Limiting referrals

Secret deals of HMOs

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This is a story about secret deals, hidden conflicts of interest and legal "kickbacks." Many health maintenance organizations — HMOs — pay doctors large sums of money for **NOT** referring their patients to specialists, hospitals and other providers. A family physician in one major HMO can "earn" more than $50,000 a year in bonuses by restricting referrals.

Those bargains may compromise the medical decisions that affect millions of Americans and their access to health care services. Yet patients are rarely informed of the financial incentives — or warned how the arrangements can affect the judgment of their physicians.

A six-month investigation by News 12 Long Island focused on the secret deals of HMOs. The result was a four-part series and half-hour documentary revealing 11 of Long Island's 12 HMOs reward doctors who limit referrals — or penalize doctors who don't.

News 12's project blazed a trail in uncharted territory seldom explored by journalists. This article is a guide for you to pursue a similar investigation in your own backyard. You are likely to encounter familiar names in the insurance business — including Aetna, Prudential, Travelers, Metropolitan Life, CIGNA, New York Life and Blue Cross & Blue Shield.

The italicized passages in this article are from News 12's story scripts. Visualize this article as a TV "Show & Tell" session without any TV monitors.

The world of medicine is in a state of revolution. Half of the nation's doctors have contracts with HMOs. They provide care to the 50 million Americans who are HMO members.

In New York State, four million people belong to HMOs. And 540,000 Long Island residents now depend on HMOs for their health care needs. In this Brave New World, doctors are not only paid for what they do to help patients. They are also paid for what they don't do. To save money, many HMOs reward or penalize doctors based on the cost of the care their patients receive.

STEVE WIGGINS: "It brings the doctor around from the other side, puts the physician squarely on the same side as us. Now we're all trying to do the same thing. We're not fighting one another." (Wiggins is CEO of Oxford Health Plans, the nation's fastest growing HMO.)

ARNOLD S. RELMAN, M.D.: "Whose side do you want your doctor to be on? Do you want your doctor to be on the side of businessmen or investors who have an interest in spending as little on your health care as they can get away with? Or do you want your doctor to be on your side?" (Relman is editor-in-chief emeritus of the New England Journal of Medicine.)

HMOs use a variety of different deals to bring doctors to their side of the table. These arrangements are usually secret, often complex and rarely disclosed to patients.

Bonuses are a common incentive used by HMOs. Doctors can earn thousands of dollars in extra income by limiting services to patients. The bonuses are based on how much money the HMO saves.

RELMAN: "It's certainly unethical. And I think it ought to be made illegal. I think arrangements of that kind ought to be against the law because it provides powerful economic incentives for doctors to act in an unprofessional way."

The types and amounts of bonuses can vary greatly between HMOs.

HIP, New York's largest HMO, offers doctors bonuses ranging from zero to 10 percent of their annual salaries. The bonuses are solely based on the collective ability of groups of doctors to keep patients out of hospitals.

Another major HMO, U.S. Healthcare, has a more complicated incentive plan. It uses computers to chart the inverse relationship between the amount of patient referrals and the size of the doctor's income.

Each month, U.S. Healthcare sends its doctors a report detailing how much money the HMO spent on each patient. It also shows doctors how much extra they could make by cutting the cost of specialists and hospital care.

ARNOLD LIEBOWITZ, M.D.: "It has a financial

Bargains made by HMOs may compromise the medical decisions that affect millions of Americans. This story can serve as a guide for doing this story in your community.

tag on it because we don't know what other incentive a physician would respond to." (Liebowitz is corporate medical director of U.S. Healthcare.)

This sample report illustrates the bonus potential of a family doctor with 925 U.S. Healthcare patients — less than half of a typical private practice. In this example provided by U.S. Healthcare, the doctor would receive $1,700 a month — more than $20,000 a year in bonuses. Depending on the cost of patient care, this doctor could earn more than $52,000 in bonuses. Or as little as zero.

DAVID U. HIMMELSTEIN, M.D.: "The doctor could be thinking, 'Maybe I want a specialist's opinion, but gee, I'm going to lose a couple of thousand from referring patients to specialists. And I can't afford that'." (Himmelstein is an associate professor at Harvard Medical School.)

Government regulators seldom ask HMOs to disclose these deals. But an enlightened journalist can find big clues buried in HMO annual reports. In New York and most other states, HMOs are required to file financial statements and other disclosures with both the insurance and health departments.

In U.S. Healthcare's financial spreadsheets, there is a line item for "Physician Services." That's what the HMO pays doctors for providing services to its members. There is a separate line item for "Physician Distribution." "Distribution" is U.S. Healthcare's euphemism for bonus.

For three months, I questioned U.S. Healthcare about its bonus system. Finally, the HMO provided 20 pages of internal documents detailing its complicated formula for reimbursing physicians. Included were tables that showed exactly how bonuses increased based on a doctor's ability to decrease the cost of specialty and hospital care received by patients.

News 12 found bonus systems were also used by PruCare (Prudential), Cigna, ChoiceCare and Travelers.

Another widespread incentive is called the withhold — also known as a holdback. When some HMO's say doctors, they "hold back" some of the money — usually 20 percent. The doctors only get that money if they meet the HMO's goals for saving money...

HIMMELSTEIN: "I think it's called kickback in any other field. In medicine, it's called holdback."

Under a withhold system, a portion of physician fees are placed in a separate fund — often called an "incentive pool." How much of this money doctors eventually receive depends on the cost of care they approve for patients.

Different HMOs use different equations to govern payments from the incentive pool. But in general, doctors can take a larger amount from the pool by minimizing their referrals and approvals — and limiting the tests, specialty care and hospital services that patients receive.

Evidence of an HMO's withhold incentives can often be found in the HMO's annual financial reports to state authorities. Look for spreadsheet line items with names like "Incentive Pool" or "Withhold Adjustments."

Key public records can also be found at the U.S. Securities and Exchange Commission. Sometimes HMO corporations tell their investors what they don't tell patients.

In a 10-K annual report filed with the SEC, Oxford Health Plans Inc. offered this description of its withhold incentives:

"The company generally withholds 20 percent of agreed compensation to primary care physicians, and 15 percent of agreed compensation to specialist physicians. Withhold may increase to 50 percent of agreed compensation for primary care physicians who exceed their capitated budget allowances. The company returns to the physicians a portion of such withhold, at its discretion, based upon system-wide and individual physician medical costs compared to actuarially budgeted expenditures."

News 12 discovered withholds were also used by Aetna, PruCare, MetLife, Sanus (New York Life), ChoiceCare and Empire Blue Cross & Blue Shield.

There is another type of incentive called "Direct Risk." Some HMO doctors have a direct financial stake in the cost of the care their patients receive. When they refer patients to hospitals or specialists, doctors may have to pay the bills from their own incomes.

WIGGINS: "In many ways, it does shift some of the risk to the provider. Some of the insurance risk is being shifted, as well as the reward. And for the first time, physicians on their own are lowering the rate of surgery, they're lowering the rate of hospitalization, there are fewer specialists visits."

There is no common name for this type of incentive, so we called it "Direct Risk." Under this arrangement, the physician agrees to assume a direct financial liability for a portion of the cost of each patient's care — including the bills from hospitals, specialists and other medical providers.

For physicians, it can go far beyond losing a bonus or a withhold. The difference is the doctor could actually lose thousands of dollars from his or her own pocket by approving medical services for a sick patient requiring extensive care.

Tips on covering HMOs

Bonuses, withholds and direct risk arrangements are the three basic types of economic incentives HMOs offer doctors. The particulars of each deal can vary greatly from HMO to HMO. Here are some tips:

- **Many doctors are paid by HMOs under "fee-for-service" contracts; they bill the HMO for each service provided to a patient. Withholds are the usual incentive within fee-for-service arrangements.**
- **Other physicians are paid under "capitation" contracts; they accept a monthly flat fee as payment for all services they provide for an HMO patient. Expect to find bonuses, withholds, direct risk deals or a combination.**
- **Some HMOs provide care through staff physicians hired as employees. The doctors receive a salary; profit-sharing bonuses are common. For HMO employee-doctors, job preservation is perhaps the greatest economic incentive.**
- **Even non-profit HMOs offer incentive deals to doctors. However, such deals are less likely when non-profit HMOs contract exclusively with non-profit groups of physicians.**

As a result, the doctor becomes a miniature insurance company. And the physician's financial interests are likely to conflict with the medical needs of patients. That conflict is not disclosed to the patient — who still depends on the doctor's judgment and advice.

Unfortunately, this incentive is more difficult to detect than bonuses or withholds. I did find a brief disclosure in a 10-K filed by Oxford Health Plans: "Such agreements effectively shift all or a significant portion of the company's health cost risks to the health care providers..."

According to Oxford's Steve Wiggins, doctors usually profit from the risk-sharing arrangements. Off-camera, he also admitted that a small group of doctors could lose up to $75,000 on a single patient.

RELMAN: "They (HMOs) have a hook into you - a financial hook - which influences the decisions you're going to make. I don't want to be taken care of by a doctor in that position."

HIMMELSTEIN: "We're, in essence, doing an experiment on probably millions of patients around this country on how we pay their doctors without having any real idea what it does to quality... The HMOs, by and large, won't give outsiders access to their data. So it's tough to do studies to document quality. But I think any human being would expect that quality would suffer."

In their own defense, HMOs point to abuses in traditional fee-for-service medicine: Doctors earn more money by performing more services. They tend to prescribe more tests, procedures and surgeries than necessary. Those excesses contribute to the high cost of health care, which has reached an estimated $1 trillion a year in the U.S.

As an alternative, HMOs try to provide cost-efficient medical care. To control costs, many HMOs try to control physicians by reversing the economic incentives. Those deals may tempt doctors to prescribe fewer tests, procedures and surgeries than necessary.

Systematically, HMOs often pit the doctor's wealth against the patient's health. Regulators seem oblivious to the potential dangers.

The state's chief health officer admits that his staff does not keep track of the deals between HMOs and doctors.

MARK CHASSIN, M.D.: "It's a question we could look into. We haven't done that so far. (Chassin was New York State's health commissioner.)

The truth is that government officials do not want to regulate HMO incentives.

CHASSIN: "I'm not sure that we really want to get that heavy-handed about limiting the particular ways in which HMOs or other managed health care entities deal financially with their physicians."

Government authorities usually rely on HMOs to monitor their own abuses through internal "quality assurance" programs. Those public servants appear content to let the fox guard the henhouse — without fair warning to the hens.

That leads us back to the patients. They are the ones truly at risk when HMOs make secret deals with doctors.

Lena Lange of Deer Park had cancer. She says her doctor told her no test was needed.

PATIENT: "You know, they were playing with my life."

Hazel Taus of East Islip was in danger of going blind in one eye. She says her doctor said the condition was not serious.

PATIENT: "They would let me lose the sight in my eye rather than give me a referral."

As a newborn, Luke Kube had a serious infection. Doctors told the family not to worry. But by the time Luke received the care he needed, it was too late.

PATIENT'S MOTHER: "I think it could have been totally avoided by a simple blood test."

These are more than just three isolated cases of questionable medical care. They are clues to a hidden danger that may affect you and millions of other Americans."

The News 12 investigation began with an exhaustive review of HMO public records, particularly the files of regulatory agencies. In general, regulators were not quick to cooperate. But they did eventually comply with the state's Freedom of Information Law.

The next step was to get each HMO to confirm, then explain its incentive deals with physicians — on camera, preferably. The reluctance of HMO officials made it the most tedious and time-consuming phase of the investigation. But after months of stalling and stonewalling, a reporter's persistence paid off.

The final challenge was to show the potential dangers of the incentives through the case histories of HMO patients. You can find victims through court files of malpractice suits, consumer complaints to regulators, database searches, story libraries — even the calls and letters from your viewers or readers.

Tapes of News 12's investigative report are available from the IRE Resource Center. So are my "first drafts" for this type of project — the Asbury Park Press' "Profits vs. Patients" series in 1991 and "Target 8: IMC Gold Plus" from WXFL-TV (now WFLA) in Tampa, circa. 1986.