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Managed Care 2000

Where's managed care headed?

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Not away, in case you were hoping. But just about everything else is up for grabs in dizzying scenarios of the future.

By Ken Terry
Managed Care Editor

As the public continues to express hostility toward managed care, big shots and experts are again debating health care reforms. Does this mean that HMOs and PPOs will soon be history? Fat chance. Nobody except single-payer devotees talks about tossing out managed care; there's no credible alternative.

With that as a given, where's managed care headed, and how will that affect you and your patients? Two things seem certain: First, managed care will change in response to whatever market, legal, or regulatory pressures are exerted on it. Second, insurance companies, like any other businesses, will do what they must to survive and prosper. That means they'll keep trying to influence how you practice, one way or another.

Including HMOs, PPOs, and point-of-service plans, managed care now covers 90 percent of insured workers, over half of Medicaid recipients, and 16 percent of those in Medicare.

During the past decade, according to managed care guru and physiatrist Paul M. Ellwood, it has saved US health care purchasers nearly \$1 trillion. While studies are sketchy, managed care has achieved these savings without causing a documented deterioration in overall patient outcomes.

But managed care has also stirred a powerful public reaction against its limitations on care. And, despite an average 8.2 percent premium hike in 1999 for HMOs, only some of the large managed care companies are reporting profit gains; most smaller plans are losing money, and many have gone bankrupt.

All of this raises serious questions about the future: Given the triple whammy of the consumer backlash, expensive new technology, and a rapidly aging population, can managed care plans continue to control costs? If they can't within the current system, how will employers deal with high annual rate increases? Will consumers pay significantly more for health care, or will health plans gouge more out of physicians and hospitals?

Also being hotly debated is the future of Medicare managed care. HMOs are continuing to leave the Medicare program or cut back their participation, mainly because of what they deem to be insufficient payments. Many of the plans that remain are charging higher premiums and requiring members to pay a bigger share of drug costs. Consequently, enrollment in senior HMOs has remained flat for the past two years. So physicians needn't worry that most of their Medicare patients will join HMOs any time soon.

Medicaid is a different story. According to InterStudy, enrollment in Medicaid plans jumped 23 percent last year, on the heels of a 46 percent increase in 1998. Medicaid HMOs have pulled out of some markets, and there's been concern that many more might follow. But a 1999 InterStudy poll showed that only 7 percent of Medicaid HMOs planned to reduce their service areas, and 26 percent intended to expand them.

Looming over all of these issues is the problem of the uninsured, now approaching 45 million. Since there's little support for a single-payer system, health care experts and policymakers have been focusing on free-market solutions. The most prominent of these is the idea of enabling—or even requiring—individuals to purchase health insurance with some combination of tax credits and voluntary contributions from employers.

By giving employees a set amount of money for insurance

instead of buying it for them, employers would limit their financial exposure. But this "defined contribution" approach would also burden consumers and the government with a higher portion of health care costs. One reason it's being considered seriously right now: Uncle Sam is flush with cash.

But why should the government fork over more to cover everyone? Because if enough people become uninsured, perhaps during an economic downturn, the free-enterprise health care system would be endangered. Political pressure would build for the Feds to take it over and institute a tax-supported single-payer system.

"I don't think there's any chance of the government taking over everything, a la Medicare or the Canadian system," says Ellwood, who's president of the Jackson Hole Group and InterStudy. "But the chance of the government assuming greater financial responsibility for making sure that everyone has health insurance is very high."

Short-term solutions to long-term problems

While these enormously consequential changes are discussed behind the scenes, managed care companies are struggling to keep up with a consumer-driven market that demands greater access to providers and coverage of everything from Viagra to fertility treatments. As long as the labor market is tight and profits are up, many employers are willing to subsidize the cost of rich benefits and broad physician panels. But what will happen when there's an economic downdraft, or if PPOs start costing much more than HMOs? Will HMOs continue to become more like PPOs, or will they grow more restrictive?

The commercial market share of closed-panel HMOs has remained flat at about 30 percent for the past two years, while the PPO market share has jumped to 43 percent. When consumers have a choice, they're likely to select a PPO or a point-of-service plan. While the cost spread between HMOs and the more loosely managed plans isn't huge, this trend places an additional burden on employers, who are reeling from substantial rate hikes in all insurance lines. In a recent survey, however, only 15 percent were trying to control costs primarily by raising employee contributions.

Much of the current pressure to raise premiums results from plans' being forced to offer more services and let people seek care out of network, notes Melissa Gannon, vice president of Weiss Ratings, a credit-rating firm based in Palm Beach Gardens, FL. But in the long term, she thinks employers are more likely to ask their employees to pay extra than to return

to traditional, closed-panel HMOs. "I don't believe consumers will ever go back to pure HMOs," she says. "They just won't stand for it."

Another observer disagrees. While plans might never be as restrictive as they once were, purchasers might again favor closed-panel HMOs over PPOs, says Richard G. Shaw, managing senior financial analyst for A.M. Best Co., an insurance-rating company in Oldwick, NJ. This could happen, in his view, because the gap between HMO and PPO premiums is bound to widen. Despite their current difficulties, he says, HMOs are in a better position to manage costs than PPOs, which rely mostly on discounting of provider charges.

Neither Shaw nor Gannon believes managed care plans will continue to cut physician compensation to the degree they have in the past. It's hard to imagine doctors getting paid much less than they already do in California, where the premium cuts of the last few years have driven some groups and IPAs into bankruptcy (See [The California nightmare: Is this where managed care is taking us?](#), Jan. 24, 2000). But elsewhere, in the view of HMO executives, there's still fat to trim, and some intend to bargain even harder in the future.

That could accelerate counterattacks by physicians and hospitals. More and more of them are walking away from contracts they deem unfair, both individually and as part of provider networks. In Orange County, CA, Phoenix, and Kansas City, HMOs have had to make concessions to provider groups.

Meanwhile, HMO executives are split on where further savings can be found. Oncologist Lee N. Newcomer, senior vice president, health policy, for UnitedHealth Group, advocates passing on more costs to consumers, as many plans already have with tiered copayments for prescription drugs. But FP Sam Ho, vice president and corporate medical director for PacifiCare Health Systems, believes the answer lies in contracting with physicians more selectively.

While consumers would complain, some large corporations would be delighted with smaller, more cost-efficient networks. In a recent issue of *Health Affairs*, internist Robert S. Galvin, director of corporate health care for General Electric, said that since "supply creates demand," the only way to contain costs is to reduce the number of physicians and hospitals.

"From purchasers' point of view," he noted, "overcapacity in health care is still the big issue, from an oversupply of hospital beds to a great excess of specialists. And as employers have learned, all of the process improvement in the world will not

lower a cost base unless capacity is addressed."

Physicians mistrust HMOs' stress on "quality"

Despite the overcapacity, physicians have a relatively small chance of being terminated by an HMO or a PPO. "One of the profound changes in managed care over the past five to seven years is the move from small, selective networks to large networks," notes internist Allan J. Chernov, regional medical director, southwest region, for Aetna US Healthcare. "So you're not motivated to deselect doctors. We have relatively low network turnover, and most of that is voluntary."

PacifiCare's Sam Ho feels that employer demands for access to all willing providers have hampered the ability of HMOs to compete on the basis of quality. But purchasers are much less interested in quality than in cost and access. As a result, few HMOs have invested heavily in clinical quality improvement.

"Most managed care organizations are not in the business of managing health care or population health," says preventive medicine specialist David M. Lawrence, CEO of Kaiser Permanente. "They're in the insurance business. And most plans don't provide enough patients to individual doctors or groups to influence them very much. That's why they've had to use rather punitive methods for controlling utilization. Those methods have been unpopular and have created a huge backlash."

Partly to placate physicians and consumers, and perhaps with an eye on their increased legal liability, HMOs are reducing micromanagement of medical decisions. The most obvious example is UnitedHealthcare's move last year to eliminate prior authorization of most referrals, tests, and procedures. Other plans haven't gone that far yet. But Aetna has dropped some of its precertification requirements, and PacifiCare has opened up access to specialists. Meanwhile, many plans have replaced utilization incentives with quality incentives, which physicians consider more appropriate.

If United can control costs without prospective utilization review, it's likely that other plans will follow its example. But Paul Ellwood is skeptical. "Lee Newcomer is arguing that if United focuses on quality, that will contain costs," he says. "But any arrangement that focuses on quality is going to involve some selection of doctors by the health plans." United doesn't seem ready to make that plunge, says Ellwood.

United does track all of its doctors' utilization patterns, notes Newcomer: "We have good profiling systems that allow us to

identify outliers pretty fast." If a physician is using much more resources than his peers, and there's no obvious reason such as a big AIDS practice, the HMO would try to change that doctor's practice patterns through education and feedback. But rarely would such a doctor be dropped, maintains Newcomer. "The only reason we'd do that is if the guy is practicing against his own professional standards," he explains. "If the physician says, 'I don't care what the guideline of my specialty society says,' we wouldn't want him in our network."

Some doctors, however, distrust United's intentions. Family practitioner Frederic F. Porcase, leader of a primary care group in Jacksonville, FL, believes United has decided to terminate its outliers rather than fight physicians over authorizations. "Now that they've got data on the doctors who are costing them too much money without showing better outcomes, they're going to start bumping them off," he says. "And with that kind of peer pressure, all the other physicians will fall in line."

Welcome to the wonderful world of physician report cards

Some HMOs and business coalitions have started to publish report cards on the clinical performance of medical groups and IPAs. Sam Ho argues that group report cards, such as those of PacifiCare, Health Net, and the Pacific Business Group on Health, can persuade consumers to choose doctors in the higher-quality practices. That would help PacifiCare achieve its goal of reducing the size of its networks.

"We'd like the marketplace to vote with its feet," declares Ho. "We'd like to reward the best performers and give patients access to the best providers." PacifiCare's 18-month-old Quality Index, which rates groups on 28 indicators of clinical quality, access, and patient satisfaction, has already begun to have an impact on the market, says Ho. In the first open enrollment season, he notes, there was a "significant migration" of PacifiCare members toward groups that scored high on the Quality Index.

Some of this shift may reflect the attraction of groups that offer PacifiCare's Express Referrals program. But Ho hails it as a sign of "a new age in managed care, where everybody's going to win. Consumers will get access to the best care and the best service. Providers, for the first time, will be rewarded for good performance in terms of market share. And if that happens, they'll improve."

Even if Ho's right, the movement toward group report cards has a long way to go. Currently, they're used mainly on the West

Coast, where large capitated groups and networks prevail. It's unclear whether the same approach would work with the smaller practices and looser networks that claim the majority of doctors elsewhere.

Where there are no group ratings, consumers can look at comparative quality data on HMOs. But they tend to ignore that because they associate quality with physicians, not health plans. What consumers need and want, say Paul Ellwood and others, is information about the clinical performance of individual physicians.

This idea may strike some observers as premature. After all, outcomes research is still in its infancy, and attempts to rate physicians on process measures have been plagued by problems related to inadequate sample size. But new doctor-measurement systems are waiting in the wings. The Foundation For Accountability, a consortium of public and private purchasers and consumer organizations, is about to launch an Internet-based program that will help consumers evaluate the care they receive. And UnitedHealthcare, which is profiling 42,000 physicians on selected clinical indicators, has said it will eventually publicize its data on individual doctors.

When patients become the insurance buyers

Whatever type of quality data eventually catches on, the real breakthrough will be the ability of patients to choose physicians on the basis of something more than hearsay. Such a development would complement other forms of patient empowerment, such as e-mail communication with physicians, access to health care information on the Internet, and insurance coverage of alternative therapies.

While consumers have increasing numbers of choices in these areas, most are still unable to select their own health plans or menu of benefits. The vast majority of employers who cover their employees offer only one plan. And though two-thirds of workers—most of them in larger companies—have a choice of plans, they're usually confined to just a few.

The AMA would like to change that. For the past two years, the organization has been pushing for a new relationship between employment and insurance. The AMA's idea is to have employers give their employees vouchers to buy health insurance. Consumers could choose any plan they wanted, but would have to pay the difference if it cost more than the "defined contribution" they got from their employer. There would be a system of tax credits to subsidize the purchase of health insurance by the less affluent.

Why does the AMA support such a major change in the health care financing system? "Choice is an American phenomenon, and the public wants choice," says FP Nancy W. Dickey, immediate past president of the AMA. "Second, the market is a marvelous enforcer. If people buy something, and they don't get the service they perceive they purchased, having the opportunity to switch to another product is the single most effective thing they can do to shape the product. Under the AMA proposal, the vast majority of people would be moving in that direction.

"Third, we believe it would have an impact on the cost of health care. People would select plans that give them what they need. But because of the defined contribution, they'd be less likely to choose excessive coverage. And where they have copays, deductibles, or out-of-pocket expenses, they're much more likely to ask questions and forgo marginal or questionable kinds of diagnostic or treatment interventions."

While there'd be nothing to prevent patients from choosing the cheapest HMO in the market, Dickey believes the kind of financing system favored by the AMA would furnish the basis for a realistic dialogue between doctors and patients. Instead of just commiserating with the patient about the refusal of the HMO to cover something, the physician could suggest that the patient switch health plans at the next opportunity.

Approaches similar to the AMA's have supporters in Washington and on the campaign trail. Former Democratic candidate Bill Bradley, for instance, has suggested enrolling the uninsured in the Federal Employees Health Benefits Program, which offers a large menu of plans. Republicans in Congress, meanwhile, have proposed altering the connection between health insurance and the workplace and requiring consumers to buy insurance with the help of tax credits.

Even if this change were politically feasible, there would be some major transitional problems, notes Ellwood. "Once the government commits to completely tax-deductible health insurance for those who can afford it and requires that people have coverage, my feeling is that employers will simply get out of it. They'll say, 'We'll pay you for your health insurance, and you go out and buy it.' But this rush to leave health insurance by employers would create chaos. So we need some kind of transitional arrangement."

David Lawrence of Kaiser sees the system changing very slowly, because well-insured employees don't want to upset the applecart. This was clearly shown recently when Xerox floated a defined-contribution voucher proposal and had to back down in

the face of worker protests.

"Our view is that the trend is going to develop slowly until such time as unemployment rises or the economy begins to tank," says Lawrence. "At that point, we think it'll accelerate as employers look for opportunities to have more control over health care costs. The choice will go to the consumer, and the consumer will begin to organize his or her demands quite differently, with money to back up those demands."

Will doctors be able to provide all the care there is to give?

Even if the US discards employer-based insurance, the imperative to contain costs will remain. In 1998, we spent 13.5 percent of our gross domestic product on health care. Victor R. Fuchs, a Stanford health economist, predicts that caring for the soaring number of elderly alone will take 10 percent of the GDP by 2020. Add in the costs of new drugs, new procedures, and new technologies based on genetic manipulation, and health costs could ascend into the stratosphere. Hence the need for managed care, or something like it, should increase over the next 10 to 20 years.

Will the managed care of the future be friendlier to doctors and patients, or will it be even grimmer, chopping compensation and terminating physicians with a meat-ax? The state of the economy will determine part of that. But in the long run, the answer lies with doctors and patients.

As health care quality expert David M. Eddy has pointed out, we are in the midst of a messy transition from the fondly recalled days of freewheeling fee-for-service to a new era of cost-effective, population-based health care. In Eddy's view, the hardest part of this transition is getting patients used to the idea that they can't have everything they want, and getting doctors accustomed to basing decisions on what's best for a population, rather than for each patient who comes to the office (See [What defines a good doctor is about to change](#), Apr. 28, 1997). Managed care drug formularies are a good example: If a particular drug is marginally better than another, but costs five times as much, the physician is supposed to prescribe the slightly less effective agent.

Population-based care also relies on clinical guidelines that allegedly reflect the best evidence in the literature. To HMO executives, it's axiomatic that getting doctors to practice evidence-based medicine will both improve quality and lower costs. But the science often isn't clear, and that can cause problems.

FP Nancy Dickey, who practices in rural Texas, notes it's uncertain how often physicians should screen for kidney or thyroid problems. To do so frequently on all patients would be clinically inappropriate and very expensive. The same applies, she says, to the preventive use of drugs such as cholesterol-lowering medications. Whether they'd be right for an asymptomatic patient would depend on that patient's cholesterol level, family history, weight, ability to diet, and other factors. "For whom are we willing to pay for the drug?" asks Dickey. "I'm not sure we've answered that question, or others like it, as a society."

Kaiser's David Lawrence objects to requiring doctors to make such decisions on their own. "We should agree as a society on what services to cover, the way Britain has, rather than forcing those choices down to the level of a physician or a health plan," he says.

Former Colorado Governor Richard Lamm has cited the Oregon experiment with Medicaid rationing as an example of how society can make these vital choices. Oregon residents attended town meetings and public hearings to discuss which services to cover. A state commission based recommendations on the citizens' input, and the legislature appropriated funds accordingly.

Perhaps that concept could be expanded to virtual "town meetings" on the Internet, with consumers voting electronically on which services they think are most important. The results could be incorporated into standard benefits packages that all plans would have to offer.

This approach needn't cut doctors out of the loop. Physician committees designated by professional societies would help draw up the choices to be presented to voters, and doctors could advise patients on the options. If consumers prioritized the care they wanted, rationing could be done on the basis of societal values, rather than just money, and doctors would be able to sleep better at night.

A population-based approach to care may be inevitable, but it will not be easily accepted. Patients want the best care they can get, and physicians want to provide it to them. Doctors don't want to weigh the value of heroic measures to save a 90-year-old patient with CHF against the value of giving more poor women mammograms. And they don't want to be judged by the sheer number of services they use.

Managed care plans have stumbled badly by overemphasizing costs. Penalizing doctors for overutilization has proved

counterproductive, and placing them at financial risk has made many physicians feel morally compromised. But the plans won't give up trying to bring doctors around. Most likely, they'll use some combination of quality and financial incentives, profiling, and feedback to persuade physicians to choose what's best for the population—and for the plan.

HMOs and PPOs: Two peas in a pod?

Now that PPOs are the largest and fastest-growing form of managed care, HMOs are imitating some of their features. At the same time, as costs escalate, PPOs are becoming more like HMOs.

While traditional PPOs rely on discounting and retrospective review, about 30 percent take financial risk for care, and many designate primary care doctors as gatekeepers. An increasing number of PPOs, even those that don't take risk, are aggressively managing utilization, says Gary Carneal, president and CEO of URAC, which accredits PPOs, UR firms, and other health care entities. For example, he notes that PPOs' use of drug formularies has doubled since 1994. According to the American Association of PPOs, 72 percent used formularies in 1998, and about the same number retained pharmaceutical benefit managers to control drug costs.

PPOs are also becoming more interested in improving the quality of care. "PPO managers are now engaged in discussions of how they can better manage care," says Carneal. "So they're carrying the torch for the positive side of the managed care industry, which has been successful in many ways, once you move beyond the anti-HMO rhetoric."

That anti-HMO sentiment—and the political explosion it has set off—greatly concern AAPPO President Karen Greenrose. She's afraid that if Congress passes strong patients' rights legislation, including the right to sue HMOs, PPOs will be next on the hit list.

"I'm concerned about the liability issue," she explains. "I don't think the answer to patients' rights is trial attorneys. A more appropriate answer would be external review guidelines with some real meat in them." Right now, she adds, most PPOs have internal appeal processes, but not external review.

In other ways, PPOs and HMOs are becoming more alike. For instance, all PPOs have an out-of-network option, but so do point-of-service HMOs. PPOs have borrowed from HMOs the

concepts of per diem payments to hospitals and fixed patient copayments. Both kinds of plan determine medical necessity, and some PPOs are adding prospective reviews. Meanwhile, UnitedHealthcare has stopped doing preauthorizations, pays doctors fee-for-service, and has open access to specialists. In many ways, it looks like a PPO.

United has always avoided capitation and allowed self-referral to specialists. But other HMOs are still much more restrictive, and 44 percent of all physicians accepted capitation in 1998, up from 40 percent in 1996. (See [Capitation on the rise](#), Dec. 6, 1999).

Internist Allan Chernov, regional medical director, Southwest region, for Aetna US Healthcare, strongly defends capitation in the context of Aetna's quality incentive program. "We believe this is an appropriate way to compensate physicians fairly for the work they do and create a climate linked to their compensation that encourages quality work," he says.

That might surprise some physicians who don't feel Aetna reimburses them fairly and who think its oversight *reduces* the quality of their work. But that's why HMOs—if they remain HMOs—will never be PPOs.

Groups are no longer the model

Back in 1970, when the Nixon administration decided that HMOs could help control health costs, it believed that prepaid care would encourage doctors to form groups that would allow them to practice more efficiently. The models were large group practices like the Mayo Clinic, Group Health Cooperative of Puget Sound, and Kaiser Permanente.

Those organizations are still around, but many others have fallen by the wayside, especially in the last few years. Beset by declining reimbursement, mismanagement, and consumer preference for a wide choice of providers, many group practices aligned with hospitals, PPMs, and HMOs, as well as some run by physicians, bit the dust. Staff-model HMOs' membership has declined to 1 percent of the HMO total. The venerable Harvard Pilgrim Health Care, built around a core group, recently went into receivership. Kaiser is still hauling itself out of a \$500 million financial hole.

Thousands of physicians in groups owned by PPMs like FPA, MedPartners, and PhyCor are now starting new practices or trying to put their old ones back together. Meanwhile, an

astounding 33 percent of integrated delivery systems have turned their employed physicians loose, rather than continue to lose money on them.

"Those weren't real groups," says Kaiser Permanente CEO and preventive medicine specialist David M. Lawrence. "The difference between the Mayo Clinic or the Cleveland Clinic and a lot of what has formed and disbanded is like night and day. When your purpose is to integrate medical practice, that's like what the Mayo brothers created in the late 1800s. When you create a group to be effective in negotiating with the insurance industry, that's a whole different purpose—and those groups haven't done very well. Most were amalgams of individual doctors who had no history and no experience of working collectively."

There's much truth in this, although some groups that have run into trouble—like the Burns Clinic of Petosky, MI, and New Orleans' Ochsner Clinic—have a long and distinguished history. But the larger point is that the percentage of doctors in group practices has leveled off.

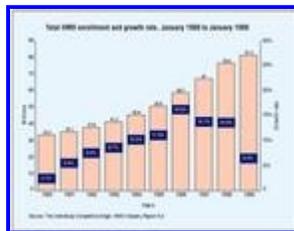
From 1995 to 1997—a period that predates the bulk of the group failures—the number of physicians in group practices fell 2 percent, to 206,557, according to AMA figures. At the same time, groups were getting bigger: Between 1996 and 1998, the percentage of doctors in practices of more than eight physicians increased from 18.7 percent to 23.3 percent. So while successful groups are continuing to grow, it doesn't appear that group practice is going to dominate health care anytime soon.

"I don't think the traditional multispecialty practice has a very bright future," says physiatrist Paul M. Ellwood, president of the Jackson Hole Group and InterStudy and a longtime proponent of group practice. "This has as much to do with economics and organizational ability as it does with the merits of practicing in that kind of setting. It's obviously desirable if you can make it work. But when multispecialty groups are subjected to severe economic pressures, such as those generated by managed care, they have trouble making it."

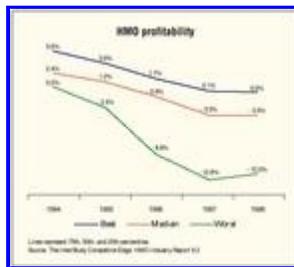
It is indeed ironic that big groups, once the fountainhead of managed care, have now become its victim. But that still leaves the problem of how to get doctors to work together in interdisciplinary teams that can deliver optimal care at the lowest cost. Ellwood's solution is to form salaried primary care groups, each taking risk from a single HMO and contracting out for specialty services. IPAs, he thinks, are mainly negotiating entities that have little ability to coordinate or improve care.

Lawrence, in contrast, foresees "virtual groups" of physicians springing up, united by the Internet and cooperating in many of the same ways that doctors do in financially integrated groups. These could be IPAs, such as Hill Physicians Medical Group, which not only has proved effective in controlling costs but also is wiring its doctors' offices together with the help of Healtheon/WebMD. Lawrence adds that he's seen several other examples of this around the country.

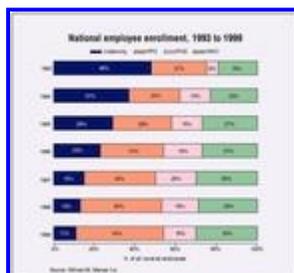
"Today, roughly three-quarters of doctors practice in groups of fewer than 10," he notes. "You're not going to pull them out and form megagroups like ours or the Mayo Clinic. But they are going to be under increasing pressure to obtain greater efficiencies and better outcomes. So they'll have to figure out ways to work more effectively together without abandoning the small-group setting."



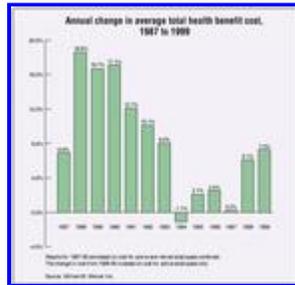
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