

## The Downward Spiral of Healthcare

This article summarizes the San Diego County Medical Society's Healthcare at the Crossroads: A Code Blue Report on the Critical Condition of Healthcare. To view the entire report, please visit the following website: <http://www.sdcms.org/webpages/codeblue.asp>.

In a time when the medical industry is at its peak in terms of new technology and pharmaceutical discoveries, many medical groups and private physicians are facing possible bankruptcy and underfunding. Managed healthcare organizations (familarly known as HMOs) such as Cigna, Aetna, Pacificare and Wellpoint/Bluecross have implemented a specific method to pay physicians for services rendered to insureds: capitation rates. Under this payment scheme, a lump sum is paid to physicians for every patient they see regardless of how much care is needed. Capitation rates don't contribute extra money for unexpected illness or medical services over the capitation rates under many HMOs, leaving the physicians and medical groups to absorb the cost. This creates a tremendous financial burden on physicians, and medical care suffers as a result. With the skyrocketing cost of medical care today combined with extremely low capitation rates, physicians and medical groups won't be able to survive much longer without a large overhaul of the healthcare system.

Under some HMO plans, physicians receive as low as \$12 per patient per month for their capitation rate. That \$12 is supposed to cover all medical care for that patient and help the physicians pay their administrative costs. Capitation rates often do not change in correlation to the age, sex, health, etc. of the patient. For example, a physician treating an 80-year-old patient in poor health would receive the same rate of reimbursement as for a 20-year-old healthy patient. In order for many physicians to try to make up the difference in costs, they have been forced to take on many more patients. More patients means less time spent with each patient.

From 1994-1999, managed healthcare companies imposed increases in premiums (3-5%) while they lowered the capitation rates to physicians. The reasons given for the increased premiums were higher pharmaceutical and technological costs, costs which the physicians have had to absorb. Healthcare organizations keep on average 38% of the premium while only 62% actually goes toward medical costs. Under the current healthcare system, the insurance companies can regulate and distribute funds however they see fit, while physicians can do nothing but hope the situation improves.

Many medical groups have gone bankrupt or out of business in California. Two of these groups, FPA and Medpartners, served two million people and left \$300 million in unpaid bills. When medical groups go out of business, many physicians are stuck with large, unpaid bills, and the patients within the group are stranded and forced to learn new networking plans and find a new primary care physician.

Because of the disparity between capitation rates and the cost to provide healthcare, many physicians have decided to leave private clinical practice altogether for a more stable field. Nationally, 76% of physicians age 50 or older plan to leave the private setting or retire, leaving medical care in the hands of younger, less experienced physicians. In San Diego alone,

approximately 40% of the physicians are age 50 years or older. If these physicians follow the national trend and retire or leave clinical practice, there won't be enough physicians to treat everyone.

Our current managed care system continues to get worse and worse without any recourse in sight. As it stands now, the only motivational factor for private physicians to treat HMO patients, with all the resources at their disposal, is the physicians' ethical responsibility. That's an unsettling prospect considering the less treatment physicians give to an HMO patient, the more they will earn. For example, under some HMO systems, there is a pool of money set aside throughout the year to pay for treatment by specialists. If there is money left in the pool at the end of the year, the networking physicians split it. In other words, if a physician does not refer patients to specialists for treatment, they are paid more. This should be worrisome to patients.

Another startling fact about the downward spiral of healthcare is that physicians in some cases receive more compensation from seeing a patient who receives publicly funded healthcare than some HMO patients. At the same time, California spends less than any other state, per capita, on public healthcare. This is a disturbing trend given that approximately ten years ago, physicians made enough in their regular private practice to afford to see some public healthcare recipients.

If the current healthcare problem is not remedied expeditiously, there could be catastrophic consequences. Medical groups are already going out of business at a rate of one every 2-3 weeks, and two out of every three are losing money. Physicians cannot continue to take on more and more financial and administrative responsibility associated with healthcare. The trend of the insurance companies has been to raise premiums while lowering or maintaining low capitation rates to doctors. Associated medical costs, however, are skyrocketing. Physicians can't stop taking HMO patients (approx. 70% of the population) or they will not have enough patients to stay in business. Right now the insurance companies have all the power to do as they choose in terms of funding because physicians and medical groups have no other choice now but to take whatever they can get, no matter how small. Who suffers the most? Ultimately, the patient.