Health care: The rise of the HMOs

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This article is the second in a series on health care reform. Our new health care law, aka Obamacare, has a myriad of features. It is extremely difficult to anticipate what their effects will be in the short run, let alone in years to come.

As with most complex systems, the "devil is in the details." This law has so many details there may be a lot of devils. Let us hope there are a few "angels" hiding in there as well. But before I try to wade through the new law, let's look back to see how we got to where this law became necessary.

The HMO Act of 1973

Richard Nixon is given credit for starting the HMOs. The story as I understand it is that Lee Iacocca, CEO of Chrysler at the time, went to the president complaining of the cost of health care to his company. He shocked the president by telling him that his company spent more on health care than they did on steel. This put American car makers at a decided disadvantage with the Japanese who did not have to pay for the health care of their workers at all. The Nixon administration responded with the HMO Act of 1973. It is said that he had the very successful California-based medical organization, Kaiser-Permanente, in mind at the time.

The HMO Act of 1973 designated the HMOs to be not-for-profit entities, but during the Reagan years of deregulation this requirement was dropped, and state-by-state the for-profit HMOs took over the playing field. The 'for-profits' were allowed into the New York market about five years after they got started in the west. So when a very attractive young lady, who will be known in this article as "Winkie," entered my office in 1986, the for-profit

HMO formula was well established in places like California, Minnesota and Arizona, but most of the New York docs, including me, had never even heard of it.

HMOs

Winkie's presentation totally blew me away. It wasn't her attractiveness, or her frequent winks, it was the insurance plan that she proposed. She described something like this ... I kid you not. Let's say a single man aged 40 paid $2,000 per year to Some New Insurance Plan (SNIP.) SNIP would create three funds: $500 for the primary care doc and whatever tests and medication he ordered; another $500 for specialty care; another $500 for hospital care; and the final $500, out of the original $2,000, was for the HMO's administration and profit margin. Now $500 for specialty care or hospital care might not sound like a lot, but if you consider that the vast majority of healthy people don't use either in a given year, setting aside $500 per patient leaves plenty to pay for those who do.

The HMOs had plenty of statistics by this time and they knew exactly how much a given group of patients would need. Most importantly, their statistics told them that if the primary care doc was a "good gatekeeper" he would average way less than $2,000. If he was a leaky gatekeeper, he might average more. Their plan was to make the good gatekeepers fat and happy, and get rid of the bad gatekeepers. This is how they did it. At the end of the year, if there was money left in any of the funds, it all went to the primary care doc (… wink … wink). Let's do some math. Let's say a primary care doc has a "panel" of 500 SNIP patients. (Average family doc has 2,000-3,000 active patients.) Winkie told me that these people would average 3.1 visits per year to my office. (I subsequently kept the records and she was exactly right.) Out of the $250,000 that was in the primary care fund (500 x $500) I got a "capitation" of about $15 per patient per month. That adds up to $15 x 12 months x 500 patients = $90,000. Not bad. But there was still $160,000 in the primary care fund as well as

$250,000 in the specialty fund, and $250,000 in the hospital fund. If I could keep my patients out of the hospital and away from the specialists, I got whatever was left in those funds. A reasonably good gatekeeper who didn't refer or hospitalize unnecessarily could easily get the kind of bonuses usually reserved for Wall Street.

Implications of HMOs

Let's see who benefits and who gets hurt from this. The primary care doc could do great depending on his or her practice style. The specialists, obviously, hated it. The hospitals hated it. Employers liked it, since it worked, and was much less expensive than other plans. SNIP did great. They expanded like crazy. The patients didn't really know what was going on. In fact, that HMO contract I signed prohibited me from revealing the plan to anyone. I'll reassure you that this system existed in our area for only a brief period of time before Congress appropriately abolished it. But let's consider whether the patient's interest was really endangered.

Effect on patients

The reason that Congress abolished Winkie and friends is that they judged it to be coercive on the docs. It certainly was extremely coercive, I have no argument there. For the brief period of time that I worked under it (months, I think) I was very uncomfortable with it. In fact I think I referred more liberally with my capitation patients out of fear of being accused of "gatekeeping-for-profit."

That said, I contend that the current fee-for-service system is just as coercive, but in the opposite direction. To demonstrate what I mean, let's create a hypothetical situation:

You've just arrived in a foreign country. You are sick and you think that there might be something seriously wrong with you. You are directed to a medical office. As far as you know the doctors in this country are generally

good, well-meaning docs. They tell you that they run a dual system. If you walk through door 'A' you see a doc whose financial incentive is to do more. If you walk through door 'B' you see a doc whose financial incentive is to do less.

Now, we all understand that in a perfect world both docs would give the exact same care, but the world as we know it is not perfect. Which door do you walk through?

Part 3 in the series is scheduled for the issue of Dec. 2.

Dr. Alan Cooper, retired, maintained a family practice of medicine for many years in the Three Village area. Consult your physician for personal medical decisions and care.