Squeeze Play

HMOs faced with profit losses, tight finances

By Alexandra Matisoff-Li

HMOs, heralded as saviors of health care and a means of providing quality preventive care to millions at rock-bottom prices when they first took off in the mid-'80s, are now seen by many industry watchers as a victim of their own success.

Although HMOs transformed the way most Americans get their health care, the industry has suffered from growing pains in recent years, experts say. In the face of recent steep drops in profits and perceived consumer discontent, healthcare policy experts agree HMOs are at a crossroads.

Tough times

After riding high with steady growth for six straight years in the late '80s and early '90s, HMO profits started on a road of steady decline in 1994, according to Weiss Ratings Inc., a Palm Beach Gardens, Fla.-based company that tracks the insurance industry.

In 1997, 60 percent of HMOs lost money—about $900 million industry wide. Oxford Health Plans, an industry leader, lost $291 million in 1997, and by the first half of last year, the plan had wracked up a whopping $553 million in losses. Industry analysts attributed Oxford's problems to computer and record-keeping difficulties.

The nonprofit Oakland, Calif.-based Kaiser Permanente, a perennial giant in the managed care universe, ended 1997 with record losses of $270 million, which

Kaiser officials said were due in part to billing difficulties for nonmember services, an underestimation of the need for premium increases, and problems tracking the costs of a California flu epidemic. By 1998, four HMOs—Health Power of Columbus, Ohio; AmeriCan Medical Plans of Georgia and Mississippi; and Personal Physician Care of Cleveland, Ohio—had failed.

In Texas, HMOs have followed the national downward trend, losing hundreds of millions of dollars over the last three years. Texas Insurance Commissioner Elton Bomer reported aggregate HMO losses of $322 million in 1997. Thirty-two of the 51 HMOs operating in Texas lost money in 1998, according to state insurance department statistics.

Lost promise

Many inefficiencies in the managed care model have taken HMOs away from their original goals, said Larry Levitt, director of the Kaiser Family Foundation's Changing Health Care Marketplace Project in Menlo Park, Calif.

"The promise of the group model staffing for HMOs—where one group of providers manages the care and accepts the financial risk—hardly exists anymore," Levitt said. "Instead, we have plans with dozens if not hundreds of medical groups managing so many different plans that there's little accountability."

Levitt said some medical groups may be participating in so many HMOs that they rarely consult the various requirements of each individual plan in which they take part. "How can a physician or nurse or hospital practice medicine one way for one patient and another way for another?" he said. "This could be a train wreck waiting to happen."

Under pressure

One problem is that HMOs have bowed to consumer and marketplace pressures to expand services, often sacrificing efficiency and cost savings in the process, said Sara Singer, MBA, executive director of the Center for Health Policy at Stanford University. "In order to please consumers, HMOs have contracted with wide numbers of physician groups," Singer said. "The result is there is no loyalty between the HMOs and physicians, no working to share information. There can be 10 sets of guidelines to follow, 10 eligibility processes, 10 drug formularies to consult; every time decisions have to be made, it has to be figured out which procedure to follow."

The unpredictability of the managed care market has prevented HMOs from reaching their cost containment objectives, said Diana Bianco, staff attorney and health policy analyst with the West Coast regional office of Consumers Union in San Francisco.

"Heath care is different than other businesses where people make profits," Bianco said. "The idea that [HMOs] were a cash cow just didn't pan out. It is a complex business because health care is not a commodity; people get sick—it just has presented many difficulties."

Consumer backlash

Bianco said HMOs face an uphill public relations battle to win back the trust of many healthcare consumers. Consumers sense HMOs have lost sight of their original mission of keeping patients out of the hospital longer through a preventive care emphasis, she said. "HMOs have a big problem right now—they are Darth Vader, or that's how the public sees them," Bianco said. "In a way, this backlash serves a great purpose: to show [HMOs] that people take their health care very seriously."

Singer said the booming economy only exacerbates frustrations some consumers have with HMO-imposed constraints on patient services. Recent technological and medical advances, and Food and Drug Administration drug approvals have also put pressure on HMOs to augment their services in the face of rising costs, she said.

People's sense that HMOs are taking away their healthcare options has created a backlash, Singer said. "There's a feeling they are not giving us our free choice of providers, are taking away services, and are trying to consolidate the number of procedures allowed."

Despite a general public perception that HMOs issue frequent coverage denials, the data doesn't support this claim, said Singer,

Good News
Bad News

Even as HMO net income plunged between 1994 and 1997, overall enrollment in managed care rose 72 percent, and total revenues rose 77 percent during the same period, according to a Kaiser Family Foundation study published last month.

Larry Levitt, director of the foundation's Changing Health Care Marketplace Project in Menlo Park, Calif., said the disparity between net income and total revenue is due in large part to competitive pricing, escalating claim costs, and growing administrative expenses.

However, despite heavy losses, many publicly traded HMOs have benefited from the surging stock market in the past 10 years, helping offset some of their losses. The total stock value of HMOs grew from $3.3 billion in January 1987 to $38.9 billion at the end of 1997, a nearly 12-fold increase, according to the foundation.

Average annual stock returns for HMOs have suffered recently relative to the overall stock market—they experienced periods of significant price declines between July and September of last year. But HMO stocks generally outperformed the market as a whole over the last decade, Levitt said.

During the mid-'80s to mid-'90s, HMO stocks were increasing dramatically, Levitt said. "During this period, enormous numbers of people were shifting to HMOs, and stock analysts said these were good bets," Levitt said. "But, since then, HMOs have become unprofitable, and people's expectation for growth in the industry has changed a lot."

who was the lead investigator of a Stanford study examining ways to improve managed care decision making. "We found that the vast majority of requests [for coverage] are either approved or modified successfully, or alternative treatment is suggested to patients," she said.

Support for the model

Marjorie Byers, PhD, RN, FAAN, executive director of the American Organization of Nurse Executives, said most nurses support managed care's emphasis on preventive care to maintain wellness, although she said most nurses are concerned when a patient is denied coverage for certain procedures.

"As nurses we learned to provide a continuum of care and a consistency of care for our patients," Byers said. "Nurses really advocate for patient health so the basic philosophy of HMOs—for a patient to maintain his or her own health—is really what nursing supports." Byers said some nurses chafe at restrictive treatment protocols imposed by some managed care plans. "I think when managed care tries to make uniform rules when each patient is actually unique, that's when you can run into problems," Byers said. "Nursing is really about critical thinking, and what nurses don't like is arbitrary decisions about care before anyone actually sees the patient."

Cutting back

In an effort to deal with recent losses, and in response to lower Medicare reimbursement rates following the passage of the Balanced Budget Act of 1997, nearly 100 HMOs either reduced services or terminated contracts with Medicare in 1999, the Kaiser Family Foundation study showed. The pullbacks affected more than 400,000 Medicare beneficiaries nationwide.

"This is very unfortunate, because in a lot of markets, these are the only avenues for patients to seek care," said Harold Hunter, PhD, MBA, professor and director of the healthcare administration program at California State University, Long Beach. "From the patient level, it's patient desertion. Even though it could be a good business decision [for HMOs], it's a bad end result for patients."

Bianco said HMOs seem to be running out of places to trim fat from the system and said consumers and healthcare professionals need to remain vigilant to ensure the quality of patient care. "The concern is, where are they going to go if we've already wrung out all of the savings?" Bianco said. "Streamlining services is commendable ... But once you start cutting costs or reducing the number of nurses, we need to be very careful."

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Premium Prospects

The pressure on HMOs to expand services and offer more options to consumers has led to a drive toward higher member premiums, said Harold Hunter, PhD, MBA, professor and director of the healthcare administration program at California State University, Long Beach. An annual survey by Milliman and Robertson actuaries found a 7.8 percent nationwide average premium increase of per enrollee in 1998, up to $138.30 per month from $128.28 per month. This represents the largest jump since the actuaries began surveying premiums seven years ago.

Ironically, consumers are likely to bear the brunt of HMOs' current financial woes because of increasing pressure on health plans from Wall Street to combat losses through premium hikes, said Larry Levitt, director of the Kaiser Family Foundation's Changing Health Care Marketplace Project in Menlo Park, Calif.

In Texas, some HMOs—such as Universal Healthplan and Exclusive Healthcare—fall below the national average with premiums at $71.06 and $85.47 per month, respectively. But rates vary widely statewide. Healthfirst HMO is at the high end of the spectrum, charging members $179.84 per month. "We're going to get to the point in several years where premiums will be high, and employers will not want to pay this much. Then we will have to go through another cycle of cost-cutting," Hunter said. "The only way to cut costs in the end will be to provide fewer choices to patients in the long run. Then there will be another round of complaints, and a new cycle will begin."