Health Maintenance Organizations (HMO) in the U.S.

by Hirosuke Iwasaki
Life Management Dept.

Introduction

In a telling scene from the movie *As Good As It Gets*, Helen Hunt portrays a single mother whose son has frequent seizures. To spare her the agony of rushing to the emergency room each time, an interested suitor played by Jack Nicholson hires a doctor, who does some simple tests on the son. When the son turns out to be allergic, the doctor asks the mother why the tests were not done earlier. The mother angrily replies that her HMO would not pay for the tests.

HMOs are a type of private health plan that has grown rapidly due to their relatively low premiums and high quality of care. But as the movie suggests, HMOs are not without problems.

In this paper, we look at medical insurance issues in the U.S., the advantages and disadvantages of HMOs, and pending legislation in the U.S. Congress to regulate HMOs.

1. Health Insurance Issues in the U.S.

Health insurance is facing a dilemma in the U.S.—many people are uninsured, while medical care costs continue to rise.

(1) Increase in Number of Uninsured Persons

The most serious problem of health insurance in the U.S. is that a large and growing number of people do not have any. Unlike Japan, the U.S. does not have national health insurance. Public health insurance programs cover only 26 percent of the population through Medicare, which covers disabled persons and the elderly, and Medicaid, which is aimed at the unemployed and low-income groups. Most people must enroll themselves in an insurance program. As a result, approximately 15 percent of the population has no health insurance.

Of course, a few of these people are rich enough not to need insurance. But the problem lies with lower income workers (and their families) who cannot afford to buy insurance. Since they cannot afford to see a physician very often, they tend to let their condition worsen before seeking treatment. The eventual medical costs may turn out to be devastating should drastic treatment be needed.

Table 1 Status of Medical Insurance Coverage in the U.S.

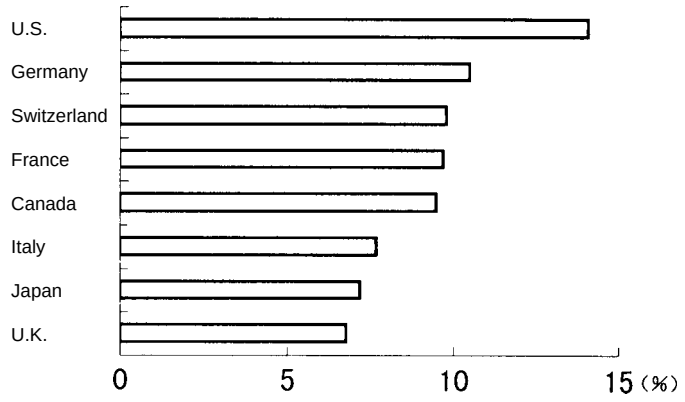
	1988		1995	
	Million persons	%	Million persons	%
Population	242.4	100.0	263.6	100.0
Private medical insurance	180.5	74.5	185.7	70.4
Employer sponsored plan	158.5	65.4	159.0	60.3
Other	22.2	9.2	26.6	10.1
Public medical insurance	55.5	22.9	69.0	26.2
Medicare	30.5	12.6	34.6	13.1
Medicaid	20.7	8.5	31.8	12.1
Military plan	9.2	3.8	8.6	3.3
Persons not covered	32.7	13.5	40.6	15.4

Note: Discrepancy in totals arise because some people are enrolled in both private and public insurance plans.
Source: *EBRI Databook on Employee Benefits, 4th Edition.*

(2) Rising Medical Costs

Rising medical costs are a serious problem for the U.S. economy. In 1996, the ratio of national medical expenditures to GDP reached 14 percent, which is very high by international standards. Moreover, the Department of Health and Human Services warns that unless something is done, the ratio will rise to 18 percent in 2000 and 32 percent by 2030.

Figure 1 Ratio of Medical Expenditures to GDP (1996)



Note: Values for Switzerland and Japan are for 1995.
Source: *OECD Health Data 1997.*

Higher medical costs translates into higher insurance premiums. As a result, small business owners would become unable to pay premiums for their employees, causing the proportion of uninsured people to grow. The Congressional Budget Office estimates that 200,000 people would lose their insurance coverage for every 1 percent increase in premiums.

The cost efficiency of medical care is in need of improvement. Managed care, of which HMOs are typical, is one solution.

2. Private Health Insurance Types and Managed Care

(1) The Four Types of Private Health Insurance

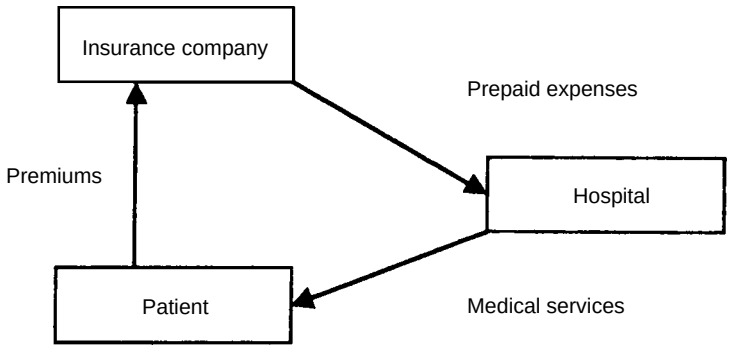
Previously, the majority of private health plans consisted of what is called fee for service (FFS). Today there are four main types of insurance available.

1. HMO

An HMO is an insurance company that operates a network of hospitals and physicians, and pays for medical services only if they are supplied within the network. People who belong to an HMO are assigned to a physician, but can received specialized care from another physician by referral. They can use other hospitals in medical emergencies, but must first call the HMO for instructions because certain rules and restrictions apply.

In many cases, the insurance company prepays the hospital a fixed amount per patient regardless of actual costs incurred. The hospital must carefully budget this payment to cover costs. By giving hospitals and physicians an incentive to cut costs, this system aims to reduce unnecessary expenses and thereby minimize insurance premiums.

Figure 2 Schematic Diagram of HMO



2. POS (Point of service)

This is an improved version of HMO that offers a wider selection of hospital and physicians. Participants are assigned an attending physician. Medical treatment within the network is free of charge, but participants must pay the medical bill first and receive a full refund from the insurance company later. They can also receive medical treatment outside of the network, but must pay a deductible.

3. PPO (Preferred provider organization)

A PPO operates a network of hospitals and physicians, but members are not assigned to a particular physician. The insurance company secures a fixed number of patients and pays the hospital a predetermined amount, in return for which the hospital discounts its medical costs. Premiums are lower than with FFS due to the discounting.

4. FFS (Fee for service)

This is a traditional type of insurance wherein the insurance company pays the full actual cost of treatment to the hospital or physician. Policyholders can basically choose any hospital they like. Of the four types of insurance, FFS premiums are the highest.

Figure 3 Schematic Diagram of FFS

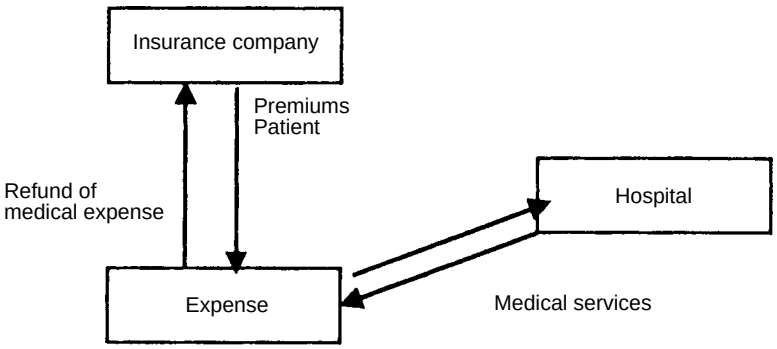
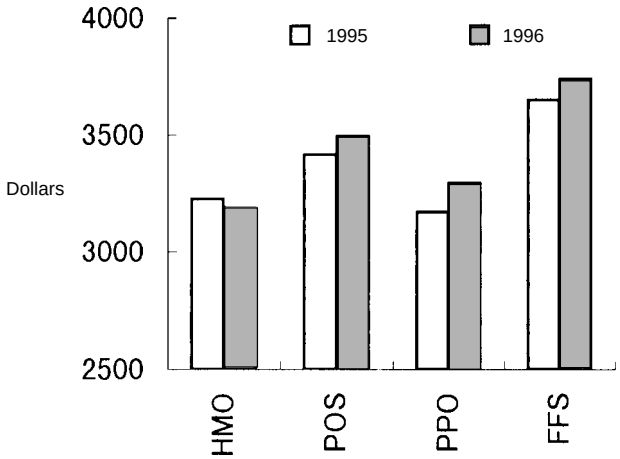
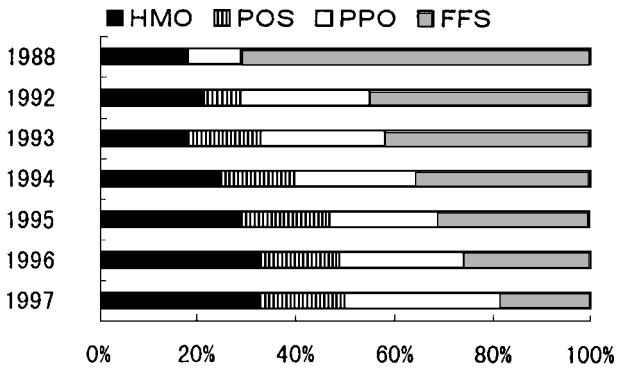


Figure 4 Insurance Premiums per Person



Source: Foster Higgins

Figure 5 Private Insurance by Type



Note: Shows proportion of policyholders.
Source: KPMG Peat Marwick

In terms of market share, FFS used to enjoy a majority share, but has fallen below 20 percent as of 1997 due to the rapid growth of the other three types in recent years.

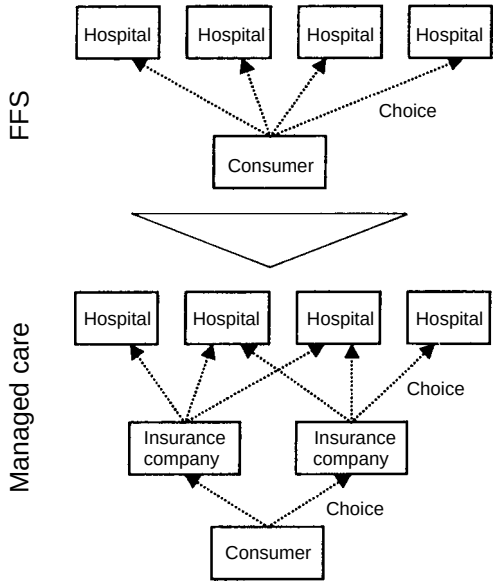
(2) Managed Care Plans

Managed care, which is comprised of HMO, POS, and PPO, refers to organizations or systems that comprehensively manage medical services for convenience, cost, and quality of care.

The major difference between receiving medical care and transactions such as buying a car or eating at a restaurant is that consumers (patients) often do not have adequate information on medical services, or have difficulty understanding the information they are given (asymmetry of information). It is difficult for most people to judge whether the medical treatment they receive is appropriate and necessary. As long as this situation persists, medical service suppliers can avoid competition.

Managed care acts as an intermediary between the consumer and hospital and alleviates the problem of information asymmetry. To make their insurance products as attractive as possible, insurance companies sign up new hospitals that offer efficient medical care while encouraging their existing hospitals to cut costs and improve quality. By encouraging competition, managed care thus plays an important role in improving the efficiency of medical services.

Figure 6 Schematic diagram of FFS and Managed Care



3. Pros and Cons of HMOs

While HMOs and other forms of managed care have played a major role in improving the efficiency of medical services, HMOs have also been the target of many complaints.

(1) Efficiency Improvements

Examples of how HMOs strive to improve ef ficiency include measures for preventive treatment and early detection, and guidelines for medical consultations.

1. Prevention and early detection

Medical costs can often be reduced through preventive measures and periodic physical checkups for early detection. These practices also boost the patient's satisfaction, and contribute to a high level of medical care overall. HMOs thus emphasize prevention and early detection by offering vaccinations and annual cancer examinations free of charge.

2. Guidelines for medical consultations

Previously, physicians relied heavily on their experience and intuition for diagnosis, there were often disparities in the quality of care. In addition, physicians tended to perform more tests than necessary to be safe causing medical costs to increase.

Table 1 Guidelines for Bladder Infection

● For women age 18 to 64 who have simple symptoms of bladder infection, urine cultivations are not necessary for diagnosis. ● Infections can be eradicated with three days of antibiotic treatment.

After these guidelines were introduced, there was a decrease in the proportions of both urine cultivations and antiobiotic treatments lasting more than three days. As a result, annual costs have been reduced by $5,500 per employee.

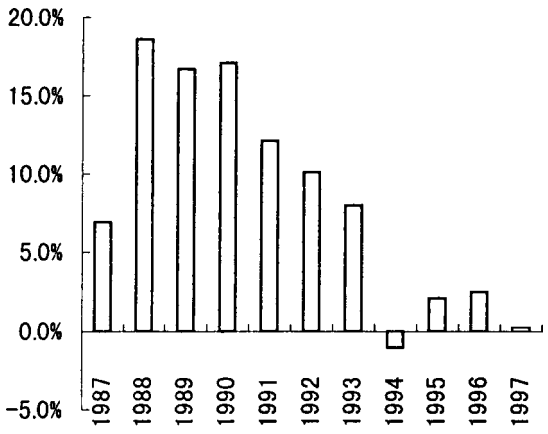
Source: *Journal on Quality Improvement,* November 1996.

Recently, medical consultation guidelines have been established based on scientific data collected primarily by HMOs, and introduced in network hospitals. Table 1 contains an excerpt from the Mayo Clinic's guidelines.

Such guidelines are formulated after creating a database of actual medical care actions taken and statistically determining which actions are most efficient. By establishing a statistical basis for medical care based on actual data, this approach aims to improve the quality of medical care while cutting costs by omitting unnecessary actions. But the guidelines have also been criticized for restricting physicians from using their own judgment.

In fact, growth in medical costs, which had exceeded 10 percent annually from the late 1980s to early 1990s, slowed suddenly from 1994. While HMOs attribute this to their cost cutting efforts, further analysis is needed to verify this claim.

Figure 7 Growth Rate of Medical Costs for Employees



Note: Includes retired employees.
Source: William Mercer

(2) Horror Stories

The growth of HMOs has triggered a number of consumer complaints, including inadequacy of medical care due to excessive cost cutting, excessive restrictions in the choice of hospitals, and the need to follow instructions from the HMO even in emergencies. Mishaps regarding HMOs frequently appear in newspapers.

Table 2 Horror Stories

● In California, a 27 year old male was forced to check out of the hospital just four days after undergoing heart transplant surgery because the HMO refused to pay for a longer stay. Moreover, the HMO refused to pay for bandages to prevent infection after the operation. The man died. (The Enterprise Record, January 21, 1996)
● In Atlanta, a six month old baby boy was suffering from severe palpitations and high fever. The mother called her HMO hot line at 3 a.m. and was instructed to go not to a nearby hospital but one 68 kilometers away. The resulting delay in receiving medical treatment resulted in having to amputate the boy's arms and legs. (Long Island Newsday, February 11, 1996)
● A young boy with severe head injuries from a traffic accident was rushed to the hospital, where doctors gave him only a few hours to live. Miraculously, after 16 days in a coma, the boy awakened and responded with awareness although he could not speak. When the physician sought to transfer the boy to a rehabilitation facility, the HMO would only approve an affiliated nursing facility. The HMO finally yielded, but not until the parents had appealed to their state and U.S. representatives. (from Congressional testimony, October 1997)
● In Florida, an elderly woman collapsed in her home and was rushed to a hospital, but died from a brain hemorrhage. Her HMO refused to pay the $30,000 medical bill on the grounds that she was taken directly to the brain specialist without a referral from the emergency room. (U.S. News and World Report, October 13, 1997)

4. HMO Legislation

Congress is presently deliberating on legislation to regulate HMOs. HMO reform is becoming a hot issue in this midterm election year.

Over 50 HMO reform bills have already been introduced in the Congress. One of the most prominent is PARCA (Patient Access Responsible Care Act), which was introduced by Rep. Charles Norwood (R–GA) and has 211 bipartisan co-sponsors.

(1) PARCA

Some of the stipulations in PARCA are as follows.

* HMO networks must provide an adequate number of physicians in diverse fields, and guarantee that patients can receive medical care promptly at hospitals that are adequately close to their homes or workplaces.
* A uniform definition is established for emergency care, and as long as patients receive emergency care in conformance with the definition, the HMO must pay costs regardless of the hospital or treatment.
* If deemed necessary, the HMO must guarantee that patients can receive special treatments that are not available within the network.
* HMO contracts cannot contain provisions that restrict the physician's ability to discuss treatments with patients (that is, to inform patients of treatments not covered by the HMO).

(2) Opposition to PARCA

While PARCA is enjoying strong support in Congress, opponents the regulations as unnecessary and costly.

In particular, opponents claim that PARCA will force insurance companies to raise their premiums, thus increasing the number of people not covered by insurance. According to one estimate, PARCA would increase premiums by as much as 23 percent. Using the CBO's assumption that every 1 percent increase in premiums causes 200,000 persons to become uninsured, as many as 4.6 million people could lose their health coverage. This amounts to a 10 percent increase in the number of people without insurance. PARCA is also opposed by the Health Insurance Association of America and insurance companies.

5. Conclusion

The managed care approach, which pursues efficiency based on competition among medical service providers, is of great relevance to Japan. In its final opinion issued on December 12, 1997, the Administrative Reform Committee recognized this alternative by calling for a new social insurance system based on new standards of value for efficiency, cost consciousness, and competition. But before managed care can be introduced in Japan, the groundwork must be laid by formulating medical treatment guidelines and developing methods to evaluate medical care.