

Are HMOs Really a Dying Breed?

Jeff Goldsmith and Dan Beckham Debate the Issue

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Dan Beckham's "The Beginning of the End for HMOs," a two-part article in the Nov./Dec. 1997 and Jan./Feb. 1998 issues of this journal, contends that the capitation/channeling model of healthcare and the entire HMO industry that has been built on it is dying. In a recent letter, Jeff Goldsmith, noted healthcare futurist and frequent contributor to this journal, raises questions about Beckham's article.

As a longtime fan of Dan Beckham's thinking and writing, it is difficult to let his article, "The Beginning of the End for HMOs," pass without some comment as it does not equal his usual high standard. There is no disputing his point of departure: Health plans are in economic and political difficulty, much of it of their own making. However, to segue effortlessly, as Beckham does, to the conclusion that this industry is finished, combines wishful thinking with a lack of historical perspective on health insurance. As those with memories longer than a decade will remember, health insurance is a brutally cyclical business. The last time health insurance profitability bottomed out (1986-87), the whole industry, HMOs included, lost billions of dollars and evoked an earlier wave of obituary notices. What revived managed care was an explosive surge in health costs, followed by a recession, which rekindled employer interest in cost containment.

Health plans today are, in part, victims of their own success in containing health costs. In 1996, the U.S. health cost increase of 4.4 percent was the lowest in more than 30 years. Subsiding general inflation, which Beckham cites, does not explain why the business health cost trend declined so much more steeply than public sector costs. The reason is simple: The public sector Clung to a "reimbursement" model of healthcare payment while private health insurance converted to contractually negotiated payment in an oversupplied provider market. Managed care played a significant role in the unprecedented deceleration of U.S. health costs.

Beckham is absolutely correct that managed care's bargaining leverage has been reduced markedly in the past three years. Two factors were decisive here: (1) a lengthy economic expansion, which has diminished employer urgency in cost management, and (2) consumer preference for broad network health plans like PPOs and point of service. Managed care plans that Sought to be "total replacement" carriers (an employers sole carrier) had to bring their employer clients virtually all the hospitals and doctors in the marketplace, markedly weakening their bargaining leverage with providers.

The allegedly dispensable "middleman"

Where Beckham lets the reader down is in his advice about what to do with this leverage. Providers seem almost achingly ready to dispense with the health plan "middleman." Here, Beckham tells them exactly what they want to hear: "a powerful and irresistible stream ... washes away impediments to free and direct commerce between willing buyers and willing sellers based on value." He implies, without the benefit of any historical or

cross-industry qualification, the inevitability of direct provider contracting with employers or Medicare beneficiaries.

Beckham fails to point out that to do this in a broad network environment, providers must contract with all of their competitors, both their employed and unemployed physicians and those of their competitors (including the practice management companies!) and manage everyone's utilization and quality as well as their own. Failing to do this will prevent them from matching the cut-rent insurance products offered to employers or patients by the allegedly dispensable "middlemen," the health plans, or prevent the provider system from offering the same cost-control capability.

Then, in the second part of his article, Beckham waffles on the feasibility of doing this, correctly pointing out that providers have historically had great difficulty bearing and managing risk. What he advocates instead is using cartel-style negotiating leverage to raise rates to health plans without offering measurable increases in the value of their products or troubling over what consumers really want from the health system.

From a consumer or societal standpoint, paying more for health services merely because they have been "consolidated" into a few megasystems creates no value for anyone. The reality is there has been little consolidation (meaning reduced physical or human capital), merely concentration of ownership. Only strategies that create value for the customer rest on a solid foundation.

He also encourages providers to embrace "care management," which he does not seem to understand will put provider organizations in the same difficult position health plans are in: determining what care is appropriate, when and, critically, by whom. The idea that this will be more feasible for hospitals, which are matrixed six ways to Sunday with specialists (whose activism encouraged managed care's growth in the first place), than for health plans defies common sense.

Health plans have a number of potential remedies for their current problems. Some of them, like raising rates, fall into the same "Where's the value?" category as the cartel strategies some providers are pursuing. For health plans to become consumer advocates, instead of adversaries, they will have to help consumers make intelligent provider choices, and help them narrow the unacceptably high variation in risk of death or injury that exists in the health system. As health plans have become increasingly commoditized, it is clear that the real variation, both in cost and quality, is in the delivery system. By allowing these variations to become increasingly transparent and rewarding consumers for choosing the highest-value provider system or network, health plans can convert the present liability of broad panels into an asset.

Dangerous misdirection

Where Beckham does offer hospitals or health systems specific advice, he dangerously misdirects them. Assuming, without any evidence, that acquiring primary care practices has offered hospitals any measurable leverage in negotiation with health plans, he seems

to advocate extending this costly and risk-laden strategy to specialty physicians as well. Beckham cites the threat of specialty physician practice management firms as justifying this strategy.

Hospitals already have enough assets that are declining in value or earning power without buying specialist practices at the top of the market. Beckham) seems not fully to appreciate the consequences of the initial wave of practice acquisitions, the bill for the primary care practice acquisitions is only now coming due: not only in heavy and unsustainable operating losses but in the emerging nightmare of physician unionization. He does not appear to realize that PPM executives (to their great amusement) are being besieged with hospital and health system offers to "take my physicians, please!" or to understand why this might have occurred.

To advocate expanding physician employment by hospitals in a wildly oversupplied specialty market is authentically irresponsible advice. Telling health system managers what they want to hear is one thing; advocating that they double their losing bet on incorporating physician practice into the hospital is quite another. Even wealthy organizations are discovering that the supply of other peoples money can run out right quickly when they pursue reactive, defensive strategies that offer no real value to the community.

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Beckham replies: As a regular reader of Jeff Goldsmith's writings, I have always found much to agree with. And there are, several points in his letter I agree with too. But there is much with which I disagree as well. For me, the most befuddling thing about the letter are assertions he attributes to me that a reading of my article will clearly indicate I never made.

On the topic of the "cyclical " nature of the health insurance business, I'd contend that HMOs represent a relatively young business that hasn't been around long enough to have had a "cycle" yet. The traditional health insurance business is not the same thing as the HMO business. Old-line insurers, like Aetna and CIGNA, certainly don't regard the business that bottomed out in the late '80s to be the same business that bit the skids in the late '90s. To suggest that cycles of the traditional health insurance business apply to HMOs is an apples-to-oranges comparison.

Just because Goldsmith insists on giving HMOs credit for the "unprecedented deceleration of U.S. health costs" doesn't make it so. I'll stick to my assertion: That the real cause was the economic downturn that led to downsizing combined with growing reliance on part-time workers. The steeper declines for health costs in the business sector vs. the public sector that he cites may be explained by the relatively lesser political power

of business sector employees in the last decade vs. the power of those who represent the interests of the elderly (who comprise most public sector spending).

The AARP is simply a much more powerful negotiating union than the UAW. The elderly were able to resist changes in Medicare reimbursement. Employees generally were not. As I indicated in my article, many of those employees found themselves without the rich benefit packages they once enjoyed.

This was not a triumph of HMOs. It reflects the shifting of the workforce out of richer health benefits, which resulted in lower overall costs as those employees reduced their utilization of care. In today's labor market, characterized as it is by worker shortages, health inflation is rising again, which is the economic effect you would expect. When the demand for labor is high, health inflation will rise; when it is low, it will fall.

A third reason

Goldsmith cites two factors as responsible for a reduction in leverage for HMOs in today's market: 1) a lengthy economic expansion that has diminished employer urgency in cost management, and (2) consumer preference for broad network health plans, which caused health plans to offer virtually all the hospitals and doctors in the marketplace, markedly, weakening their bargaining power. He's tight on both counts. But he forgot to mention a third reason and I would argue the most important one—for that reduced leverage: Consumers are increasingly dissatisfied with the kind of care their HMOs force them to receive.

My article was written in July 1997 many months before audiences applauded the Helen Hunt character's ravaging of HMOs in the movie *As Good As It Gets*. As much attention as Hunt's diatribe gets, even more powerful, I think, is the scene where she walks across the room and kisses the doctor who took time to listen to her when she talked about her son's medical problems. Even Hollywood screenwriters understand what consumers really want -- a personal relationship with a doctor who listens to them.

HMOs have been deleveraged because they are increasingly viewed by consumers as not having their best interests at heart. As Robert Goldberg, a senior research fellow with the Medical Science and Society Project at the Ethics and Public Policy Center in Washington, says in the July 17, 1998 issue of the *Wall Street Journal*, "Managed care is dying. HMOs such as Aetna, Kaiser and Oxford are losing money because they are no longer able to dictate to consumers which healthcare services they can have."

On the question of my telling providers exactly what they want to hear, I must point out that I do mention in this article, and in many others, the failures of providers in keeping their own houses in order. I really feel that one of the greatest tragedies of the HMO experiment has been that its overwhelming financial has been such an onerous and overwhelming distraction for providers who really have better things to do than chase managed care contracts -- namely, provide better care by driving fragmentation out of their hospitals, clinics and practices.

To Goldsmith's suggestion that eliminating the middleman and pursuing direct contracting "in a broad network environment requires providers to contract with all Their competitors and manage everyone's utilization and quality as well as their own, - I must admit that I'm not sure I know what a "broad network environment" is, but if by that he means big systems with many hospitals and doctors spanning a wide geography, I'd suggest that if in such situation you contracted with all your competitors, you would be creating a monopoly and engaging in restraint of trade. Furthermore, few markets are so consolidated or bereft of providers that you would be compelled to contract with your competitors.

I don't envision most hospitals and doctors going out and contracting directly anyway. I do envision them creating organizations they control to go out and do that. I explicitly suggested that providers should not go into the HMO business. I also suggested that they should be in the "care management" business, which will require them to have much of the infrastructure that is currently found in health plans. They should not try to make their living in managed care (insurance) but instead use their managed care infrastructure to help them make money in the care management business. As Doug Emery, a research fellow for the Institute Of Political Economy at the University of Utah has suggested, "The fundamental for economic value in healthcare is 'the episode of care' -- managing it is a job only providers can do."

My article or someone else's?

A couple of Goldsmith's comments had me wondering if he had my article mixed up with somebody else's. I did, as he suggested, advise providers to use their market leverage (particularly primary care coverage) to pressure health plans to increase reimbursement. (Although I'm not clear why he calls this "cartel-like " when he doesn't attribute the same description to the heavy-hand billy-clubbing health plans have used on patients, physicians, hospitals and small employers over the past decade.)

I did not suggest or imply that such increased reimbursement be pursued "without offering measurable increases in the value of their products or troubling over what consumers really want from the health system." I pointed out that "providers have been guilty of inefficiency, over treatment and fragmentation but these are largely sins of omission, not commission. And only the people who provide the care can fix these problem." I also asserted that "consumers value a relationship with a physician above any other in the delivery system" and that "financing is secondary to the fundamental benefit the consumer is seeking from the product."

Nowhere in the article do I make a plea for "consolidation" into "a few megasystems." Goldsmith argues that such megasystems create no value for an one. I agree 100 percent, which is why my article says nothing about them. Those who have read my other articles or heard me speak on the topic of integrated delivery systems know, I'm no fan of megasystems. When Goldsmith says "strategies that create value for the customer rest on a solid foundation," I thought, "I couldn't have said it better myself."

Then I thought, "Well, I think I have said it better myself on many occasions in this very publication."

That's what providers are supposed to do

Goldsmith is right that I encourage providers to embrace "care management " (which refutes, I think, his earlier point suggesting that I was advocating consolidation that creates no value for anyone). He accuses me of not seeming to understand that "care management will put provider organizations in the same difficult position health plans are in, determining what care, is appropriate, when and, critically, by whom." But that's precisely what providers are supposed to do! I've already suggested they're not doing it well enough now. They need to start. That some insurance bureaucracy that's hired a few doctors a decade removed from touching a patient should do these things really "defies common sense."

Finally, I do not suggest that hospitals purchase primary care practices. In fact, I have been a lonely voice suggesting, again in these pages and elsewhere, that health systems and hospitals create equity, not employment, relationships with physicians. And I sure wouldn't advise them to acquire specialists. I do suggest that having done the former -- acquired lots of primary care practices and potentially being forced to acquire specialists in the future — health systems should use the market clout that a dominant position in physician manpower can provide to stem losses by getting paid more.

The reason physician practices produce huge losses for health systems that acquire them are, I think, twofold: (1) physicians have been stripped of entrepreneurial spirit and converted into day laborers, and (2) the owners of the practices (the health systems), with a few exceptions, have not had the chutzpah to play hardball when negotiating with HMOs.

Goldsmith accuses me (as have others, frankly) of "wishful thinking." To this charge, I plead guilty. I wish health system executives would reclaim their markets and defragment their hospitals. I wish doctors would reclaim their patients and talk more to their colleagues. And, like a rapidly growing number of Americans, I wish HMOs would put patients first.