

How Will I Alter My Practice During the Next 5 Years?

Changes in reimbursement may be a driving force.

BY RICHARD A. LEHRER, MD

Over the next 5 years, glaucoma practices will evolve in many ways. I expect changes in how physicians prescribe medications and perform surgery as well as in employment, payment, and practice ownership. Patients' access to medical services will also change radically. The transformations are intertwined and are related to changes in health care laws and in insurance coverage. Unfortunately, at the time of this writing, the full extent of the implementation of laws and insurance coverage remains unknown. This article shares my personal observations and speculations.

INSURANCE CONSOLIDATION

As a busy glaucoma doctor in an independent, rural, private, multisubspecialty ophthalmology practice in Northeast Ohio, I have witnessed many changes in health care during the past 20 years. In the mid-1990s, my colleagues and I were concerned about insurance consolidation in our marketplace. To prepare and position our practice for the expected influx of health maintenance organizations, we merged with a national group (Eyecorp, later PRG) composed of more than 50 other ophthalmology practices. In so doing, we hoped to be able to negotiate national contracts with insurers, pool resources, negotiate better pricing on supplies and equipment, and make a few dollars in the publicly traded stock. The venture was unsuccessful and went bankrupt, and the lesson and headache are not to be repeated. I share this cautionary tale with readers in case their practices are approached about something similar.

Before joining a national group, we performed a careful investigation with attorneys, accountants, and consultants, but the merger took many years and great expense to unravel and reverse. The slight initial market

penetration in our area by health maintenance organizations fizzled. Although this time around I believe that market network consolidation and alignment may come to pass, my colleagues and I learned that we should evaluate many strategies before selling our practice.

INSTITUTIONAL SHIFTS

Over the past few years, several competing local hospitals have bought and employed more and more primary care and specialty groups in my area. Two large university-based hospitals in Cleveland (70 miles away) are opening satellite specialty clinics, including ophthalmology, near my practice.

Recently, my practice was dropped without cause by United Healthcare Medicare Advantage Plan (UHCMA). It is probably the first of many shifts, as insurers and institutions align themselves to share available health care dollars. Patients have told me that they have been assigned to a doctor 25 miles away in lieu of their local primary care physician. Patients of mine in the aforementioned plan have not been told which ophthalmologists are in their network. Both they and I are frustrated not to know where they will receive care, but our complaints seem to fall on deaf ears. I predict a continuation of this trend: university hospitals will drive the health plans, and patients will be required to travel great distances for care, especially for subspecialty services that may now be locally available and perhaps more cost-effectively delivered. A heartening alternative last week was one of my patient's telling me why he was changing his insurance plan: "Insurance companies are a dime a dozen. You are not."

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CHOICE OF THERAPY

My frustration over prescribing medication for glaucoma patients has reached a fever pitch. My practice receives at least 10 faxes or calls a day requesting changes in medication. Although generic equivalents may suffice for a number of patients, I see many others whose IOP is not adequately controlled by or who cannot tolerate these agents. Over the next few years, I worry that it may become more difficult to prescribe newly available therapies. As I continue to advocate for my patients' best interest, I anticipate that formularies will become increasingly restrictive and that it will be more difficult to obtain exceptions.

Insurance companies that restrict physicians' ability to prescribe medication will also institute policies that affect ophthalmologists' ability to offer novel surgical options. Payors are slow to approve the use of new technology for their insured, even when well-controlled clinical trials demonstrate safety, efficacy, and cost savings. Now, when I discuss surgical options with patients, I first look at their insurance status to determine what will be covered instead of initially trying to identify the most efficacious surgery. The situation will become worse as more microinvasive glaucoma procedures become available. My colleagues and I will be forced to stick to trabeculectomies and traditional tube shunts, even when we do not think these procedures are in our patients' best interest.

MY 5-YEAR PLAN

I plan to continue providing the best care for my patients that I am able. Doing so will require me to keep abreast of the latest research, clinical trials, and medical and surgical options. On the business side, I will carefully evaluate options for my practice and my partners, perhaps with more selective participation in insurance plans.

I have no doubt that insurance companies' profits and government legislation drive medical decisions and practices, but financial considerations, while important, cannot be the overriding factor in medical decision making. Perhaps the best way for practitioners to provide quality care is to support their medical societies, which pressure lawmakers and insurance companies to let doctors be doctors. ■

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