# THE HMO REPORT CARD: A CLOSER LOOK

by Humphrey Taylor and Michael Kagay

**Prologue:** *In the current volatile health care environment, there is a vast amount of data generated from the government, academia, advocacy groups, and the press on the implications of various policy changes and on the effects of new trends. Despite this wealth of information, though, there are very few specifics on the attitudes of people affected by the changes. Humphrey Taylor and Michael Kagay, polling professionals at Louis Harris and Associates, are among the few people to have gathered such information. In the following article, Taylor and Kagay summarize a poll conducted lust summer for the Henry J. Kaiser Family Foundation on the attitudes of physicians, employers, and the public towards health maintenance organizations (HMOs). This is the second such effort by Harris for the Kaiser Foundation—the first was carried out in 1980—so that Taylor and Kagay are able to present some valuable trend data. Specifically, the authors have found that interest in HMOs by non-HMO members has continued to increase, employers are generally enthusiastic about HMOs' cost-effectiveness, and, perhaps most interestingly, the hostility of physicians is declining. The overall conclusion is that the stage is set for continued growth in HMOs into the 1990s. Between them, the authors have been conducting opinion polls for around thirty years. Taylor, president of Louis Harris and Associates, founded and managed his own survey research firm in his native Britain before it was acquired by Harris in 1970. His longstanding interest in and commitment to health care was shaped by his parents who were both physicians. Kagay, vice-president for foundation-sponsored research, joined Harris in 1982 after a decade of teaching at Princeton's Woodrow Wilson School of Public and International Affairs. Five of those years were spent as a polling consultant for the New York Times. Kagay has a Ph.D. in political science from the University of Wisconsin. Taylor has a degree in mathematics and social anthropology from Cambridge University in England.*

Much has changed in the health care delivery sphere since Louis Harris and Associates conducted its first survey of health maintenance organizations (HMOs) for the Kaiser Family Foundation in 1980. Cost containment has become a major national priority in both the public and private sectors, and alternative delivery systems, including HMOs, have expanded their reach to serve a sizable proportion of the American people. An updated survey of public, employer, and physician opinion regarding HMOs was conducted in 1984 to track these changes and to predict the forces most likely to influence the future growth of HMOs.[1]

## HMOs Today

The number of HMOs and their members have grown rapidly and continuously during the last several years. This growth is reflected in many findings in the survey. In 1980, we found that 6 percent of privately insured households nationwide included at least one family member who belonged to an HMO. By 1984, 9 percent of privately insured households included at least one HMO member. Employers' familiarity with HMOs also increased, with the proportion of corporate benefits officers very familiar with prepaid health care rising from 63 percent to 77 percent over the four years. More dramatically, among corporate employers who offer their employees an HMO option, the numbers reporting that at least 10 percent of their employers had joined HMOs almost doubled from 26 percent to 45 percent between 1980 and 1984.

The growth of HMOs and HMO membership has been paralleled by substantial improvements in the image of HMOs with eligible nonmembers, employers, and physicians. In the past, many doctors and leaders of organized medicine were extremely hostile to prepaid practice. Now the nation's physicians are becoming increasingly positive about HMOs. By 1984, 50 percent of the country's physicians said they were at least somewhat favorable to HMOs. In 1981, only 36 percent had been favorable. Many of the country's physicians still have deep reservations about HMOs, but the trend is clear. Physicians are becoming steadily more positive about prepaid plans.

Furthermore, the survey revealed clearly that HMO subscribers are generally well pleased with the medical care they receive. Indeed, 90 percent of HMO members were satisfied with the quality of their doctors, and 76 percent were satisfied with the quality of hospital care. In both instances this level of satisfaction among HMO members slightly exceeded the satisfaction of patients paying on a fee-for-service basis. However, many employers and most doctors will be surprised by these findings. Sixty-four percent of all physicians and 47 percent of employers perceived—wrongly—that patients' overall satisfaction with health care services would

be better with the traditional system.

## Prospects For Continued Growth

One reason why, when we released the 1980 study, we were so confident in predicting a strong growth of HMO membership was the large number of eligible nonmembers who expressed an interest in joining HMOs. At that time, 10 percent of eligible nonmembers said they were very interested in joining, and a further 28 percent said they were somewhat interested.

In 1984, the prospects looked even more favorable for HMOs. The proportion of eligible nonmembers very interested in joining a prepaid plan was still 10 percent, but the proportion who were somewhat interested increased 12 points to 40 percent of eligible nonmembers.

**HMO renewals should remain high.** Of course, the growth of HMO membership depends not only on the number of new HMOs and the number of new HMO members, but also on the renewal rate among current members. In 1980, we predicted that HMOs would continue to grow because the overwhelming majority of HMO members said that they would renew their membership. The actual numbers were 75 percent who said they would certainly renew, and a further 17 percent who said they probably would do so, leaving only 6 percent who were negative or unsure.

The picture in 1984 was almost, but not quite, as promising for HMOs. Those who said they would not renew or 'were unsure were still only 7 percent. However, the proportion who said that they certainly would renew, had fallen from 75 percent to 61 percent with more HMO members saying that they probably would renew (32 percent, as compared with 17 percent four years earlier).

Conceivably, this could be the beginning of a dangerous trend for HMOs, with HMO members. becoming less loyal. However, our own view is that this finding reflects the rapid influx of new HMO members, many of whom have not yet become totally committed to prepaid practice. Indeed, among those who had been members for five years or more, 75 percent said they would certainly renew, whereas only 51 percent of those who had been HMO members for two years or less said they would do so.

**Members are satisfied with health care services.** Another of the many pieces of evidence that HMO growth will continue at a rapid rate is the relative level of satisfaction of HMO members and nonmembers with their health care services. In many important respects, HMO members are now substantially happier with their health care services than are eligible nonmembers. And these differences have increased considerably since 1980.

For instance, those who said they were very satisfied with their overall

health care services included 48 percent of HMO members, but only 34 percent of eligible nonmembers. Fully 55 percent of HMO members were very satisfied with their ability to see a doctor whenever they needed, as compared with only 38 percent of eligible nonmembers. Forty-seven percent of HMO members were very satisfied with the quality of hospital care, as compared with only 34 percent of eligible nonmembers. Forty-nine percent of HMO members were satisfied with the availability of doctors and medical services twenty-four hours a day, seven days a week, as compared with only 32 percent of eligible nonmembers. And when it comes to cost, the difference is even more striking. Fully 59 percent of HMO members were very satisfied with the cost they and their families paid for health care, as compared with only 21 percent of eligible nonmembers.

Indeed, when we look at the cost issue in more detail, the differences in satisfaction between HMO members and eligible nonmembers are enormous. Seventy-two percent of HMO members were very satisfied with the cost of major medical expenses, as compared with 47 percent of eligible nonmembers. Seventy-four percent of HMO members were very satisfied with the amount paid for their family's treatment for minor illnesses and lab tests, as compared with 35 percent of eligible nonmembers. Seventy-two percent of HMO members were very satisfied with the amount paid for their doctor's visits, as compared with only 35 percent of eligible nonmembers.

So in analyzing the 1984 survey we conclude that there were massive differences in satisfaction particularly, but not only, with the cost of care, and that these differences had widened substantially in favor of HMOs over the previous few years.

**HMOs attract a broad cross-section of Americans.** Images and perceptions do not always move hand in hand with reality. In many areas the public image of an institution reflects the recent past as much as, or more than, the present. This survey shows that HMOs are changing, and that some of the old images of prepaid plans are no longer accurate. The image of HMOs as institutions which serve mainly blue collar or low-income employees no longer applies. We found indications that HMOs are increasingly attracting nonunion, white collar workers.

**HMOs are less expensive than traditional fee-for-service practice.** The main reason that government and many employers have looked favorably on HMOs is the belief that they provide less expensive care. The 1984 survey provided substantial confirmation that prepaid health care is, indeed, more cost-effective. (This was not, of course, a direct study of the actual costs of prepaid and fee-for-service practice. The Rand Corporation recently reported the results of a major study on that subject, which found that HMOs are typically 20-25 percent less expensive—everything else being equal—mainly because HMO members spend far

fewer nights in the hospital.)

While HMO members have long felt that HMOs are less expensive, it has taken longer for employers and physicians to come around to this view. But they are now doing so. We found that 85 percent of employers agreed that HMOs are effective in containing health care costs, as did 78 percent of physicians. These numbers compare with only 59 percent of employers and 57 percent of physicians in 1980.

As physicians and employers have gained more experience with HMOs, they have become increasingly positive about prepaid plans—particularly about their cost-effectiveness. While both groups still had reservations about the quality of HMO care, they overwhelmingly applauded HMOs on cost-effectiveness grounds. Indeed, it is undoubtedly the perception of the cost-effectiveness of HMOs—a perception shared by both employers and employees—that is the main driving force behind the substantial growth of prepaid plans.

More than three times as many employers reported that HMO membership had decreased the cost to their companies as those who reported that it had increased costs. Thirty percent said HMOs decreased costs, 8 percent said the plans increased costs, and slightly over half (51 percent) reported no effect.

There is dramatic evidence that competition from the rapidly growing HMO movement has had a significant impact on physicians in recent years. For example, in 1981 only 27 percent of physicians said that they were considering affiliating with an HMO. By 1984, the number considering an HMO affiliation had nearly doubled to 46 percent. Moreover, six out of ten physicians who were not part of an HMO or other prepaid plan said they believe prepaid plans would affect their practices over the next ten years, and 26 percent believed they would be affected a great deal.

Furthermore, the competition generated by HMOs for traditional health care providers has begun to affect the cost of traditional fee-for-service care. Twelve percent of physicians in traditional practice reported that they had reduced their fees because of prepaid plans in the area, and 14 percent said they had reduced either the number or duration of hospital stays among their patients because of competition from prepaid plans. And 18 percent of fee-for-service physicians told us that prepaid plans operating in their areas had caused a reduction in their own total income.

**Quality of HMO care.** The majority of physicians (78 percent) believed HMOs are effective in containing health care costs. However, about two-thirds also believed that the cost-containment incentive causes HMOs to lower the quality of care to an unacceptable level. Critics of HMOs and prepaid plans have frequently focused on this issue of quality—the quality of doctors, the doctor/patient relationship, available specialists, and hospital care.

On this quality issue, our results will be somewhat reassuring to proponents of HMOs. Overall, HMO members were more likely than members of the general public or eligible nonmembers to be satisfied with the quality of the doctors. Ninety percent of HMO members, as compared with 84 percent of the general public and 85 percent of eligible nonmembers, were satisfied with the quality of their physicians.

Employers, from their perspective, also disagree with physicians when it comes to quality. A majority of employers (57 percent) said that HMOs do not lower the quality of care to an unacceptable level.

Another common quality of care criticism is that HMO patients do not have a continuing relationship with one doctor. In fact, the difference on this score between HMO members and nonmembers was not very great. Fifty-one percent of HMO members said that they had one personal physician compared to 55 percent for nonmembers. Furthermore, HMO members were less likely than nonmembers to object to seeing a physician other than their usual physician so any disparity would not appear to affect their overall satisfaction with HMO services.

Yet the feeling that HMOs offer inferior quality care, while not shared by either HMO members or employers, continues to be the view held by most physicians. Sixty-five percent of physicians, the same proportion as in 1981, said that HMOs offer inferior care, mainly because they were thought to perform fewer lab and diagnostic tests than may be necessary, employ less qualified doctors, or do not allow for an adequate doctor/patient relationship.

An objective measure of the quality of care is notoriously difficult, if not impossible. However, our survey did include two measures, though not exhaustive, of the quality of physicians: whether or not they are board certified and how long they have been practicing. On these two measures we found no significant difference between the quality of prepaid and fee-for-service physicians.

## Adverse Selection

Adverse selection is a term used when high-risk or unhealthy members of an eligible population select a particular plan in greater numbers than average, causing higher than average costs to be incurred by that plan. Some people have feared that heavy users of health care services–those with chronic illness or large families, for example–would tend to use HMOs because of the benefit to them of the coverage provided by a prepaid plan. If this happened in large numbers, HMOs would be in big financial trouble.

Conversely, other critics have suggested that one reason why HMOs are apparently so cost-effective is that they benefit from favorable selection, leaving heavy users of health care to be covered by traditional insurance

plans. The 1984 survey found that there were few, if any, differences between the health status of HMO members and eligible nonmembers nationwide, whether in the incidence of chronic illness, in days spent in bed due to illness, or in health status. Insofar as there were any differences, HMO members appeared to have marginally lower health status, but the differences were not statistically signigicant. And the survey also found that only 14 percent of employers who offered HMOs said they had experienced adverse selection in any of their health plans because of HMO enrollment patterns.

These findings support previous research concluding that the low cost of HMO care is not due to favorable selection by HMOs of healthy individuals in the population. However, one should note here that individual HMOs or individual health care plans may benefit from favorable selection or suffer from adverse selection due to local conditions or local factors that might cancel out one another in our nationwide data.

## Perceived Differences Between For-Profit And Not-For-Profit HMOs

Until a very few years ago the overwhelming majority of HMOs and prepaid plans were run on a not-for-profit basis. However, with the dramatic growth of HMOs, major corporations and Wall Street investors have been attracted by the potential profitability of HMOs, which have now become big business.

Our survey did not provide any hard data on the differences between nonprofit and investor-owned HMOs, However, employer and physician attitudes differed markedly. On balance, employers tended to favor investor-owned HMOs as being more likely to offer high quality medical care and more likely to control costs. Physicians tended to agree that investor-owned HMOs may do a better job of controlling overall costs, but, by a small margin, physicians thought that nonprofit HMOs would be better at controlling premium costs and would also be more likely to offer high quality care.

## Comparing HMO And Fee-For-Service Practice

Most of the questions which we asked physicians concerned, directly or indirectly, the benefits or disadvantages to consumers and society generally of HMOs. In addition, however, we asked physicians to compare HMO practice with traditional fee-for-service practice.

Regarding their own satisfaction, physicians in prepaid plans and physicians in traditional fee-for-service practice showed comparable levels. However, physicians in HMOs were more satisfied with three areas of their practice–professional peer support, affiliations with a major medical center, and the time available to devote to nonprofessional interests,

family, and friends. On many other aspects of their practice, there were only small differences between the levels of satisfaction of fee-for-service physicians and HMO physicians.

The only criterion on which fee-for-service physicians were more satisfied related to current income. HMO doctors were marginally less satisfied with their incomes than were fee-for-service doctors. On the other hand, they were marginally more optimistic about their earnings prospects in the future. The high levels of satisfaction among doctors in prepaid practice were underscored by the fact that 86 percent of doctors in prepaid group practice planned to continue working in prepaid practice.

## Conclusion

The most important single conclusion of our study is that HMO membership will continue to grow very rapidly for the rest of this decade and into the 1990s. It will grow very rapidly because the great majority of HMOs satisfy the needs of their members better than fee-for-service practice satisfies the needs of many fee-for-service consumers; they are generally seen as successful in containing costs; employer support for HMOs is rising and is likely to continue to rise; physician hostility is now declining; and prepaid practice will look increasingly attractive to consumers during an era of rising insurance premiums, deductibles, and copayments.

We do not mean to imply, of course, that every individual HMO will succeed and grow. Some will surely stagnate or even fail, depending on the quality of their management and of their marketing efforts in dealing with local conditions. HMOs will need to contend with competition from other HMOs in their catchment area, an area which they may previously have had to themselves. In such a competitive environment, some HMOs may decide to target an upscale, quality-conscious market while others may target a more cost-conscious market of consumers. Some of these strategies in some local circumstances are bound to prove wrong.

Moreover, HMOs are not, of course, the only alternative to traditional fee-for-service medicine. The last few years have seen a rapid growth in a variety of alternative delivery systems including preferred provider organizations (PPOs), urgent cafe centers, surgicenters, and other ambulatory care services. We are surely going to see even further increased competition of this sort in the health care marketplace.

While the fee-for-service sector will remain strong for years to come, PPOs in particular are becoming increasingly popular with employers because they combine prepayment with attractive aspects of the traditional system. If PPOs thrive, then HMOs will face even further competition from within the ranks of prepaid health plans.

What is certain is that new delivery systems will continue to grow and to influence the future of the health care industry. American families,

employers, and physicians are becoming more willing to embrace alternative methods of funding health services, and the number of alternatives has never been larger. Each system has its supporters and critics, and an increasingly large segment of the country is willing to try the various new alternatives.

## NOTES

1. A Report Card on HMOs 1980-1984 is available in two forms from the Henry J. Kaiser Family Foundation, 525 Middlefield Road, Suite 200, Menlo Park, California 94025. One is a forty-page summary report which includes all key findings and tables. The second is the 250-page full report which includes extensive cross-tabulations, methodological discussion, and all questionnaires. In addition, the actual data set has been archived at the Inter-university Consortium for Political and Social Research, University of Michigan. We are grateful to the Henry J. Kaiser Family Foundation for supporting this research. Louis Harris and Associates is responsible for final selection of topics, question wording, data collection, and interpretation of results. Project directors at Harris were Elizabeth Montgomery and Asha Paranjpe, Ph.D.

   The survey solicited data from five separate samples, each of which was surveyed with a different questionnaire: (1) A representative, nationwide cross-section of 1,004 adults within the continental United States, with a subset of 230 adults who lived in areas where one or more HMOs were located, who were under sixty-five years of age, and who were members of households where the main wage earner was employed in an organization with twenty-five or more employees. Such people are, by definition, eligible to be members of HMOs, and we describe them throughout the report as eligible nonmembers, (2) A nationwide sample of 1,004 adult members of HMOs. (3) Two separate samples of employers, comprising 200 benefits managers and 203 senior executives *in 320* companies located in areas served by HMOs. (4) A nationwide cross-section of 501 physicians. (5) An oversample of 171 physicians affiliated with HMOs.