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# Myths about HMOs -- What You Need to Know before Making the Jump, Part II

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*Editor's note*: This series of articles will dispel some of the misconceptions about HMOs. Part I of this series appeared in the August issue of *Acupuncture Today*; parts III and IV will appear in the October and November issues, respectively.

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HMOs: Myth vs. Reality

Myth #4: As HMOs remove doctors who overtreat, the HMOs will increase the fees paid to the panel doctors.

Reality: HMOs are in business to make money. There is nothing requiring the HMO to be generous to its panel doctors. In fact, because of market pressure, the HMO may very well reduce the doctors' reimbursement. For example: In 1991, one HMO paid $45 per visit for three therapies. Some doctors felt this was a decent reimbursement and signed on. After 10 years, there has been no increase in the provider fee schedule. Figuring a 4% annual inflation rate over 10 years, today's reimbursement should be $62 per visit. The rent has gone up; office and medical supplies cost more; and employees have received their pay increases, but the doctor has not seen a pay raise.

Another HMO was reimbursing at $35 per visit and promised to increase the reimbursement eventually. What happened instead was that the HMO reduced the panel doctors' fees twice and claimed market pressure forced them to do it. Instead of paying the HMO panel doctors better, the HMO gave its executives very large salaries and handsome bonuses.

Myth #5: The HMO will negotiate for the best reimbursement possible for you. If you do not like the fee schedule, you can drop off later.

Reality: HMOs need doctors to sign on as willing providers to maintain geographic coverage. Once the HMO gets the contract, there is no requirement to pay you, the doctor, at any specific rate. What you will get paid is what the HMO wants to pay you to maximize its profit margin. If the HMO reimburses its doctors too low, the doctors will drop off because they cannot afford to stay in business or simply do not like the fee schedule.

Myth #6: The California Department of Managed Care (DMC) limits how much the HMO can take for its own salaries and bonuses. Therefore, the rest of the money is to go to patient care and the doctors. The DMC watches over this and has laws in place to protect the doctor and consumer.

Reality: Wrong. The California DMC, in my opinion, exists to protect the consumer, not to correct HMO abuses concerning provider fees. Often, the department's response to fee disputes is that this is a contract issue between the provider and the HMO. The department's guidelines do recommend

a specific percentage overhead for the HMO, but the HMO's cut usually is over this amount. Where does the money go? To the HMO's exorbitant officer salaries and bonuses, etc. In situations like these, the DMChas been useless.

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