



Your Practice - 2005 A.D.



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In the last issue, the author contended managed care is dying and that employers will turn to a new way of financing health care coverage for workers. That means big changes for practicing physicians.

FOR DECADES, EMPLOYERS HAVE purchased defined benefit health insurance programs, which provide employees with a predetermined package of covered services, independent of cost. Employees have little option in selecting the benefit design of the product selected.

But the trend is toward defined contribution programs that provide a set amount of pre-tax dollars for employees to buy their own health coverage. The growing consensus is that the nation's vast health care market won't work with full accountability until patients themselves hold the purse strings.

Suppose employers abdicated paternalism and returned decision-making to the patient. Assume as well that managed care recedes to a peripheral role over the next five years, just as indemnity receded during the early 1990s. If so, what will the effects be upon practicing physicians in Sacramento?

Your practice lacks the capital resources to make the transition from capitation to an accounts receivable structure.

Physicians love to hate capitation and generally wish for its demise. Beware! Capitation contracts are easy to enter into and hard to leave. Following an established patient into a capitation contract provides working capital for a physician's practice 60 to 90 days in advance of the normal accounts receivable cycle. Until the accounts receivable cash flow runs out, the physician's practice enjoys a doubling of working capital for the transitioned patient account.

Unfortunately, the reverse occurs when the physician follows the patient out of a capitation contract. The physician is contractually encumbered with 30+ days of service liability with no aging of receivables. It will take 60 to 90 days to re-establish a sustainable cash flow from a newly-booked receivable account.

If you work for a medical group, you will need to find a new job.

Most medical groups and IPAs will no longer exist in five years. In retrospect, one of the dumbest ideas of the 1990s was to disassociate physicians from their own business. Physicians make lousy employees - it is far easier to herd cats than to manage physicians. The prevailing wisdom held - wrongly - that economies of scale would greatly enhance the efficiency of larger practices.

Today, 80 percent of recent medical school graduates take salaried jobs with medical groups. If a medical group now employs you, don't count on a long-term job. Most medical groups and IPA networks were established to service the contractual food chain

within managed care. With the rise of defined contribution, that contracting infrastructure will no longer exist.

Most hospital-dependent medical groups do not transition into stand-alone businesses. Quite simply, they are too inefficient to survive. Hospital-owned integrated delivery systems now lose, according to industry statistics, as much as \$79,000 per employed physician per year.¹ Hospital-owned practices turn out to be 50 times less profitable than those owned by medical groups or practice management companies.²

The physician entrepreneur will return.

The most efficient physician practice business unit is the solo entrepreneur who employs family members - usually at low wages and with no benefits. This business unit is similar to a family-owned restaurant or laundry. Despite the best efforts of corporate America, it has been unable to kill this resilient American classic in any industry. Across all markets, there is simply no more efficient business unit.

The solo practitioner makes cost effective technology investments, few substantial business mistakes and maximizes the financial take out of the practice. There is no time lapse for business decision-making or consensus development.

The hospital/physician relationship will resume a more traditional structure.

In the past, hospitals placed a very high priority on their relationship with the individual practicing physicians. Twenty years ago in competitive urban markets such as Houston, Miami or Los Angeles; it was not unusual to find hospitals vying for physician admitting loyalty by providing valet parking, car washing and shoe shine services. The physician dining room provided white-coated stewards to deliver a gourmet menu provided free to the physicians on their medical staff.

The reason for this largess was that physicians had a market value of \$600,000 to over \$1 million in discretionary hospital service decision-making value depending upon their specialty. Prior to managed care, physicians had the discretion of admitting their patients to the institution they deemed most capable of providing the needed services.

This decision-making discretion was one of the first casualties of the managed care revolution. The result has been the elimination of the market value of the physician.

The physician/physician relationship will also return to a more traditional structure.

In the past, the process of physician referrals from colleagues was the business cornerstone of a practice. The esteem in which the referring physician held the specialist, and the quality of service to both the referred patient and the referring physician, were of extreme importance. Referral patterns often remained in place for decades.

The physician today has little discretion in the referral process. Typically, the managed care contract sets the referral panel. In some instances, referring physicians must use the services of a specialist that they do not know. All of that is likely to change.

If your specialty is primary care, you might think hard about retraining.

Even for those patients and providers locked in a closed system, the use of primary care physicians as gatekeepers is going if not gone. The entire concept of the gatekeeper is the product of managed care - not a response to patient demand. Furthermore, it has no historical foundation in the health care system.

Before the gatekeeper model of the 1990's, primary care physicians made up less than 40 percent of the practice population in most urban markets. Managed care created an artificial demand that pushed their numbers over 50 percent.

With the demise of managed care, patients who are afflicted with disease, and thus consume most health care services, will likely return to specialty care. The artificial market demand for primary care will collapse and trigger an immediate oversupply of primary care providers.

Medical services will cease to be a commodity.

This is both the most exciting and the most challenging prediction in this article. Today's employer-purchaser sees doctors and hospitals as commodities. Under managed care the physician's services are priced based upon a negotiated and discounted fee structure or a calculated capitation payment without considering quality of service, geographic variables, practice overhead, reputation or experience. No other group of professionals, with the notable exception of public school teachers, has experienced such a loss in controlling the pricing structure for their services.

In the evolving market, successful physicians will be far more accountable to their newly-empowered patients. Moving from a commodity to a retail-based business structure will be a significant reorientation for physicians. Many of our colleagues will not succeed in making this transition.

Physicians will lose their franchise.

A caveat is in order. Moving from a managed care contractually-based fee structure may not improve the financial position of most physicians. The market is brutal. It will pay for experience and perceived quality but will relentlessly seek the lowest cost for any given class of service. This process will be amplified in California with its multicultural society, evolving Internet infrastructure and with the oversupply of physicians in most urban marketplaces.

Losing the managed care contract will place the franchise for delivering professional services into play. For the most part, managed care, with its "evidence-based procedure authorization structure," has delivered the exclusive right to provide professional services to the physician.

There are now more visits per year to alternative care providers than to primary care physicians.³ Under defined contribution, the empowered patient/consumer is not likely to give the franchise for medical management exclusively to physicians. Thus, the physician's claim on the professional component of the group health dollar will continue to decline.

These comments are not intended to be an exhaustive list of business issues that will confront the practicing physician should defined contribution become the norm. Rather, their purpose is to shake the reader from focusing on managed care and its mounting problems.

The public perception of managed care, is now firmly entrenched. "Health maintenance organizations have placed profit-making over the health of their beneficiaries by denying certain procedures and access to certain doctors. For too long, HMOs have made medical decisions and excluded the patients where very lives are affected by these choices."⁴

Change is definitely coming.⁵ Powerful market forces will generate massive and imminent change, similar in magnitude to those resulting from the rise of managed care only a decade ago. The prudent physician will begin planning before the tsunami arrives.

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1. Medical Group Management Association.
2. A study by the Medical Group Management Association; December 20 1997 issue of Hospitals & Health Networks.
3. VHA, 2000.
4. Senator John McCain in announcing the bipartisan patients' rights plan, Feb. 6, 2001.

5. "What Comes After Managed Care?" Sierra Sacramento Valley Medicine, March 2001

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