Rough seas in US managed care

A young colleague of ours reports from New York City, where she recently began a residency in internal medicine, that her orientation included a long session about health insurance and health maintenance organizations (HMOs). She trudged home that night with a shopping bag full of brochures and application forms. Along with 160 million Americans enrolled in HMOs, she faces a bewildering assortment of options, deductibles, costs and fine print in choosing a managed care provider. But, now that most HMOs are owned by Wall Street investors, the most important question for many patients has become whether the managed-care plan they choose will be there when they need it.

HMOs have been losing fantastic amounts of money. Take for example Oxford Health Plans, an investor-owned managed care organization. Oxford, whose investors propelled stock to over US$90 in 1997, saw share prices plummet 70% by the year's end.[1] Losing money, Oxford recently told almost all their elderly plan members that they would no longer be insured by the company and would have to find other insurers — if they could.[2] Finding a new insurer would not pose a problem for our young (and healthy) friend: HMOs like to enrol the well.[3] But elderly people who are sick face a much more difficult task.

A little known and conveniently ignored fact about health insurance in the US is that most of it is paid for by government: through federal tax subsidies to employers and direct support of health insurance for the very poor (Medicaid) and the elderly (Medicare) the US government spends $2 500 per capita annually.[4] This expenditure — itself only a part of total US health care costs — is greater than the total health care costs (government and private) of all other countries in the world except Switzerland.[4]

Thus when the US federal government wanted to lighten its deficit it cut Medicare payments by changing the reimbursement formula for HMOs. The new formula, less lucrative for HMOs, was no longer based on a formula of 95% of the fee-for-service payment in the same geographic area, but on the health status of individual enrollees.

Faced with the certainty that revenue from Medicare would decrease and the uncertainty of the costs involved in caring for elderly patients, investor-owned HMOs began throwing their elderly Medicare clients overboard. This is disastrous news for someone on dialysis, but the chairman of one HMO declared in announcing second-quarter figures for 1999 (a net loss of $13.4 million) that he was "pleased" with the results.[5]

This is dirty weather that few investor-owned health care providers are likely to survive. As investor-owned HMOs seek calmer and more profitable seas, setting an estimated 400 000 elderly middle-class patients (and voters) adrift,[2] the government has started to man the lifeboats. The US Congress is debating a Patients' Bill of Rights that specifies minimum services that must be provided by HMOs and tries to re-establish that it is physicians, not accountants, who should practise medicine. But this is like trying to patch the Titanic. It becomes increasingly likely that the US government will step in with financial rescue packages for investor-owned HMOs or, as many of our colleagues in the US hope, will finally introduce universal health insurance.[4]

References

1. Ginzberg E. The uncertain future of managed care. *N Engl J Med* 1999;340(2):144-6.
2. Williams M. HMO cutbacks strand thousands of clients. *New York Times* 1998 Nov 17. Available: www.nytimes.com
3. Deber R, Gildiner A, Baranek P. Why not private health insurance? 1. Insurance made easy. *CMAJ* 1999;161(5):539-42.
4. Woolhandler S, Himmelstein DU. When money is the mission: the high costs of investor-owned care. *N Engl J Med* 1999;341(6):445-6.
5. Oxford Health Plans, Inc. Oxford Health Plans, Inc., announces second quarter results [news release] 1999 July 29. Available: www.oxhp.com/corporate/about/index.html