



Bad Times for Physicians



By David J. Gibson, MD

PHYSICIANS IN PRIVATE PRACTICE will soon begin to experience a precipitous drop in office cash flow. They will see an unprecedented increase in their account receivables and an uncontrollable accumulation of consumer debt.

The "wheels are coming off the wagon" for America's employer-based underwriting system for health care. Seventy-five percent of all U.S. adults under age 65 get their health insurance through the workplace. The *LA Times* recently editorialized that "the growth in health care premiums and in the numbers of people without insurance represents an economic drag that business cannot long endure and a level of unnecessary suffering a civilized nation cannot in good conscience allow."

Employers, stunned by double-digit increases in health insurance premiums, are desperate for cost-stabilizing alternatives. The emerging political reality: If high deductible indemnity products do not stabilize cost trends, employers will simply no longer support the current private health care underwriting system.

The latest round of healthcare inflation has exposed the folly of managed care's claims to control costs. There is now a growing momentum away from "first dollar coverage" managed care plans. As a result, managed care is both consolidating and imploding. All of the regional health maintenance organizations (Omni, Health Plan of the Redwoods, Maxicare and Lifeguard) have exited the market. By the end of 2002, California will have 17 HMOs writing commercial policies, down from 21 in March.

To monitor the dynamic movement of the health underwriting market, one must visit with the employers who make payroll each month and the brokers who work with them. In recent weeks, I have engaged many of these individuals in informative conversation. The following summarizes the profound restructuring of the health care underwriting system they indicate is well underway here and across the nation.

The dominant product for the small to medium sized employers is high deductible (\$1,000 per year with a \$2,000+ out of pocket beyond the deductible) catastrophic health insurance. The policy covers hospital services only. Office visits are not covered. Inpatient professional fees are covered at 20 percent of the negotiated fee after the deductible. There is no pharmacy benefit.

Employers can purchase "wrap products" to enhance coverage. These wraps limit liability for drugs and/or ambulatory professional services, typically at \$500 per year per family unit.

Table 1 summarizes how this indemnity catastrophic coverage product compares in cost with existing managed care products this year.

Employers are being forced to reduce benefits. The just-completed legislative session produced a string of successes for the Democratic Party's core constituent groups. As a result, employers face significant increases in costs. New laws increase worker's

compensation benefits, alter existing labor law and expand family leave. All insurance costs from liability to fire and casualty have increased. Now employers face continued significant increases in health benefits.

Large employers face 15 percent trends in health premiums for 2003 (see Table 2). Their cost differential for the HMO vs. the "basic" catastrophic product is \$1,201 for an individual and \$4,877 for a family. For the PPO product, it will be \$1,784 and \$4,640 respectively. An employer can avoid premium trends beyond the general inflation rate for the catastrophic product by increasing the deductible limit.

Table 3 shows why small to medium employers are moving to the catastrophic market even more rapidly than large employers. These employers face 60 percent increases in their group health premium costs for 2003. Their cost differential next year between the catastrophic and the HMO product is \$2,149 for an employee and \$7,977 for family coverage. The differential for the PPO product is \$2,960 and \$7,646 respectively.

Physicians are small employers and their options are limited. They can either drop coverage for employees or absorb the cost increases. It will be hard to resist moving to a catastrophic product this year, and that shift is inevitable over the next two years.

Uwe Reinhardt, PhD, professor of health economics, Princeton University, sees an evolving trend in which employers, health insurers and government are all intent on pushing more health care costs onto consumers. This could create an enormous backlash against doctors and hospitals over the next two to three years.

Implications for physician practice

The high-deductible indemnity products will have profound effects upon physician practices. Unless the altered business fundamentals are factored into business planning for next year, the physician will likely experience significant reductions in cash flow, runaway account receivables that will never be collected and an inability to meet business obligations.

If a significant portion of your revenue is generated by capitation contract; prepare in advance for a substantial reduction in cash flow. The following cautionary tale is illustrative.

The San Jose/Good Samaritan Medical Group, the largest doctors' group in the South Bay, recently announced bankruptcy. The group, founded in 1955, at one point served more than 170,000 patients. In recent years, it has had declining reimbursements from health insurers and the federal government. Those problems were exacerbated by a sharp decline in the clinic's capitated HMO patients, from 90,000 in 2001 to 60,000 in 2002.

Going into a capitation contract is profitable. There is increased cash flow resulting from first of the month capitation checks along with residuals from previously developed account receivables. Coming out of a capitation contract is another matter. Cash flow is immediately reduced when capitation ends, and it takes 60 to 90 days to receive payment from accumulated account receivables. This dynamic is at the core of the San Jose Medical Group's bankruptcy.

Carefully evaluate the liability associated with your network (IPA) contracts. Network contracts, the staple of managed care, do not translate well into the high deductible indemnity market. You may have many more of these contracts than you realize. There is a vigorous national secondary market for buying and selling these contracts (illustrated when a Sacramento physician treats a retired school teacher from Cleveland and is bound by the Ohio Blue Cross contract). These contracts generally dictate that the physician can only collect co-payment funds from the patient at the time of service. Deductibles can only be collected after the claim has been adjudicated by the insurance administrator. Unless the employer has purchased a wrap product, the catastrophic policy does not cover professional services in the ambulatory setting.

Thus the physician is bound by contract to provide service but cannot collect until the carrier confirms non-coverage. The likelihood of collecting from a patient will significantly decay after a 60 to 90-day adjudication cycle.

Payment at the time of service, or arranging for payment over time, is an absolute requirement for financial survival in the coming business environment. Continuing to perform services under your existing IPA contracts will only guarantee an out-of-control account receivable and, ultimately, insolvency.

Invest in your front office staff. You will need someone to provide financial counseling and assistance to patients at the time of service in your office. This process cannot wait until the patient receives your unexpected bills for professional services. This front office financial assistant must be able to lock down credit card revolving credit, similar to the way hotels function when a guest checks in; or set up payment arrangements for patients lacking the funds to pay for services. The survival of your practice depends upon the interpersonal and financial skills of this individual.

Develop a close business relationship with your bank. Physicians should not be in the business of consumer debt financing. Work with the bank to have them rate debt, assume these consumer debt liabilities and manage the collection process.

The fundamentals of the business of medicine are now changing dramatically — beginning in January 2003. To not recognize this reality is to invite insolvency, for both individual and group practices, in the immediate future.

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Table 1		2002 Rates				
		Basic *	HMO	Difference HMO - Basic	PPO	Difference PPO - Basic
Employee only	Per mo	\$88.56	\$175.60	\$87.04	\$217.86	\$129.30
	Per yr	\$1,062.72	\$2,107.20	\$1,044.48	\$2,614.32	\$1,551.60
Employee + Spouse	Per mo	\$213.56	\$553.46	\$339.90	\$573.75	\$360.19
	Per yr	\$2,562.72	\$6,641.52	\$4,078.80	\$6,885.00	\$4,322.28
Employee + Family	Per mo	\$220.56	\$574.03	\$353.47	\$556.80	\$336.24
	Per yr	\$2,646.72	\$6,888.36	\$4,241.64	\$6,681.60	\$4,034.88

* Catastrophic, hospital coverage
Data source: Blue Cross of California (<http://www.calhealthbroker.com>); Redwood Health Services (<http://www.rhs.org>) and 2002 health insurance quotes, Sacramento

Table 2		2003 Estimate — Large Employers *				
		Basic **	HMO	Difference HMO - Basic	PPO	Difference PPO - Basic
Employee only	Per mo	\$101.84	\$201.94	\$100.10	\$250.54	\$148.70
	Per yr	\$1,222.13	\$2,423.28	\$1,201.15	\$3,006.47	\$1,784.34
Employee + Spouse	Per mo	\$245.59	\$636.48	\$390.89	\$659.81	\$414.22
	Per yr	\$2,947.13	\$7,637.75	\$4,690.62	\$7,917.75	\$4,970.62
Employee + Family	Per mo	\$253.64	\$660.13	\$406.49	\$640.32	\$386.68
	Per yr	\$3,043.73	\$7,921.61	\$4,877.89	\$7,683.84	\$4,640.11

* 15% increase projected for managed care products
** Assumes basic premium increase by 15% as well though employer can eliminate with increased deductible

Table 3		2003 Estimate — Small – Medium Employers *				
		Basic **	HMO	Difference HMO – Basic	PPO	Difference PPO – Basic
Employee only	Per mo	\$101.84	\$280.96	\$179.12	\$348.58	\$246.73
	Per yr	\$1,222.13	\$3,371.52	\$2,149.39	\$4,182.91	\$2,960.78
Employee + Spouse	Per mo	\$245.59	\$885.54	\$639.94	\$918.00	\$672.41
	Per yr	\$2,947.13	\$10,626.43	\$7,679.30	\$11,016.00	\$8,068.87
Employee + Family	Per mo	\$253.64	\$918.45	\$664.80	\$890.88	\$637.24
	Per yr	\$3,043.73	\$11,021.38	\$7,977.65	\$10,690.56	\$7,646.83
* 60% increase projected for managed care products						
** Assumes basic premium increase by 15% as well though employer can eliminate with increased deductible						

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