

## Is the Gatekeeper Just Another Buggy Whip?

Lee N. Newcomer, MD

The gatekeeper was born early in the development of managed care. Theoretically it made sense for a primary care physician (PCP) to evaluate a patient before the patient started consuming medical resources. The PCP could efficiently handle many problems without involving a specialist, and if specialists were required, he or she could coordinate all of the additional providers. The gatekeeper would both reduce costs and improve quality, thus solving all problems related to healthcare consumption.

Even the early data supported the theory. The SAFECO study, published in 1983, became the dogma of gatekeeper advocates.<sup>1</sup> In their article in this issue, Joyce et al cite several additional references from the 1970s and early 1980s that demonstrate as much as a 15% reduction in costs using gatekeepers.<sup>2</sup>

Humbug. Joyce and colleagues destroy the gatekeeper savings dogma with their analysis of a Midwestern health maintenance organization (HMO).<sup>2</sup> The study HMO offered 2 products using nearly identical networks. One model utilized a classic gatekeeper configuration, and the other allowed members to bypass their gatekeeper to access specialists directly without any penalty (open access). Both models had identical specialist utilization, but the total number of physician visits was actually higher in the gatekeeper model because of increased PCP visits.

What's behind these new findings? I'll offer my suggestions.

First, physicians adapted their practice patterns to managed care influences. Saving 15% of costs was easy in the 1970s when physicians had never been

challenged about utilization. I'm old enough to remember the practices considered standard in those days, and I still shudder recalling them. Remember when chest X-rays were a normal component of a routine physical exam? When all hypertension was evaluated with an intravenous pyelogram during a hospitalization? This new study examines care patterns almost 2 decades later—plenty of time for new physicians to learn about efficient utilization and for experienced physicians to change their practice patterns.

Second, physicians don't change their practice patterns based on the type of insurance model. The network physicians in the study by Joyce et al worked simultaneously with gatekeeper and non-gatekeeper models, and they approached symptoms and diseases with the same algorithms regardless of their role. The decision to involve a specialist in a patient's care depended on training, experience, and local practice patterns more than the role the PCP played during that encounter.

Third, patients learned in the early 1990s that they could obtain approval for a specialist visit simply by being persistent. Women with breast cancer sued for bone marrow transplants and won, insurance commissioners sided with consumers during high-profile appeals, and legislators and the media pressured gatekeepers and their HMOs to provide access on demand. Patients routinely demanded specialty care for many conditions, and weary gatekeepers got tired of fighting with their patients. Several offices I visited during this decade assigned a clerk to complete referral forms for anyone who asked for a specialist visit without consulting the PCP. It simply became an automated process.

Regardless of the cause, the essential policy question raised by this paper is whether these findings can be generalized. I believe the answer is yes. Two additional unpublished experiences during my tenure at United Healthcare (UHC) support this conclusion.

UHC acquired St. Louis-based GenCare in 1994 and merged it with their existing health plan. This

mFrom Vivius, Inc., Minneapolis, MN.

Address correspondence to: Lee N. Newcomer, MD, Vivius, Inc., 5775 Wayzata Boulevard, Suite 300, Minneapolis, MN 55416. E-mail: lnewcomer@vivius.com.

situation was a duplicate of that examined by Joyce et al: both UHC and GenCare shared a nearly identical network of providers, but 1 offered a gatekeeper benefit design (GenCare), and the other was an open access model (UHC). UHC discovered that the 2 plans also had nearly identical utilization and costs.

Three years later, the company acquired MetraHealth, a million-member HMO with a gatekeeper model design. UHC eliminated the requirement for specialist referrals after the acquisition and tracked the results. An analysis of specialty utilization and costs 1 year later demonstrated no change from the baseline year with gatekeeper controls.

To be intellectually honest, a valid, confirming study from another site is the next step. The study by Joyce et al has an observational design, and it cannot tell us why the results occurred. Testing my theories and others would help policy makers understand why the gatekeeper system no longer works. But this is an Internet age, and it is unlikely that the marketplace will remain static long enough for those answers to be discovered.

If gatekeepers don't control utilization, what should a beleaguered employee benefits manager or HMO executive do next? Patient financial incentives are probably the answer for the next 5 years. Even conscientious gatekeepers couldn't overcome the fact that patients knew they had free care for the asking. Indeed, the marketplace is already moving this direction—consumers are being offered increased freedom of choice in new products, but they also assume financial responsibility for those choices.

In the new models the physician becomes a trusted advisor on how to spend money wisely rather than a barrier to be overcome. The 3-tier pharmacy benefit provides an excellent example of incentives controlling utilization: the consumer, not the physician, makes the decision about how much to spend. Once consumers understand that their favorite allergy medication costs an additional \$20 from their pocket, many of them will ask their physician for help understanding the alternatives.

Profiling is touted as another emerging method for plan managers to change behavior. However, as powerful as the new generation of profiling tools is becoming, they are simply impotent without incentives. UHC's profiling showed thousands of internists, cardiologists, and family physicians that they omitted key standards of care with many of their patients. The reports identified the missed patients and allowed physicians to correct the omissions, but 1 year later only a small percentage of

those patients were changed to the right medication or testing regimen. The change was small because there was no incentive for physicians to make the additional effort—poor performers were paid exactly the same as superb performers.

The physicians in the Joyce et al study did have a bonus program for low utilization, but it had 2 important flaws. First, the bonus was funded from withholds. Physicians long ago learned to ignore withholds in their price negotiations with health plans. They assumed the withhold was unlikely to occur and targeted the post-withhold fee as their "true" reimbursement. Indeed, in the study HMO, the 1994 bonus was paid and the 1995 bonus was not (interview with Chief Executive Officer of health plan by author, September 2000). Second, the bonus was solely determined by utilization rather than quality. Without good episodes profiling (not available at the time of this study), it is very difficult to teach physicians what changes they can make for improvement.

The results of this study grant benefit managers, HMO executives, and consumers the right to support freedom of choice. They can eliminate the older, established, and often despised methods of controlling costs and substitute new models with increased consumer responsibility. Consumers trade off their first dollar coverage in return for more selections in providers and therapies. Accountability for those decisions shifts from the employer to consumers and their physicians. Faced with those options, my decision is simple—give me liberty and I'll take responsibility (with apologies to Patrick Henry).

Wouldn't everyone make a similar decision?

The answer to that question, surprisingly, is no.

According to the chief executive officer of the plan studied by Joyce et al, the gatekeeper model still outsells the open access model despite almost identical pricing between the 2 products. Maybe employers and consumers don't want anything more than the right to complain.

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... REFERENCES ...

1. Moore SH, Martin DP, Richardson WC. Does the primary-care gatekeeper control the costs of health care? Lessons from the SAFECO experiment. *New Engl J Med* 1983;309:1400-1404.
2. Joyce GF, Kapur K, Van Vorst KA, Escarce JJ. Visits to primary care physicians and to specialists under gatekeeper and point-of-service arrangements. *Am J Manag Care* 2000;6:1189-1196.