

Are Health Maintenance Organizations  
Really Delivering What They Promise?

92/100

Sample Paper # 1

-Synthesis

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Careful!  
Don't do subjective  
analysis.

INTRODUCTION

The medical field is a very complex industry. Almost everyone sometime in their life will have to use the services of the health industry. For this and many other reasons, we need to understand how to get the best medical care for our money. There are many health care systems for people in the United States to choose from. Depending on the type of system chosen will determine how they will receive and pay for their medical care. These different systems have been the topic of many debates in the medical, economic, business, and public sectors. The main reason there are so many types of medical care systems is because medical care is limited in quantity but is a service that everyone must have (Gumbiner, pg. 1). <sup>mis is patently false. Not everyone DOES</sup> ~~have~~ access to U.C. | Disproving the

STATEMENT BY counterexample

Managed care is rapidly dominating the health care financing and delivery system in the United States. To illustrate, health maintenance organization (HMO) enrollment reached 51 million in 1994 (Kongstredt, pg. 3). Understanding the advantages and disadvantages between HMOs and other types of health insurance plans is an interest to many people including ourselves so we can determine which health plan will be the best for us. Some of the advantages of managed care are; reduced health care costs, HMO benefits that are comparable to those of traditional insurance, accessibility, superior quality control methods, high member satisfaction, satisfaction with managed care physicians, coordination of care, case management programs, and availability of extra services. All of these are great in theory, however there is a down side. Some of the disadvantages are; limited choice of physicians, loss of control by physicians, the balancing of cost and quality, long waiting time for care, shorter time with the doctor,

limited access to necessary services, more rules to follow, confusion about what is

what's that?  
isn't this an advantage?

expected, insignificant cost savings, and inconvenient locations (Cafferky, pg. 14-15). There has been a lot of research done in this area which evaluates these health plans. Much of the research varied in that the older studies seemed to focus on the benefits of HMOs while the newer studies seemed to uncover the problems with HMOs.

The United States is searching for the best way to provide quality medical care to the greatest number of people at the least cost. The newest system in the medical industry is the health maintenance organization or HMO as it is often referred to. An HMO is a group that contracts with medical facilities, physicians, employers and sometimes-individual patients to provide medical care to a group of individuals. An employer at a fixed price per patient usually pays for this care. Patients generally do not have any significant out of pocket expenses. An HMO is usually a for profit corporation with responsibilities to its stockholders that may take precedence over its responsibilities to the patient. The HMO directly and indirectly controls the amount of health care that the doctor is allowed to provide to the patients ([www.hmopage.org/hmonow.htm](http://www.hmopage.org/hmonow.htm)). This system was devised to give more people access to medical care, keep the costs of medical care down, and ensure good quality of care. After years of study, the question still remains if HMOs are doing what they promised to do. There are many areas that need to be looked at when trying to answer this question, but the three main issues that will be examined in this paper are access, cost, and quality of care.

## REVIEW OF LITERATURE

America has perhaps the best doctors, the best hospitals and the best medical technology and its health spending is the most lavish in the world (Cowley et al., pg. 58). Even with all of this there are still many problems within the health industry. One of the first problems that need to be looked at is how much access people have to health care. The most serious failing of the United States health care is the failure to guarantee access to care (Gumbiner, pg. 5). Access is generally measured by customary health statistics like infant mortality rates, immunization rates, and average life expectancy. The United States does rank among the highest in the world in these areas, however there is a big difference between socioeconomic classes, which is directly related to access of health care. The inherent design of HMO regulations broaden access to care by defining premium rating structure, mandating services, requiring geographic access standards, limiting out of pocket expenses, and limiting eligibility clauses designed to protect the insurer from adverse risk (Gumbiner, pg. 5).

Another way to think of access is that appropriate and necessary care is actually received by the consumer regardless of race, age, sex, and geographical distribution (Gumbiner, pg. 32). This has not always been the case. In traditional health care methods, medical care has been expensive and often hard to find if you live in an inner city or rural area. These systems also discourage routine preventive care and early diagnosis and treatment of illnesses, while HMOs emphasis is on prevention as well as cure (Gumbiner, pg.6). Early in development, HMO philosophy centered on the premise that by keeping people healthy through regular checkups, monitoring, and such concepts as well-baby checks blended with patient education, targeted services could be provided

over

→ You're treating "Appropriate & necessary care" as if that were an Absolute, something that is objectively and easily defined. But that is certainly not the case. It is almost wholly subjective, not objective, and hence extraordinarily difficult if not impossible to define.

Granted, I'm sure that researchers you read act as if this were an Absolute, objective term.

But that is merely a reflection of a major weakness w/ their own work.

less expensively and people were kept healthier longer than through the traditional system (Robbins, pg. 32).

HMOs often prepay for high volume services, empowering the practitioner to deliver services, which are preventative in nature (Al-Assaf, pg. 10). This allows the physician to go ahead and give certain early screening tests for diseases without worrying about the cost. Although HMO plans have the ability to do this does not mean it is always done. In an HMO system the physician has the role of “gatekeeper.” In theory, this role is to determine medical appropriateness, regulate the opening and closing of the gate, and direct the patient to emergency services, hospitalization, specialty services, pharmaceuticals, and durable medical equipment (Robbins, pg. 13). This idea is great for the patient when there isn’t a strong understanding of their illness and they are not sure whom they should be seeing about their problem. However, many times the patient’s perspective of gatekeeping is not a good thing. It is often one of the most frustrating and insidious elements of managed care because it is perceived as restricting, delaying, or even preventing what may very well be appropriate and timely care (Robbins, pg. 13). Part of the problem with the physician being the gatekeeper is that he/she has a conflicting role of protecting the plan’s assets as well as his/her own financial risks, while at the same time being responsible for caring for the patient (Robbins, pg. 14). The physician is also not the only one that decides how much care should be given to each patient or if a referral to a specialist should be given. There are many non-medical professionals that are part of the HMO that have the ability to decide what type of care should be given. This is usually done on the basis of the physicians’ report, but the administrative elements of the organization are trying to run a business, which usually

I think it appropriate to mention the moral hazard problem of over-utilization of services prevalent under F-F-S medicine. Without that as a reference it's difficult to place the HMO gatekeeper role in context. You should also note that it is impossible, because of scarcity, to satisfy all of T for U.C.

→ And so? This could easily be argued to be efficient. Which care you arguing?

means making a profit. Access to specialists was denied to 15 percent of HMO members, but to only 3 percent of fee-for-service patients (Cowley, pg.60). HMOs do need to limit the amount of medical care given, but without compromising the health of the patients.

→ over

When first looking at these numbers it looks really bad for HMOs, but when looking at the incentives of a fee-for-service type plan it would make sense for them not to deny as much care, therefore getting more money. Fee-for-service reimbursement encourages a "more is better" mentality of delivering services; more services maximize more reimbursement (Al-Assaf, pg. 7). Capitation, which is money paid to a provider on a per capita basis prior to delivery of services for each member the provider expects to serve, encourages maximizing volume while limiting services (Al-Assaf, pg. 7). These numbers show both of these situations. Often times to the patient it seems as if they are being denied care that they think they should have. In reality HMO patients might spend less time per visit with their physician, but they also might see their physician more frequently than someone who is not part of an HMO. The overall access to care has also been found to be the same and many times better than the traditional health plans. It is the responsibility of the HMO to find the acceptable service range where neither underutilization nor overutilization practices are rewarded (Al-Assaf, pg. 7).

good

A decade ago, when HMO's first became a huge force in health care, signing up millions of people almost overnight, the promise was top-quality; hassle-free care; and yes, a cap on exploding costs (Watson, pg.63). Under the fee for service method, as new technology comes out the cost is passed to patients because of the duplication of equipment due to individual practices (Gumbiner, pg.5). In the HMO system cost is



Do you really believe this to be true? Think of this from a societal point of view.

Suppose \$100 million treatment will "not compromise a person's health" while anything less will. Do you truly think that such should routinely be provided?

The issue from an economic perspective is one of cost effective treatment. One where  $MB$  of treatment  $>$   $MC$  of treatment.

But certainly not the notion that the health of the patient can not be compromised.

cutback because many doctors are sharing equipment therefore reducing the spending on equipment and new technology.

Another way HMO's reduce cost is by providing preventative measures for their patients, such as mammograms and digital-rectal exam. These practices save money in the long run for the patient as well as the HMO company by preventing a disease or radical treatment from occurring. However, other studies have shown that HMO companies with a pre-paid monthly fee have an incentive to provide too little of care to their patients in order to increase their profits. It has been shown that HMOs have decreased cost by decreasing the utilization of hospital services. The question still remains if this has been done because of the preventative care that HMOs provide, or if it is done because of the economic incentives to do so (Davis et al., pg. 147). To try and answer this type of question a study of HMO's and two other types of health plans were done. The Rand studies compared the cost and usage among people who were randomly assigned to one of three payment plans: free fee-for-service, fee-for-service with patient cost sharing, or a prepaid group practice. This study found that the average annual cost of providing medical services in the HMO was \$439 per person, compared with \$609 per person in the free fee-for-service. Also, 85 percent of the enrollees in the free fee-for-service group used some form of medical services over the year and 11 percent had one or more hospitalizations while 87 percent of the enrollees in the HMO group used some form of medical services, only 7 percent were hospitalized. The number of hospital days were also greater for the fee-for-service group which had 83 days per 100 persons compared to only 49 days per 100 persons for the HMO members. These lower hospital utilization rates accounted for 25 percent lower costs for HMO enrollees compared with

*this may be efficient.*

the fee-for-service enrollees (Davis et al., pg.145-146). Although this all appears to be good there are still some problems when really looking into these numbers. The question that has been under debate for a long time is if lowering the costs of medical care by having fewer stays in the hospital is lowering quality of care.

By many indications, the health care system is a mess. Managed care was supposed to boost quality while holding down costs. But quality hasn't improved by objective measures- and after five years of relative stability, costs are on the rise. Quality is rapidly becoming a global issue and is of concern to both the suppliers of services and the consumers of those services. In health care, quality is reaching a new dimension in that it is being demanded and expected and providers are judged by it (Al-Assaf, pg. 31). Understanding exactly what the term "quality of care" means is another roadblock that makes it difficult to find out which health care system is the best. Many people have many different ideas of what the term is referring to. To the provider it might mean offering the best possible care available to the patient. To the administrator it might mean providing effective care in a cost-conscious environment that may include rationing, especially when resources are limited.

good

Finally, to the patient, quality of care might mean getting care "when and where I need it by whomever I choose to cure my symptoms in the fastest possible way" (Al-Assaf, pg. 35). Not only is there differences between these three groups, there can also be some differences within the groups themselves. For these reasons it is very difficult to measure quality of care.

According to one source, quality is achieved when accessible services are provided in an efficient, cost-effective, and acceptable manner (Al-Assaf, pg.21). Is

quality better in the traditional medical plans, or have HMOs made quality better like they promised to do? Once again, this is a difficult question to answer. But, by looking at how the consumers feel about their insurance plans and the types of medical care that is provided we can help answer this question. One of the concerns that people have with HMOs and their quality of care is in the dividing of loyalty between the patient and the health plan. The inference is made that divided loyalty may compromise care (Robbins, pg. 7). The division comes from the HMO trying to save money and the physician getting some kind of incentive to deny care in order to keep costs down. If this is the case, it is easy to see where people would be concerned about their quality of care and not knowing for sure if they were getting all the possible treatments for their symptoms, or if the doctor was withholding care in order to benefit him/her self. There will always be some money-driven physicians, but there will not be anymore in an HMO than in any other health plan (Robbins, pg. 7). HMOs are raising their rates, prompting employers to trim or even eliminate benefits for their workers. And partly as a result, the number of people without health insurance is exploding. According to a new report from the Census Bureau, 44.3 million Americans, some 16% of the population, don't even have any coverage at all (Cowley, pg. 60).

*But this looks at only 1 of the 3 groups identified*

The fact is, millions of Americans receive flawed or inadequate medical care each year, and many are harmed as a result. But, HMO members are at no greater risk than anyone else is. As the Institute of Medicines Roundtable on Health Care Quality concluded in a recent study, these problems “occur with approximately equal frequency in managed care and fee for service systems of care... therefore quality of care is the problem not managed care.” (Cowley, pg. 60). The fact is, millions of Americans receive

flawed or inadequate medical care each year, and many are harmed as a result. Studies show that half or more of the eligible heart attack patients don't receive the beta-blockers that could reduce their risk of another heart attack. A "substantial number of cancer patients do not receive care known to be effective for their condition", says another study. And each year, 106,000 hospital patients die from adverse drug reactions-wrong dose, wrong drug, wrong patient or wrong mix with other drugs (Watson, pg. 64). These are serious problems that need to be fixed, but the studies show that these problems occur in all types of health plans, not just HMOs. Even with all of these problems the medical field has come along way in what it can do as far as curing diseases and better treating people. In this way quality of care has definitely gotten better on account of science.

## CONCLUSION

Americans are still learning the how and why of managed care. From most of the studies that have been done up to this point, the conclusions have been pretty vague on whether HMOs or traditional health plans are better. Just as in most areas of life there are positives and negatives, which also happens to be true with HMOs. After weighing the pros and cons of HMOs versus traditional health care plans, it seems that HMOs are a good way to go about getting medical care. They may not have done all they promised to do, but they have helped in various areas such as preventative care. This is a good change from regular insurance plans that can help with major medical problems, but don't help with everyday illnesses which is the majority of most families medical care (Gumbiner, pg. 9).

HMOs claim that they and their networks of health care providers are capable of producing the lowest cost delivery of quality care in the nation (Cafferky, p.8). Right now there is no such thing as a perfect health care system. There are many variables that still need to be studied before we can even hope for a better system. Even with all of the problems with medical care, the United States still has one of the best health care systems in the world, no matter what type of health plan is used. The debate about whether HMOs have done all they have promised will most likely continue until some strong conclusive evidence one way or another has been found. Up to this point the general conclusion has been that HMOs may not have done everything they started out to do, but they also have not had any more failings than any other health plan.

One area that still needs more research and might help with finding more conclusive answers to these questions is by tracking the health outcomes of HMO members. This would also have to include tracking the health outcomes of the HMO members that were denied care for whatever reason. By doing this type of research we would be able to see if the care that was denied really did help contain costs, or if it was just causing other problems down the road. It would also help clarify the quality of care issue. After this type of research is done we can then compare HMOs to traditional health plans and have more valid conclusions to the effectiveness of HMOs on access to care, cost containment, and quality of care.

Good Job

- Biggest problem was reference to subjective analysis.
- Good overview of problems
- Good synthesis of literature
- Plus tied it together well.

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