Presidential Address

HMOs: The View from the Right

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HEALTH MAINTENANCE organizations, HMOs, a form of managed medical care, are proliferating. In 1986 the number of HMOs increased 30 per cent from 480 to 626. The number of enrollees in these plans increased 23 per cent to 25.8 million from 21 million. It is estimated that HMO enrollment this year will increase 20 per cent to 31 million, or 11.7 per cent of the population.[1] In Metropolitan Chicago over the past year the enrollment in HMOs has increased from 12.1 per cent of the population to 15.7 per cent.[2] This represents a 30.5 per cent increase (however the monthly growth rate for March of 1987 was but 0.1 per cent, the lowest monthly rate experienced yet). The reason for this increase is the perception that HMOs will decrease the cost of medical care. Controversy exists, however, concerning whether or not this savings can be achieved without sacrificing quality of care.

The subtitle of this talk is "The View from the Right." By definition this could be from the political right, the conservative or reactionary. Traditionally members of the political right have wanted to change little or to backtrack into past times. In the United States today the political right is said to stand for free enterprise, competition, and decreasing federal intrusion into the workings of our society. A right view would also be correct in thought, statement or action. This view would rely on what is just, lawful, morally good, proper and correct. Although this speaker clearly stands to the political right of the center aisle, the main emphasis of this treatise is the moral correctness of medical practice.

In the halcyon days of the 1950s and 60s there was pressure to increase use of medical services. This pressure came from hospitals who, although full, kept building new additions. The insurance companies were eager to raise premiums to meet the demand as their profit increased directly as a percentage of the total premium dollar. Busy physicians helped fuel this use as they truly believed best medical care was delivered in the hospital setting. And finally the patient demanded to have the best of care in the most up-to-date facility. Even when care was not an issue, i.e., "Why can't you take care of grandmother for the weekend, the insurance company will pay for it," taxpayer patients were willing accomplices.

Later in the 1970s, certainly in the 1980s the pressure has been to reduce the use of health care facilities. This pressure was initiated by the federal government, which was becoming inundated by the cost of Medicare and Medicaid programs. Whereas in 1960 $26.9 billion, 5.3 per cent of the gross national product, was spent on national health care expenditures, this had risen to $248.1 billion or 9.1 per cent of the gross national product by 1980, and it is estimated that by the end of 1987 this will have risen to $511.9 billion, 11.4 per cent of the gross national product.[3] Although the rate of increase has been slowed over the past 4 years, it shows signs of another upward trend. The pressure to decrease this monetary spiral also comes from 1) traditional health insurance companies who are in a highly competitive market with alternate delivery systems, 2) industry as a payer of premiums who are shocked when the cost of medical insurance per automobile is greater than the cost of steel, and 3) from competing alternate delivery systems including HMOs.

The federal government realized sometime ago that there were tremendous differences in the economics of medical care. The admission rate from region to region varied as much as 22 per cent whereas the length of stay varied 45 per cent.[4] It is no wonder that the Medicare administrators are pushing for a single DRG that would

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cover the length and breadth of this country, eliminating regional rates of remuneration. The current DRGs, which were initiated in October 1983, have decreased the average hospital stay 9 per cent in the past 2 years.

In an alternate delivery system such as an HMO the patient/consumer pays a more or less fixed rate for his or her medical care. Regardless of how much is spent during the year, the patient's medical needs are covered. The advantages of an HMO for a consumer are equal benefits and less risk. The HMO carries most of the risk for costly care. The disadvantages to a patient are that there may or may not be physician or site selection. That is, the patient may be assigned to a doctor who will see that patient at a site that has been previously selected by the HMO. The selection of both the doctor and the site are usually based on economics. Quality of care is assumed but never proven.

The health maintenance organization must use its premium to cover all expenses and generate a profit. If the gatekeeper, usually a family practice or internal medicine physician, controls the expenses, the HMO makes a profit. However if the gatekeeper does not control expenses, the HMO does not show a profit and loses money. Less care generates a greater profit.

In the average HMO it is estimated that the distribution of expenses are as follows.[5] Thity five to 45 per cent goes to professional medical compensation. Traditionally the physician receives 20 per cent of the medical dollar. The 35 to 45 per cent figure includes all outpatient services including professional services. Twenty five to 35 per cent of the HMO expenses goes to inpatient hospitalization expenses. Fully 12 to 15 per cent goes into administration. This figure is actually higher for those smaller HMOs and those HMOs that are just beginning. Ten to 15 per cent is earmarked for other expenses.

HMO administrative expense is higher compared with traditional health insurance. The Blue Cross and Blue Shield 1985 National Cost Survey reported an 8.2 per cent increase in man years despite a 3.6 per cent business decrease. Their 11 per cent decrease in productivity was attributed in part to the addition of staff for managed care.

Currently there is a favorable HMO climate. Empty hospital beds are the rule in most communities. The occupancy for the Chicago Metropolitan area for the first quarter of 1987 was 61.5 per cent. This decrease was evident both within the city limits (60.2%) and in the suburbs (63%).[6] Secondly it is clear that we have too many physicians. Whereas in 1970 there were 312,000 total physicians, in 1985 we had 511,000 and it is projected by the year 2000 we will have 683,000 physicians. Correspondingly the number of physicians per 100,000 of population has increased from 183 in 1970 to 214 in 1985.[7] This favorable HMO climate was maximal in the early 1980s when there were few HMOs in competition with each other.

Conversely an unfavorable HMO climate would exist if there were full hospitals and thus hospitals would not feel compelled to negotiate for discounts, if there was no over supply of physicians so that the physician would not feel compelled to negotiate for a discounted rate, and if there were too many alternate delivery systems in existence so that competition among HMOs would drive down their profit.

The administrators of Medicare have initiated and encouraged HMOs to care for the Medicare patient. They believe the competition will keep prices down. They are aided and abetted by the political "grey power" that lobbies through the AARP in the halls of Congress. And in fact costs have been reduced. Dr. Otis Bowen in his Shattuck lecture of 1987[4] stated that there were 14 plans that charged no extra monthly premiums, 19 that charged less than $20 a month, 52 plans that charged $20 to $38.51, and 40 plans that charged more than $38.51 per month for coverage. This compared with the average medigap premium of $49.80 that was available on the commercial market. This push for cost savings for Medicare has not been entirely painless as is evidenced by the contract termination of International Medical Centers in the Miami area.[8]

Yet all is not well in the HMO financial world.[1] Maxicare, a rather large HMO that is prominent in the Chicago area, last year increased their enrollment by 221 per cent to 2.2 million from 695,000. Their revenues increased 75 per cent to a total of $914 million. Yet their profit decreased 79 per cent netting $4.3 million compared with $20.4 million the year prior. HMO America likewise reported an increase in revenues but a decrease in profit. This Chicago based HMO had a loss of $2.4 million in 1986 compared with a profit of $2.8 million in 1985. Others who either lost money or had decreased earnings during the year are Med Life Health Care Management, John Hancock Health Plans, Sierra Health Services, Hospital Corporation of America, and Humana Care Plus. This listing of financial woes should not be taken as a moanful dirge. Many HMOs are alive and well in today's economic market. These statistics do point out that competition is not only between HMOs and traditional health care but also between rival HMOs.

In the April 30, 1987 issue of the *New England Journal of Medicine* there were a series of articles including an editorial decrying the impact of managed health care.[3,8,9,10] These articles centered on the theme that the physicians received more remuneration for not treating the patient than they did for administering quality care. These articles suggested that this set of circumstances

engendered physician amorality. Arnold Relman in his editorial suggested that physicians in independent office practice should avoid any arrangement with a for profit corporation that rewards them for choosing a particular facility or service for their patients, or restricts the choices they can make. He further suggests that physicians should not enter an arrangement with any organization that directly rewards them for withholding services from their patients.

Is this really a pertinent issue? Are patients being denied care so that HMO and physician coffers are being lined at the expense of their patients' health? Potentially, a declining profit margin will pressure HMOs and their M.D.s to decrease either cost or essential services. For indeed when all the fat has been rendered from the overuse of our current medical system, the physician costs in both HMO and traditional private practice should be equal, the laboratory fees should be equal, and the hospital costs should be equal. The HMO and other managed medical systems should then sink because of the increased cost of administration. The only way this increased cost of administration can be balanced is by the amoral trimming of quality of care. Under these circumstances, quality control needs to be sharply addressed.

The federal government has contracted to a variety of professional review organizations (PROs) to insure that indeed quality is controlled. In my area these PROs are woefully inadequate. It seemingly makes little difference if my patient loses his life or suffers an unnecessary amputation yet one of the unholy sins is to discharge a patient with a temperature of 38°C. In my estimation these review organizations are charged with cost containment and they have nothing to do with the quality of medicine. There is even suggestion in a recent publication that PROs are posting excessive profits![12]

The threat of malpractice is said to ensure that we will practice good medicine. To my knowledge no studies have shown that indeed the quality of medicine increases because of malpractice litigation. I have perceived the malpractice attorney as a blind hunter with a shotgun. Sometimes he hits the correct prey but more often he injuries innocents that are around him. I do not believe that malpractice in any way, shape or form affects quality.

And what about physician morality? Although I fully understand the profession is not perfect, I am encouraged by my colleagues who everyday toil living the Oath of Hippocrates. This Oath as administered to the students at the Stritch School of Medicine, Loyola University of Chicago states in part, "I will practice my profession with conscience and dignity," and "the health of my patient will be my first consideration." As I scan the audience of the Midwest Surgical Association I see right, just, lawful and morally good physicians who are taking time from their practice to learn and ultimately better their patient care. I believe the system is in good hands.

Lastly we should discuss patient (consumer, taxpayer) pressure to control the quality of care. Dr. Bowen in his Shattuck Lecture states "Any system that truly aspires to high quality must accommodate personal preferences." In our open society the masses who perceived the effeteness of Jimmy Carter and who were repelled by Watergate as well as Irangate, will be our judges. I have great faith that this society will be correct in the end—especially if physicians promulgate the tenets of excellent care. It may well be that our profession shall have to educate the public concerning excellence. We may have to finally admit some physicians are truly superb—others are merely adequate.

It is my view that HMOs are right for the 1980s. These organizations are a vehicle for cost containment that is appropriate for trimming the excesses from our overused medical system. But in the end there may be a clash between the pecuniary interests of an administratively top-heavy HMO and the quality of medical care. Unless PROs change dramatically, the resistance to the lowering of standards of medical care will rest mainly on the shoulders of right and just physicians, such as members of the Midwest Surgical Association. If our stand is morally correct, we will be supported by an enlightened public, our well cared for patients. The end result should be a "right" medical care system.

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