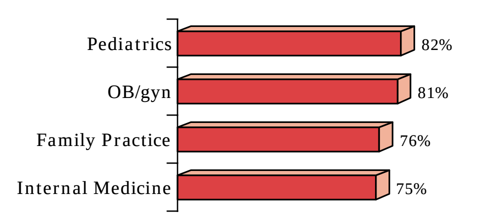
TECHNICAL SKILLS OF PROVIDER



EXPLANATION OF TREATMENT



VISIT OVERALL



Data source: American Medical Group Association Patient Satisfaction Specialty Benchmarks © 2000

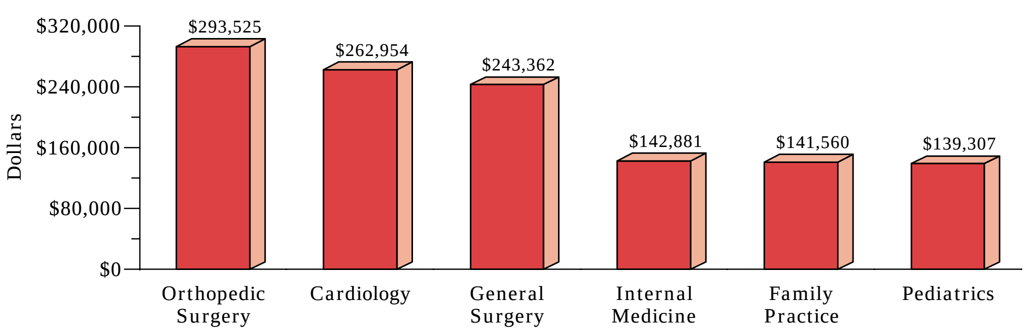
Compensation is highest for orthopedic surgeons

Of the AMGA group practice specialists profiled, orthopedic surgeons again received the highest median salary ($293,525) in 1999, followed by cardiologists ($262,954) and general surgeons ($243,362). Conversely, pediatricians ($139,307) continued to earn a lower median salary than the other specialists listed, just under family practitioners ($141,560) and internists ($142,881).

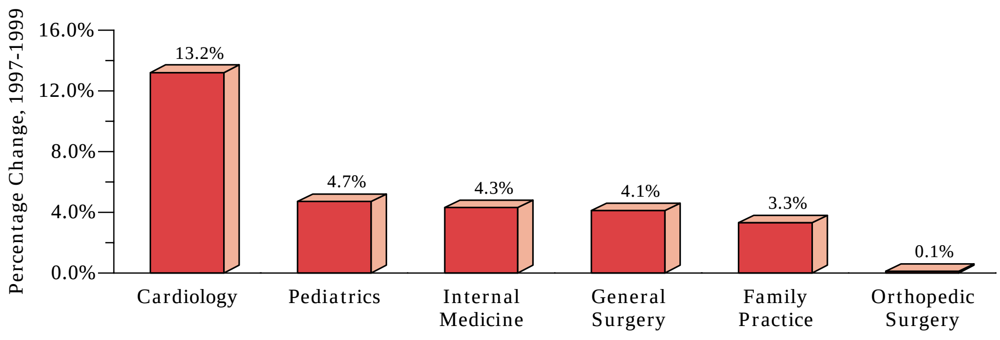
MEDIAN PHYSICIAN COMPENSATION, 1997–1999

SPECIALTY	1997	1998	1999	1997–1999 Percentage Change
Allergy/Immunology	$171,000	$171,223	$181,000	5.8%
Cardiology	232,250	253,312	262,954	13.2
Family Practice	137,100	136,741	141,560	3.3
Internal Medicine	136,948	140,000	142,881	4.3
Pediatrics	133,000	132,003	139,307	4.7
Psychiatry	138,508	140,384	144,294	4.2
Neurology	164,598	167,200	174,589	6.1
General Surgery	233,874	242,309	243,362	4.1
Orthopedic Surgery	292,071	296,630	293,525	0.1

1999 MEDIAN GROUP PRACTICE PHYSICIAN SALARY



MEDIAN GROUP PRACTICE PHYSICIAN SALARY



Data source: American Medical Group Association Medical Group Compensation and Productivity Survey © 2000

CARDIOLOGISTS RECEIVE LARGE SALARY INCREASE

The median salary among cardiologists practicing in AMGA groups jumped 13.2% between 1997 ($232,250) and 1999 ($262,954), the largest such increase among the specialists listed. Median physician salary among neurologists rose 6.1%, to $174,589 from $164,598 two years before. The percentage rise in median salary among allergists/immunologists was a comparatively similar 5.8%, to $181,000 in 1999 from $171,000 in 1997.

COMPENSATION FOR ORTHOPEDIC SURGEONS DROPS

Median annual compensation among orthopedic surgeons underwent a slight decline between 1998 ($296,630) and 1999 ($293,525), the only such drop among the AMGA group practice specialists profiled. Similarly, median annual salary among general surgeons increased only fractionally, to $243,362 from $242,309 the year before.

Highly capitated groups have highest net revenue

Net revenues in 1999 were highest for groups with more than 35.0% of income from capitation, at $556,763 per FTE physician, or 18.8% higher than for groups with no capitation revenue. Whereas gross revenues were highest when 0.1% to 10.0% of revenues came from capitation, adjustments to charges (including bad debts) were cut by nearly half for groups with 35.0%-plus revenues from capitation.

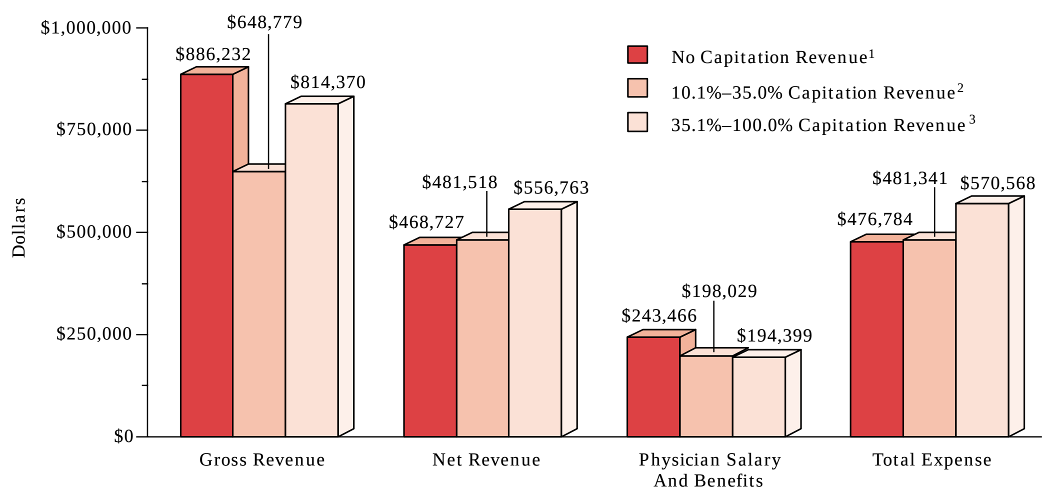
PHYSICIAN SALARY AND BENEFITS DROP AS CAPITATION RISES
Median salary and benefits per FTE physician fell in AMGA groups in 1999 as capitation revenue share rose. Physicians in groups with 35.0%-plus revenue from capitation earned median compensation and benefits of $194,399 per FTE physician, 20.2% less than the $243,466 reported for physicians in groups with no capitation revenue. However, midlevel provider compensation expenses were 213.0% more, and support staff compensation expenses were 59.8% higher, in high capitation revenue groups than in no capitation revenue groups.

HIGHLY CAPITATED GROUPS HAVE HIGH EXPENSE RATIOS
Total expenses per FTE physician were 19.7% higher for groups with 35.0%-plus capitation revenue than for groups with no capitation revenue. Similarly, medical/surgical supply expenses for high capitation revenue groups were 85.2% above those for no capitation revenue groups, while information services costs were 27.4% higher.

GROUP PRACTICE PERFORMANCE PER FTE PHYSICIAN

	Groups With No Capitation Revenue[1]	Groups With 0.1% to 10.0% Capitation Revenue[1]	Groups With 10.1% to 35.0% Capitation Revenue[2]	Groups With 35.1% to 100.0% Capitation Revenue[3]
REVENUE				
Gross Revenue	$886,232	$927,779	$648,799	$814,370
Discounts and Adjustments to Charges	321,358	297,297	171,344	162,138
Net Revenue	468,727	549,405	481,518	556,763
EXPENSE CATEGORY				
Physician Salary and Benefits	$243,466	$212,060	$198,029	$194,399
Midlevel Provider Salary and Benefits	3,380	12,640	13,056	10,580
Support Staff Salaries and Benefits	108,888	129,105	142,612	173,969
Information Services Expense	8,684	10,198	6,956	11,066
Medical/Surgical Supply Expense	17,896	24,506	34,755	33,136
Building, Insurance, Equipment and Admin. Supplies Expense	45,462	54,211	50,883	63,216
Marketing Expense	1,258	1,840	2,089	1,131
Taxes, Interest and Other Expense	36,287	37,134	37,488	62,017
TOTAL EXPENSES	**$476,784**	**$565,066**	**$481,341**	**$570,568**
SURPLUS (LOSS)	**$(2,594)**	**$(1,096)**	**$178**	**$2,031**

GROUP PRACTICE PERFORMANCE PER FTE PHYSICIAN



Data source: American Medical Group Association Financial Operations Survey: 2000 Report Based on 1999 Data © 2000

[1] 27 groups with no capitation revenue reported, and 27 groups with 0.1% to 10.0% capitation revenue reported.
[2] 17 groups with 10.1% to 35.0% capitation revenue reported.
[3] 14 groups with more than 35.0% capitation revenue reported.
NOTE: Selected key expense items are shown, therefore Surplus/Loss cannot be calculated from items displayed.

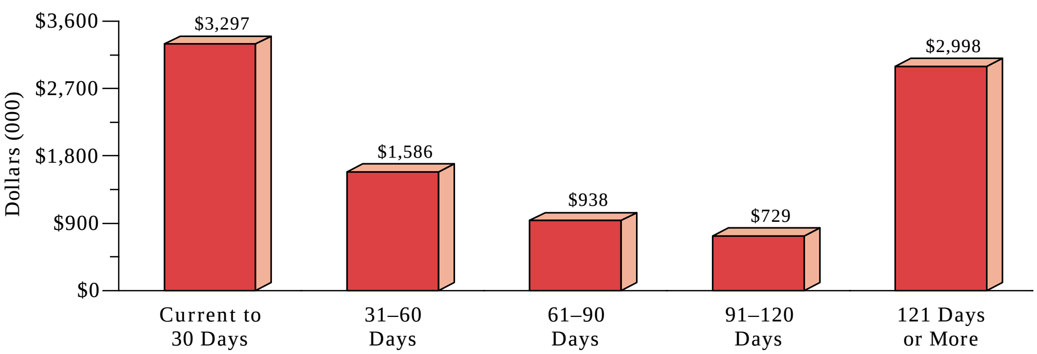
Large groups' share of receivables under 60 days is low

Very large medical groups with over 100 physicians in 1999 had a substantially lower percentage of their accounts receivable less than 60 days old (46.9%) than smaller groups. They also had a substantially higher percentage of their receivables over 90 days old (42.8%) than smaller groups. Accounts receivable aging offers a measure of a group's liquidity and the need for financing.

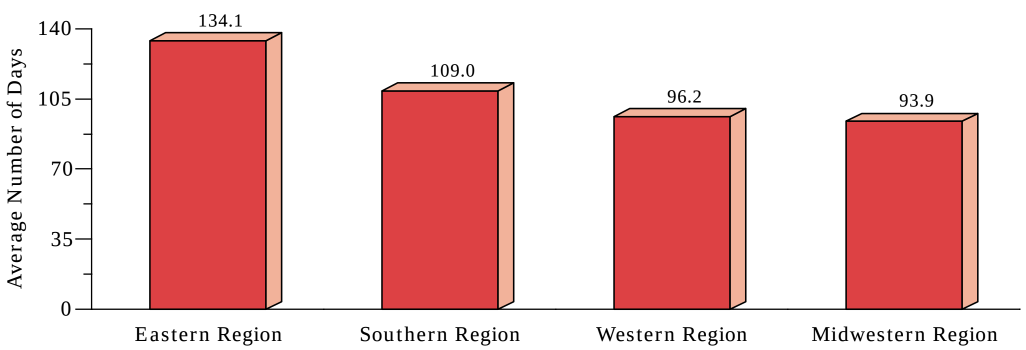
GROUP PRACTICE LIQUIDITY: ACCOUNTS RECEIVABLE PER GROUP (IN THOUSANDS)*

SIZE (# of FTE physicians)	Current to 30 Days	31–60 Days	61–90 Days	91–120 Days	121 Days or More
35 or fewer	$936	$304	$179	$128	$634
36–70	3,236	1,397	840	699	2,669
71–100	5,275	2,347	1,232	867	3,164
101 or more	7,071	4,024	2,452	1,925	8,193
REGION					
Eastern	$4,433	$2,012	$1,311	$1,025	$5,058
Southern	1,847	990	617	576	2,175
Midwestern	4,343	1,908	1,075	813	2,796
Western	2,842	1,583	846	552	2,465
ALL GROUPS	**$3,297**	**$1,586**	**$938**	**$729**	**$2,998**

AVERAGE AGE OF ACCOUNTS RECEIVABLE PER GROUP*



AVERAGE DAYS NEEDED TO COLLECT ACCOUNTS RECEIVABLE



Data source: American Medical Group Association Financial Operations Survey: 2000 Report Based on 1999 Data © 2000

RECEIVABLES SHARE OVER 90 DAYS IS HIGH IN SOUTH AND EAST

Longer collection times are more common among group practices in the South and the East regions. Groups in the South region averaged $2.75 million per group in accounts more than 90 days old, or 44.3% of total receivables. Groups in the East region had an average of $6.1 million per group in outstanding receivables over 90 days old, or 44.0% of average receivables per group. By comparison, groups in the West had 36.4% of receivables uncollected over 90 days, while North region groups had only 33.0% uncollected over 90 days.

GROUPS IN EAST TAKE 134 DAYS TO COLLECT ACCOUNTS

Group practices located in areas of the country where managed care is lowest in penetration—the East and the South—take longer, on average, to collect their accounts than groups in other regions. The average number of days to collect is 134.1 in the East and 109.0 in the South, compared with 96.2 days in the West and 93.9 days in the Midwest.

* Accounts receivable aging is presented in thousands and shows the amount of money that has not been collected or written off.

Midwest groups have highest revenue per physician

Median net revenue per FTE physician was highest, by region, in 1999 at AMGA group practices in the Midwest ($589,798) and the East ($532,978). By comparison, net revenue per physician was lowest, by region, at groups in the South ($462,475). Net revenue at groups in the West ($500,844) was 8.3% higher than at groups in the South, but 15.1% lower than at groups in the Midwest.

MIDWEST REGION SUPPORT STAFF EXPENSES ARE HIGH

Group practice support staff costs for compensation and benefits were highest, by region, in the Midwest, at $171,658 per FTE physician (or 29.1% of net revenue per physician). In Western states, where managed care penetration is highest in the nation, these support staff expenses were $156,875 per physician (or 31.3% of net revenue per physician, the highest percentage of any region).

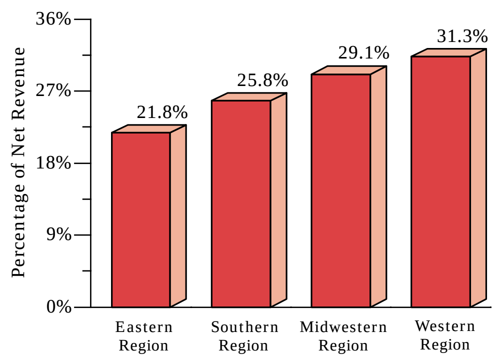
EASTERN GROUPS HAVE HIGH NET PER SQUARE FOOT

Median net revenue per square foot was highest, by region, in 1999 at groups in the East ($333). By comparison, groups in the South had the lowest net revenue per square foot ($227). Meanwhile, support staff expenses per square foot per group were relatively constant among all regions (at 27.0% to 31.8% of net revenue). Medical/surgical supply expenses were highest, by far, in Midwest groups, at $24 per square foot (or 8.3% of net revenues per square foot). Expenses for midlevel providers per square foot were higher in the West and the Midwest than in other regions ($6).

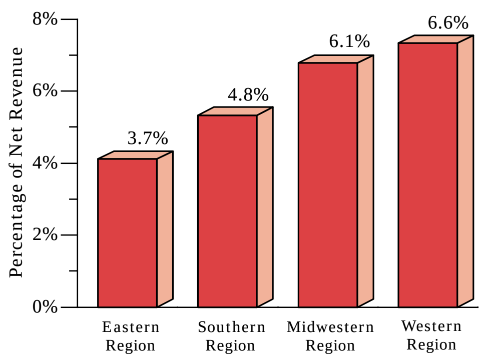
GROUP PRACTICE PERFORMANCE PER FTE PHYSICIAN, BY REGION

REVENUE/EXPENSE	Region: East	West	South	Midwest
Net Revenue	$532,978	$500,844	$462,475	$589,798
Midlevel Provider Expense	$2,562	$8,973	$8,971	$10,629
% of net revenue	0.5%	1.8%	1.9%	1.8%
Support Staff Expense	$116,172	$156,875	$119,194	$171,658
% of net revenue	21.8%	31.3%	25.8%	29.1%
Medical/Surgical Supply Expense	$19,760	$33,119	$22,293	$35,794
% of net revenue	3.7%	6.6%	4.8%	6.1%
Insurance Expense	$9,335	$5,140	$5,127	$8,646
% of net revenue	1.8%	1.0%	1.1%	1.5%

SUPPORT STAFF EXPENSE AS A PERCENTAGE OF NET REVENUE



MED./SURG. SUPPLY EXPENSE AS A PERCENTAGE OF NET REVENUE



GROUP PRACTICE PERFORMANCE PER SQUARE FOOT, BY REGION

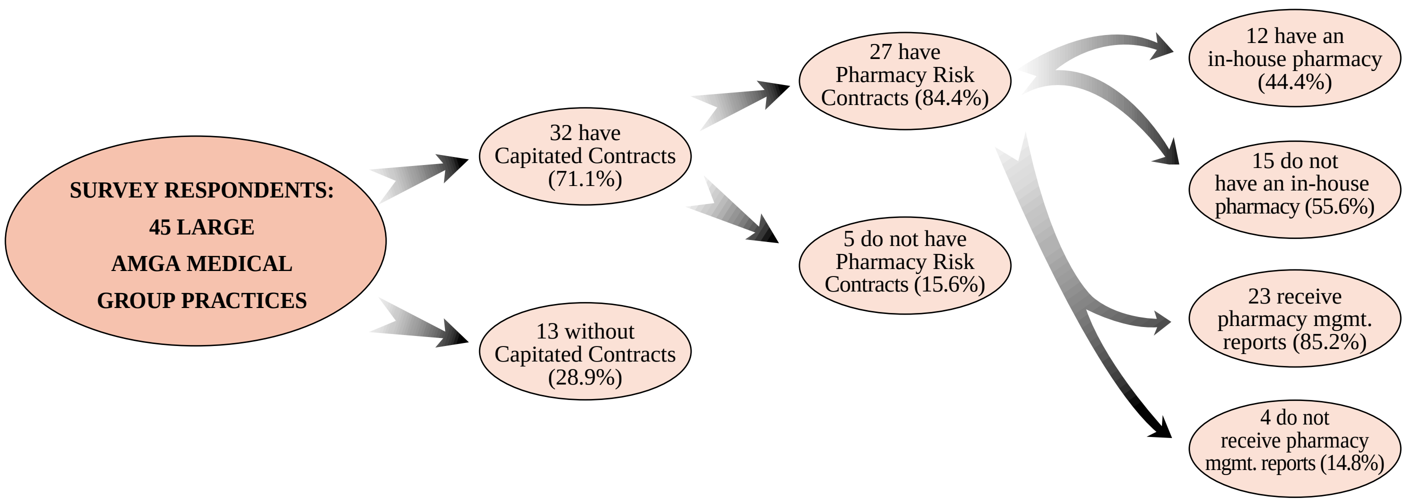
REVENUE/EXPENSE	Region: East	West	South	Midwest
Net Revenue	$333	$319	$227	$289
Midlevel Provider Expense	$1	$6	$4	$6
% of net revenue	0.3%	1.9%	1.8%	2.1%
Support Staff Expense	$106	$86	$70	$84
% of net revenue	31.8%	27.0%	30.8%	29.1%
Medical/Surgical Supply Expense	$14	$15	$10	$24
% of net revenue	4.2%	4.7%	4.4%	8.3%
Insurance Expense	$5	$3	$2	$4
% of net revenue	1.5%	0.9%	0.9%	1.4%

Data source: American Medical Group Association Financial Operations Survey: 2000 Report Based on 1999 Data © 2000

NOTE: Selected key expense items are shown, therefore Surplus/Loss cannot be calculated from items displayed.

Pharmacy risk contracts are common at AMGA groups

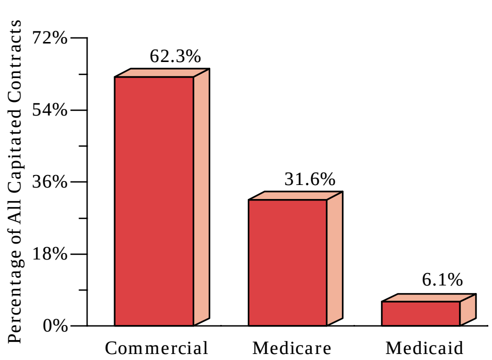
Of 45 reporting AMGA group practices, 32 (71.1%) had a total of 329 capitated health plan contracts in 1998. Although 27 (84.4%) of these 32 groups had a total of 136 pharmacy risk contracts, none had these pharmacy risk contracts independent of capitated HMO contracts. In 1998, 12 (44.4%) of the 27 reporting group practices that had pharmacy risk contracts had in-house pharmacies.



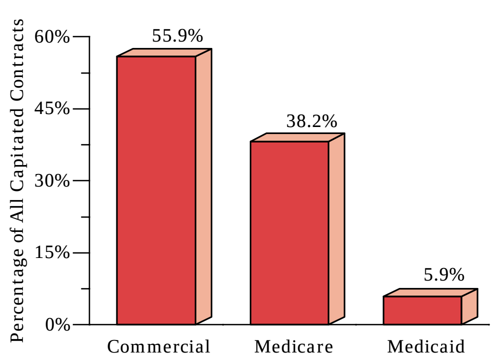
MEDICAL GROUP CONTRACTS

	Number of Capitated Contracts Held by 32 Group Practices	Number of Pharmacy Risk Contracts Held by 27 Group Practices
Commercial	205	76
Medicare	104	52
Medicaid	20	8
TOTAL	**329**	**136**

TYPES OF CAPITATED CONTRACTS HELD BY 32 GROUP PRACTICES



TYPES OF PHARMACY RISK CONTRACTS HELD BY 27 GROUP PRACTICES



Data source: American Medical Group Association Pharmacy Risk Survey: 1999 Report Based on 1998 Data © 2000

MOST CAPITATED HMO CONTRACTS ARE COMMERCIAL

Of the 329 capitated contracts held by reporting AMGA groups, 205 (62.3%) covered commercial members, 104 (31.6%) covered Medicare members and 20 (6.1%) covered Medicaid members. Of the 136 total pharmacy risk contracts held by these group practices in 1998, 76 (55.9%) were for commercial members, 52 (38.2%) were for Medicare members and 8 (5.9%) were for Medicaid members.

Groups document deficits in pharmacy risk arena

AMGA group practices that reported pharmacy risk contract results had net losses between 1996 and 1998 on combined senior and commercial plans amounting to $550,150, or an average deficit of $51,213 per contract. Gross losses under the contracts were actually much larger—on the order of some $23 million—but group practices benefited from maximum losses they could sustain (some data not shown).

OVERALL LOSS FOR EACH GROUP HITS OVER 2 TO 3 YEARS

Although the net bottom line pharmacy loss for each AMGA medical group over three years was lessened substantially by contractual caps on the losses they would sustain, health plans were expected to recoup during 1999 and 2000 the portion of the gross pharmacy benefit losses they had to contractually absorb. Hence, the gross loss on pharmacy benefits was considered by AMGA to be an important indicator of "net impact to be sustained" by groups over several years to come.

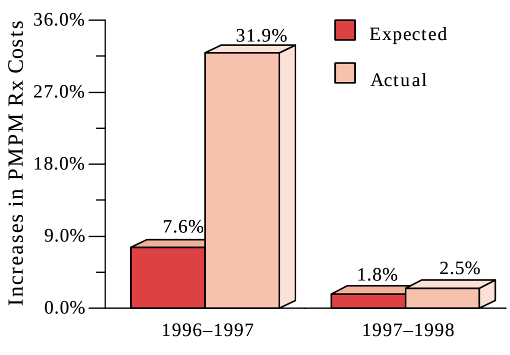
EXPENSES OUTPACE FUNDING LEVELS ON PHARMACY RISKS

Between 1996 and 1998, pharmacy risk funding target levels PMPM (expected claims) increased 9.6% (to $30.23 from $27.59) for senior coverage and 19.1% (to $12.48 from $10.48) for commercial coverage. Over this same three-year period, by comparison, actual pharmacy benefit expenses PMPM at these groups jumped 35.2% (to $48.15 from $35.62) for senior coverage and 33.7% (to $13.89 from $10.39) for commercial coverage.

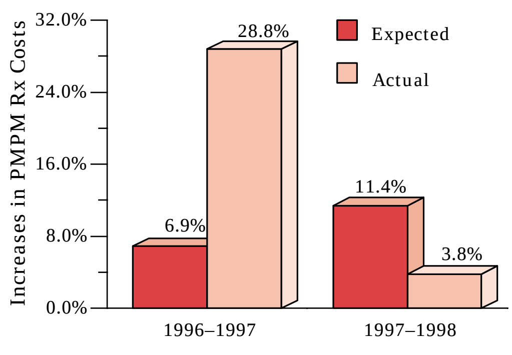
PHARMACY RISK SURVEY FINANCIAL FINDINGS SUMMARY

	Senior*			Commercial		
INDICATOR	1996	1997	1998	1996	1997	1998
Funding Target (PMPM)	$27.59	$29.70	$30.23	$10.48	$11.20	$12.48
Expenses (PMPM)	35.62	46.98	48.15	10.39	13.38	13.89
Rebate Credit (PMPM)	0.14	0.10	0.12	0.20	0.21	0.21
Group Share of Surplus/Deficit(Avg.)	68%	62%	67%	68%	64%	63%
Group Deficit Maximum (PMPM)	$1.00	$2.11	$1.33	$0.23	$0.39	$0.05
Total Member-Months	275,724	291,368	628,009	1,342,581	2,067,853	3,391,474
NET RESULT ALL GROUPS	**$565,897**	**$(296,583)**	**$(1,675,358)**	**$(264,283)**	**($491,547)**	**$1,611,724**
AVG. NET RESULT PER CONTRACT	**$56,590**	**$(22,814)**	**$(104,710)**	**$(18,877)**	**$(25,871)**	**$64,469**
AVG. RESULT PMPM	**$2.05**	**$(1.02)**	**$(2.67)**	**$(0.20)**	**$(0.24)**	**$0.48**

INCREASES IN PMPM PHARMACY COSTS: SENIOR*



INCREASES IN PMPM PHARMACY COSTS: COMMERCIAL



Data source: American Medical Group Association Pharmacy Risk Survey: 1999 Report Based on 1998 Data © 2000

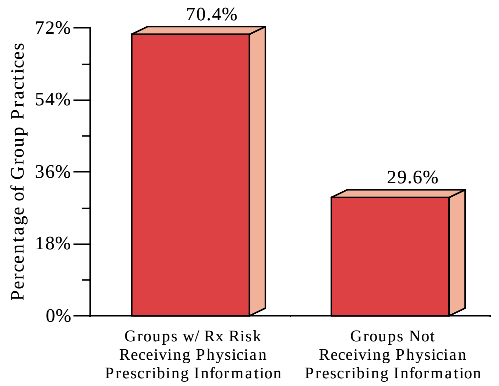
* "Senior" refers to those HMO members who are enrolled in Medicare risk plans. Most, but not all, of these members are senior citizens.

NOTE: Generally speaking, medical groups share both losses and profits 50-50 with health plans under pharmacy risk contracts (the norm). But when contracts are written to limit a medical group's downside risk (losses), then the health plan will generally require that the group's potential upside gain (surplus) be limited as well. These averages represent a wide variety of provisions in pharmacy contracts.

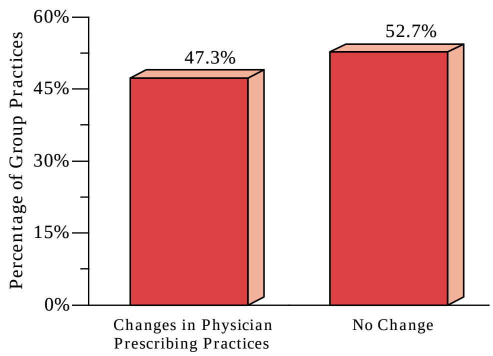
Groups often share prescribing pattern information

Of 27 reporting AMGA group practices with pharmacy risk contracts in 1998, 19 (70.4%) indicated that prescribing pattern information provided by the health plan was shared with physicians in their groups. Moreover, 1 of 18 AMGA groups that held no pharmacy risk contracts nevertheless shared prescribing pattern information from the health plan with physicians in the group practice.

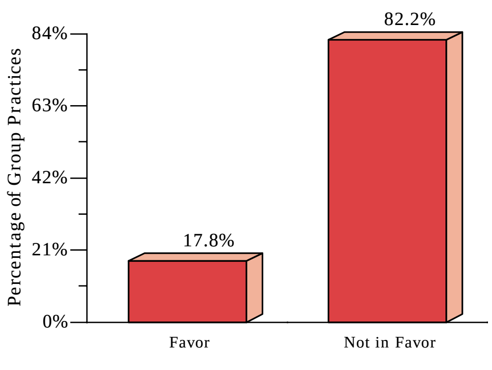
GROUP PRACTICES RECEIVING PRESCRIBING PATTERN INFORMATION



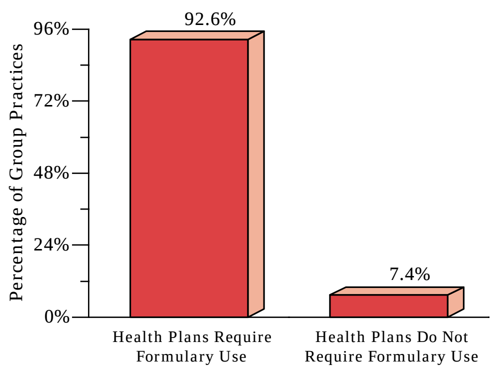
GROUP PRACTICE RESPONSES TO PHYSICIAN PRESCRIBING INFORMATION



GROUP PRACTICE OPINIONS OF PHARMACY RISK CONTRACTING



GROUP PRACTICES REQUIRED TO MAKE USE OF A DRUG FORMULARY



Data source: American Medical Group Association Pharmacy Risk Survey: 1999 Report Based on 1998 Data © 2000

Rx INFORMATION BRINGS CHANGES
Of 19 AMGA groups with pharmacy risk contracts that shared prescribing pattern information from health plans with physicians, nine (47.3%) indicated that this information resulted in changes in the pharmacy prescribing habits of their physicians.

FEW GROUPS SUPPORT Rx RISK
Eight (17.8%) of the 45 reporting AMGA groups with and without capitated contracts were generally in favor of pharmacy risk contracts.

HMOs WANT GROUPS TO USE FORMULARY
In 1998, 25 (92.6%) of 27 group practices with pharmacy risk contracts reported that health plans required the use of a drug formulary. Of these 25, 11 (44.0%) said the health plan's formulary was compatible with the group practice's formulary.

RISK POOLS EXTEND BEYOND SINGLE GROUP CONTRACTS
Of 27 reporting groups with pharmacy contracts, 24 (88.9%) indicated that the pharmacy risk pool is charged for prescriptions written by physicians outside their medical group (data not shown).

Medical group practice leaders discuss current issues

Medical group practice leaders, including Donald W. Fisher, Ph.D., CEO of the American Medical Group Association (AMGA), participated in telephone focus group discussions during which they were asked to share their views on various issues currently confronting group practices and managed care. These physician executives and administrators represented a number of health care

ON THE EFFECTS OF MANAGED CARE

"There are some significant changes—and I would call them improvements—in medical care delivery over the past 20 years that were brought on by managed care; and many of these are in the hospital or surgical area. A good example is reducing the length of time in the hospital for a prostate operation. It used to be that the patient would have to spend 10 days in the hospital for this procedure, until the urine in the catheter was clear. Now, the hospital stay is down to about three days.

"There are medical improvements like laparoscopic procedures for gallbladder removal and other abdominal surgery—even arthroscopic surgery for joints—that are a result more of new technologies than of managed care.

"The achievement of managed care is that it forced us to look very critically at health care delivery and ask, 'Is it really necessary for a patient to be in the hospital, or can that patient be treated at home with a nurse?' "

ON PHARMACEUTICALS AND UTILIZATION COSTS

"I have been talking with the pharma companies for years, and I think it is a problem that we have always looked at pharmacy costs as though they were a unique add-on phenomenon to the health care experience. In fact, we ought to be looking at health care costs in total. We ought to look at the entire experience and all the dollars that go into that. We now have so many new pharmaceutical magic bullets that have the effect of avoiding not only surgical procedures but also hospitalizations.

"Unfortunately, what happens is that people are unhappy about the cost of pharmaceutical products because they see hundreds of dollars being spent per prescription per patient. In fact, if they looked at the total cost of care, those drugs may have saved thousands of dollars because there were not as many hospital visits or hospital admissions or surgical procedures needed as a result of the use of the product. I think, right now, we are just at the very tip of that iceberg.

"With the Human Genome Project and all the new discoveries coming along, we are probably going to see pharmacy costs double or triple. It won't be long before pharmacy costs will greatly exceed the cost of inpatient care. But in the long run, if you look at the total dollars spent per patient per year, a two-fold or three-fold pharmacy cost increase might actually help hold down increases in total costs of care.

"When you look at the total cost, the advent of good, strong, magic bullets in the form of new lifesaving drugs are helping to save money on health care delivery. The challenge is for somebody to do the study that actually demonstrates this empirically, so that we can move on and embrace that concept more fully."

ON MEDICAL MANAGEMENT AND PHYSICIAN STANDARDIZATION

"One of the issues in medical management these days is standardization of care—the effort to get physicians on the same page, following the protocols and doing the right things at the right time. We have guidelines. We try to make them evidence-based, and yet physicians have so many different modes and practice styles. From a clinical perspective, it is a constant challenge to reduce variation among practices. Of course, many large medical groups find it difficult to follow the differing protocols and guidelines of different health plans—and for good reason: They would go in circles if they did that, because they contract with many health plans and each one has its own guidelines, for instance, for treating conditions such as type-2 diabetes.

"The reason we are talking about reducing variation in practices is because that is where the true waste is in health care today. When you have two providers doing totally different procedures with similar outcomes, and one costs twice or three times as much as the other, but you are not getting any better outcome from it, you immediately realize there is room for improvement. The driver behind physicians trying to wring out variations and replace them with standardization is that physician practices are not doing well. The problem providers have is that there are still some conditions for which there are no agreed-upon norms or best practices. So much of what is done in medicine today is clearly not as evidence-based as people would like."

organizations from across the country. Topics included recent increases in medical utilization, changes in capitation contracting, the correlation between the use of pharmaceuticals and reduced acute-care costs, the positive effects of managed care, the movement toward physician adoption of standardized care guidelines and the effects of the Internet on the patient-physician relationship.

ON CAPITATION CONTRACTING

"I think capitation, probably three to four years ago, was looked upon as the most likely reimbursement mechanism to survive the 1990s into the year 2000. Today, most people are betting that this was just one of the stops on the journey to a better method of reimbursement. We do not yet know what the destination is, but it is not likely going to be capitation.

"Groups that took global capitation, which included the professional fees as well as the hospital side and the pharmacy risk, found that if the group collected the capitation, no matter how hard they tried they could not control anything but the physician services side of costs. They really could not get their arms around the hospital side as well as they liked. And the group lost total control over the pharmacy side.

"Physicians found themselves in the middle, having to make decisions about patient care based on dollars they took on a capitated rate, and it made them uncomfortable professionally. Some groups are pulling back from global capitation and continuing to do capitated contracts, but perhaps only for their professional services. And even these groups are not as numerous as, say, a year ago or 18 months ago.

"In the last few years, providers have focused on business operations, and they now have a better handle on what it actually costs to deliver care. We are a lot better at good cost accounting in health care now than we were even a year ago.

"Providers now know that some capitation rates being offered are just not acceptable to deliver the standard of care they believe necessary. So they are walking away from these contracts. And when they do, they sometimes come back with an offer of discounted fee-for-service, which is often more acceptable."

ON THE INTERNET'S EFFECT ON DOCTOR-PATIENT RELATIONSHIPS

"Most physicians actually welcome the patient coming in with much more information and knowledge than heretofore. They welcome the Internet bringing this information to patients, and they think it will actually help engage the conversation between the provider and the patient in a way that has a meaningful outcome.

"Patients coming in armed with a lot of information about their disease or the drugs that they may or may not think are appropriate improves the patient-physician relationship. What the provider community really wants is a better outcome and a higher quality of care for their patients. One of the ways to do this, as a provider organization, is to make better use of the Internet.

"There is no reason why a lot of the information, a lot of the questions, a lot of the exchange that goes on between the patient and the provider could not take place over the Internet, through e-mail and other means, where it is a little bit more cost effective and more efficient. I think you are going to see those kinds of innovations coming down the pike as we find that we have to continue improving productivity and seeing as many patients as everybody needs to during the day to meet the demand of access, but also to deal with the requirements that are brought on by people coming in armed with more information. On balance, though, providers really want their patients to be as knowledgeable and informed as they can possibly be."

ON RISING MEDICAL UTILIZATION RATES

"Utilization rates are skyrocketing, especially on the senior side. This is mainly because of our aging population, but the rates are also going up on the commercial side. Some of the reason for this is regulatory; we have a mental health parity bill that went into effect in July, 2000, for instance, which will have a big impact. And then there are other reasons we cannot understand.

"We look carefully at the average length of stay, and that has gone up some, but we also have an increase in the number of admissions. I can't explain it, other than to say that there is an unlimited demand for health care and limited resources.

"Part of the reason for higher medical utilization rates is that our society seems to be medicalizing everything. On the one hand, people do not enjoy going to physicians, but on the other hand they visit the physician more often and seek more treatment because they seem to feel they do not have to suffer in silence in ways they did before."

Market compels groups to focus on operations side

Medical groups that would normally be focused almost exclusively on the clinical side of health care—trying to improve outcomes and the quality of patient service—are increasingly focusing on the operations side. In an effort to achieve stability in a precarious market that has already seen a number of bankruptcies, groups are undergoing a fairly substantial correction in the way that they operate.

ON RISK-BASED RELATIONSHIPS

For many medical group leaders, the most difficult area of health care to manage is no longer the clinical side, but the financial operations side—the bottom line. This change in focus is attributable to a number of causes, depending on the point of view: The Balanced Budget Act of 1997, for instance, as everyone knows, has had a significant impact on provider organizations, particularly those that have a close affiliation with a hospital. Then, of course, from the managed care perspective, having to provide more benefits with the same or even fewer resources over the last several years threatens to have an impact on quality of care.

In any event, one consequence of this change in focus is that providers have been less willing to accept capitation contracts. Thus, the percentage of MGMA medical group practices deriving revenue from capitation contracts declined overall (to just over two in five groups) and in four of six group size categories profiled.

PHARMACY RISK CREATES CHALLENGES FOR GROUPS

In recent years, medical group practices have been taking big financial hits in the area of pharmacy risk under their managed care contracts. In some instances, they have been able to turn lemons into lemonade—gross losses into net surpluses—after collecting rebates and applying the caps in their contracts with health plans that limit medical groups' out-of-pocket losses to agreed-upon maximums. Improvements in actuarially based funding levels, for example, allowed certain CAPO-member physician organizations to realize a net surplus of nearly $32,000 per group for the commercial pharmacy risk business they undertook in 1999. However, regardless of those caps, when health plans absorb substantially higher pharmacy risk expenses than they have funded or expected, they are likely to seek ways to recoup their deficits over the ensuing year or two.

In the coming years, look for health plans to take risk pool monies held for medical group practices under managed care contracts and shift them to cover pharmacy funding. Instead of paying out the risk pool funds to physicians at the end of the year, as physicians expect, health plans are likely to reallocate withholds to pharmacy benefits to make sure funding is adequate for expected claims in the future.

Health plan moves are already creating some physician dissatisfaction with the money they receive under managed care contracts, compelling them to take a harder line during contract negotiations. They will push for increases in pharmacy benefit funding by managed care plans or they'll pull out of contracts.

MEDICAL GROUPS EXPAND THROUGH INTEGRATION

Notwithstanding their recent well-documented troubles, the overall number of medical group practices is increasing, and physicians practicing in medical groups account for a growing percentage of all U.S. physicians. Many groups are members of integrated health systems, further strengthening their competitive and financial positions. Recently, the percentage of groups that are members of an integrated system has undergone a slight increase. Declining capitation payments, increasing pharmacy costs, and HMOs' and employers' resistance to higher premiums will all be factors continuing to motivate groups into such consolidation.

Physicians are increasingly looking to practice in or form larger multispecialty group practices, and often these groups are integrating with other health care organizations, including hospitals, ambulatory care facilities and insurers. One consequence of this development is that organizations are often geographically decentralized, with multiple satellite sites. Groups are expanding into rural and underserved areas, and attracting Medicare and Medicaid members with comprehensive services. These systems allow providers to organize financial and utilization objectives.

In 1999, single specialty groups accounted for the larger proportion of the sector, with approximately two-thirds of all group practices.

Groups will likely increasingly grow in size and become multispecialty in nature and scope. Primary care groups will continue to gain in importance and stature, while many groups will continue to work closely with integrated systems.

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