Health care coverage: The demise of the HMO

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This article is the third 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 health maintenance organizations were created to control the ever-rising costs of health care. They failed exactly because they succeeded in doing what they were designed to do. The only decade since the 1940s in which health care cost increases did not far exceed cost-of-living increases were the 1990s. This was certainly the effect of HMOs.

Prior to the HMOs most everyone in the health care business (except nurses) were getting rich. With the reversal of incentive, doctors, hospitals, pharmaceutical companies, physical therapists, optometrists, etc. suddenly saw their income growth curtailed. They squawked. They were in a perfect position to be heard by the ones who mattered most, their patients. The politicians couldn't stand the heat. They watered down the reverse incentive of the HMO to the point that the cost of health care resumed its dramatic uphill climb.

The original plan was to empower the primary care doctors to control costs, and to strongly incentivize them to do so. When the powerful financial incentives were removed, a new form of cost control evolved. I called it cost control by annoyance. For anyone to see a specialist, get a test, etc. they had to get a referral from their gatekeeper. (I hate that word. I used to tell patients that my mother didn't raise me to be a gatekeeper.)

Insurance companies would sell their plans telling people they could have whatever they wanted as long as they got approval from their primary care provider. The trick was that when my office called for approval, the HMO would say no. The people from the HMO who spoke with the patients were different from the ones who spoke to the docs. The idea was to make me look like the bad guy. I had started off believing in the reverse incentive concept, but it didn't take long before I was bad-mouthing it like an under-paid surgeon.

That said, when I felt a patient really needed a test or a referral and the HMO was resisting, it was always possible to overcome their resistance. First, you had to contact the medical director. This was not easy. Medical directors could be hard to locate. Once you did you had to threaten you were going to write in the chart that the patient's care was being directly blocked by the medical director. That always worked.

If I didn't like the referral process, you can imagine how much the specialists didn't like having to get approval from the primary. Everybody started chanting, "HMOs give bad care." Little by little the rules on what needed referrals and what didn't were eased. But as the rules eased, so did the savings.

Pretty soon health care costs started climbing again. As they climbed, media reports started showing that American health care was much more expensive than in the rest of the world (by at least half), failed to cover large parts of the population and was often inferior. For a nation that strives to have the best of everything, this was intolerable.

So, what were the options open to us?

1) Move toward a socialized health system similar to England. In this system, doctors get employed by the government. Everybody's health care is covered by the government. Advantages are that everyone is covered and health costs are controlled. Disadvantages are that doctors will hate it, and they will convince the public they should also hate it. Politically, it would never get off the ground. Proof that it is not politically viable is that the Obama administration couldn't even get a public option included in its plan, this while he supposedly had complete control of Congress.

2) We could go back to indemnity insurance. That would surely lead to greater and greater expense with less and less people covered.

3) Persist with managed care, an option that had already failed.

4) Copy the system of another government that seems to be working. This is basically what the Obama administration seems to have done. Actually, it was originally Hillary Clinton's idea to adopt the main features of the Dutch health system. The Dutch require everyone to buy health insurance and penalize those who don't through the tax system. It works for them. Whether it will work for us remains to be seen. It doesn't address the issue of what type of incentive to use to get the best care out of the providers.

Never fear, the Obama administration has dreamed up a new three-letter acronym to solve our problems: the ACO, or accountable care organization. In my next article, I will try to explain what the ACO is supposed to be. It will be a bit difficult since the ACO hasn't been defined yet, but I'll do my best.

Part 4 in the series is scheduled for the issue of Dec. 16.

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.