

Strategies in Healthcare

Spring 1997

Provider-Sponsored Managed Care Companies

The Search For The New Paradigm

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Publicly-Held Managed Care Company Comparison

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About Shattuck Hammond Partners Inc.

Introduction

The development of provider-sponsored managed care companies has enabled healthcare providers – hospitals, health systems and physicians – to take an important first step towards addressing the changes in healthcare created by managed care. Sponsoring and owning managed care companies, principally health maintenance organizations, has allowed providers to gain control over a portion of the healthcare premium dollar and to begin asserting control over medical management. Now, as the managed care industry continues to evolve and mature, new opportunities, strategies and risks are appearing for provider-sponsored managed care companies. Decreasing operating margins are fueling the rapid pace of consolidation as the national and multi-regional managed care companies strive for market share and economies of scale, while smaller, regionally focused managed care companies confront increasing competition from the emerging “Goliaths” of managed care. At the same time, the motivations and rationale for developing or owning a provider-sponsored managed care company have changed over time. While provider-sponsored HMOs were originally seen as a strategy for enhancing volume for providers, the reality of declining utilization is accepted universally by providers. Consequently, today the HMO is viewed more as a means of asserting control over a larger portion of the premium dollar, rather than as a mechanism for creating a captive source of patient volume.

The competitive realities of the market, combined with increasing interest on the part of national managed care companies to enter into capitated provider contracts or other risk-based strategic partnerships, are suggesting that ownership of an HMO may not be necessary for a provider to assert control over a significant portion of the healthcare premium dollar. In many cases, this new realization is transforming the provider-sponsored managed care company into a transitional entity which can be monetized for the benefit of the provider-sponsors. The financial benefits are not only derived from the transaction proceeds, but also, and in many cases more importantly, from the provider’s leverage related to the negotiation of a provider agreement. In most instances, a global capitation provider agreement negotiated in conjunction with the sale of a provider-sponsored HMO can enable the provider to retain control over the premium dollar *and* the delivery of care, while transferring administrative and marketing responsibilities to an organization that specializes in these services.

Paradoxically, despite increasing competition and consolidation, the number of newly-formed provider-sponsored managed care companies is increasing. The short-term success of these companies will depend on the dynamics of their specific market, their capitalization, the commitment of the provider-sponsors to the success of the managed care company and the quality of management. The

long-term success, especially if success is defined in terms of the financial health of the provider-sponsors and control over the delivery of care, will be heavily dependent on the vision of the provider-sponsors and their ability to anticipate changes in their markets and the managed care industry, rather than react to changes.

In order to gain insight and perspective on the challenges facing, and the opportunities presented to, provider-sponsored managed care companies, this paper examines:

- The current state of the managed care industry and the status of provider-sponsored companies within the industry;
- The “ingredients” for the successful development of a provider-sponsored managed care company;
- The considerations affecting the ability of provider-sponsored managed care companies to compete against national managed care companies;
- Strategies for monetizing the value of a provider-sponsored managed care company;
- The importance of the provider contract in a divestiture or strategic transaction involving a provider-sponsored managed care company; and
- Strategies for enhancing the value of a provider-sponsored managed care company.

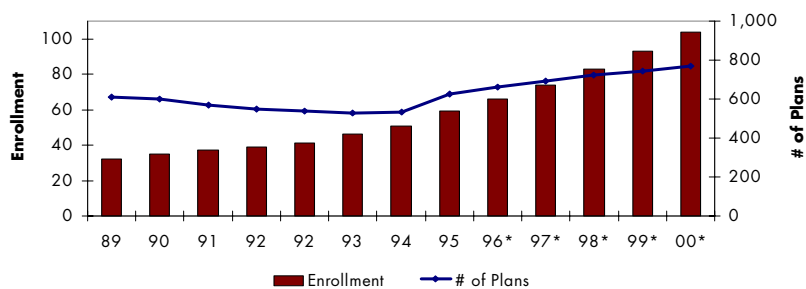
Overview of the Managed Care Industry

Continued Growth, But Lower Margins

The impact of managed care on the healthcare industry shows no signs of abating. The only change is in the competitive landscape and the relationship between providers and payers. HMO enrollment is projected to increase at a rate of 12% per year and to exceed 100 million members by 2000. A significant portion of this increase is attributable to Medicare and Medicaid members, but managed care continues to gain acceptance by commercial employers and employees as well. Despite consolidation, increased competition and a related adverse impact on profitability, the number of HMOs is expected to increase through 2000, part of a trend that began in 1994. According to industry studies and published reports, the majority of these new managed care companies are or will be provider-sponsored, primarily by physicians who have organized themselves through a medical society, IPA or other similar type of organization.

The increased desire of providers to own a managed care company is in response to continued membership growth as well as concern that national and multi-regional managed care companies are gaining too much power from their control of the premium dollar and the delivery of care. As shown in Figures I and II, the start of the increase in the number of HMOs coincides with the high-water mark for HMO operating margins reached in 1994. It appears that after four years of steadily increasing profit margins in the HMO industry and continued reductions in payments to institutions and physicians, providers responded by forming their own HMOs at an even faster pace.

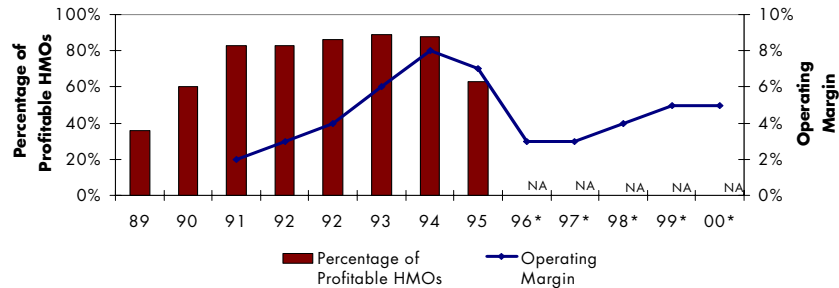
**Figure I
Industry Growth
Enrollment and Number of Plans**



Sources: Health Affairs, GHAA, Modern Healthcare

* Based on estimates by Bernstein Research and Shattuck Hammond Partners Inc.

Figure II
Financial Performance
Percentage of Profitable HMOs and Industry Operating Margin



Sources: Interstudy, HCIA, Bernstein Research

* Based on estimates by Bernstein Research and Shattuck Hammond Partners Inc.

The increase in HMOs is projected to occur during a period of time when HMO operating margins will remain significantly below the levels experienced in 1994. Indeed, during 1995, operating margins of national, regional and provider-owned HMOs all declined on average and continued to decline in 1996. While industry leaders are hopeful that this trend will be reversed in 1997, it is too soon to tell. The decline in operating margins will mean that many of the newly-formed HMOs will not be successful and that certain existing local and regional managed care companies, including many provider-sponsored managed care companies, will find it increasingly difficult to compete.

Publicly-Traded Managed Care Companies

The issues facing the entire managed care industry are clearly discernible in the financial statistics of the publicly-traded managed care companies. Table 1 on pages 6 and 7 presents a margin analysis of publicly-traded regional HMOs vs. national HMOs. For the purposes of this analysis, we defined a national HMO as having more than one million full-risk lives and operations in more than one geographic market. As in the data presented in Figure II for the entire industry, operating margins for publicly-traded HMOs peaked in 1994. However, the data in Table 1 shows a clear dichotomy between regional HMOs and national HMOs. The average margins related to (i) earnings before interest, taxes, depreciation and amortization (“EBITDA”), (ii) earnings before interest and taxes (“EBIT”) and (iii) net income were *higher* for the regional HMOs compared to the national HMOs in 1993 and 1994 and *lower* compared to the national HMOs in 1995 and the latest twelve months ending June 30, 1996. This change in margins is predominately the result of increased competition in many of the markets served by the regional HMOs. With lower administrative costs, greater buying power, stronger appeal to national accounts, higher capital investment in medical management and the ability to absorb losses in a new

Provider-Sponsored Managed Care Companies

market with profits from other markets, the national HMOs are increasingly able to exert premium pricing pressure on the regional managed care companies, forcing regional managed care companies to lower premiums in response and survive on thinner margins.

The impact of economies of scale and synergies is expected to further enhance the competitive position of the national HMOs through two mergers involving four of the companies included in our group of national HMOs: Health Systems International/Foundation Health Corporation and PacifiCare Health Systems/FHP International Corporation. Both of these mergers, involving companies with substantial geographic and administrative overlap, will result in economies of scale and synergies through reductions in redundant administrative costs and product cross selling.

Moreover, the stock market has clearly recognized the changing dynamics in the managed care industry. Figure III on page 8 presents relative share price performance of a composite of the regional HMOs, national HMOs and the S&P 500. The regional HMOs slightly outperformed both the national HMOs and the S&P 500 until the first quarter of 1995. At that point, it appears that, on the basis of disappointing first quarter results for HMOs, the stock market recognized that a change was developing in the competitive positions of the regional and national HMOs. As the graph in Figure III shows, during the same period of time that the margins of the national HMOs improved relative to the margins for the regional HMOs, the composite share price of the national HMOs significantly outperformed the composite share price of the regional HMOs.

Currently, regional publicly-traded HMOs are valued at average multiples of approximately .4x revenue and \$600 per commercial member equivalent, compared to .7x revenue and \$1,100 per commercial member equivalent for the national HMOs. Commercial member equivalents reflect adjustments for Medicare members and non-risk members. The difference in valuation, combined with the increasing competitive difficulties of the regional HMOs' and the national HMOs' search for more members and increased economies of scale, should result in continued consolidation in the industry. However, because of the new competitive realities present in the market, many of these regional HMOs will not realize as high of a value for their shareholders as they could have realized just a year ago. Clearly, the challenges of competition with larger, better capitalized companies was one of the factors motivating Healthsource, a leading regional HMO, to sell out to Cigna. The purchase price of \$21.75 represents a 46% discount from Healthsource's all-time high of \$40.125, reached in February 1996.

Provider-Sponsored Managed Care Companies

Table 3
Publicly-Held Managed Care
Margin Analysis

	EBITDA				EBIT			
	LTM	1995	1994	1993	LTM	1995	1994	1993
Regional HMOs								
Mid Atlantic Medical Services	4.9%	9.7%	11.5%	6.9%	4.3%	9.0%	10.9%	6.3%
Wellcare Management Group	-9.4%	-1.2%	5.3%	6.6%	-11.7%	-3.2%	4.0%	5.5%
Sierra Health Services	8.4%	9.0%	10.7%	6.5%	6.4%	6.8%	8.5%	4.8%
Physicians Health Services	0.5%	6.2%	7.9%	6.0%	-0.2%	5.3%	7.0%	5.4%
Health Power	-8.6%	-1.5%	8.5%	6.1%	-8.9%	-1.8%	8.3%	5.9%
Physician Corp. of America	-1.5%	1.2%	11.2%	12.7%	-3.4%	-0.8%	9.7%	11.7%
Coventry Corp.	-2.6%	1.8%	8.7%	7.9%	-4.2%	0.1%	7.5%	6.7%
RightChoice Managed Care	4.9%	5.7%	5.9%	4.9%	2.7%	3.8%	4.8%	4.4%
Maxicare Health Plans	2.7%	4.0%	2.0%	1.0%	2.4%	3.7%	1.5%	0.1%
United Wisconsin Services	3.8%	3.1%	8.8%	9.3%	3.7%	2.8%	8.4%	9.1%
United American Healthcare	13.3%	13.3%	22.0%	29.2%	9.0%	9.0%	18.0%	25.9%
Healthsource, Inc.	6.7%	8.2%	9.7%	11.1%	4.5%	6.1%	7.2%	9.0%
Average	1.9%	5.0%	9.3%	9.0%	0.4%	3.4%	8.0%	7.9%
National HMOs								
United HealthCare	7.0%	10.0%	12.4%	10.6%	5.5%	8.3%	10.6%	9.0%
Humana	2.8%	6.1%	6.6%	4.7%	1.3%	4.6%	5.2%	3.2%
Aetna	8.7%	7.2%	NA	NA	1.6%	1.7%	NA	NA
Oxford Health Plans	6.0%	5.7%	7.0%	6.6%	4.6%	4.3%	5.9%	5.6%
WellPoint Health Networks	8.1%	8.6%	9.4%	NA	7.3%	8.0%	9.4%	NA
PacifiCare Health Systems	4.5%	4.7%	4.9%	4.6%	3.8%	4.0%	4.2%	3.9%
FHP, International	5.0%	5.0%	5.9%	5.2%	3.3%	3.3%	3.8%	3.4%
Foundation Health	7.2%	7.2%	8.3%	7.2%	5.4%	5.4%	6.6%	6.0%
Health Systems International	7.2%	7.7%	8.0%	5.9%	5.5%	6.0%	6.3%	4.2%
Average	6.3%	6.9%	7.8%	6.4%	4.2%	5.1%	6.5%	5.0%

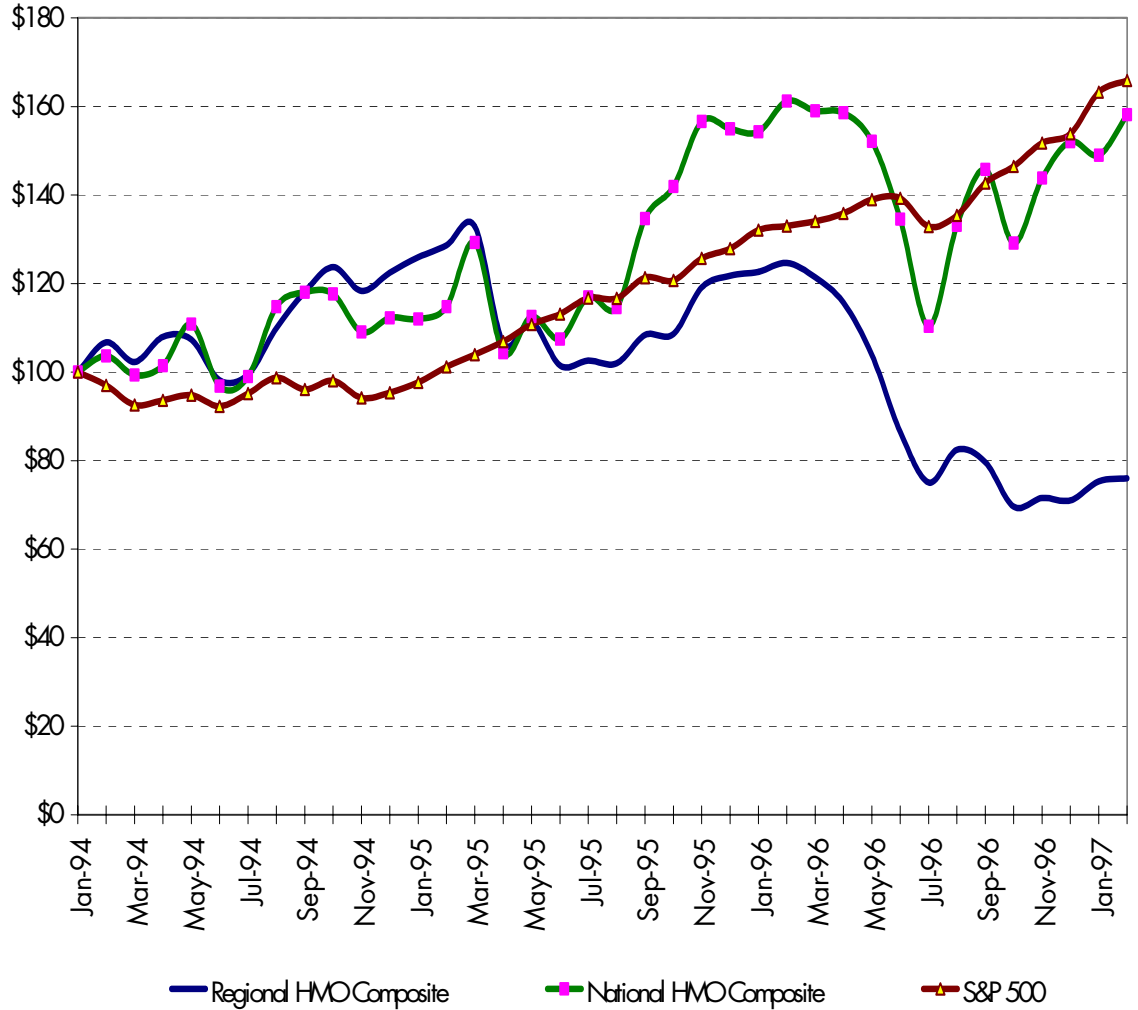
(*) Medical Expense as a percentage of Premium Revenue.

Provider-Sponsored Managed Care Companies

Table 3 (cont'd)
Publicly-Held Managed Care
Margin Analysis

Net Income				Medical Loss Ratio (*)			
LTM	1995	1994	1993	LTM	1995	1994	1993
3.4%	6.5%	7.3%	3.9%	88.5%	83.5%	81.3%	86.3%
-4.0%	1.5%	2.9%	4.9%	104.4%	100.9%	81.7%	80.2%
7.8%	8.1%	9.6%	6.1%	84.7%	82.4%	80.1%	83.9%
1.2%	4.8%	4.9%	4.3%	82.8%	77.3%	77.7%	82.2%
-5.1%	0.2%	5.9%	6.3%	84.4%	78.6%	72.6%	77.2%
-2.3%	-0.7%	6.5%	7.3%	87.9%	84.6%	73.9%	72.8%
-2.4%	0.0%	4.0%	3.4%	87.3%	84.5%	79.8%	81.8%
3.6%	4.4%	4.7%	5.3%	77.9%	76.1%	74.8%	76.0%
4.7%	5.8%	3.2%	1.3%	88.4%	86.8%	87.8%	89.7%
1.1%	0.6%	4.4%	4.8%	81.2%	81.8%	74.4%	76.2%
2.5%	2.5%	9.9%	16.7%	86.6%	86.6%	NA	NA
3.2%	4.5%	6.7%	9.0%	85.7%	77.4%	76.7%	74.9%
1.1%	3.2%	5.8%	6.1%	86.7%	83.4%	78.3%	80.1%
4.5%	6.8%	8.5%	6.9%	83.2%	79.7%	78.3%	80.4%
1.8%	4.1%	5.1%	2.8%	84.0%	81.7%	81.6%	83.8%
2.3%	2.5%	NA	NA	104.0%	106.5%	NA	NA
3.0%	3.0%	3.7%	4.0%	79.0%	77.5%	74.1%	73.2%
6.3%	7.2%	7.9%	NA	76.3%	75.6%	72.8%	NA
2.8%	2.9%	2.9%	2.8%	83.3%	82.5%	82.1%	83.3%
1.6%	1.6%	1.8%	2.4%	84.5%	84.5%	82.8%	83.2%
5.0%	5.0%	7.3%	4.0%	62.6%	80.1%	78.9%	80.3%
3.4%	3.7%	3.8%	1.9%	82.3%	81.0%	80.3%	80.6%
3.4%	4.1%	5.1%	3.6%	82.1%	83.2%	78.9%	80.7%

**Figure III
Relative Monthly Stock Performance**



Source: Shattuck Hammond Partners

Emerging Class of Super National Managed Care Companies

Recent mergers and proposed mergers among the national publicly-traded managed care companies are creating a new superclass of competitors. The acquisition of U.S. Healthcare by Aetna and the mergers of Pacificare Health Systems and FHP International Corporation and Health Systems International and Foundation Health Corporation are reforming the competitive landscape. Table 2 below presents the merged entities on a pro forma basis, along with data for United HealthCare Corporation, which has been an active acquiror of HMOs. Synergies between the merged entities will result in enhanced operating margins and further competitive pressure on local and regional managed care companies. Health Systems International estimates that savings from economies of scale and revenue enhancement from synergies will result in total incremental

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pretax earnings of \$110–\$150 million, an amount that is greater than the revenue of most provider-sponsored managed care companies.

Table 2
The New Super Nationals
(Excludes Synergies; \$ in millions)

	Aetna/ U.S. Healthcare	Health Systems Int'l/ Foundation Health Corp.	PacifiCare Health Systems/ FHP International	United HealthCare Corporation
LTM Revenue	\$16,842	\$6,785	\$9,174	\$9,410
LTM EBITDA	\$1,472	\$452	\$445	\$568
LTM Net Income	\$393	\$262	\$219	\$372
Full-Risk Members	4,018,000	3,347,000	3,958,000	4,327,000

Comparative Profitability of Provider-Sponsored Companies

In general, the fact that provider-sponsored managed care plans on average do not perform as well as publicly-traded and other independent managed care companies should not be surprising for a number of reasons:

- First, and probably most importantly, operating margins may be affected by the amount that the provider-sponsors pay themselves for the delivery of care. In many industries, this is known as transfer pricing. For provider-sponsored managed care companies, there is an especially strong incentive to lower profit margins through high fee schedules, especially if the company is a for-profit entity: Why pay taxes twice? For example, M.D. Enterprises of Connecticut, a physician-owned HMO that was acquired by Health Systems International in 1995, had operating margins for the two years prior to the acquisition of (.5%) and .3%. In the absence of any changes, the \$101.5 million acquisition price could not be supported by the historical financial performance of the plan. However, as part of the transaction, the physician owners of M.D. Enterprises of Connecticut normalized their fee schedules through a new provider agreement, which on a pro forma basis significantly enhanced the profit margins of the company.
- Second, operating margins may be affected by high administrative cost related to corporate overhead allocations from a parent organization. This type of allocation generally occurs when an HMO is owned by a hospital system. As described above, a portion of the overhead allocation may in effect be a method for minimizing taxation on the plan. In addition, the overhead allocation may include an interest and depreciation allocation related to

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system assets that do not serve the plan or an allocation for the time of senior administrators and other resources of the sponsor which are not used by the plan. In an effort to determine the true profitability of a plan, we have frequently examined, and normalized, administrative overhead allocations between the plan and its sponsor(s).

- Third, because many provider-sponsored managed care companies are smaller than the publicly-traded managed care companies, they may not be able to realize the economies of scale of a larger plan in terms of administrative cost and medical cost.
- Finally, certain provider-sponsored plans may not have the management depth and MIS resources required to optimize medical management and capitalize on operational efficiencies.

Table 3 on the following page presents a comparison of the operating or EBIT and net income margins for (i) the managed care industry, (ii) a composite of provider-sponsored managed care companies, (iii) regional publicly-traded managed care companies and (iv) national publicly-traded managed care companies. Operating margin has more significance for this analysis because it excludes the impact of interest income and expense which are the result of balance sheet differences. The composite of provider-sponsored managed care companies includes 11 companies, from 11 different states, all of which had at least \$150 million of revenue in 1995. Since the data come from a variety of sources, it is important to look at trends rather than specific numbers.

Provider-Sponsored Managed Care Companies

Table 3
Profitability Ratios

Provider-Sponsored Health Plan	State	Net Income Margin							
		LTM	1995	1994	1993				
Mathew Thornton Health Plan	WA	NA	1.5%	5.4%	4.9%	NA	3.4%	5.8%	6.0%
Partners Health Plan of Arizona	AZ	NA	2.1%	1.8%	0.3%	NA	2.7%	2.3%	0.7%
CareAmerica Health Plans	CA	NA	-0.3%	1.5%	1.7%	NA	0.7%	2.0%	2.4%
Av-Med Health Plan	FL	NA	2.5%	7.3%	6.6%	NA	4.2%	8.4%	7.5%
MEDICA	MN	NA	-1.1%	3.9%	2.1%	NA	2.1%	2.2%	4.8%
Health Alliance Plan of Michigan	MI	NA	0.2%	1.1%	0.4%	NA	1.5%	1.9%	1.4%
Capital District Physicians' Health Plan	NY	NA	-1.1%	2.5%	7.2%	NA	1.0%	4.2%	7.9%
ChoiceCare	OH	NA	-9.7%	3.0%	1.7%	NA	-5.2%	3.9%	4.7%
SelectCare Health Plans	OR	NA	-4.2%	-3.3%	2.1%	NA	-3.2%	-2.7%	2.8%
Geisinger Health Plan	PA	NA	-0.4%	1.0%	1.5%	NA	0.4%	1.5%	2.0%
Harris Methodist Health Plan	TX	NA	-6.2%	-7.6%	0.4%	NA	-5.1%	-7.0%	1.1%
Provider-Sponsored Health Plan Average		NA	-1.5%	1.5%	2.6%	NA	0.2%	2.0%	3.8%
Industry Average		NA	6.0%	8.0%	7.0%	NA	NA	NA	NA
Regional Publicly-Held HMO Average		1.9%	5.0%	9.3%	9.0%	0.4%	3.4%	8.0%	7.9%
National Publicly-Held HMO Average		6.3%	6.9%	7.8%	6.4%	4.2%	5.1%	6.5%	5.0%

Source: HCIA, Company Reports, Berstein Research

Clearly, the provider-sponsored managed care companies operate at lower margins than the other indexes. In addition, it appears that operating margins for the provider-sponsored companies began to decrease a year before operating margins for the industry as a whole, as well as the publicly-traded managed care companies, began to decrease. This lag between the provider-sponsored managed care companies and the other managed care company indexes implies that the non-provider-sponsored managed care companies benefited from the ability to reduce medical costs while the provider-sponsored plans may have been reticent, or unable, to cut their own fee schedules in order to get them in line with fee schedules paid by competing managed care companies. Furthermore, as described above, the operating margins of the provider-sponsored managed care companies may have been negatively impacted relative to other managed care companies by the inability to realize the same economies of scale from an administrative perspective.

Critical Elements for Successful Provider-Sponsored Managed Care Companies

Increasingly, the ability of provider-sponsored managed care companies to compete effectively is market and plan specific. Without question, national managed care companies, especially those that are publicly-traded, have advantages in competing with provider-sponsored managed care companies. Nevertheless, well capitalized provider-sponsored managed care companies with effective management can succeed. A local or regional provider-sponsored managed care company, especially one that is associated with a leading hospital and/or physician organization, can be a formidable competitor, even if it lacks the capital resources of, or operates with a higher cost structure than, national or multi-regional managed care companies.

From our analysis, an important determinant of the success of a provider-sponsored managed care company, beyond capitalization or cost structure, is the level of market penetration of managed care. It is clear that provider-sponsored companies can more readily succeed in less penetrated markets, and that, as the penetration level of the market increases, the prospects for long-term success decline. For example, in the State of Louisiana, which is in the bottom quartile in terms of managed care penetration in the United States, two of the largest managed care companies in the state are provider-sponsored. Oschner Health Plan is the largest managed care company and is owned by the Oschner Clinic. Gulf South Health Plans, Inc., in Baton Rouge, is the third largest managed care company in Louisiana and is owned by the General Health System, a not-for-profit health system. The cost of competing in such markets is much lower than in highly penetrated markets.

Once larger competitors begin to enter a market and the level of managed care penetration increases, providers who are owners of a managed care company run two risks. First, in a more competitive market, a provider-sponsored managed care company may confront premium pricing pressure from new entrants who are able to use their stronger financial position to buy market share. Second, the providers themselves may find that, not only are these new competitors taking away profits and market share, but they are also reluctant to contract with a provider that they view as a competitor. Consequently, their position as leading healthcare providers may be undermined.

With an appreciation for the challenges that a provider-sponsored managed care company will confront as the market matures and penetration increases, a provider-sponsored plan can have reasonable prospects for success if it incorporates into its operating, capital and governance structure certain crucial ingredients. These crucial ingredients include, at a minimum, those presented below.

Adequate Capitalization

Many provider-sponsored managed care companies are undercapitalized; in many instances, the companies possess only the minimum capital required for licensure. For a managed care company, undercapitalization limits growth in terms of the ability to: (i) develop new products; (ii) market; (iii) maintain reserves; (iv) be price competitive; and (v) finance acquisitions. The tendency for providers to undercapitalize their managed care ventures is in part related to the inability to access capital from public equity markets. Moreover, providers often will have competing capital demands, and such capital as is available must be rationed between competing goals. A not-for-profit health system will have many competing capital needs, only some of which can be financed with tax-exempt bonds. Tax-exempt bond financing proceeds cannot be allocated to a for-profit HMO subsidiary, and only under restricted circumstances to a not-for-profit subsidiary. Moreover, in certain instances, bond covenants may limit the amount of cash that a hospital can transfer to its managed care subsidiary. A hospital CEO who must choose between the medical staff's desire to maintain the hospital as state-of-the-art, the Board's desire to develop an integrated delivery system by acquiring physicians and an HMO administrator's desire to increase the marketing budget or undertake an acquisition faces painful decisions. Furthermore, while many physician-sponsored managed care companies are initially capitalized by raising funding from individual physicians, secondary fundings of this type are often difficult to complete.

Underestimating the amount of capital required to launch and develop a successful managed care company can be its death knell, for once the initial capital is exhausted, it is increasingly difficult to replenish it. Unfortunately, however, there are no reliable formulae for calculating how much capital is required: variables such as how much capital should be devoted to marketing or how administrative services should be staffed make each case separate from the next. However, we have found that it is rarely possible to establish a competitive HMO product in a moderately penetrated market for much less than \$10 million. While this amount does not need to be fully invested at the commencement of operations, it is most unlikely to be generated from operations in the early years. Consequently, the sponsors of the managed care venture would be strongly advised to undertake a thorough strategic capital plan for the new venture before launching it.

Marketing

Although the provider-sponsors of a managed care company may enjoy an excellent reputation as healthcare providers, this reputation does not necessarily translate into an assurance of growing enrollment. Indeed, many providers confront a rude awakening when enrollment fails to meet expectations. Frequently, we find that the failure to grow enrollment is due to premium

pricing: since these plans tend to be “benefit-rich,” they carry higher prices than other products. However, in many cases, disappointing enrollment is attributable to insufficient or underfinanced marketing. While the impetus for the providers to emphasize quality of care is understandable, the sheer necessity of marketing a managed care product cannot be overlooked, especially if consumers have access to the provider network through other healthcare payers.

Broad Provider Network

The provider-sponsors of a managed care company may justifiably desire exclusivity from their affiliated company. However, the realities of the market may demand that unaffiliated providers also be included in the network, especially if they are available in competing insurance products. Occasionally, an added complication for a provider-sponsored plan (especially hospital-sponsored plans) is that certain competing area providers will choose not to contract with the plan in order not to enrich the providers who are affiliated with the HMO.

Management and Governance

Managing a managed care company is becoming increasingly complicated as new products are developed, provider relationships continue to evolve and competitive pressures become ever more acute. Without question, the senior management of many provider-sponsored managed care companies consists of experienced and competent individuals. However, these managers frequently tell us that the most frustrating aspect of their jobs is navigating between the provider-focused interests of their sponsors and competing with other plans whose sole focus is building a successful managed care company. When directors wear their provider “hats” into the board room, the outcome of decision-making is frequently disappointing to the managers. Moreover, on a practical level, provider-sponsored plans have difficulty structuring compensation packages that can compete with those offered by the national managed care companies (inclusive in certain cases of stock options), and may increasingly find that they are losing their best managers or are unable to attract the best and the brightest.

Provider/Managed Care Company Conflicts

Sooner or later, the inherent conflict of interest embodied in a provider-sponsored managed care company must be acknowledged. In many situations, the managed care company is the tail, not the dog. However, if the plan is to succeed, its independent goals and objectives *must be recognized* as equal, and not subordinate, to its sponsors’ goals. In a market with low penetration and few competitors, it may be possible initially to avoid confronting this issue, but acknowledging the imbedded conflict and establishing an agreed hierarchy of decision-making is a *sine qua non* for long-term success.

Provider-Sponsored Managed Care Companies

In an effort to identify the ingredients for success for a provider-sponsored managed care company, Shattuck Hammond Partners has compiled the following provider self-assessment that presents eleven critical issues for providers who own or contemplate forming an HMO or similar managed care organization. Affirmative answers to these questions will be critical to success.

Provider-Sponsored Managed Care Company Self-Assessment

1. Who are my competitors and do I have the financial wherewithal, cost structure and administrative expertise to compete against them? Why have the regional publicly-traded HMOs performed so poorly compared to the national publicly-traded HMOs? More importantly, is the competitive landscape in my market about to change and how will I be affected?
2. If my HMO is currently competitive, will I be able to manage it effectively as it expands outside of my central service area?
3. If I am a hospital, can I resolve the tension between filling beds and declining utilization?
4. If I am a hospital, do I have the fortitude to reduce, if necessary, physician compensation to stay competitive. Will the physicians retaliate against the hospital?
5. Am I the dominant provider in my market? Are competing managed care companies not contracting with me because of my affiliation with a managed care company or do they have no choice but to contract with me because of my dominant market position? How much potential business am I losing, if any?
6. Is my HMO management team capable of effectively competing in an increasingly competitive and complicated market?
7. If I am not capitated, will a provider contract with a managed care company result in more patients sent to me, which will offset the impact of decreased utilization?
8. If I am a physician-sponsored managed care company and have been experiencing losses due to product development or temporarily lower premiums, will my physician shareholders be willing to provide a second round of financing?
9. What other competing capital needs do I have? If I have built up value in my managed care company, should I monetize the asset and put some money away for a “rainy day”?
10. If I sell all or a portion of my managed care company, will I effectively give back the proceeds through reduced payments to me as a provider? How much of my business as a provider is related to my managed care company?
11. Will a risk-based provider contract protect my revenue stream? More importantly, can I manage a risk contract? From a regulatory perspective, what are the implications of a risk contract in my state?

New Realities and Opportunities for Provider-Sponsored Managed Care Companies

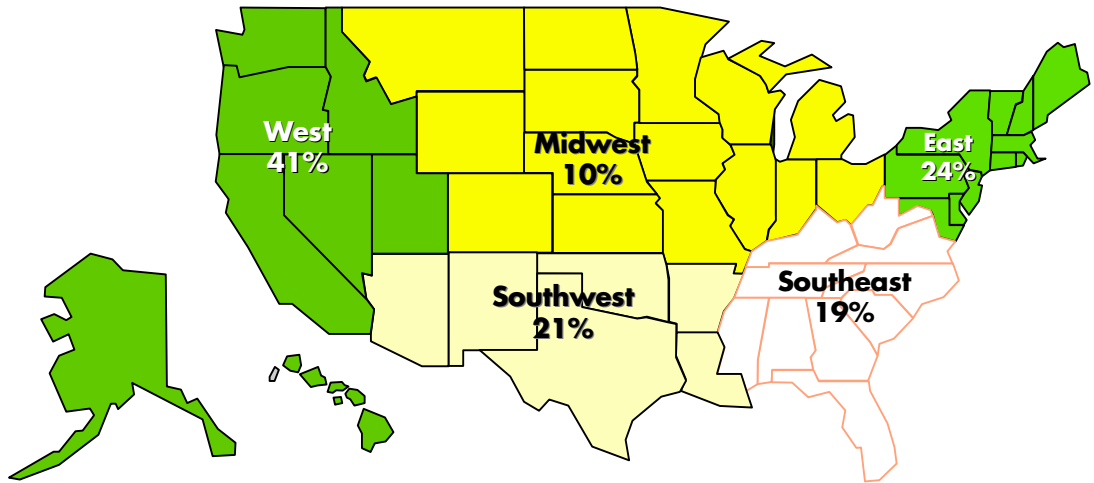
The desire of providers to have access to patients, control over the delivery of care and control over the premium dollar has manifested itself through the creation of, and growth of, provider-sponsored managed care companies. However, as we have seen, these local or regional entities are increasingly running head-on into the realities of a consolidating and ever more competitive industry. The success of existing or newly created provider-sponsored managed care companies will be heavily dependent on the dynamics of a particular market. Some provider-sponsored managed care companies will thrive and prosper indefinitely; many will face short or medium-term success followed by a deteriorating financial position as (i) their markets become more competitive, (ii) they are unable to match the operating efficiencies of some of their competitors and (iii) certain managed care companies refuse to contract with providers who own competitors. The level of managed care penetration and the competitive position of the provider-sponsor, combined with the quality of HMO management and the commitment of the provider to control medical costs all have a significant impact on the success or failure of the provider-sponsored HMO. A provider-sponsored managed care company in a highly penetrated market in which the provider is (i) the dominant provider in the market and (ii) has the commitment and expertise to control medical costs can be an effective competitor that does not have to worry about being “black listed” from the panels of other HMOs. However, it is important to point out that the competitive realities of an underpenetrated market can change rapidly. For example, Idaho has one of the lowest HMO penetration rates in the country. In mid-1996, a small physician practice management company began marketing an HMO called Primary Health Network HMO in southern Idaho’s “Treasure Valley” area, which accounts for a large portion of the state’s population. In the latter part of 1996, two of the states’ largest healthcare organizations, Saint Alphonsus Regional Medical Center and Blue Shield of Idaho, announced that they were also entering the market through a jointly owned company.

Figure IV on the following page provides a regional overview of average HMO cost efficiency versus traditional indemnity insurers. The diagram shows that HMOs are more efficient in every part of the country. This implies that a well-run provider-sponsored HMO should be able to be an effective competitor when the competition is primarily indemnity insurers. The figure also shows that in the western region of the United States, HMOs are significantly more cost efficient than in other regions. The west, particularly California, is generally used as an example of the end-game in managed care – high penetration dominated by a handful of companies with increasingly efficient operations. In this type of market, it becomes increasingly difficult for a local or regional provider-sponsored managed care company to compete on a profitable basis. Figure V shows the change that has occurred in the competitive profile of the

Provider-Sponsored Managed Care Companies

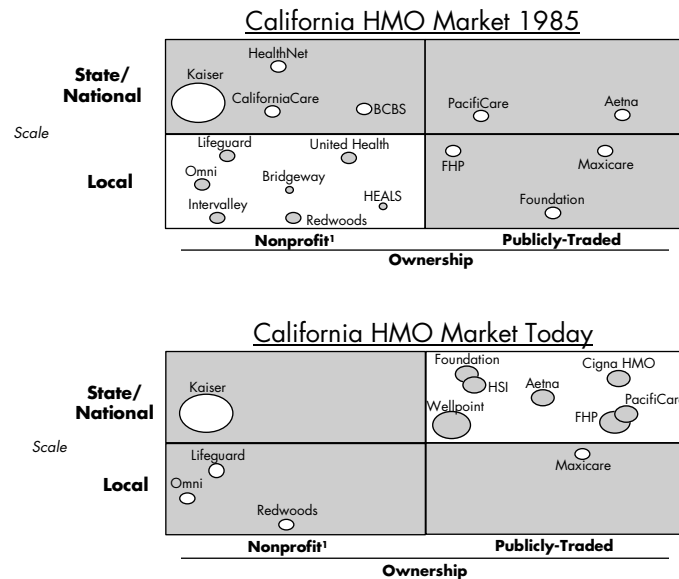
California managed care market over the past ten years. This type of change will serve as a paradigm for many other parts of the country.

Figure IV
HMO Cost Efficiency
Advantage Over Indemnity Insurers



Source: Hewitt Associates; Modern Healthcare

Figure V
The Evolution of the California HMO Market



Note: Size of circles denotes number of enrollees.

¹Primarily provider-sponsored.

Source: The Advisory Board Company; *Los Angeles Times*, 8 July 1985; Interstudy; *HCIA Guide to the Managed Care Industry*, 1995; Governance Committee analysis. Company Reports.

Provider-Sponsored Managed Care Companies

At the same time that the competitive environment has become tougher, the acquisition of provider-sponsored managed care companies has become an important source of growth for the publicly-traded managed care companies who are eager to expand into new regions and who recognize the importance of developing relationships with local providers. Although the pace of such acquisitions has slowed since the downturn in public company earnings began in the second quarter of 1996, national managed care companies find that it is less expensive, and faster, to enter a new market or expand in an existing market by buying rather than building. Recent acquisitions of provider-sponsored HMOs have generally ranged from \$500 to \$1,500 per member and .3 to .8 times revenue. Specific values paid are highly dependent on a particular market, the financial performance of the company and, especially, the terms of a new provider contract. Moreover, prices paid for provider-sponsored or other privately-owned managed care companies are generally less than prices paid for publicly-traded managed care companies, both of which have declined since their highs during early 1996. The majority of this valuation differential is attributable to illiquidity and private company valuation discounts.

For example, Health Systems International, Inc. (now Foundation Health Systems, Inc. through a 1997 merger of equals with Foundation Health Corporation) has been one of the most acquisitive managed care companies (Table 4). All of Health Systems International's acquisitions or other strategic transactions since 1994 have involved provider-sponsored managed care companies. Indeed, one of Health System International's constituent companies — QualMed — began as a physician-sponsored company in Colorado. Health Systems International has used transactions with providers as the central part of its strategy to expand in the Northeast. Continuing with this strategy, in May 1997, Foundation Health Systems closed on an investment in FOHP, Inc., the parent of First Option Health Plan, a New Jersey-based, provider-owned plan, and announced the proposed acquisition of Physicians Health Services, Inc., a managed care plan based in Connecticut.

Similarly, excluding the merger with FHP International, the majority of PacifiCare Health Systems' recent acquisitions have been of provider-sponsored managed care plans. The number of acquisitions of provider-sponsored managed care companies should increase as potential acquirers seek to expand in conjunction with establishing enhanced relationships with local providers.

Provider-Sponsored Managed Care Companies

Table 4

Date	Company, State	Risk Members	Consideration	Provider Sponsor
1997	Physicians Health Services, Inc. ¹ , CT	425,000	\$280.0 million	Connecticut-based physicians
1997	FOHP, Inc., NJ	150,000	\$51.7 million ²	New Jersey based physicians and hospitals.
1996	Advantage Health, PA	60,000	\$12.0 million	St. Francis Health System
1995	Greater Atlantic Health Services, PA	85,000	\$94.0 million	The Graduate Health System
1994	M.D. Enterprises of Connecticut, Inc., CT	57,500	\$100.5 million	Physicians affiliated with Connecticut State Medical Society

¹ Pending.

² Investment of \$51.7 million in debentures convertible into 71% equity of FOHP, Inc..

The acquisition appetite of the national managed care companies has created an extraordinary opportunity for many provider-sponsored plans to monetize an asset and redeploy the capital elsewhere, such as in integrated delivery system development. The key is having the vision to enter into a transaction at the appropriate time and on appropriate terms. Managed care companies that are losing market share and money are assets with declining financial value. The critical question is whether the financial benefits of monetizing a managed care asset can be matched with the provider's desire to direct patients, retain control over the delivery of care and control a large portion of the premium dollar? We believe that the answer is yes and that many of today's provider-sponsored managed care companies will serve as transitional entities for the benefit of the providers who have the vision to be proactive rather than reactive.

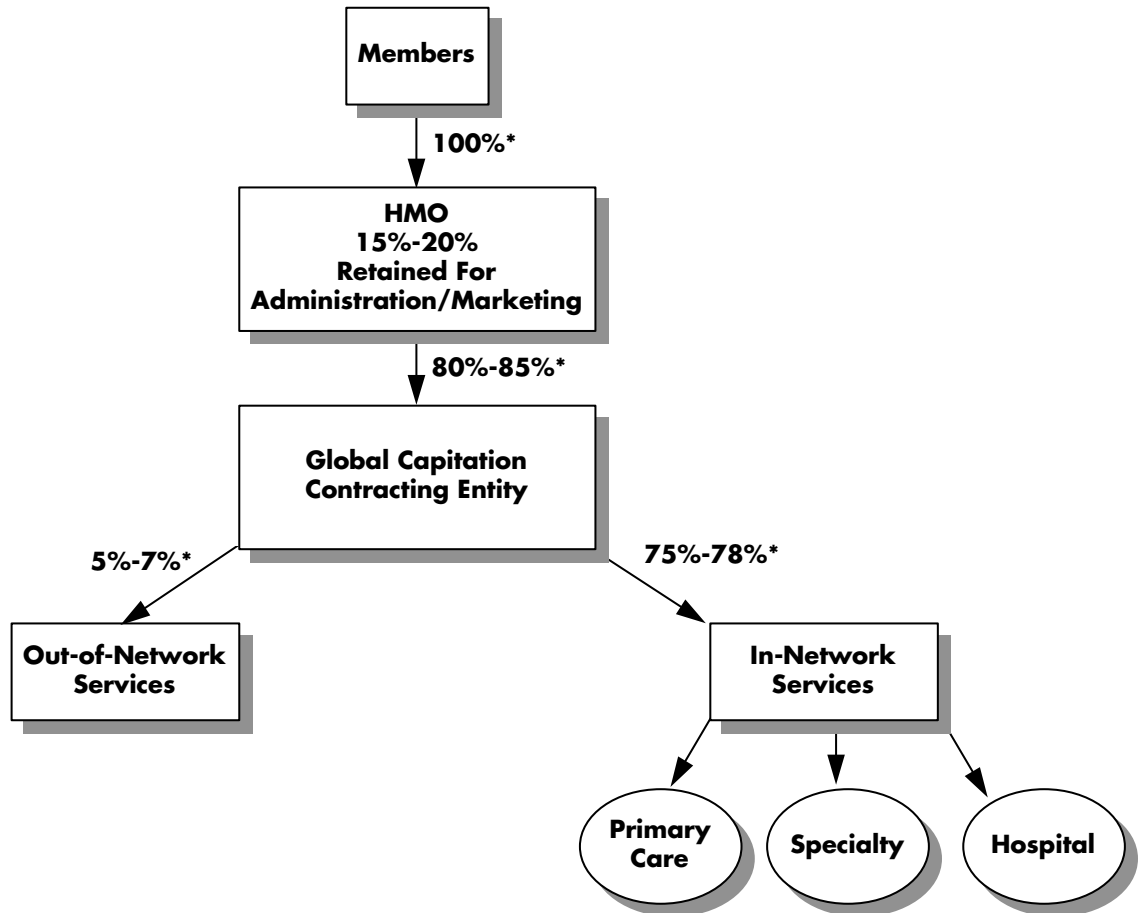
Global Capitation and the Rise of Virtual HMOs

Global capitation, whereby providers are taking the financial risk for institutional and professional costs and leaving administration and marketing to the HMO, is becoming increasingly popular among providers and payers. Through a global-risk contract, a provider in effect becomes a virtual or “private label” HMO for a defined population service area. In this way, the provider attains many of the goals that served as a motivation for entering the HMO business in the first place: control of patients; control of the delivery of care; and control over a larger portion of the premium dollar. At the same time, the provider avoids the administrative and marketing portions of the business, areas in which it frequently has difficulty competing. As part of a global-risk arrangement the managed care company may even be willing to “tout” the provider in its advertising, at no charge to the provider, thereby potentially increasing the number of members included in the global-risk arrangement. Similarly, the provider may be willing to help promote the HMO by participating in marketing events. Humana, a publicly-traded HMO, and Advocate Health Care Network, a multi-hospital, 2,000 physician, not-for-profit health system in Chicago, are currently undertaking this type of relationship as part of a Medicare global-risk contract. As global capitation increases, this type of joint marketing effort should become more common.

For the managed care company, a global-risk contract limits risk with regard to the medical loss ratio and, while it may result in lower profit margins, it provides less variability and more predictability to earnings. Because a global-risk contract can lower an HMO’s profit margin and in effect empower the providers, not every managed care company is currently willing to enter into such a contract. Increasingly, however, publicly-traded HMOs that are interested in transactions with provider-sponsored managed care companies are recognizing that they must incorporate some form of a global-risk contract into the provider agreement. In this way, they not only acquire an HMO, but establish a strategic relationship with providers and a more predictable cost structure.

The rules and regulations regarding global-risk contracts differ from state to state. In some states, global risk contracts are not allowed; in other states, global-risk contracts are allowed but the provider must establish reserves or obtain a license (such as a Knox-Keene license required in California). Recently, the issue of global-risk contracts has become politicized as a number of state legislatures have proposed legislation that would prohibit global-risk contracts, arguing that global-risk provides an unacceptable incentive to providers to withhold needed treatment. A global-risk contract can be between an HMO and a variety of entities, including a hospital, PHO, IPA, MSO or physician group. A basic global-risk contract is structured as illustrated in the following figure.

Figure VI
Global Capitation - Flow of Premium Dollar



* Percentages refer to percent of premium dollar

However, it is important to note that there can be many variations on this basic model, including the three summarized below.

Shared Risk With HMO.

Depending on what entity is taking the global-risk contract, there may be shared risk with the HMO. For example, if a physician related entity is the contracting entity, there might be shared risk with regard to institutional or out-of-network costs.

Fee-For-Service Versus Capitation.

Depending on what entity is entering into the global-risk contract, specialists and institutions could be paid on a fee for service basis or receive a subcapitation. In addition, hospitals could be paid on a per diem or case rate basis.

Hybrid Contract.

In states where global capitation is prohibited, or in situations where a payer refuses to enter into a direct global-risk contact, it may be possible to construct a hybrid global-risk contract. Such a contract would be constructed by a hospital

Provider-Sponsored Managed Care Companies

and a physician organization, each individually entering a capitated provider contract and then assigning the capitation to another entity which is jointly-owned by the providers, such as a PHO.

While many providers desire to enter into global-risk contracts and are entering into alliances or making acquisitions to position themselves to do so, many currently lack the experience, infrastructure and organizational discipline to manage the risk effectively. In most instances, the ability to manage the risk will come through hands-on (a sometimes painful) experience and the support of the managed care company or another entity, such as a physician practice management company which has experience in the area. The learning curve can be expensive. Moreover, it may be the case that the hospital is ready to be capitated before the physicians are ready, especially if the physicians are not currently organized and have worked predominantly in a fee-for-service environment. In this situation, a global-risk contract may be a second step for a provider who is selling its HMO to a managed care company.

Negotiating the Provider Agreement - the Key to the Deal

Multi-year provider contracts with managed care payers will increasingly shape the future and fortunes of providers as they look to retain a piece of the premium dollar. The sale of part or all of a provider-sponsored managed care company to a national HMO gives the provider negotiating leverage above and beyond other providers in the market. In many instances, it is critical to remember that it is the provider contract, not the sale price, that is the key to a successful deal from the provider's perspective. The importance of the provider agreement is affected by two factors: how much business the HMO currently does with the provider and how much business the HMO is projected to do with the provider in the future. A provider that focuses only on maximizing the sale proceeds of its HMO may find that it slowly "bleeds" those proceeds back to the entity that bought the plan if the acquirer is expected to account for a material amount of the provider's revenues.

In negotiating the provider agreement as part of a strategic transaction, the provider must balance its desire for a "Special Relationship" with the strategic partner/acquirer and its existing relationships with other key payers in the market. Frequently, the strategic partner/acquirer will want long-term competitive advantages imbedded in the provider agreement, particularly if that strategic partner/acquirer is a new or recent entry into the provider's market. From the strategic partner/acquirer's perspective, those long-term competitive advantages justify much of the purchase price for (or investment in) the provider's managed care plan and are the underpinning of its strategic decision to enter or expand into that market. Providers must closely examine their relationships with other key managed care players and decide whether they want to remain truly "neutral" or enter into a meaningful strategic alliance with the potential strategic partner/acquirer. In many cases, the inclination to sell the provider-sponsored plan and, in effect, withdraw from the retail managed care business suggests a preference for neutrality among providers. In certain cases, however, a provider may view a close partnership with a particular payer as being in that provider's long-term strategic interest.

As previously discussed, the provider may be able to obtain most the benefits of owning a HMO through a global-risk contract. The problem is that very often the optimal time to sell a provider-sponsored managed care company may not coincide with the provider's ability to enter into a global-risk contract. A two-step provider contract may be necessary to allow the provider adequate time to transition to global risk. The provider agreement may include certain structures as outlined on the following page.

Provider-Sponsored Managed Care Companies

Type of Contract:	Tiered	Partial-Risk		
Description	<ul style="list-style-type: none"> • Provider paid a daily rate. • Rate based on a negotiated schedule. • Common payment method in many provider contracts. • Easy method for creating a provider contract if comfortable with strategy for taking out per diem contract with a full-risk contract. 	<ul style="list-style-type: none"> • Same as per diem, except addresses provider issue resulting from decreased ALOS and increased intensity by raising the per diem payment rate during the first few days and then stepping it down. 	<ul style="list-style-type: none"> • Provider paid a fixed amount based on a definition of a medical condition (DRG). 	<ul style="list-style-type: none"> • Generally, capitated for either institutional or physician costs. • Can also be structured so that provider is paid on per diem, case rate, etc., but shares in profits and losses of managed care company within provider's service area. • Can be used for hospital-sponsored, physician-sponsored or hospital/physician-sponsored managed care companies.
Variations	<ul style="list-style-type: none"> • Can be combined with stop-loss insurance. • Can be combined with case rate payments for selected high cost carve outs. 	<ul style="list-style-type: none"> • Can be combined with stop-loss insurance. • Can be combined with case rate payments for selected high cost carve outs. 	<ul style="list-style-type: none"> • Can be combined with stop-loss insurance. • Can be combined with per diems for selected procedures. 	<ul style="list-style-type: none"> • For non-capitated piece there may be risk sharing based on savings or cost overruns.

Provider-Sponsored Managed Care Companies

Type of Contract:	Per Diem	Tiered Per Diem	Case Rate	Partial-Risk
Issues - Providers	<ul style="list-style-type: none"> • Over time may result in losses for hospital if costs cannot be reduced. • Days/1000 may decrease without an increase in overall lives. • ALOS may decrease at same time that intensity of service increases resulting in a double hit to profitability. • Pricing. 	<ul style="list-style-type: none"> • Over time may result in losses for hospital if costs cannot be reduced. • Days/1000 may decrease without an increase in overall lives. • Pricing. 	<ul style="list-style-type: none"> • Preferred by hospitals because it protects against medical management by payer. • Incentivizes cost reduction at hospital. • Pricing. 	<ul style="list-style-type: none"> • Greatest management risk to providers. • Pricing
Issues - Payers	<ul style="list-style-type: none"> • Per diem contract gives significant power to reduce medical cost and increase profitability at expense of the hospital. • Pricing. 	<ul style="list-style-type: none"> • Reduces ability to profit from decreased days/1000. • Pricing. • Concern that providers will code procedure in a higher DRG. 	<ul style="list-style-type: none"> • Although fixes cost per procedure, generally do not like it because it limits ability to profit from medical management and does not have the same certainty as capitation. 	<ul style="list-style-type: none"> • Depends on structure.

A transition into a global-risk contract gives the provider the time to gain the experience, develop the network, reduce costs, develop the systems and adapt to the culture and attitudes necessary to manage global risk profitably. The sale of a provider-sponsored managed care company can provide the capital to successfully manage the transition through one of the following means.

Set Aside a Portion of Sale Proceeds

In addition to funding capital expenditures for network development and MIS systems, the money should be viewed as a reserve to fund losses as the provider learns how to work within a global capitated environment. In order to be successful within the framework of a global contract, the provider will have to reduce operating costs. Many of these cost reductions, even if they involve variable costs, will take time to accomplish. Often a hospital must change its culture from one focused on filling beds to one focused on utilization reduction while maintaining the quality of healthcare.

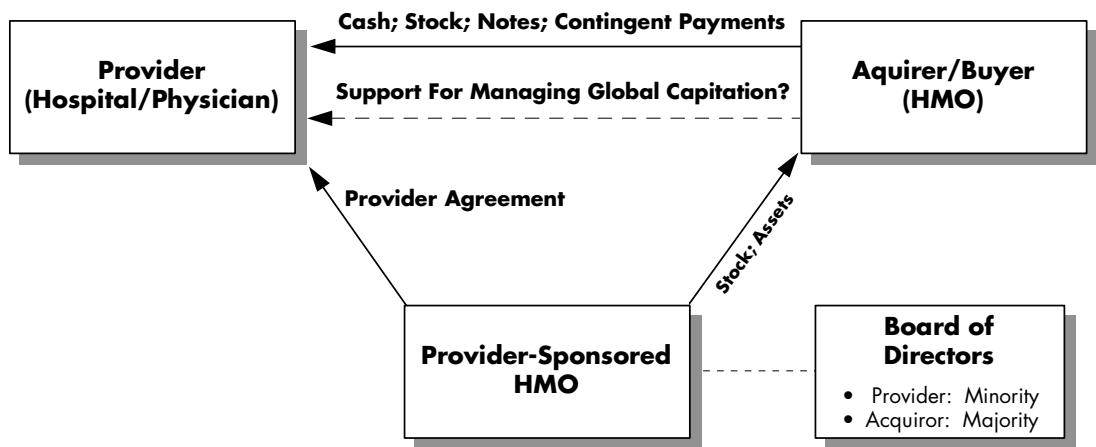
**Interest Income Must be Taken Into Account
In Negotiating A Provider Agreement**

After a set-aside reserve has been established and the invested capital recouped, the remaining sale proceeds can be viewed as an endowment. As the provider agreement is negotiated, the benefit of the interest earnings may be taken into accounting in the development of the financial framework of the provider agreement.

Models for the Sale of Provider-Sponsored Managed Care Companies

There are two basic models for the sale of a provider-sponsored managed care company: a sale of 100% of the company and the sale of less than 100% of the company.

Model A - 100% Purchase



Business/Structural Overview

- 100% of the stock or assets is sold to another company. Tax issues and accounting treatment will affect desire of purchaser to buy stock or assets.
- Consideration can consist of cash, stock (if a public company), notes or other debt securities and contingent earn-out payments. Such payments might be based on achieving certain membership levels or other criteria.
- Provider agreement created as part of transaction. Provider agreement may be very different than the one that currently exists between provider and HMO. As part of provider agreement, acquirer may provide certain utilization review and data services which will help provider manage a global-risk contract.

Governance**Health Plan Employees**

- Role of employees may need to be defined up front, depending on the buyer's existing operations within the market.
- Employees' incentives during divestiture process must be aligned with provider's strategic goals in selling its plan. This can be accomplished through "pay-to-stay" plans and key employee bonuses dependent on the close of the transaction.

Potential Benefits

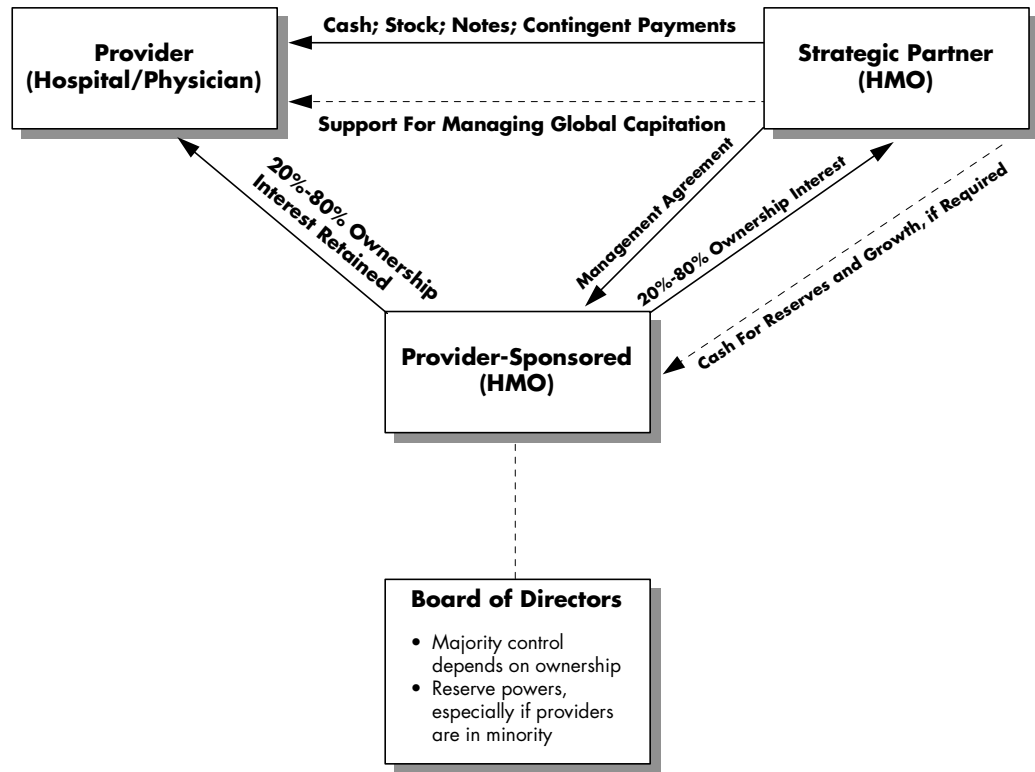
- With the exception of contingent payments, if any, all business issues are concluded upfront.
- Separation of provider from HMO may result in other HMOs contracting with provider.
- Capital available to redeploy and/or fund losses associated with transition to global capitation.

Potential Risks

- If provider misjudged impact of new provider agreement, there could be serious financial consequences over time.
- New acquirer may not be able to grow plan and direct additional lives to provider which were an important part of provider agreement calculations.
- In a non-capitated provider contract, medical management of acquirer impacts provider's ability to deliver quality care.
- Relationship with other key payers may be affected by the sale of plan and by terms of provider agreement.

Provider-Sponsored Managed Care Companies

Model B - Less Than 100% Purchase



Business/Structural Overview

- Strategic partner/acquirer purchases a portion of company's equity directly from providers or makes an investment in company. Provider-sponsored managed care company must be for-profit.
- Form of consideration will generally be cash but can be stock or include notes or contingent payments.
- Strategic partner/acquirer may be willing to own less than 50% initially, but will want to have ability to increase ownership over time. Publicly-traded managed care companies are earnings sensitive and may not be willing to undertake a transaction that will be dilutive to earnings in the short-term. If the strategic partner/acquirer owns less than 50% of the HMO, they do not have to consolidate the financials. Moreover, depending on the type of investment made by the acquirer, it may be possible to structure a transaction in which the strategic partner/acquirer does not have to book any earnings of the provider-sponsored HMO until the earnings turn positive.

Business/Structural Overview (cont'd)

- Mechanism will be necessary to allow strategic partner/acquirer to increase ownership or at least have a right of first refusal on purchase of additional shares. Mechanism can include a call (option owned by strategic partner/acquirer to purchase additional shares) or a mandatory tender offer.
- Provider agreement created as part of transaction. Provider agreement may be very different than one that currently exists between provider and HMO. As part of provider agreement, strategic partner/acquirer may provide certain utilization review and data services which will help provider manage a global-risk contract.

Governance

- Acquirer enters into a management contract with the HMO. Management fee would be negotiated but would generally include a profit margin. Management contract would include appropriate incentives to ensure that interest of strategic partner/acquirer and providers are aligned.
- Control of Board of Directors would reflect ownership percentages of various parties. At point when strategic partner/acquirer became majority owner, provider Board members would have certain reserve powers to protect minority interest.

Potential Benefits

- Allows providers to effectively “team up” with a strategic partner and maintain an interest in HMO.
- Provides up-front consideration and the potential for an even higher share value at a later date. Up-front payment provides capital to redeploy and/or fund losses associated with transition to global capitation.

Health Plan Employees

- Role of employees may need to be defined up front, depending on the strategic partner's/acquirer's existing operations within the market.
- Employees' incentives during divestiture process must be aligned with provider's strategic goals in selling its plan. This can be accomplished through “pay-to-stay” plans and key employee bonuses dependent on the close of the transaction.

Potential Risks

- Significant part of value of provider's ownership in plan tied to value of shares at a later date. At risk for poor management by strategic partner/acquirer and/or dispute over value of shares.
- Other HMOs may not view provider as separated from HMO and continue to be unwilling to contract with "competitors".
- Early on, Board control with providers, management control with strategic partner/acquirer. Potential for conflicts and disagreements exists.
- If provider misjudged impact of new provider agreement, there could be serious financial consequences over time.

Enhancing and Understanding the Value of a Provider-Sponsored Managed Care Company

As part of the proactive process of maximizing the value of a provider-sponsored managed care company, there are a number of steps that can be taken and issues that should be considered.

Timing is Critical.

A growing HMO with accelerating profitability is going to be more marketable to a potential acquirer/strategic partner than an HMO that is losing membership and in which losses are increasing. Many publicly-traded HMOs will not undertake an acquisition or other strategic transaction which is dilutive to their earnings. Even if the reasons for the loss at the provider-sponsored managed care company can be easily addressed, the perception of risk, let alone actual risk, may lower the value of the company. Also, once a provider-owned HMO is in financial trouble, the provider may no longer be in a position of strength to negotiate a deal, especially if the HMO requires an infusion of cash to maintain regulatory reserves. Too often, providers refuse to see “the writing on the wall” and wait until financial problems or membership losses have occurred before considering a strategic transaction. It is important to anticipate changes in the marketplace that may have an adverse financial impact on the managed care company. Those that act first and act boldly often reap the greatest gains.

Establish a Framework for a Provider Agreement Early On.

Unrealistic expectations and uncertainty over the type and terms of a provider agreement can delay or derail a transaction. The purchase price will be related to the terms of a provider agreement. Establishing the framework and general terms of provider agreement early on in the process will help ensure that the initial valuation proposed by a potential acquirer/strategic partner will not change significantly. At the same time, retain flexibility; each potential acquirer/strategic partner may have suggestions or recommendations that can enhance the effectiveness of the provider agreement. As previously discussed, a well thought-out provider agreement needs to take into account the proceeds from a sale and cost reductions by the provider.

Update a Budget and Create Multi-Year Projections.

The budget should be a monthly budget and have results that are attainable. Projections need to be well thought-out and should be aggressive, but within the bounds of what is realistic in the market. The projections should attempt to show what the plan can achieve if it is part of a larger organization, as opposed to if it remains provider-sponsored.

Make Historical and Projected Income Statement Easy For a Potential Acquirer/Strategic Partner to Understand.

Break out full-risk revenue, membership and medical cost by product line (large group, small group, individual, Medicare, Medicaid). Profitability at a provider-sponsored plan may be adversely affected by one product line or a large account

Provider-Sponsored Managed Care Companies

within a product line. If this information is clear to a potential acquirer/strategic partner and the product or account can be fixed or eliminated, valuation may be enhanced.

Cut Costs Now.

If there are obvious areas for cost reductions, implement them before you begin the divestiture process. Potential acquirers/strategic partners will place more value on cost reduction programs that are in place and showing results than those that will be implemented in the future.

Medicare is an Asset, Despite Losses.

Medicare-risk members are one of the most highly valued members due to growth potential and high premium levels relative to commercial premiums. Medicare members are often valued at two to three times a commercial member. Start-up Medicare losses are common at many provider-sponsored managed care companies. In many instances, the losses are so high that they offset a large portion of a plan's profitability. A Medicare-risk business is an asset and can be accounted for under a separate income statement which takes into account the high start-up and administrative expense associated with the Medicare-risk members. It is important to point out to a potential acquirer/strategic partner that despite start-up losses, your Medicare-risk business enhances the value of the HMO.

Separate Non-Risk and Full-Risk Administrative Cost.

A potential acquirer/strategic partner will focus on the ability to reduce administrative cost, one of the largest areas for realizing the benefits of economies of scale in an acquisition of a provider-sponsored managed care company by a national HMO. Administrative cost on full-risk business will be the main area of focus and should be separated from overall administrative cost. Helping the potential acquirer/strategic partner to fully understand the true costs will enhance the divestiture process.

Some Members are Worth More Than Others.

Per member valuations are a common form of valuing an HMO. However, simply counting the number of members that you have can result in an unrealistic expectation of value. As previously discussed, Medicare-risk members generally are valued at a significant premium to commercial members. Moreover, full-risk members are valued much higher than non-risk members. However, the value of high utilization groups and groups with large blocks of members are often discounted to reflect lower profitability and account concentration risk, respectively.

Delineate Overhead Allocation.

Many provider-sponsored managed care companies, especially if they are hospital-sponsored, are allocated a portion of the parent's overhead which is included in the administrative expense. The amount of the allocation, and what it is an allocation of, should be made clear to a potential acquirer/strategic

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partner. In many instances the allocation will include parent level interest and depreciation as well as an allocation for services which the HMO does not use.

Consider Converting Provider Employees to Full-Risk Members.

Increasing the full-risk membership base by converting provider employees can enhance the value of the HMO. However, it must be kept in mind that such a conversion must be profitable for the HMO and at the same time not increase the healthcare cost of the provider.

TPA/Non-Risk Business may be a Hidden Asset.

In many TPA and other non-risk businesses there may be a significant likelihood for converting members to full-risk status. Accounts, especially large accounts, that are considering converting, should be delineated for a potential acquirer/strategic partner.

Pro Forma Extraordinary Gains and Losses.

Certain one time expenses or revenues may be included as an operating expense or revenue, but may be extraordinary in nature. Such expenses and revenues can include fees paid to advisors, unusual marketing expenses or consulting fees received (but, generally, do not include unanticipated medical costs). If the amounts are material, they should be excluded from the income statement on a pro forma basis so that a potential acquirer/strategic partner can better understand the true profitability of the plan.

Think Through and Point Out Synergies to a Potential Acquirer/Strategic Partner.

Potential synergies may be different with different potential acquirers/strategic partners and may not be readily apparent to a potential acquirer/strategic partner.

Exclusivity.

Historically, many provider-sponsored plans are exclusive to the provider. Providers often want to continue to have exclusivity in conjunction with the sale of the plan. From the purchaser's perspective, exclusivity limits the potential of the plan and generally results in a discount in the valuation. If the potential acquirer/strategic partners can grow the plan more effectively without exclusivity, and actually increase the number of members sent to the provider, requiring exclusivity may be short-sighted and costly. Furthermore, in certain instances, potential acquirers/strategic partners will not undertake a transaction if exclusivity is a prerequisite.

Turn Weaknesses into Strengths.

High utilization, physician fee schedules and administrative cost can all result in low profitability or losses. At the same time, many of these problems are also easily fixed and represent significant opportunities to the potential acquirer/strategic partner. Point out to the potential acquirer/strategic partner what the problems are and how they can be addressed.

Protect Essential Employees

Provider-Sponsored Managed Care Companies

A sale process can be extremely disruptive and demoralizing for employees of a provider-sponsored managed care plan. Many employees, especially management, may be concerned that they will be replaced by the new owner. In addition, management may not have any equity ownership in the plan, thereby removing the incentive to be helpful throughout the sale process. If senior management resigns during the sale process to take positions elsewhere, the plan suffers financially and the result may potentially affect the terms of a transaction. In many instances, it is recommended that a “pay to stay” plan be implemented, whereby key employees are guaranteed a bonus once the transaction is completed. Under certain circumstances, it may also be advisable to tie the bonuses to the value of the plan.

Engage a Financial Advisor Who Understands Mergers and Acquisitions and Provider Issues.

In order to maximize the value of the managed care company, it is generally helpful to engage an investment banker or other financial advisor that can manage the strategic transaction process including the development of a Strategic Options Assessment, Confidential Information Memorandum and valuation, as well as screening and negotiation with potential acquirers/strategic partners. With regard to provider-sponsored plans, it is also essential to engage a financial advisor who combines strong merger and acquisition skills with a detailed knowledge of provider issues and agreements. Depending on the type of provider, it can be important to select a financial advisor with experience working with not-for-profit institutions. Legal and financial issues related to not-for-profits can directly impact how a transaction is structured.

Management’s Knowledge of Local Market may be a Key Strength.

In the case of a potential new or recent entrant into the provider’s market, the provider-sponsored plan’s management will frequently possess valuable experience and contacts within that market. The quality of the management should be highlighted and communicated to the potential acquirer/strategic partner.

Conclusion: The Provider-Sponsored Managed Care Company is in Transition – Act, Do Not React

Managed care continues its relentless climb to ever increasing penetration of the healthcare market, creating new opportunities and challenges for managed care companies and providers. The competitive dynamics are changing at the same time that global capitation is enabling many providers to obtain what they sought in the first place: control of the delivery of healthcare and control of a portion of the premium dollar. The provider-sponsored managed care company is a valuable asset that can help providers transition into global-capitation contracts and provide a financial endowment for the future. In many markets, providers will find that competing as an HMO will be increasingly difficult; while in other markets, providers will find that a window of opportunity still exists for a provider-sponsored managed care company. Those providers that have the vision and the will to act will maximize the value of their managed care companies and their ability to create a profitable provider agreement. Those providers that wait to react risk devaluing their managed care asset and losing leverage in the negotiation of the critical provider agreement.

This article is intended to present provider-sponsored managed care companies with an overview of the current and future managed care market as it specifically affects them as well as strategies for competing in that market. It is our belief that the managed care market will quickly produce winners and losers, and that provider-sponsored managed care companies should proactively examine the strategic opportunities available to them within this context.

Appendices

References

1. *Bernstein Research, "HMOs: Cycle Bottoming; Secular Opportunity Undiminished", July, 1996.*
2. *The Almanac of Hospital and Financial Operating Indicators, The Center for Healthcare, Industry Performance Studies, 1996-1997 Edition.*
3. *The Rising Tide, Emergence of a New Competitive Standard in Health Care, The Advisory Board Company.*
4. *Physician Compensation and Production Survey: 1996 Report Based On 1995 Data, Medical Group Management Association.*
5. *Integrated Healthcare Report, September 1996.*
6. *The Guide to the Managed Care Industry, HCIA, Coopers & Lybrand L.L.P., 1996.*
7. *The InterStudy Competitive Edge, Part II: Industry Report, September 1995.*
8. *Focus on Provider-Sponsored Managed Care, Cain Brothers, Shattuck & Company, Fall 1992.*
9. *Managed Care Week, February 5, 1996; October 21, 1994*
10. *Health Care Strategic Management, March 1995; February 1995*
11. *Modern Healthcare, June 17, 1996; June 24, 1996, November 4, 1996; June 3, 1996; March 18, 1996; July 29, 1996; August 5, 1996; February 5, 1996.*
12. *Journal of Health Care Finance, Fall 1996*
13. *Medical Economics, December 11, 1995.*

Publicly-Held Managed Care Company Comparison

Operating Data (\$ in Millions)

Regional HMOs (1)	Revenue (3)				EBITDA (3) (4)				EBIT (3) (5)				Net Income (6)			
	LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993
Mid Atlantic Medical Services	\$1,083	\$943	\$743	\$646	\$19	\$91	\$85	\$44	\$12	\$85	\$81	\$41	\$17	\$61	\$55	\$26
Wellcare Management Group	125	115	120	73	(26)	(1)	6	5	(29)	(4)	5	4	(14)	2	3	4
Sierra Health Services	528	442	383	366	42	40	41	24	32	30	33	18	39	36	37	22
Physicians Health Services	452	343	290	275	(14)	21	23	16	(16)	18	20	15	(4)	16	14	12
Health Power	64	59	54	46	(7)	(1)	5	3	(7)	(1)	4	3	(6)	0	3	3
Physician Corp. of America	1,396	1,198	814	546	(20)	14	91	69	(44)	(9)	79	64	(23)	(9)	53	40
Coventry Corp.	990	852	777	642	(22)	16	68	51	(38)	1	58	43	(24)	0	31	22
RightChoice Managed Care	638	592	584	576	14	34	34	28	(1)	23	28	25	9	26	28	30
Maxicare Health Plans	539	477	432	440	13	19	8	4	11	18	6	0	21	28	14	6
United Wisconsin Services	1,072	997	747	562	35	31	66	52	32	28	63	51	9	6	33	27
United American Healthcare	132	101	67	44	18	13	15	13	13	9	12	11	4	3	7	7
Healthsource, Inc.	<u>1,619</u>	<u>1,167</u>	<u>584</u>	<u>291</u>	<u>79</u>	<u>96</u>	<u>57</u>	<u>32</u>	<u>43</u>	<u>72</u>	<u>42</u>	<u>26</u>	<u>30</u>	<u>52</u>	<u>39</u>	<u>26</u>
Total	\$8,639	\$7,286	\$5,595	\$4,505	\$132	\$372	\$499	\$342	\$8	\$270	\$432	\$301	\$59	\$221	\$316	\$225
National HMOs (2)																
United HealthCare	9,410	5,511	3,651	3,052	568	549	452	324	436	455	388	274	372	376	310	212
Humana	6,363	4,615	3,592	3,147	148	282	238	149	50	212	188	102	87	190	182	89
Aetna (7)	16,842	16,031	NA	NA	1,472	1,147	NA	NA	277	278	NA	NA	393	406	NA	NA
Oxford Health Plans	2,697	1,746	753	308	154	99	53	20	115	76	45	17	83	52	28	12
WellPoint Health Networks	3,653	2,972	2,684	NA	274	255	253	NA	242	237	253	NA	202	214	213	NA
PacifiCare Health Systems	9,174	4,637	3,731	2,893	445	212	177	142	342	179	148	121	219	131	108	85
Foundation Health	3,642	3,339	2,403	2,323	232	240	199	168	168	179	158	139	159	166	174	94
Health Systems International	<u>3,143</u>	<u>2,732</u>	<u>2,306</u>	<u>1,957</u>	<u>220</u>	<u>211</u>	<u>186</u>	<u>116</u>	<u>168</u>	<u>163</u>	<u>146</u>	<u>82</u>	<u>103</u>	<u>101</u>	<u>89</u>	<u>37</u>
Total	\$50,558	\$41,583	\$19,120	\$13,681	\$3,285	\$2,994	\$1,557	\$920	\$1,641	\$1,780	\$1,325	\$735	\$1,534	\$1,637	\$1,104	\$529

(1) HMOs with less than 1 million full-risk members.

(2) HMOs with more than 1 million full-risk members.

(3) Excludes Interest and Investment Income.

(4) Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)

(5) Earnings Before Interest and Taxes (EBIT).

(6) Adjusted for non-recurring items.

(7) EBITDA and EBIT includes 87% of Interest Income, which is estimated percentage of interest income from required cash and investments on balance sheet.

Includes US Healthcare 1995 and 1996 results on a proforma basis.

(8) LTM = Latest Twelve Months of available financial data.

Publicly-Held Managed Care Company Comparison

Membership & Balance Sheet Data (\$ in Millions)

Regional HMOs	Membership		Mkt. Value	Working Capital	Debt	BEV (10)
	Full-Risk	Comm. Equiv. (9)				
Mid Atlantic Medical Services	644,300	748,400	\$926	\$132	\$2	\$796
Wellcare Management Group	91,140	91,140	49	25	31	54
Sierra Health Services	155,868	241,521	458	297	81	242
Physicians Health Services	304,868	325,868	182	44	19	156
Health Power	37,932	37,932	15	3	0	12
Physician Corp. of America	913,000	990,500	199	426	684	457
Coventry Corp.	726,430	758,402	235	(11)	108	354
RightChoice Managed Care	108,672	501,306	282	115	91	259
Maxicare Health Plans	NA	NA	395	106	1	289
United Wisconsin Services	NA	NA	328	275	126	179
United American Healthcare	217,159	217,159	33	27	27	33
Healthsource, Inc.	<u>922,200</u>	<u>1,156,640</u>	<u>1,061</u>	<u>226</u>	<u>269</u>	<u>1,104</u>
Total	4,121,569	5,068,868	\$4,161	\$1,665	\$1,439	\$3,936
National HMOs						
United HealthCare	4,327,000	5,768,940	9,455	1,883	536	8,108
Humana	3,193,800	3,637,930	3,253	426	338	3,165
Aetna	4,018,000	6,049,500	12,904	5,581	5,228	12,550
Oxford Health Plans	1,401,100	1,518,610	4,380	400	0	3,979
WellPoint Health Networks	983,813	2,746,262	2,751	1,101	1,034	2,684
PacifiCare Health Systems	3,958,109	4,883,340	4,072	650	212	5,273
Foundation Health	1,538,000	1,778,900	2,247	446	597	2,398
Health Systems International	<u>1,809,431</u>	<u>1,968,058</u>	<u>1,427</u>	<u>285</u>	<u>375</u>	<u>1,518</u>
Total	19,316,253	26,041,540	\$38,930	\$10,642	\$8,110	\$38,037

(9) Converts Medicare Risk members at 1:2 ratio, Insured PPO members at 4:3 ratio, Indemnity members at 2:1 ratio, and ASO/TPA members at 10:1 ratio; Medicaid full-risk and POS members converted at 1:1 ratio.

(10) Business Enterprise Value (BEV) represents the market value of the company's operating assets, excluding cash and other working capital.

Publicly-Held Managed Care Company Comparison

Margin Analysis

	Margins															
	EBITDA				EBIT				Net Income				Medical Loss Ratio (11)			
	LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993
Regional HMOs																
Mid Atlantic Medical Services	1.8%	9.7%	11.5%	6.9%	1.1%	9.0%	10.9%	6.3%	1.5%	6.5%	7.3%	3.9%	91.4%	83.5%	81.3%	86.3%
Wellcare Management Group	-20.9%	-1.2%	5.3%	6.6%	-23.5%	-3.2%	4.0%	5.5%	-11.2%	1.5%	2.9%	4.9%	107.3%	100.9%	81.7%	80.2%
Sierra Health Services	8.0%	9.0%	10.7%	6.5%	6.0%	6.8%	8.5%	4.8%	7.5%	8.1%	9.6%	6.1%	85.3%	82.4%	80.1%	83.9%
Physicians Health Services	-3.0%	6.2%	7.9%	6.0%	-3.6%	5.3%	7.0%	5.4%	-0.9%	4.8%	4.9%	4.3%	84.5%	77.3%	77.7%	82.2%
Health Power	-10.7%	-1.5%	8.5%	6.1%	-11.0%	-1.8%	8.3%	5.9%	-9.1%	0.2%	5.9%	6.3%	87.1%	78.6%	72.6%	77.2%
Physician Corp. of America	-1.4%	1.2%	11.2%	12.7%	-3.1%	-0.8%	9.7%	11.7%	-1.6%	-0.7%	6.5%	7.3%	88.0%	84.6%	73.9%	72.8%
Coventry Corp.	-2.2%	1.8%	8.7%	7.9%	-3.9%	0.1%	7.5%	6.7%	-2.4%	0.0%	4.0%	3.4%	87.5%	84.5%	79.8%	81.8%
RightChoice Managed Care	2.1%	5.7%	5.9%	4.9%	-0.1%	3.8%	4.8%	4.4%	1.4%	4.4%	4.7%	5.3%	81.3%	76.1%	74.8%	76.0%
Maxicare Health Plans	2.4%	4.0%	2.0%	1.0%	2.1%	3.7%	1.5%	0.1%	4.0%	5.8%	3.2%	1.3%	88.8%	86.8%	87.8%	89.7%
United Wisconsin Services	3.2%	3.1%	8.8%	9.3%	3.0%	2.8%	8.4%	9.1%	0.9%	0.6%	4.4%	4.8%	81.2%	81.8%	74.4%	76.2%
United American Healthcare	13.8%	13.3%	22.0%	29.2%	9.5%	9.0%	18.0%	25.9%	2.7%	2.5%	9.9%	16.7%	84.2%	86.6%	NA	NA
Healthsource, Inc.	4.9%	8.2%	9.7%	11.1%	2.7%	6.1%	7.2%	9.0%	1.9%	4.5%	6.7%	9.0%	80.1%	77.4%	76.7%	74.9%
Average	-0.2%	5.0%	9.3%	9.0%	-1.7%	3.4%	8.0%	7.9%	-0.5%	3.2%	5.8%	6.1%	87.2%	83.4%	78.3%	80.1%
National HMOs																
United HealthCare	6.0%	10.0%	12.4%	10.6%	4.6%	8.3%	10.6%	9.0%	4.0%	6.8%	8.5%	6.9%	84.1%	79.7%	78.3%	80.4%
Humana	2.3%	6.1%	6.6%	4.7%	0.8%	4.6%	5.2%	3.2%	1.4%	4.1%	5.1%	2.8%	84.0%	81.7%	81.6%	83.8%
Aetna	8.7%	7.2%	NA	NA	1.6%	1.7%	NA	NA	2.3%	2.5%	NA	NA	104.0%	106.5%	NA	NA
Oxford Health Plans	5.7%	5.7%	7.0%	6.6%	4.2%	4.3%	5.9%	5.6%	3.1%	3.0%	3.7%	4.0%	79.5%	77.5%	74.1%	73.2%
WellPoint Health Networks	7.5%	8.6%	9.4%	NA	6.6%	8.0%	9.4%	NA	5.5%	7.2%	7.9%	NA	77.0%	75.6%	72.8%	NA
PacifiCare Health Systems	4.8%	4.6%	4.7%	4.9%	3.7%	3.9%	4.0%	4.2%	2.4%	2.8%	2.9%	2.9%	84.5%	84.4%	83.6%	83.1%
FHP, International	5.2%	5.0%	5.9%	5.2%	3.6%	3.3%	3.8%	3.4%	1.9%	1.6%	1.8%	2.4%	84.5%	84.5%	82.8%	83.2%
Foundation Health	6.4%	7.2%	8.3%	7.2%	4.6%	5.4%	6.6%	6.0%	4.4%	5.0%	7.3%	4.0%	81.0%	80.1%	78.9%	80.3%
Health Systems International	7.0%	7.7%	8.0%	5.9%	5.3%	6.0%	6.3%	4.2%	3.3%	3.7%	3.8%	1.9%	82.8%	81.0%	80.3%	80.6%
Average	6.0%	6.9%	7.8%	6.5%	3.9%	5.0%	6.5%	5.1%	3.1%	4.1%	5.1%	3.6%	84.6%	83.5%	79.0%	80.7%

(11) Medical Expense as a percentage of Premium Revenue.

Publicly-Held Managed Care Company Comparison

<i>Valuation Multiples</i>	BEV Multiples (LTM)				Market Value Multiples		
	Revenue	EBITDA	EBIT	Commercial Member Equiv.	Net Income (LTM)	Projected 1996 EPS	Projected 1997 EPS
Regional HMOs							
Mid Atlantic Medical Services	0.7 x	41.9 x	68.1 x	\$1,064	55.8 x	NA x	30.7 x
Wellcare Management Group	0.4	NA	NA	\$593	NA	22.1	7.8
Sierra Health Services	0.5	5.7	7.6	\$1,002	11.6	11.1	9.9
Physicians Health Services	0.3	NA	NA	\$480	NA	NA	162.5
Health Power	0.2	NA	NA	\$309	NA	NA	NA
Physician Corp. of America	0.3	NA	NA	\$461	NA	NA	6.7
Coventry Corp.	0.4	NA	NA	\$467	NA	71.3	12.3
RightChoice Managed Care	0.4	18.9	NA	\$517	31.9	NA	34.4
Maxicare Health Plans	0.5	22.6	25.2	NA	18.5	21.4	12.9
United Wisconsin Services	0.2	5.2	5.5	NA	35.0	47.3	20.3
United American Healthcare	0.2	1.8	2.6	\$152	9.3	11.1	NA
Healthsource, Inc.	0.7	13.9	25.6	\$955	35.0	33.9	26.0
Average (12)	0.4 x	11.4 x	13.3 x	\$548	23.5 x	31.2 x	32.3 x
National HMOs							
United HealthCare	0.9 x	14.3 x	18.6 x	\$1,405	25.4 x	26.1 x	21.5 x
Humana	0.5	21.4	63.3	\$870	37.5	20.8	17.9
Aetna	0.7	8.5	45.3	\$2,075	32.9	19.1	15.4
Oxford Health Plans	1.5	25.9	34.7	\$2,620	52.6	47.1	32.7
WellPoint Health Networks	0.7	9.8	11.1	\$977	13.6	13.9	13.8
PacifiCare Health Systems (13)	0.6	11.9	15.4	\$1,080	18.6	19.0	15.8
Foundation Health	0.7	10.3	14.3	\$1,348	14.1	18.2	15.7
Health Systems International	0.5	6.9	9.0	\$771	13.8	14.0	12.4
Average	0.8 x	13.6 x	26.5 x	\$1,393	26.1 x	22.3 x	18.1 x

(12) Excludes Mid Atlantic Medical Services, except for projected 1997 EPS multiple.

(13) PacifiCare acquired FHP on February 18, 1997; combines PacifiCare and FHP results for latest twelve months.

Selected Provider-Sponsored Managed Care Company Comparison

Operating Data (\$ in Millions)

Provider-Sponsored Health Plan	State	Total Revenue				Premium Revenue				EBIT				Net Income			
		LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993	LTM	1995	1994	1993
Mathew Thornton Health Plan	WA	NA	\$167	\$135	\$107	NA	\$164	\$134	\$106	NA	\$2	\$7	\$5	NA	\$6	\$8	\$6
Partners Health Plan of Arizona	AZ	NA	177	154	140	NA	176	153	139	NA	4	3	0	NA	5	4	1
CareAmerica Health Plans	CA	NA	398	430	284	NA	394	428	282	NA	(1)	7	5	NA	3	9	7
Av-Med Health Plan	FL	NA	504	334	302	NA	495	330	299	NA	13	24	20	NA	21	28	23
MEDICA	MN	NA	1,077	883	871	NA	1,043	898	847	NA	(12)	35	18	NA	23	19	42
Health Alliance Plan of Michigan	MI	NA	831	786	709	NA	820	779	702	NA	1	8	3	NA	12	15	10
Capital District Physicians' Health Plan	NY	NA	279	229	193	NA	273	225	192	NA	(3)	6	14	NA	3	10	15
ChoiceCare	OH	NA	298	261	257	NA	286	259	249	NA	(28)	8	4	NA	(16)	10	12
SelectCare Health Plans	OR	NA	206	164	83	NA	204	163	83	NA	(8)	(5)	2	NA	(7)	(4)	2
Geisinger Health Plan	PA	NA	218	197	170	NA	216	196	169	NA	(1)	2	3	NA	1	3	3
Harris Methodist Health Plan	TX	NA	393	296	203	NA	389	294	202	NA	(24)	(22)	1	NA	(20)	(21)	2

Profitability Ratios

Provider-Sponsored Health Plan	State	EBIT Margin				Net Income Margin			
		LTM	1995	1994	1993	LTM	1995	1994	1993
Mathew Thornton Health Plan	WA	NA	1.5%	5.4%	4.9%	NA	3.4%	5.8%	6.0%
Partners Health Plan of Arizona	AZ	NA	2.1%	1.8%	0.3%	NA	2.7%	2.3%	0.7%
CareAmerica Health Plans	CA	NA	-0.3%	1.5%	1.7%	NA	0.7%	2.0%	2.4%
Av-Med Health Plan	FL	NA	2.5%	7.3%	6.6%	NA	4.2%	8.4%	7.5%
MEDICA	MN	NA	-1.1%	3.9%	2.1%	NA	2.1%	2.2%	4.8%
Health Alliance Plan of Michigan	MI	NA	0.2%	1.1%	0.4%	NA	1.5%	1.9%	1.4%
Capital District Physicians' Health Plan	NY	NA	-1.1%	2.5%	7.2%	NA	1.0%	4.2%	7.9%
ChoiceCare	OH	NA	-9.7%	3.0%	1.7%	NA	-5.2%	3.9%	4.7%
SelectCare Health Plans	OR	NA	-4.2%	-3.3%	2.1%	NA	-3.2%	-2.7%	2.8%
Geisinger Health Plan	PA	NA	-0.4%	1.0%	1.5%	NA	0.4%	1.5%	2.0%
Harris Methodist Health Plan	TX	NA	-6.2%	-7.6%	0.4%	NA	-5.1%	-7.0%	1.1%
Provider-Sponsored Health Plan Average		NA	-1.5%	1.5%	2.6%	NA	0.2%	2.0%	3.8%
Industry Average		NA	6.0%	8.0%	7.0%	NA	NA	NA	NA
Regional Publicly-Held HMO Average		1.9%	5.0%	9.3%	9.0%	0.4%	3.4%	8.0%	7.9%
National Publicly-Held HMO Average		6.3%	6.9%	7.8%	6.4%	4.2%	5.1%	6.5%	5.0%

About Shattuck Hammond Partners

Shattuck Hammond Partners Inc. is an investment banking firm specializing in the healthcare services industry with particular focus on the managed care, hospital, physician practice and long-term care sectors. Through offices in New York, San Francisco and Atlanta, Shattuck Hammond provides municipal and corporate finance services to healthcare providers and payers throughout the country. Shattuck Hammond's professional staff of 28 investment bankers makes the firm one of Wall Street's largest firms serving the healthcare services industry. Our managed care experience includes a wide range of provider-sponsored and publicly-traded managed care companies. Recent transactions involving a provider-sponsored managed care company include the following:

Health Direct, Inc. (Chicago, IL)

HMO subsidiary of Advocate Healthcare Network sold to Humana, Inc.

Greater Atlantic Health Services (Philadelphia, PA)

HMO subsidiary of Graduate Health System sold to Foundation Health Systems (formerly Health Systems International)

Physicians Health Plan of South Carolina (Columbia, SC)

Recapitalization and For-Profit conversion of this physician-owned HMO; IPO pending

M.D. Enterprises of Connecticut (New Haven, CT)

For-profit physician-owned HMO sold to Foundation Health Systems (formerly Health Systems International)

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