SOCIETY OF ACTUARIES

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Letter to the Editor

by Mark Troutman

DEAR JEFFREY:

I read with great interest the back cover article from Mr. Gary Smeddinghoff on HMOs in the December 2000 edition. I have enclosed a counterpoint article for publication consideration in your next Health Section News. Please contact me if you have any questions. Thank you for your consideration and constructive comments.

HMO Is Not A Four-Letter Word

Mr. Smeddinghoff is, in my opinion, wrong from the start. Everyone doesn't hate HMOs. I don't and there are many more like me who don't hate them. There are good HMOs and bad HMOs just like there are good eggs and bad eggs. Allow me to address Mr. Smeddinghoff by way of counterpoint.

A. ERRONEOUS PREMISES – I BELIEVE THE ARTICLE HAS SEVERAL ERRONEOUS PREMISES REGARDING HMOS.

1. *Everyone hates HMOs.*
I could point to a number of surveys which show that the vast majority (80+%) of people in HMOs and other managed care plans are satisfied or highly satisfied with their healthcare plan. Surveys such as those performed by Sachs / Scarborough, National Research Corporation, Consumer Reports and others report high HMO satisfaction ratings. Published data on quality of care is also favorable.

As far as the providers, no one makes them contract with HMOs to deliver more benefits at lower costs and actually monitor usage of healthcare. It's a free market. If providers begrudgingly contract with managed care plans, they must not have any other economically viable alternatives or they would exercise them. Ah, the free market. Are we saying that's bad?

Does the fox hate it when someone else guards the henhouse? When you cut out the fat, you can add more beef! How is it that most HMOs provide higher benefits at comparable or lower costs to traditional indemnity plans? By eliminating unnecessary costs. I was always impressed by candy bar companies when they advertised a bigger candy bar for less cost.

2. *There is no feedback loop.*
I assert the feedback loops are much quicker than with an indemnity program as member services units and customer satisfaction surveys are part and parcel of a managed care plan. When was the last time your doctor sent you a card and said "how did I do," "how long did I make you wait," etc.? Let the price, benefits, service, quality and access points compete in the market.

HMOs are also more likely than traditional indemnity plans to have grievance and appeals committees, wellness benefits and healthy lifestyle newsletters.

3. *The HMO market is overregulated.*
What seems to be missing here is some description of why the HMO Act was put into place. The healthcare system was broken. It also focused on treating sick people rather than promoting health maintenance. Medical cost increases continued to rise at two or three times normal inflation rates. The U.S. government also instituted Medicare and Medicaid reform and instituted programs aimed at providing people with choices for managed care programs which offered better benefits at attractive rates. Their attempts to control cost increases in these areas is a normal ebb and flow of a major purchaser trying to obtain favorable terms from its vendors.

The author indicates that it is the government which has propped up HMOs. Admittedly, the HMO act allowed HMOs to get a foothold by allowing them to mandate employers to offer that choice, but it is hardly enough at this point in time to justify the significant market penetration of HMOs. If nearly 80 million people are involved in HMOs in some fashion, there must be more to it than a government mandate. Employers who pay for the healthcare and consumers who consume it must find it satisfactory.

4. *One-stop shopping / coordination of care is bad.*
The author also seems to overdramatize the ineffectiveness of one-stop shopping as embodied by an HMO, (i.e., you must get your healthcare from the network providers unless it is an emergency). One-stop shopping is not such a terrible thing. I agree we should let the consumers decide whether it's appropriate to do one-stop shopping in a given situation. Taken to extremes, the author might oppose a supermarket because it allows all goods to be placed in one spot. Why not only have meat markets only, vegetable markets, fruit markets only, etc.? Hey, if people like picking up milk at the same time they're getting gas, let them do so. If they don't, then pay for the gas and leave. This is another point where we agree. Let the consumers decide what they like and don't. Vote with your pocketbook!

The other point forgotten in the rhetoric was that the original concept of Health Maintenance Organizations was not to be all things to all people at the highest quality and low cost as described in the article. It was through the concept of "an apple a day keeps the doctor away." (Apples cost less than physician office visits.) Provide wellness visits and physicals, so that people stayed healthy. An ounce of prevention is worth a pound of cure. Promote healthy lifestyles. What a great idea.

B. THE ECONOMICS OF HEALTHCARE

The article seems to forget the pressure points and the mutual exclusivity of choice versus cost. HMO plans may restrict choice, but they also favorably impact cost. Indemnity plans provide the widest array of choice, but their costs are significantly greater because of this. Many opponents of managed healthcare don't like it because somebody actually tries to be a gatekeeper and take control of a system which is out of control. Maybe we should get rid of quarterbacks on football teams and just let everyone run around aimlessly with the football?

Another point is the natural component in economic theory of supply and demand. Healthcare costs were increasing at two to three times normal inflation rates all while there were too many hospitals and too many doctors in the system. Hospitals were 33% unoccupied and many should have closed if economic theory was correct. The thought of managed care was to bring the element of supply and demand into this product as well. Healthcare is being overutilized and continues to be overutilized in various fashions. Doctors often prescribe too many tests as there is no economic incentive not to provide those. Why is it that lab tests are dramatically increased when providers doing the prescribing also run the lab? It must be a statistical anomaly? Everyone knows when you don't pay for something, you tend to overutilize it. When you go to a buffet and it's all you can eat, you eat a couple more pieces of pizza or desserts than usual, don't you? Healthcare is no different. Note there is one point where I agree with the author — the tax advantageous nature of employee benefits does lead to overutilization as people have less incentive to actually be wise consumers.

The current backlash against managed care is a logical, inevitable competitive swing back against any program which becomes too successful. It's also a function of a tight labor market and a booming economy. Rest assured, employers would pay less attention to employee desires and more attention to costs when their profits are under attack.

Another big debate today is regarding patient rights. I think they should have rights to sue people who make medical care decisions. Unfortunately, HMOs don't make medical care decisions, they make coverage determination decisions. Information made available by the American Association of Health Plans shows that only 1–3% of services are denied by HMOs, depending on the type. Any employer who develops a plan document or buys a group health insurance plan actually makes coverage determination decisions by putting exclusions of limitations in the contract. It would be ludicrous to assume that we should cover everything under every circumstance or to hold them accountable for the medical care on benefits they provide. Doctors make medical decisions and hospitals make medical decisions. They should be held accountable for making the medical decisions regardless of the presence or absence of medical benefits. Admittedly, some fail-safe system should exist in the United States so that everyone receives a minimum amount of healthcare for both wellness and catastrophic situations

C. POSITIVES OF HMOS

HMOs, like any other product, have advantages and disadvantages. If one product were superior in all regards, everyone would buy it (if they were rational). As the author has pointed out several potential disadvantages of HMOs, I would like to point out several potential advantages.

HMOs actually do provide a greater credentialing of providers than indemnity plans. There's no guarantee that they're all the highest quality, but they do provide greater quality than the randomness associated with picking your own doctors. Many people appreciate the fact that somebody has taken a look at physician's credentials. Also, take a look at provider malpractice records. If physicians and hospitals were perfect, there would be no need for malpractice insurance. If there are no issues associated with malpractice insurance, then the AMA and AHA wouldn't so vigorously oppose making such records available to the public.

As stated above, HMOs typically provide more benefits for comparable or lower price. They also provide better coordination of care.

Though I understand Minnesota is a hot bed of HMO activity, I didn't realize that the area is being consolidated into 10,000 lakes and one health plan. Perhaps the author means one type of health plan given HMO penetration. The only threat to one health plan is a government plan which would be mismanaged because of the government's inability to make the hard choices regarding what to pay for and not pay for and how to fund it through taxes while still maintaining control of providers and utilization.

Summary

It's funny that what goes around comes around. This includes ties, skirt lengths, etc. Scheduled indemnity plans were a start. Then came major medical. Then managed care. Now maybe back to scheduled plans? I agree with the author that a defined contribution approach he has spoken of in many other venues may be a logical next step as a reaction to consumerism responses to managed healthcare ala HMOs. Critics of the current employer-based system contend that managed care is ineffective and that employee benefits programs continue to shelter consumers from the true cost of healthcare and unnecessarily restrict their choices. Defined contribution models now being promoted by companies like HealthMarket give consumers information regarding provider cost and quality and allow them to choose. It allows the employer to facilitate the employee taking more responsibility for their healthcare decisions and gives them the informational tools they need to effectively handle this new authority.

Whether these new models can continue the important aspects of the current employer-sponsored program with government tax advantages remains to be seen since it promotes the pooling of risk and reduction of adverse selection which are also important to controlling healthcare cost. It is obvious that employers would flee en masse in many programs if they were held more responsible for medical care liability when offering and funding a managed care plan. Employers should fear the government and the legal profession attempts to place blame or liability in areas where it doesn't belong.

I thank the author for his thought-provoking article.

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