An HMO with Private Family Physicians Coordinating Care and Controlling Costs

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There has recently been a renewed interest in controlling the escalating costs of medical care by allowing different types of delivery systems to compete for patients. This renewed interest in control of medical costs through private sector alternative delivery systems has resulted in the creation of several new systems. To most physicians, health maintenance organization (HMO) means the traditional, closed panel HMO in which physicians are on salary and patients have to come to a central facility in order to obtain health care. As a result of stiff competition for patients, several types of private practice HMOs have now started forming. The most common are those in which an existing group practice develops its own HMO benefit package and markets it to employers in that area, thus requiring patients to come to that group practice in order to get their health care. Another common type is the independent practice association (IPA), which is a more loosely organized network of private practice physicians. This plan has large numbers of physicians of all specialties participating so that the employee can usually remain with his or her existing physician and still obtain the more comprehensive benefits of the IPA plan.

There are several major differences between the IPA and the closed panel HMO. With the IPA, private physicians continue to see patients in their own offices rather than in a separate facility. They are also free to serve all patients, not just those enrolled in the plan. They usually continue to be paid on some form of fee for service rather than salary. However, a risk sharing system is built around the principle that in order for each participating physician to collect his full fees, the plan must have money left after paying for other services. When this risk sharing system in the IPA is not taken seriously at the individual physician level, the plan usually has to implement some controls on use of the hospital. If the private physicians are able to lower the use of the hospital, then the IPA does become an efficient delivery system within which private physicians can compete for patients who are now being taken away by closed panel or group practice HMOs.

Increasingly, the IPAs, as well as the group practice HMOs, are coming to rely on a "gate-

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keeper" or "coordinator" role for the primary care physician. This new dimension to the traditional IPA has been termed the "primary care network."[1] Many group practice HMOs, such as the Med Center Plan in Minneapolis, Minnesota, the Blue Cross Take Care Plan in northern California, and the Lovelace Health Plan in Albuquerque, New Mexico, all ask that the patient consult a primary care physician before seeing a specialist. The rationale for this "channeling" of patients through primary care physicians is to create the role of coordinator and financial manager for one physician in the delivery system. The hope is that it will eliminate duplicated services and encourage, through incentives and education, one physician to take financial responsibility for total patient care. Many of the new traditional IPAs are also introducing this additional dimension into their delivery system. Several primary care network plans are modeling their whole delivery system around well-chosen broad based family physicians who use only the most cost-effective specialists. These plans are those which provide the most viable alternative for an independent solo or small group physician to compete for patients being pulled away by closed panel or multispecialty group plans.

The United Healthcare Plan

An example of a primary care network IPA is the United Healthcare Plan of California and Washington. United Healthcare is a prepaid insurance plan that depends on private practicing physicians to deliver care in their own offices. It currently has about 40,000 enrollees and 700 primary care physicians, 40 percent of whom are family physicians or general practitioners.

Thirty percent of these primary care physicians are in solo practice and 70 percent are in partnerships or small groups. The plan is marketed to groups of employed persons by the SAFECO Insurance Company in northern California (since 1975) and in Washington State (since 1976). It was initially called Northwest Healthcare in Washington State and the SAFECO Health Foundation in California but is now referred to as United Healthcare. The plan is currently being sold by its original owner, SAFECO.

There are three important features in the United Healthcare system. First, the entire health care delivery system is organized around the primary care physicians. These primary care physicians become the "general managers" or "gatekeepers" for specialty referral, emergency room use, and hospital admission. Each family member must select one primary care physician from the list of physicians who have contracted with the plan. An adult may choose either an internist or a family physician. A child can choose either a pediatrician or a family physician. The enrollee is then required to have all care coordinated and approved by that physician. If the enrollee goes to a specialist or emergency room without the physician's approval, he or she must pay the bill unless it is authorized in retrospect by the designated physician. All authorized care is paid out of the physician's account, except the patient must pay a $4 charge for prescriptions, a 50 percent copayment for mental health care, and a $50 charge for each emergency room visit.

The second feature of the United Healthcare plan is that each family physician becomes the financial manager for the costs of care to his or her patients. The family physician is responsible for controlling the use and costs of all health care services for patients who choose him as the coordinating physician. An account (Figure 1) is set up for each participating physician. The plan puts a specific amount of money (determined by the age and sex of the patients) into this account on a monthly basis and leaves it to the physician to manage that account in a cost-effective way. The physician is reimbursed for office and hospital visits on a fee-for-service basis from that account. Normally, between 25 percent and 35 percent of this account goes to pay the family physician's charges for pirmary care rendered. The remainder of the account is used to pay for referral care, including hospitalization but not out-of-area emergencies. This includes laboratory or x-ray work done outside the physician's office, referral specialist professional fees (usually by fee schedule), emergency room charges, and prescriptions. The United Healthcare plan pays these charges out of the account only after the primary care physician has reviewed and authorized the bill. This serves to promote cost consciousness in making future

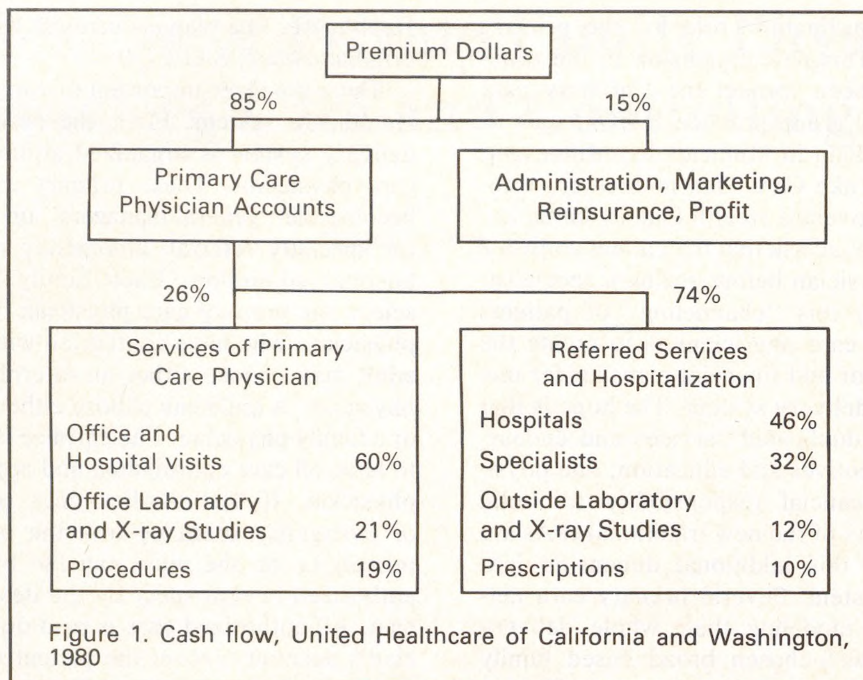

Figure 1. Cash flow, United Healthcare of California and Washington, 1980

referrals by educating the primary physician about charges for various procedures and specialists. It also deters overcharging by specialists. A monthly financial statement summarizes how the dollars for all medical care have been spent out of the account.

In addition to the education about the costs of care, there are incentives and penalties to encourage the family physician to take seriously his new role as coordinator and financial manager for total patient care. At the end of the year any deficit or surplus in his account is shared between the physician and the plan. If there is a deficit, the physician is required to pay a maximum of 20 percent of his fee-for-service billings back to the plan. If there is a surplus in the account, he keeps 50 percent of it. Catastrophic costs (more than $5,000 per year per patient) are removed from any risk sharing arrangement within the account and paid for by the plan.

The purpose of these financial incentives is to give each family physician a reason to be concerned not only with quality and convenience of care but also with cost. This coordinator and gatekeeper role is one frequently assumed by the family physician in the past, but he was usually not reimbursed. In this system the efficient and cost-effective family physician not only collects his own fees but is rewarded for good management at the end of the year with a 50 percent share of any surplus in the account. Because each account is individual, one physician's efficiency is not diluted by another physician's inefficiency.

The uniqueness of this United Healthcare system lies in its ability to place with the individual physician the incentive for the plan to succeed. The individual physician has been put at risk for most of the costs of medical care. An attempt is made to create a more equitable account by limiting the risk to $5,000 for each patient during the year. With small numbers of patients an occasional accident or uncontrollable rare event will penalize a physician's account unfairly, but the inequities are outweighed by the usefulness of individual accountability.

Initially, the United Healthcare plan chose to

leave the cost effectiveness of the consultants up to the primary care physician. An attempt was made to educate primary care physicians about average costs for certain procedures and hospitalizations and rely on them to monitor utilization of hospital by the consultants. When hospital use patterns were monitored, there were such wide variations in the length of stay for the same procedure or episode of illness that the plan administration thought it was necessary to become more involved in the delivery of medical care than was planned in the beginning. It was initially hoped that primary care physicians would watch hospitalization habits of their consultants carefully, since payment was coming from the primary care physician's account. However, such was not the case.

With hospital costs averaging $390 per day, they were easily the largest factor in the total costs of care. To stop the excessive hospital costs and help the primary care physician and the plan have adequate money in the account to pay for all care, standards and criteria were developed for hospitalization and length of stay. It was relatively easy to have a group of physicians agree to standard lengths of stay for surgical problems and agree to authorize with the medical director's office any complications or exceptions. This is a job better done by the United Healthcare plan than by the individual primary care physician, who does not feel comfortable as the "policeman" of the consultant. During the first three years of the plan, it became clear that the primary physician is interested in coordinating care and deciding when a referral is appropriate, but he is not interested in watching and trying to influence the consultant about outpatient workups or hospital length of stay. The task is neither familiar nor enjoyable to a busy primary care physician.

Standards and criteria were developed with the help of consultants and applied to elective surgery or elective procedures. It was impossible to create standards for medical conditions such as congestive heart failure or gastrointestinal bleeding. After the standards were created, consultants were approached on the basis of recommendations by the primary care physicians. If they agreed to preauthorize hospital admissions, to cooperate with the standards on length of stay, and to accept a maximum fee schedule for their own services, they were listed on the panel of participating consultants. Use of these consultants by the primary care physician has been required except in extenuating circumstances or emergencies.

Since these controls have been installed, there is much less variation in hospital costs. For example, all patients with uncomplicated deliveries are home in two days, hysterectomies in four, transurethral resections of the prostate in three, and hernia repairs in one. All tubal ligations, dilatations and curettages, ear tube insertions, and tonsillectomies are performed as outpatient procedures.

In addition to emphasizing to physicians the importance of controlling the costs of hospitalization, the plan has used incentives with patients. The historical precedent of paying more if the patient is hospitalized has been reversed. The plan will pay 100 percent of all charges if the workup or surgery is performed on an outpatient basis, but the patient is billed for $80 for each day of overnight stay. This puts pressures on patients as well as physicians to lower hospitalization rates.

Incentives for the pharmacist have also been used to lower pharmacy costs. A guarantee of $8 per prescription is paid to the participating pharmacy. Any saving he can accomplish within that fixed fee is his to keep. This encourages use of generic drugs rather than name brands. When physicians agree to a standing substitution order for high-quality generic drugs, this allows the pharmacist to lower the cost of prescription drugs to the benefit of everyone.

Future of the Primary Care Network

The United Healthcare network has learned some important lessons in its first five years. The first and perhaps most important is that it is possible to gain widespread participation from independent physicians in office practices. This model provides an alternative to the traditional closed panel HMO. It is flexible and does not require large start-up costs because it does not have to build facilities and hire physicians. It is more acceptable to patients because physicians are more accessible geographically in the community. It allows a wider range of choice of physicians than does the traditional HMO.

This model is the only viable alternative for the solo or small group primary care physician or consultant. Most of the new nontraditional HMOs (nonsalaried physicians) are being built around existing multispecialty group practices. The primary care network model is the only one, except the totally open independent practice association, which allows small independent groups to compete for patients.

The second important lesson is that this more open primary network approach can only successfully compete if it becomes an efficient system of cost-effective physicians delivering high-quality services for a lower total cost. The most important ingredient to that success is the level of involvement and commitment by the participating family physician. Unless he or she takes the role as gatekeeper and financial manager for total patient care seriously, the plan cannot succeed in competing with the closed panel or group practice HMO.

The family physician must become a more cost-effective physician who is willing to take costs of care into consideration in his decision about what is appropriate care. This is an unfamiliar and difficult task, especially if considerations of quality and convenience run counter to cost considerations. There are, however, many areas in medicine where excess procedures, laboratory tests, x-ray studies, and hospitalizations can be trimmed without compromising quality. The well-motivated, broad based physician is the only person in the delivery system with the knowledge to carry out that task in an intelligent yet ethical way. Thus, if there is to be a competing delivery system with independent nongroup-practice physicians involved, the family physician will be asked to take an increasingly aggressive posture in defining what is cost-effective vs excessive medical care.

The coordinating family physician is now being asked to consider more than just the welfare of the individual patient in his medical care decisions. The physician has now become the agent for the insurance plan and (in the larger sense) the agent of society in conserving medical resources and controlling the costs of medical care. Not only must he now be willing to consider the medical, social, emotional, and family aspects of his decisions, but also he must be increasingly concerned about the financial impact. He must acknowledge and convince his colleagues that it is impossible to triumph over uncertainty no matter how many laboratory tests and x-ray examinations are done to confirm or deny a clinical impression. He must recognize the art in medicine and balance it with the science. The family physician of the future must train himself to be the person able to balance the increasingly sophisticated specialization and technology of medicine, the practical needs of patients, and the mandate of society to halt the upward spiral of medical costs.

This new coordinator and financial manager for total patient care must be willing to educate himself about the indications for procedures and surgeries done by consultants. He must be able to converse at the consultant's level and work together to develop criteria for expensive procedures such as coronary angiography, colonoscopy, upper endoscopy, and CT scans. He must articulate his beliefs in the trade-offs between quality and costs. He must not be intimidated by those who espouse the philosophy that the highest quality of medicine demands that we never hold back hospitalizations, new technologies, procedures or laboratory tests. To the contrary, the survival of the private medical care system depends on the willingness of physicians to arrive at the least costly mix of services to accomplish the objective. Since most physicians are unfamiliar and uncomfortable with resource constraints, and since their training has not included the need to maximize the efficiency of the delivery system, this task requires new effort and learning. If the past five years are an accurate harbinger of the next decade, then the future belongs to those who can respond quickly and sufficiently to these new pressures for lowering medical care costs.

Reference

1. Moore SH: The primary care network: A new type of HMO for private practice physicians. West J Med 132:418, 1980