

Why Primary Care Physicians Join HMOs

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Abstract

Objective: To determine the reasons why primary care physicians affiliate with health maintenance organizations (HMOs) and assess how these reasons vary with personal and practice characteristics.

Study Design: A 1996 national telephone/mail survey of primary care physicians who were affiliated with at least 1 HMO plan for more than 9 months.

Methods: Survey responses were assessed according to geographic region, age, income, level of involvement in managed care, and HMO penetration rate. The sample consisted of 210 primary care physicians who played a role in the decision to affiliate.

Results: The overwhelming reason primary care physicians affiliated with an HMO was to retain patients. Eighty-three percent reported this as one of the reasons for affiliating and 59% reported it as the primary reason. Physicians with the greatest portion of income from managed care and physicians practicing in areas with high HMO penetration were most likely to report quality of life issues—such as more personal time, more predictable work hours, or reduced administrative burden—as the rationale for HMO plan affiliation.

Conclusions: These findings support the view that the majority of HMO-affiliated physicians join HMOs to avoid a perceived penalty associated with

lack of affiliation, rather than for positive reasons. The data also suggest that physicians with managed care experience affiliate more often for quality of life reasons.

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With the continued expansion of managed care, there is considerable attention devoted to physicians' participation in and their reactions to the variety of financial and organizational arrangements that fall under the general rubric of managed care. The proportion of physicians contracting with an alternative delivery system [HMOs, independent provider associations (IPAs), and preferred provider organizations (PPOs) as defined by the American Medical Association (AMA)] rose from 63% in 1988 to 88% in 1996.¹ During this same time, the proportion of revenue physicians received from these contracts rose even faster—from 23% to 44%.¹ A national survey of physicians conducted in 1994 found that approximately 20% of physicians had undergone organizational changes in their practices in the last year and about half of all physicians were associated with a health plan that placed the doctor at some financial risk.²

Although managed care has altered the organization and financing of services in many ways, the physician remains an essential healthcare decision maker. Thus, it is important to understand how ongoing changes affect physicians and the reasons behind physicians' decisions to affiliate with managed care plans. In this article, we use data from a 1996 national survey to illuminate the reasons why primary care physicians affiliate with HMOs and assess how certain physician or practice characteris-

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tics—including geographic region, age, income, and level of involvement in managed care—may influence the physician's rationale for joining an HMO.

... BACKGROUND ...

A number of articles have reviewed physician satisfaction with managed care, and several studies show that managed care-affiliated physicians are more satisfied than many would expect.³⁻⁵ Far fewer studies have explored the reasons physicians join a plan. Only 2 published studies appear to specifically address this topic. In the early 1980s, a Health Care Financing Administration (HCFA) survey of physician practice costs showed that three-quarters of physicians in all specialties joined alternative health plans "to maintain or increase patient load" and 39% joined due to "philosophical commitment to alternative health plans."⁶ Similarly, a more recent study showed that preserving market share was the most prevalent reason rural primary care doctors in Oklahoma and Minnesota participated in an HMO.⁷

... DATA AND METHODS ...

We analyzed data from a national survey of primary care physicians affiliated with managed care plans. The survey was designed by the Project HOPE Center for Health Affairs with input from the Center for Survey Research at the University of

Massachusetts, which implemented data collection. Funding was provided by the Robert Wood Johnson Foundation. The survey of physicians was 1 component of a larger project examining the methods managed care organizations use to influence physician prescribing of pharmaceuticals, referrals to specialists, and use of technologies.

We randomly selected a sample of general practitioners, family practitioners, and general internists from an extract of the AMA database. We excluded other physician specialties, federal employees, fellows and residents, hospital-based physicians, and Alaskan physicians. We then further refined the sample by including only those physicians who had a minimum 9-month affiliation with at least 1 managed care plan and 20 hours per week of direct patient-care activity. Since this survey was also part of a companion study focused on HMOs, we tried to limit physician responses to HMOs (including IPA arrangements). However, some physicians may have responded with a different managed care structure, such as a PPO, in mind. Nevertheless, we were most interested in those HMOs that were likely to exert the greatest amount of influence (both financial and nonfinancial) over physician behavior.

The final sample size totaled 335, for a response rate of 55%. One-third of the interviews were conducted by telephone and the remaining two-thirds were self-administered, via a mailed questionnaire. While this response rate raises the possibility of nonresponse bias, it is comparable with and perhaps even favorable to response rates of other physician surveys.^{8,9} Moreover, there is evidence that physician surveys, particularly single specialty surveys, are less vulnerable to bias than surveys of other types of respondents.¹⁰⁻¹²

For this analysis, we focused on the 210 respondents who said they played a role in the decision to affiliate with a managed care plan (in some cases, a group manager made the decision). We derived a list of 7 reasons why a doctor might join an HMO through a review of the literature and input from a physician panel involved in the survey design (Table 1), and we read this list to all respondents. Multiple responses were permitted, although we asked the respondents to denote their most important reason. For all plan-specific questions, respondents were asked to focus on their main plan, defined as the plan covering the largest number of patients.

Annual income figures were based on the physicians' responses to a categorical question asking for all sources of income from medical activities in the prior year, after practice expenses but before taxes.

Table 1. Reasons for Plan Affiliation*

	Percent citing as reason
Avoiding loss of patients	83
More predictable income	47
Increased patient load	43
Increased earnings	40
Reduction in administration	21
More predictable hours	13
More personal time	11

*Based on responses from 210 physicians who reported playing a role in the decision to affiliate. Respondents were instructed to indicate more than one reason if applicable.

County-level rates of HMO penetration (defined as the percent of the population enrolled in an HMO) were linked to each physician by the zip code of each physician's practice location. We also briefly compared several characteristics of physicians who reported that they did not make the decision to affiliate with those of decision makers.

We used Student's *t* test to determine if differences in population estimates existed. Only those significant differences with a 95% level of confidence are discussed in the text.

... FINDINGS ...

Primary care physicians affiliated with HMO plans for 1 overwhelming reason: To avoid losing patients

(Table 1). Eighty-three percent of primary care physicians surveyed reported this as a reason for joining, and 59% reported this as the single most important reason for affiliating with managed care. Moreover, no more than 10% of respondents reported any other reason as the primary reason for affiliating with managed care.

The reasons for affiliation cited by the respondents varied somewhat by geographic location, age, income, proportion of income from managed care, and county-level HMO penetration. Regional differences were primarily found between physicians in the Midwest or West and those in the Northeast and South (Table 2). Physicians in the Midwest were more likely than those in the Northeast or South to have joined a managed care plan in order to have

Table 2. Reasons for Plan Affiliation by Selected Physician Sociodemographic Characteristics—Percent of Physicians Citing as Reason.

	Sample Size	More Personal Time	More Predictable Hours	Steadier Income	Increased Income	Avoid Patient Loss	Increase Patient Load	Decrease Administrative Burden
All	210	11	13	47	40	83	43	21
Age								
Less than 50*	131	14	15	47	47	80	41	21
50 or older	78	6	9	46	29 [§]	87	45	23
Income								
Less than \$150,000*	119	18	18	45	39	77	43	24
\$150,000 or more	80	3 [§]	8 [§]	49	41	91 [§]	37	21
Location								
MSA (Metropolitan Statistical Area)*	171	11	13	48	43	83	45	20
Non-MSA	33	9	6	36	27	91	30	21
Region								
Northeast	56	5 ^{†§}	9 ^{†§}	34 ^{†§}	46	84	38	14 ^{†§}
Midwest	47	19	15	53	32	79	38	19 ^{†§}
South	61	7 ^{†§}	8 ^{†§}	44	38	85	43	16 ^{†§}
West	46	15	22	59	43	83	52	39

*Reference group.

†Reference group is Midwest.

‡Reference group is West.

§Estimate is significantly different from reference group at 95% level of confidence.

||Estimate is significantly different from reference group at 90% level of confidence.

more personal time (19% vs 5% and 7%, respectively). Those in the Midwest and West were more likely to report predictable hours as a reason for joining (22% for those in the West, 15% for the Midwest, and less than 10% for the Northeast and South). A reduced administrative burden was cited by twice as many physicians in the West than in the other regions (39% vs less than 20%).

Compared with older physicians, younger physicians (here defined as those less than 50 years of age) were more likely to cite more personal time as a reason for joining a managed care plan (47% vs 29%, Table 2). At the same time, younger physicians were also more likely to report increased income as a reason (14% vs 6%). As Table 3 shows, there was some variation by level of reported income. Overall, 41% of respondents reported annual income of less than \$150,000. Physicians earning more than \$150,000 per year were more likely to report avoiding patient loss as a reason for affiliating (91% vs 77%), but they were less likely to cite more personal time or more predictable hours.

Just under half reported that less than 40% of their income derived from managed care plans, and reasons for affiliation varied considerably by level of HMO involvement.* However, there was no statistically detectable variation in reasons for affiliation between physicians paid by their primary plan on a fee-for-service vs those paid on a capitated basis (Table 3). Those who derived a larger portion of their income from managed care (more than 40%, which was the mean) were more likely to report more personal time, more predictable hours, steadier or more predictable income, and reduced administrative burden as reasons for affiliation.

Salaried physicians are paid with an annual salary, not based on the number of services delivered (FFS) or the number of patients (capitation). 65% of physicians paid with a salary cited "more personal time" as a reason for affiliation. 78% cited "decreased administrative burden," 70% cited "predictable hours." While the data suggest the possibility that the reasons given by salaried physicians differ dramatically in their focus on quality of life issues such as having more personal time and reducing administrative burden, our sample size was too

small to make reliable estimates. This hypothesis would have to be tested with a data set offering larger sample sizes.

Reasons for HMO affiliation varied with the extent of local HMO penetration. Physicians practicing in areas with more HMO enrollees were more likely to have joined a managed care plan to increase personal time (15% for high penetration areas vs 4% for low penetration areas) or to have more predictable work hours (17% vs 5%). In contrast, more than 90% of physicians in low-penetration areas joined an HMO to avoid patient loss compared with 77% of those in areas with more HMOs. Caution should clearly be used in interpreting this finding, as physicians in low-penetration areas may join in anticipation of managed care growth while physicians in high-penetration areas may no longer anticipate patient loss.

Thirty-six percent of primary care physicians played no role in the affiliation decision. These physicians may have been employees of a practice or may have joined the practice after managed care contracts were in place. Not surprisingly, physicians who were not involved in the affiliation decision were substantially more likely to be younger; of those involved in the affiliation decision, 19% were less than 40 years old compared with 37% of non-decision makers. Although the proportion of females making the decision was lower than that of males, our overall sample of female physicians (n=44) was quite small, and there were no statistically significant differences in the proportions of female and male physicians who were not involved in the affiliation decision. Primary care physicians in multispecialty group practices were less likely than those in either solo or single-specialty groups to participate in the decision to affiliate.

... DISCUSSION ...

Our results confirm earlier findings that most physicians are affiliating with HMOs to retain patients. The percentage of respondents citing patient loss as a reason for joining their main managed care plan never fell below 76%, regardless of personal characteristics or other qualifying factors. As a result, it appears that primary care physicians are joining HMOs to escape a perceived penalty that comes with lack of affiliation (ie, loss of patients). From the perspectives of policymakers or administrators who may be seeking a commitment of primary care physicians to managed care, this may

*We were unable to examine differences by physician gender or for physicians paid on a salaried basis because of small sample sizes; of the 210 physicians who played a role in the decision to affiliate with their main managed care plan, there were only 25 females and 24 physicians paid on a salaried basis.

offer little encouragement.

The remaining question then becomes: How committed are these physicians once they begin practicing in a managed care environment? For managed care to survive, a fully committed physician workforce is critical. The response rate for reasons other than fear of patient loss varied, suggesting that there is a small subset of physicians who have joined a managed care plan for quality of life attributes that are generally positive. These quality of life attributes—including more personal time, more predictable work hours, a more predictable income, and reduced administrative burden—were more prevalent among physicians who received more of their income from managed care, physicians in areas with a higher HMO concentration and, to a lesser extent, physicians practicing in the West where managed care is more common. While these were not gener-

ally the primary reasons cited, they identify some HMO features that may attract physicians.

There is limited evidence that physicians participating in managed care plans adapt and are satisfied over time. This is an issue worthy of further exploration. It is possible that physicians with no role in the decision to affiliate—particularly younger physicians and, potentially, female physicians—may be more adaptable to the changes in healthcare delivery. Halm and colleagues reported that physicians practicing for a shorter time were more positive about managed care gatekeeping requirements than physicians who had been in practice longer.¹³ It would be useful to examine the relationship between plan structure and HMO affiliation, as this would help us determine which features of managed care draw physicians and which aspects turn them away.

With time and further study, we will gain insight

Table 3. Reasons for Plan Affiliation by Selected Managed Care Characteristics—Percent of Physicians Citing as Reason.

	Sample Size	More Personal Time	More Predictable Hours	Steadier Income	Increased Income	Avoid Patient Loss	Increase Patient Load	Decrease Administrative Burden
Type of Payment*								
Fee-for-Service	99	5	7	39	42	90	43	13
Capitated	86	2	5	47	47	90	47	16
HMO Penetration†								
Low	57	4	5	35	32	91	32	16
Medium	96	12	13	51	47	84	50	19
High	52	15 [§]	17 [§]	49	38	77 [§]	42	26
Length of Time with Plan								
Less than 5 yr	100	10	10	45	39	84	47	17
5 yr or more	109	12	16	49	41	82	38	26
Income from Managed Care								
Less than 40%‡	101	2	5	40	38	91	39	14
40% or more	108	19 [§]	20 [§]	54 [§]	42	76 [§]	46	29 [§]

HMO = health maintenance organization

*Cell size for type of payment = salary too small for reliable estimates (n=24).

†Defined as the ratio of HMO enrollees to total population by county. Low penetration was defined as less than 9%; medium was defined as 9 to 27%; high was defined as greater than 27%. Reference group is low penetration.

‡Reference group.

§Estimate is significantly different from reference group at 95% level of confidence.

into physicians' attitudes about managed care. As managed care becomes even more pervasive and physicians gain experience practicing in the managed care environment, we will find out if those physicians who joined under pressure come to appreciate the positive aspects of managed care.

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