OUTLINE FOR PROGRAMS ON HMOs

I. The reasons HMOs got started:

A. Generally.

1. The growth of technologies and subspecialties from 1965 onwards.
2. The associated increases in costs.
3. Business became desperate to rein in the medical benefits it was paying.
4. Wall Street types saw an opportunity because of "inefficiencies" in medicine.
5. Doctors did not pay attention to the economics of their profession.
6. The perceived arrogance and lack of accountability of doctors (and the existence of medical schools fiefdoms) and a desire of others for accountability.
7. Doctors ignored the poor. Give examples.
8. Doctors thought (ala Bevan) they would be stuffed with gold.
9. As HMOs got big, it became impossible economically for doctors to remain independent.

B. The Effect of Vietnam.

1. Enthoven and company.
2. Top/down centralized control. War and medicine "by-the-numbers," i.e., based on ratios, averages, statistics, etc., etc. Failure to understand the human element.
3. Failure in one area being no disqualification in another area.

II. Fundamental flaws in the scheme.

A. The HMOs are subject to Wall Street thinking: large rates of profit uber alles, stringent control of costs. HMOs are managing costs, not managing care.

B. Were undercapitalized by normal insurance standards.

C. In effect a sort of Ponzi scheme. That is, as HMOs got bigger and bigger and got more and more subscribers, they inevitably got people who are sick, and also healthy young subscribers get old and sick, so their costs start rising like

mad, their profits drop, which Wall Street hates, and their fees (employers' payments and employees' co-pays) rise. And more and more they deny coverage and treatment to save costs.

D. Some things, like medicine and education, are not solely a matter of economics and business.

1. The business mentality is so pervasive in HMOs that sometimes clinics are referred to as "stores," the HMO personnel speak of "owning" patients, HMOs justify themselves not by the care given patients but by all the money they are pumping into the local economy through salaries, construction of office buildings, etc.

E. Rather than lowering the costs of medicine and making it more efficient, HMOs have raised the costs by creating armies of bureaucrats (hundreds of thousands of them) to oversee doctors and do paperwork, by building enormous, expensive office buildings, and by requiring huge rates of return. Give examples. Apparently about one-third of their revenues go to administrative costs and profits.

III. Because it is cost cutting uber alles, HMOs exist *not* to treat patients.

A. They deny needed treatments altogether. Give examples.

B. They delay treatments and require preauthorizations for them.

C. They send mothers and other patients home from hospitals early, when this is dangerous. Give examples.

D. They cut off treatments, at home and in clinics, that are achieving success and need to be continued, on the false ground that the very success that is being achieved shows the treatments are no longer needed. Give examples.

E. They limit from inception the number of visits to (or from) doctors or other health care persons (e.g., physical therapists). Give examples.

F. They use a "primary doctor" system under which the "primary physician" must recommend specialists and approve treatments. This causes delay, denial of treatment, and puts people in the charge of -- and at the mercy of -- generalists who know the least about the problem. Give examples.

G. They prevent people from seeing specialists outside the plan, and prevent their doctors from recommending those specialists, even though the outside specialists are far better able to handle a problem than the HMOs' doctors. Give examples.

H. They create "in-house" clinics, therapy groups, home care groups; use them to destroy "outside" groups that render good service; and then fail to give the needed care, give it too infrequently, etc. Give examples.

I. They use restricted formularies (lists) of drugs, so that doctors are unable to recommend drugs they know about and are familiar with, and have to recommend other drugs that may work less well.

J. They cut off whole "populations" from coverage by refusing to cover certain diseases or conditions or by refusing to cover certain industry groupings. Give examples of each.

K. They stop giving certain shots or treatments, saying that people (especially poor people) should go to county and other public hospitals for them.

L. They use *restrictive, merely statistically based* guidelines, which ignore specific individual cases, as to when treatments are proper, and they require slavish adherence. 50 year old doctors with 20 plus years of experience find themselves trying to persuade 22 year old, nine dollar an hour clerks that a treatment should be permitted under a guideline or despite it. Give examples.

M. They use a capitation system under which a doctor is paid only so much a year for each patient. This creates an economic incentive *not* to see or treat patients beyond the amount that would be covered by the capitation fee.

N. Sometimes they combine the capitation system with holdbacks and penalties, under which a doctor does not receive part of his/her income until the end of the year, and only if he or she has met the HMOs's requirements by not "overtreating" and doctors can even end up owing the HMO large sums of money because of "overtreating." Give examples.

O. They have used a variety of "reviewers" to insure that doctors are not "overtreating," including doctors, coordinators, medical directors and, now, outside companies that do utilization reviews. None of these worked very well for them except the outside companies, which work well because of anonymity. Give examples of and reasons why none of them worked well until

the outside reviewing companies.

P. They cut back hours in which clinics are open and the personnel at clinics. Give examples. Often they buy medical groups and then start this process of cutting back. Give examples.

Q. They "overbook" patients, limit the amount of time a doctor can see a patient, and nurses come knocking on doors to move doctors along. This causes doctors not to get the whole picture. Give examples.

R. They refuse to do or pay for allegedly "experimental" procedures even when those are the only way to save lives and even though doing them, and thereby perfecting them, is the only way for the experimental to become routine.

S. They create "two sets" of doctors, one set being those who are not allowed to see patients in hospitals so that they cannot track the patients and lose contact with the latest developments in medicine, and the other who practice *only* in hospitals, so that they know nothing about the patient, her history, etc.

T. They put more and more trust in the hands of nurses rather than doctors. Then they cut the nurses and put the tasks in the hands of lesser trained people.

U. To save themselves money via the law, they have created, or furthered, a mainly false destinction, which the Supreme court and other courts have *stupidly* accepted (I use the word "stupidly" advisedly), between determining whether a person has a covered condition and treating a condition which admittedly is covered. Much of the time -- probably in millions upon millions of cases annually, and particularly in more complex or difficult cases -- this is nonsense because the question whether a person has a given problem, and the question of treatment, are the same. E.g., if a doctor says (in an unclear case) that you do *not* have appendicitis (the condition), the HMO will *not* pay for an appendectomy (the treatment). If he says you *do* have appendicitis, the HMO *will* pay for an appendectomy. All of the financial incentives and the pressures are for the doctor to say you do not have a condition so that you will not get the treatment. Give examples of all of this.

IV. Destruction of medical ethics.

A. The result of all this is destruction of the medical ethic that a doctor's first duty is to his patient, and a loss of trust between doctors and patients. The doctors' economic incentives are structured *against* providing needed care, and patients

know very well that they are being treated shabbily.

B. Another effect of all of this is that often doctors don't have time to engage in the discussions of cases, the conferences, by which they share knowledge and learn. This too results in lower quality medicine.

V. What happens to medical groups or doctors who won't cooperate?

A. Medical groups find their payments delayed, referrals drying up. Give examples.

B. Contracts with medical groups are not honored. Give examples.

C. Doctors are criticized, subjected to "social isolation," spoken to, warned. Give examples.

D. Office mangers won't schedule appointments. Give examples.

E. Doctors with 20 and 30 years experience are summarily fired, are literally walked out the door right then and there by company thugs, are told never to come back, are denied access to their files. Give examples.

F. The HMOs interpret non-competition clauses very broadly, so that a fired doctor cannot set up a practice or get employment anywhere in the state or area.

G. If sued, the HMOs pay off the doctor and require that he enter a clause agreeing not to tell anyone what happened, in order to insure the public will not find out what is going on.

VI. Are PPOs different than HMOs in any significant way? Discuss.

VII. How do HMOs get away with it?

A. They rely on the "Bonhoeffer" syndrome. (When they came for the communists, I didn't say anything because I was not a communist, etc., etc.) People who don't have a particular problem ignore the plight of those who do, and individuals in the latter group are each isolated and helpless.

B. They spend gazillions buying Congress and buying state legislatures and governors.

1. They also spend fortunes on high priced lawyers to persuade judges who are business oriented to begin with

C. The only times they have gotten into difficulty are when (i) legislators (or judges) themselves suffer widely from their practices, as when legislators' wives were dismissed from hospitals shortly after giving birth, or (ii) when a group got so despondent that it organized, as gays did (and even at times had to threaten physical violence -- which raises an interesting question, unfortunately). Explain examples of these points.

VIII. Can freedom of choice laws or plans solve the problems? Discuss. Can freedom of choice laws be enacted, given the extent to which HMOS and other businesses buy the politicians? Discuss.

IX. Can the problems be solved by doctors themselves starting group practices and "selling" their services to businesses? Can doctors learn enough about the economics of medicine to make a go of it? Will businesses accept it? Has it been done? Will HMOs defeat it in legislatures by exercising political muscle? Discuss all this.

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