

MANAGING FINE: HOW TO LOVE THE HMO



For 35 years, Canadians have defined their health care system mainly in terms of what it is not: the US model. But, these days, what is the US model? In this reprint from the March 20, 2000 issue of The New Republic, Senior Editor Gregg Easterbrook provides an update on the Health Maintenance Organization, the institutional device that now dominates US health care. Although the US system still does not provide universal health insurance, Easterbrook argues that HMOs have done a remarkable job of controlling health care costs, and are not quite as ruthless in walking away from their contractual obligations as is often thought.

Gregg Easterbrook

Depuis 35 ans, les Canadiens définissent leur système de soins de santé en fonction de ce qu'il n'est pas : le modèle états-unien. Mais où en est, de nos jours, ce modèle états-unien ? Options politiques reproduit ici un article publié le 20 mars dernier dans The New Republic, sous la signature de l'éditorialiste en chef Gregg Easterbrook. L'auteur rafraîchit nos connaissances sur les « Health Maintenance Organizations » (HMO), ou Organisations de préservation de la santé (OPS) : il s'agit de l'appareil institutionnel situé au cœur du système de santé actuellement en vigueur chez nos voisins du Sud. Ce réseau, sans offrir encore l'assurance-maladie à l'ensemble de la population, possède selon Easterbrook deux caractéristiques intéressantes. D'une part, il a effectué une besogne remarquable dans la maîtrise des coûts du régime. D'autre part il respecte, plus qu'on ne le pense souvent, les obligations contractuelles qui lui sont imparties.

Managed care companies work hard to be despised, and they're succeeding. They've offended the public, lost its trust, and recently landed themselves in the Supreme Court. In February, the justices heard the case of Cindy Herdrich, who went to her HMO complaining of abdominal pain. The examining physician found hints of an inflamed appendix. Yet, instead of sending Herdrich for an immediate, full-price ultrasound at the local hospital, the doctor told her to wait eight days — until an appointment became available at an ultrasound facility that offered the HMO a discount. During the wait Herdrich's appendix ruptured, threatening her life. She's already sued the doctor for negligence and won. Now, in her Supreme Court case, Herdrich is arguing that because her HMO gave end-of-the-year bonuses to physicians who held costs down, it violated its fiduciary responsibility to put patients first. Since almost all health insurers now reward cost containment, Herdrich's case could turn managed care upside down, if not outlaw it altogether.

The industry isn't any more popular in the other branches of government. This month [March 2000] the House and Senate will try to hammer out a compromise

version of patients' rights legislation, whose main purpose is to make it easier to sue HMOs. (Some anti-HMO suits are currently barred by a quirk of the law.) Managed care reform also occupies a prominent place in Al Gore's presidential campaign: recently the vice president has berated Aetna U.S. Healthcare for denying home care to a disabled six-month-old boy in Washington state. Even George W. Bush has begun bragging about a Texas patients' rights law passed on his watch, though he neglects to mention that he opposed it at the time.

What makes the assault on managed care so peculiar is that Americans are healthier than ever. It's one thing for the public to loathe an industry whose performance is declining, but the health care business is losing stature at a time when its performance is *improving*. By almost all measures, US public health gets better every year. Americans are living longer than ever before, and heart disease, stroke, hypertension, AIDS, and most forms of cancer are steadily declining. Almost every US health trend has been positive during the decade of managed care. And, after rising at a frightening pace for most of the 1980s, the cost of health care has stabilized. There are still serious problems with the system —

chiefly that 43 million Americans, a staggering 16 percent of the population, have no health insurance. But bashing managed care, as has become so fashionable, doesn't solve that problem. It just distracts us from it.

The headquarters of Aetna U.S. Healthcare, the nation's largest managed care firm, sits in a suburban office park in Blue Bell, Pennsylvania, near Philadelphia. Inside the complex, company analysts dictate what medical procedures will or will not be paid for, computers scan records to determine which doctors are holding down costs and which are spending freely, and nurse practitioners line the phone banks that patients and doctors must call to authorize treatment. Aetna controls medical care for about 21 million people; about 300,000 physicians, more than a third of the country's doctors, participate in its plans.

This market power makes Aetna remarkably similar to the "regional alliances" that formed the centerpiece of Bill and Hillary Clinton's 1993 health care plan. Under Hillarycare, a few large regional insurance alliances would have used their clout to negotiate discounts with doctors and hospitals. This is exactly what Aetna and all other major managed care firms now do. Over the past five years, the nation's 18 largest for-profit plans have evolved into six — Aetna, United Healthcare, Cigna, Foundation Health Systems, Pacificare, and Wellpoint Health Networks; and, at this writing, Aetna and Wellpoint were talking about a merger. In about half of all states, the five biggest managed care firms now account for at least 50 per cent of patients; in 16 states, they account for more than 70 per cent. As a result, the vast majority of physicians and clinics, not to mention almost all hospitals, must accept managed care to stay in business. About 125 million Americans belong to HMOs or similar plans — roughly three-quarters of the non-Medicare population, with the proportion steadily rising. In effect, Clinton's "regional alliance" plan passed — but through the free market rather than through Congress.

And, at least when it comes to cost control, the plan is working. In 1993, health care consumed 13.7 percent of the nation's GDP, and the rate was shooting upward; many projected it would hit 15 or even 18 per cent by the year 2000. By 1998, the most recent year for which statistics are available, spending was down to 13.5 percent of GDP. Because runaway medical inflation is a story that *didn't* happen, the

accomplishment has been overlooked. But that does not diminish its significance. If health care expenditures had risen as expected, today this issue would dominate domestic politics. Middle-class Americans would face ruinous increases in insurance premiums, and voters would be livid. Instead, against the best predictions, health care inflation has cooled. Managed care deserves the credit.

Indeed, little-noticed in the coverage of Herdrich's case was the Clinton administration's decision to file a friend-of-the-court brief opposing her position. The White House may bash opponents of the patients' bill of rights legislation before Congress, but it continues to advance the theory of managed care. In one of his final domestic policy initiatives, Clinton recently proposed that Medicare be allowed to steer senior citizens to physicians and hospitals that offer low fees, just as managed care companies like Aetna do. The administration realizes that if Herdrich wins her Supreme Court case, managed care could go down in flames, taking medical cost control along with it — and we'd suddenly be back to a health care "crisis."

But aren't managed care's cost-control methods excessive? Not necessarily. Many HMOs control costs through "capitation," or paying a fixed amount per year per patient. Physicians endlessly complain that this means they lose money on really sick patients; they rarely add that it also means they come out ahead on healthy customers. All managed care plans negotiate discounts, mainly through "preferred provider organizations" or "independent practice associations" in which patients are steered to physicians or hospitals that agree to lower their rates. Under such pressure, the prevailing obstetrician's fee for prenatal care and normal delivery of a baby in Washington, D.C., to cite one example, has fallen from about \$3,000 in 1993 to about \$800 today. While few doctors or hospital administrators are happy about the pressure to discount, discounting has hardly made medicine unrewarding. The income of the average US physician has fallen five per cent in real-dollar terms since 1993, but, at \$164,000 annually, it remains the highest average physician salary in the world.

To be sure, managed care sometimes imposes maddening precertification requirements—maddening to doctors as well as to patients, since, essentially, the new system automatically questions their judgment. Then there is "utiliza-

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tion review” — insurance companies mine files to see whether particular doctors are ordering unneeded tests, allowing patients to spend too many nights in the hospital, or prescribing proprietary drugs when generic would do. “Case managers,” usually nurses, may recommend cost-cutting ideas to the physicians of seriously ill patients who are running up big bills. Finally, managed care firms sometimes reduce costs by brute force — simply refusing to pay some or all of what physicians and hospitals charge and causing financial disaster for patients who assumed their bills would be covered. (The law on this point is elaborate, but health insurers are not always obligated to pay.)

Some managed care techniques are clearly designed to baffle patients and physicians in the hope they will give up and go away. The section of Aetna’s website that lists information patients must know to comply with company rules is 60 printed pages long. And the red tape creates inequality: White-collar professionals accustomed to reading fine print can usually pressure their managed care firms to pay for whatever they need, while the less educated are more likely to give up in frustration. These represent real problems, but they don’t explain why so many Americans consider managed care a failure.

Working on this article, I spent weeks negotiating with Aetna for permission to enter its Pennsylvania stronghold and interview the people who set its claim-approval policies and answer its preapproval phone lines. Arranging interviews at Aetna, it turns out, is harder than arranging them at the Pentagon. The company kept scheduling interviews and later canceling them, then finally declared that its officials and preapproval personnel were just so incredibly, astonishingly busy — every single one of them — that no meeting was possible. Aetna, which has a horrible public image, seemed determined to convince me that it deserved it. In this it reflects the managed care industry in general, which has compiled the most spectacular record of negative public relations since the nuclear power industry of the 1970s.

The shame is that if managed care companies were less creepy, they could make a compelling case that their existence serves the public good. HMOs are not some marketing gimmick; they arose as a rational response to the faults of the old pass-along system, in which physicians passed along unlimited invoices and insurers passed along unlimited inflation. Patients may suffer when a test or procedure is not immedi-

ately approved, but they can also be harmed by overtreatment — which the old system encouraged by paying doctors and hospitals to run up the bill. It’s not necessarily bad to have case managers watching over a doctor’s shoulder; they may point out something the doctor has missed. And some aspects of the new order actually make things easier for patients. In many managed care plans, you never have to fill out forms or front the cash before filing for reimbursement; you just flash your card — a convenience previously known only in national health systems.

Advantages like these are rarely discussed, because we have become convinced that what Cindy Herdrich experienced is now the norm — that managed care is responsible medical horrors. Yet, if that were really the case, public health would be getting worse. Instead, Harry Rosenberg, chief of mortality data for the National Center for Health Statistics, called 1999 “a banner year” for US public health. A new study by economists Kevin Murphy and Robert Topel of the University of Chicago estimates the annual value of the ever-higher US life expectancy at about \$2.8 trillion, more than twice what the nation spends on health care. That people are living longer, more productive lives while losing less time to illness and pain, Murphy and Topel suppose, is one reason the economy is so robust.

Nor have studies found any association between managed care and those health care problems that persist. Robert Brook, Elizabeth McGlynn, and Mark Schuster, three physicians who specialize in care-quality data, recently completed an extensive study for the RAND Corporation. They concluded that for overall health outcomes, there is no difference between managed care and traditional fee-for-service programs. (Problems like inequity in service between affluent and poor communities, they found, predate managed care.) Most other studies also conclude that managed care has not harmed patient health, though some analysts find that patients do better in nonprofit managed care than in for-profit plans.

Many people assumed managed care would stunt the development of more effective or more humane treatments by driving all medical services toward whatever is cheapest. That has not happened; expensive procedures continue to proliferate. Two decades ago, for example, artificial joints were a rarity; now almost all insurers pay for hip-replacement surgery. Heart

bypass surgery is much more frequent than it was a decade ago—extending life, with vigor, even for those who have the operation in their seventies. Traumatic invasive procedures have been replaced by laparoscopic surgeries, done routinely on an outpatient basis with short recovery times. Not that long ago, a middle-aged adult experiencing chronic knee pain would have been informed that joints begin to ache with age, given ibuprofen, and told to live with it. Today, anything from laparoscopic surgery to an artificial knee is likely to be approved by almost any managed care plan, with the result that the pain is removed.

And, stereotypes aside, waiting is rarely a problem under the new system. The reason Herdrich's case drew so much attention is because what happened to her is so unusual; even with cost containment, patients rarely queue. Today, in Canada's national health system, there is a median wait of six weeks to consult a specialist for nonemergency conditions and a median wait of eleven weeks for a non-emergency MRI. Figures for many Western European national health systems are similar. In the United States, waits of more than a few days for nonemergency tests or therapy are almost nonexistent, because — even under managed care — American medicine has far more hospital beds, specialists, and high-tech equipment per capita than national health systems do. Managed care has pressured the specialists and the owners of fancy medical machines to cut prices, but it has not put them out of business. Unless you're one of the uninsured, this is a best-case result.

Health has improved at the same time as costs have declined because managed care has forced doctors and hospitals to become more efficient; they may not enjoy this experience, but their increased efficiency serves society. Though many predicted managed care would cause health care rationing, for the insured, at least, there is zero evidence of it. Stories of HMOs denying a class of treatment almost always involve experimental procedures of questionable merit, such as bone-marrow transplants to treat breast cancer, which new studies suggest are worthless. Extremely expensive but proven procedures, such as bypass surgery and organ transplants, are routinely paid for by managed care, not rationed. Kafkaesque nightmares do occur under managed care, but, contrary to conventional wisdom, they are kinks in a basically successful system.

Working out the kinks remains important. But the stampede toward more anti-HMO lawsuits may not be the best course. As often happens in politics, the debate runs behind developments in the field. Responding to patient dismay, several large managed care organizations — including United Healthcare, the number-two insurer nationally, and many of the Blue Shield plans — have recently eliminated most pre-certification requirements and now allow patients to go directly to specialists without the approval of a “gatekeeper.” Assuming United Healthcare's approach proves popular, firms like Aetna will have to either match it or lose business.

Moreover, denied claims appear to be less of a problem now than they were in the early '90s, when the managed care industry was first figuring itself out. Although it took until 2000 for Herdrich's case to reach the Supreme Court, her mistreatment occurred in 1991. Since that time, fears of liability under existing law, predating a congressional patients' bill of rights, have changed the managed care landscape. In 1993, a California HMO lost an \$89 million judgment to the estate of a woman named Nelene Fox, who had been denied needed treatment. This and other decisions shook the industry, making the big carriers look more favorably on treatment requests, especially with juries inclined to believe the worst about HMOs.

While a national patients' bill of rights would increase pressure on managed care firms to act responsibly, it would also generate litigation costs — which would mean higher premiums. The ideal middle ground might be independent arbitration panels that resolve patients' grievances against managed care without decade-long litigation. Unfortunately, in the current HMO-bashing climate, there seems to be more interest in headline-grabbing than in hashing out middle-ground solutions.

None of this is to imply that America's health care system is, by any stretch, morally acceptable. In no other Western nation does a larger percentage of the population lack health insurance. Just as managed care is a logical outcome of market forces, so are the uninsured. Insurers have no free-market incentive to seek out customers who have trouble paying their premiums or who suffer from “preexisting” conditions. Employers trying to cut back health

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of all international organizations — the WTO, naturally, but also the World Bank and the IMF — and also of independent research firms. Indeed, the WTO will be the minor player since it has very little independent capacity to gather country data. That co-ordination will not be easy and may be resisted by the organizations themselves.

A number of critical areas are obvious targets for monitoring and surveillance, including: the reform of state-owned enterprises (SOEs); the evolution of the macro-economy; and the reform of administration and the judiciary in trade-related areas, in other words the development of the rule of law. In the case of SOEs, the examination could include tracking the reduction in government and bank lending and corresponding increases in private sector lending. In the macro-economy, the committee could examine the amount of non-social public spending as a percentage of GDP. In the rule of law area, tracking could include the number and result of complaints by foreign firms with respect to trade-related matters — as well as a large number of other things.

Quantitative and qualitative data should be gathered in each area, using a number of indicators, and should then form the basis of a report that can be examined by whatever committee is assigned the task in the WTO. If such reports were made every two years or so, material progress could be rewarded with a reduction in safeguard actions against Chinese products. On the other hand, a persistent pattern of failure could lead member countries to withdraw benefits. Though it would be best to require WTO action in such cases, the reality of Geneva politics is that some countries would be unwilling to act or would be pressured not to. Thus as a condition of accession, individual countries would have to be given the right to eliminate benefits, though a “reasonable response” test would govern. Such a “carrot-and-stick” approach would provide the right incentives for the Chinese leadership to encourage continued economic reform.

Not surprisingly, Chinese negotiators have been cool, if not downright hostile to our proposals — notwithstanding that such steps would facilitate China’s integration into the world economy. But current trade negotiators from the chief trading parties have been equally skeptical and in some cases flat-out dismissive. And of course the later these discussions, if any, are put off and delayed, the less likelihood that in the final scramble to complete the *Protocol* for China that anything serious can be included, other than superficial mechanisms of little consequence. The result may be a China that cannot reform and a WTO that cannot ensure the integration of China into the global economy. That’s the trouble with China.

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benefits are only acting logically, given the way the rules are currently written. The market controls costs, and it pursues quality of care much more effectively than most commentators acknowledge. But the free market will never look after everyone. That is not its incentive structure.

Insuring that everyone is cared for is the natural role of government. Perhaps that means helping people buy into the federal employees’ health care system, as Bill Bradley proposes. Perhaps it means creating new health-coverage tax credits and allowing younger people to buy into Medicare, as Al Gore suggests. Perhaps it means finding some other hybrid between efficient free-enterprise medicine and protection for those who falter in the market. Any solution will cost money, though some of the funds will be recovered through better health and higher productivity among those now uninsured. But the good news is that such money is available, in part because managed care helped save it.

Managed care proves that extensive reform of the medical system, often deemed impossible, can actually happen quickly and with success. Now it’s time to apply that knowledge to America’s one true health care crisis: the lack of universal care.

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God in the Constitution (*continued from p. 60*)

under judgement. We acknowledge that our political, economic, and cultural achievements are always flawed in the light of a perfect standard that we perceive and acknowledge even if we cannot fully actualize it.

There can never be an end to history, if by this one means we have attained a perfect state of affairs in ordering our communal life, as in, for example, a liberal democratic, capitalist society. To affirm God’s supremacy is to abandon, not our striving, but our utopian delusions about our political and economic programs and achievements.

These general principles that are conveyed by the term “God,” are not the full-blown message of salvation that Christians or other religious groups might wish to promulgate. But they are enough to provide a foundation for a peaceful and humane social order and hence they justify the retention of “God” in the Constitution. The only true atheist, it has been said, is the nihilist. The alternative to “God” is therefore a much longer re-write of the Constitution.

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