HEALTH CARE PRESCRIPTION

Alan Sager & Deborah Socolar

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A 10-step plan for healthy HMOs

PLEASE RECONSIDER YOUR UTOPIAN faith that a self-regulating free market is solving our health care cost and coverage problems. Instead, imagine a world of Massachusetts health care where maximizing shareholder profit drives almost all surviving HMOs; where only 10 or 15 hospitals remain open; where more than one-quarter of the people lack health insurance; where surviving caregivers coalesce into cozy cartels; and where doctors, hospitals and HMOs all make more money when you and your family get less care. Our state is moving quickly in these directions.

Lamentably, no free market is possible in health care. A few reasons: patients' dependence for clinical advice on physicians who face growing financial incentives to give less care; the tendency for patients and employers to shop for HMOs by price because quality is so hard to measure; the shrinking number of suppliers and enormous barriers to the entry of new competitors.

HMOs claim they save money but don't underserve, asserting that giving appropriate care now avoids higher costs later. But too few members stay long enough to pay dividends on health maintenance. Recent rates of HMO disenrollment show only 82 of 100 original members remain in the average Massachusetts HMO at the end of one year. After four years, a majority have left.

These and other market failures make it dangerous to rely on price competition to contain cost and on education and regulation to safeguard quality. Instead, we should reverse the roles of competition and regulation, and rely on regulation to contain cost and competition to protect quality of care. Here is a 10-step method:

1. Sponsor new and geographically focused HMOs organized around – but not dominated by – individual hospitals or other networks of caregivers. Restructure existing HMOs along the same lines.

2. Require by legislation that all HMOs be operated not-for-profit, so they work for patients, not stockholders.

3. Require that each HMO expend its entire operating budget annually to care for its patients. Then, the only reason to deny a medical service to any one person is to liberate funds to care for another person in greater need. No HMO makes more money by giving less care.

4. Pay all HMOs the same price, adjusted only for patient age or other cost-associated attributes of members. HMOs could not compete on the basis of price.

5. Guarantee payment of all legitimate fixed costs incurred by HMOs. Then, pay only variable costs per patient. This removes the incentive for wasteful marketing and focuses managers and clinicians on giving needed care efficiently. It also stabilizes the finances of HMOs losing members – which gives them resources needed to reform and rebuild. This keeps competitors open, useful since competition requires competitors.

6. Require that HMOs pay their physicians, hospitals and other caregivers in financially neutral ways. Caregivers would then have no financial incentive to withhold needed care or give unnecessary services.

7. Under these circumstances, HMOs will compete for members on the basis of compassion, competence and quality – which is how we want them to compete.

8. Allow residents to choose their HMOs. They would have choice because HMOs' service areas would overlap appreciably, as those of hospitals do today.

9. Cap total annual spending cooperative agreement among payors, not by competition.

10. Pool all revenue from existing payors in one regional fund to be used to pay the HMOs. Each state resident would receive a uniform, standard card certifying eligibility.

Together, these steps give us universal coverage with cost control and with quality protections.

Alan Sager and Deborah Socolar are coprinicpals of the Access and Affordibility Monitoring Project at the Boston University School of Public Health.