HMOs vs Traditional Insurance

Medical practitioners and HMOs must coexist

By Clarence Smith, Jr., M.D.

There has been a notion passed along to prospective new practitioners that starting a new solo medical practice is a thing of the past.

There are many reasons why this idea exists, however, there are three reasons that come to mind and they are as follows:

The expansion of health maintenance organizations (HMO's), the saturation of medical practices in the middle to upper income suburbia;

And lastly, yet most importantly for minorities, the idea that inner city practices are unworthy ventures.

These three reasons are certainly worthy of serious consideration, however we must not allow them to impact negatively upon one's desire to serve all people based upon need. I propose that minority health care providers in particular must focus more on the inner city as a viable alternative for providing their professional services.

While HMO's have improved in the area of continuity of care for patients, I continue to hear patients complain of not seeing the same physician on repeat visits.

This has traditionally been a problem among the larger clinic type settings. Minority patients have been known to have a tendency to delay seeking medical attention and not having established a relationship with one doctor would seemingly serve to only further delay their seeking medical care.

Minority providers should be keenly aware that HMO's need not necessarily be our competitor, but rather we must insist that they involve us in their network and allow us to participate in the care of their enrolled patients, many of whom are minorities.

When assessing suburbia as a practice option, not only is it reaching a saturation point for providers, but the demographics are generally difficult for minority providers.

We must face the reality that we cannot build a practice in a predominantly white middle class area despite the growing numbers of minorities scattered throughout these communities.

Within the inner cities we find areas that are grossly underserved with quality health care, particularly when you evaluate neighborhoods that are not considered to be "upward."

What you do find, however, are people who generally have greater health care needs but are restricted by virtue of their circumstances and therefore may have difficulty improving their health status.

Many of these neighborhoods consists of minorities and the socio-economically deprived, but they also consist of the working class.

Yet, they too must rely on clinics (often poorly staffed and operated) and whatever else happens to be available in the community.

Many of these people are in the medical assistance program and they are certainly in need of this assistance.

However, one of the glaring problems that I have experienced with this program is the lack of focus on preventive medicine.

These patients are often in need of educational programs, more specifically pertaining to illnesses such as hypertension, heart disease, diabetes, obesity and chemical dependency (drugs and alcohol).

In many instances it would seem to be more efficient for medical assistance to provide programs in weight reduction, home glucose monitoring (recommended by the American Diabetes Association for all diabetics), bulk laxatives for the elderly and better after care for chemically dependent patients who have completed a five-day detox program.

These are but a few examples of the need for better focusing by the medical assistance program and the difficulties that are thereby presented when treating these patients.

HMOs and Medical programs

Health maintenance organization (HMOs) in Maryland have saved the State Medicaid program $5 million during the past 3 years, according to a comprehensive new analysis released by the Maryland HMO Association.

During this period (State Fiscal Years 1986-1988), HMOs have saved the State between 3.5 and 13.0 percent of comparable costs for Medicaid recipients not enrolled in HMOs.

For the current fiscal year, HMOs will save the Maryland Medicaid program between $3.4 and $4.2 million.

"This analysis presents conclusive evidence that HMOs are an effective means of reducing Medicaid costs at a time of growing State concern about the future of the Medicaid program," said Pamela Metz, Executive Director of the Maryland HMO Association.

"It also highlights important shortcomings with the current methods the state uses to set HMO rates — problems which have deterred HMOs from participating in the Medicaid program."

Of the 20 HMOs licensed to do business in Maryland, only 4 participate in the Medicaid program.

"The weaknesses in Medicaid HMO rate setting identified by the Coopers & Lybrand team have to be corrected quickly if HMOs currently caring for Medicaid patients are to be treated fairly and if additional HMOs are to participate in the program," Metz observed.

In the HMO program, Medicaid recipients choose to enroll in a participating HMO, which is paid a specified per capita rate to provide virtually all health care to these people each month.

State HMO rates are set at a level which automatically provides the Medicaid program with a cost savings, since Medicaid pays the HMOs only 92.5 percent of what it would otherwise have cost to provide health care for Medicaid recipients.

"Obviously, the level of these rates is crucial for the financial well-being of the HMO," Metz pointed out. "If rates are too low with respect to actual costs of service, the HMO has to absorb the excess cost, which produces a deficit in its budget.

Over time, if rates are set too low, HMOs will be forced to drop out of the program and the Medicaid program will lose the cost savings which the HMOs produce."

Since HMOs provide access to personalized, preventive care often unavailable to Medicaid recipients — who must rely on hospital emergency rooms and clinics for medical attention — losses from HMO withdrawal from the Medicaid program will be human as well as financial.

"The State should be promoting Medicaid enrollment as a means of assuring Medicaid recipients with access to needed health care," Metz stated. "To do so, the State must assure that the rates it pays HMOs are fair and adequate."

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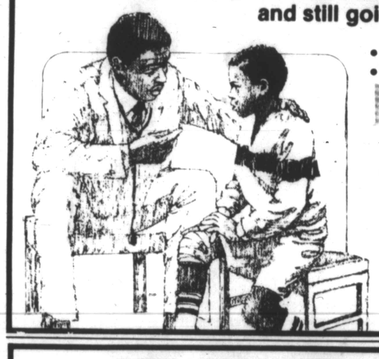

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Dr. Clarence Smith, Jr.
Internal Medicine

Lupus hits young, black women most often

There is no known cause or cure for Lupus, a serious and life-long disease of the body's immune system.

Nor is it understood why this illness strikes more blacks than whites — particularly young black women in their child-bearing years.

Nine out of 10 Lupus patients are women.

Lupus is one of the more mysterious of the auto (self) - immune diseases.

In auto-immune disease, the body manufactures substances that attack the healthy tissues of the patient's own body.

In Lupus the attack can take place anywhere — joints, skin, kidneys, heart, lung, brain — and the symptoms can be extremely varied and difficult to diagnose.

A young black woman who develops joint pain or skin rashes — particularly after exposure to the sun — severe fatigue:

Or Raynaud's disease — an alteration in the color of the fingertips on cold exposure — should see a physician and be evaluated for Lupus.

A low grade fever, chest pains and abnormalities in blood and urine may also be symptoms of Lupus.

Although 25 years ago, Lupus was often considered a fatal disease, the good news is that today 80 - 90% of Lupus patients will live a normal life span.

Patients will, however, require close monitoring by a physician as well as multiple blood tests on a regular basis and probably need medication throughout their lives.

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