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Hawaii’s Message To The Nation

To the Editor:

In “Hawaii: A Pioneer in Health System Reform” (Health Affairs, Summer 1993), Deane Neubauer expressed the essential element in Hawaii’s health care system: Competition within clearly structured ground rules can hold down costs while allowing near-universal coverage of basic health care. This is our message to the nation.

Hawaii’s Prepaid Health Care Act not only requires employer-sponsored health coverage, it also contributes to preserving a system of community rating that guarantees affordable coverage to small businesses. Early access to basic health care has kept our population healthy and use of high-cost services and tertiary care low. Our employer mandate has been an integral part of our universal access strategy and an effective cost containment mechanism, which has not had a devastating effect on business.

We are still seeking to improve. Most recently we received a Medicaid waiver from the Health Care Financing Administration for our Health QUEST program to allow a managed care approach to providing health care, as well as mainstreaming of the Medicaid population into the health insurance system. We also are seeking further statutory changes to our existing Employee Retirement and Income Security Act (ERISA) exemption in order to adjust portions of our Prepaid Health Care Act to reflect current economic conditions and health needs.

Flexibility for states in designing and implementing reforms of their individual systems is also very important. Hawaii’s ERISA exemption was critical in the development of a health care system that is now a model for other states.

The federal government can best help states’ reform efforts by ensuring that certain key principles guide all states’ individual efforts. Universal access to a standard, basic health benefit package is essential. A mechanism by which this benefit package can be periodically evaluated for medical necessity and appropriateness is necessary to ensure responsiveness to changing health needs. An employer mandate should be the foundation of a reformed health system. It has proved to be an effective part of Hawaii’s universal access strategy. Insurance reforms disallowing waiting periods, exclusions due to preexisting illnesses, and copayments or deductibles for preventive services, and requiring community rating of insurance policies, also are necessary. Finally, the health industry must be encouraged to share proprietary information with the purchasers of health care. Full information will encourage increased participation and better-informed purchasing and utilization decisions.

The United States should not accept any proposal for a new health care system that costs more than current spending. By pursuing administrative efficiencies, eliminating inappropriate and ineffective medical care, and identifying and treating preventable conditions early on, as described above, we believe this can be done.

John Waihee
Governor, State of Hawaii
Honolulu, Hawaii
To the Editor:

In their Commentary, “Academic Medical Centers and Managed Care: Uneasy Partners” (Health Affairs, Spring 1993), Peter D. Fox and Jeff Wasserman present a pessimistic picture of the incompatibility of academic medical centers (AMCs) with managed care reimbursement and delivery systems. Only at the end of their paper do they acknowledge that AMCs and their physicians are indeed adapting “whether willingly or grudgingly” to these changes in our health care system.

In fact, I believe that many AMCs have been trying for some time to help realize the great potential of coordinated, systems-based managed care. The New England Medical Center (NEMC), for example, was a cofounder along with the Tufts University School of Medicine of the Tufts Associated Health Plan, an individual practice association (IPA) model health maintenance organization (HMO), as early as 1981. While we at the NEMC have encountered several of the problems cited in the paper, we continue to work together with the medical school and the HMO to consider capitation models, appropriate teaching programs, and coordinated tertiary referral networks. In addition, the commitment of the NEMC to working with managed care plans has led to internal integration of the hospital and our physicians in negotiations with all plans.

The authors portray a dichotomy between the primary function of the AMC—“the advancement of medical knowledge”—and that of the HMO—“the efficient delivery of high-quality care.” For many of us in academic medicine this is not an accurate description. We have strived for many years to pursue a balanced, tripartite mission of high-quality patient care, research, and teaching. More recently we have embraced the efficiency and effectiveness as values alongside quality. This orientation affects all of our endeavors. In research it means the study of the organization and operation of delivery systems and creation of instruments and systems to measure outcomes, in addition to our continuing efforts in biomedical research around the origins, diagnosis, and treatment of disease. In education and training, it means teaching about efficiency, prevention, and practicing within a system of care, in addition to imparting diagnostic and therapeutic skills.

In a managed care environment, AMCs need to address their relationships within a seamless fabric of care encompassing community and tertiary hospitals. A second set of issues emerges when AMCs and their physicians provide both primary and specialty care to managed care enrollees. Many of the authors’ points regarding differences between AMCs and community hospitals are supported by our experience. I believe that two main issues need to be raised: linking outcomes measurement to understanding and improving delivery systems, and implementing appropriate pricing models that accurately reflect risk factors. AMCs face the problem of enrolling a sicker patient population as HMO members select our panels based on their existing or perceived needs for specialty care. Similarly, concerns over adverse selection create the incentive for health plans to insure only healthy consumers. As a strategy for guaranteeing universal coverage and access, it is critical that we develop and apply case-mix factors to the rates paid by purchasers to health plans and by plans to providers. We have come far in our capacity to assess risk factors related to demographics and medical condition, and this work needs to continue.

Other challenges remain, but AMCs are continually improving their ability to organize and deliver care—both tertiary and primary—in an efficient, high-quality, affordable manner. By working with our own clinicians and managers, with affiliated hospitals and providers, and with managed care plans, we believe that we can play an important role in helping to create new strategies and systems for improving the health of the population, not only through patient care but also via this expanded agenda of research and training.

Jerome H. Grossman
New England Medical Center
Boston, Massachusetts
Understanding Faculty Practice Revenue

To the Editor:

In the essay by Peter D. Fox and Jeff Wasserman (“Academic Medical Centers and Managed Care: Uneasy Partners,” Health Affairs, Spring 1993), the statements regarding support of the medical school budget by revenue from faculty practice plans may easily be misunderstood. While it is true that 29.8 percent of medical school revenues in academic year 1990-1991 came from medical practice plans, most of this amount was not the so-called dean’s tax, which provides general support for medical school programs. The largest part of the cited “other financial payments by practice plans” consisted of medical practice-related compensation paid to clinical faculty. The dean’s tax was less than 2 percent of medical school revenues in 1990-1991.1

Many people have the impression that income from medical practice is subsidizing instruction and research at U.S. medical schools. While it is true that today’s schools have many more clinical faculty than they could afford without practice income, these faculty spend a great deal of their time taking care of patients. There probably is a small cross-subsidy, but medical practice income primarily pays for services to patients by faculty physicians.

Paul Jolly
Association of American Medical Colleges
Washington, D.C.

NOTE

1. Data are from the AAMC Institutional Profile System.

AMCs: The Authors Respond

To the Editor:

Regarding Jerome Grossman’s comments on our paper, we believe that the Tufts University School of Medicine and the New England Medical Center have handled their relationship with managed care, including their own HMO, better than most academic medical centers (AMCs) have. However, the relationship that Grossman describes is more exemplary than it is typical.

Grossman challenges the existence of a dichotomy between “the advancement of medical knowledge” and “the efficient delivery of high-quality care.” We never remotely intended to imply that AMCs do not strive to deliver high-quality care. Rather, the issue at hand is efficiency. However well Tufts/New England Medical Center might manage itself, a matter to which we are not privy, we believe that the intertwined goals of patient care, research, and training generate inefficiencies as they are played out in most AMCs.

We agree with most of Grossman’s other comments, which are consistent with points we raised in our paper. However, we continue to hold to our basic premise, that is, that the relationship between AMCs and HMOs is commonly an uncomfortable one and that AMCs are anything but a “seamless fabric of care,” to use Grossman’s words. To survive and prosper in an environment in which managed care is predominant, AMCs will have to make significant changes in structure, in compensation mechanisms, in decision-making processes, and, above all, in organizational culture. These changes will not come easily.

The response from Paul Jolly of the Association of American Medical Colleges (AAMC) addresses the financial contributions of faculty practice plans to academic medicine. While accepting the statistic that 29.8 percent of medical school revenues come from faculty practice plans, he correctly points out that the so-called dean’s tax is only some 2 percent of medical school revenues. However, the 2 percent figure does not negate the critical importance of the balance of the contributions, much of which is spent in support of the academic mission, including teaching and clinical research.

Indeed, we regard the 29.8 percent figure as an underestimate, since it fails to capture all of the revenues that flow through the medical school. In many AMCs the academic mission is furthered by, for example,
affiliated foundations established by the individual practice plan departments; these activities are not part of the school’s budget and thus may not be included in the AAMC statistics.

Numbers aside, medical school deans pay close attention to the clinical revenues that flow to the practice plan, and most are very concerned with the impact the advent of managed care will have on them. We doubt that the deans would exhibit the same level of interest if the cross-subsidies were of little consequence, as Jolly’s letter would have one believe.

Peter D. Fox
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Jeff Wasserman
Rhode Island Hospital
 Providence, Rhode Island

Why Managed Competition Cannot Be Enacted

To the Editor:

Managed competition was solemnly described and debated in the 1993 Supplement to Health Affairs. But all of that effort was ill spent: Managed competition is a mirage. It cannot be enacted as a nationwide or state-wide policy, because it rests on two fundamental assumptions-closed panels of providers and lock-ins of patients—that no democratic legislature will enact.

Once all European health insurance consisted of closed panels of doctors treating each plan’s subscribers—the model for U.S. health maintenance organizations (HMOs).1 The first national health insurance laws in Prussia in 1849 and in Germany in 1883—did not mention doctor/patient relations but allowed all of the closed panels to continue as providers of care. Decades of dispute followed: Many doctors were subordinate employees of sickness funds and fought the managers; many other doctors protested the lack of access to insurance practice. Both patients and doctors in all other countries heeded the German experience and made sure that national health insurance laws contained clauses guaranteeing that every licensed doctor could treat every insured person and that every insured person could choose among all doctors, at least for primary care. Amendments to the law and constitutional decisions by the supreme court eventually brought about the same outcome in Germany.2 Even countries with full public financing, such as Canada, have similar laws. Thus maximum consumer choice and provider competition in a nationwide market replaced the small restricted arrangements of the past.

When the United States enacted Medicare, the same fundamental principles were enacted: Every patient may choose any provider, and any licensed provider may participate. No patient may be locked into any limited set of providers. No licensed doctor or hospital may be excluded altogether or restricted to a special panel.3 A Medicare patient is free to sign up voluntarily with an HMO, but the response has been limited.4 Many are lifelong satisfied subscribers to Kaiser and to other HMOs under private employer-group insurance, and they choose to continue under Medicare. Others are attracted by extra benefits. But no Medicare HMO subscriber can be required to stay within the closed panel for more than a few months.

The fate of HMOs under a comprehensive public policy was demonstrated by events in Ontario, Canada. Before the enactment of its Medicare in 1968, the province had two U.S.-style HMOs with health centers. At first, they received capitation rates from the Ontario Health Insurance Plan (OHIP)—a kind of health insurance purchasing cooperative (HIPC), to use recent American terminology. But every HMO member had the right to consult any outside doctor, and the fees were paid not by OHIP (which had already paid the capitation rate) but by the HMOs. So, the HMOs could not survive in their original form. Now they are groups with health centers, open to all citizens, and paid by OHIP according to the province’s normal fee-for-service methods.5

The United States has HMOs and individual practice associations (IPAs) only because it has no national health insurance law
and no general public financing. HMOs and IPAs are possible only in a private market, where any arrangement may be offered by employers and selected by subscribers and where closed panels may appear to offer better services and lower costs in an unstandardized, chaotic environment. Despite decades of publicity, fewer than one-fifth of Americans have joined such plans. Already the patient lock-ins, particularly among many IPAs, are being replaced by the right to see out-of-plan doctors. These are called “point-of-service” options and “preferred provider organizations.” The subscriber can consult an out-of-plan doctor, pay the extra billing in full, and relieve the IPA’s budget by paying a large deductible on all out-of-plan bills. Many U.S. IPA operations are evolving into indemnity insurance with offers of cash savings for selection of in-plan services.6

All U.S. HMOs and IPAs would be destroyed by the usual legislative clauses allowing any licensed doctor or hospital to treat and bill patients and allowing any patient to consult any provider. Congress no doubt would enact the same clauses that it has already enshrined in Medicare. The first gropings toward managed competition in a state legislature during 1993 have already come a cropper over the issue. The legislature of the state of Washington found a majority for a law only with a clause guaranteeing that “any willing provider” could join any plan.7 Selective contracting and closed panels therefore are impossible. All other state legislatures—if given the responsibility to implement reforms—likely will follow.

The Clinton administration has tiptoeed around the issue. Hillary Rodham Clinton promised the American Medical Association (AMA) that every doctor would be free to apply to any plan and that perhaps a doctor could be affiliated with more than one plan.8 But a law inevitably will guarantee that every provider can treat any patient—whether or without affiliation with a provider network—and the entire managed competition scenario will dissolve. HMOs will survive only as conventional physicians’ groups with superior health centers. IPAs will cease to exist, since they will have nothing distinctive to offer, and the entire market will operate like a single IPA with managed care.

The managed competition scheme was never more than a thinly veiled attempt by leaders of the HMO/IPA industry to make their schemes universal. If national reform with an inevitable “any willing provider” clause-conflicts with the future prosperity of their clients, they may oppose it. Managed competition then will be understood as one of the unrealistic crazes that periodically mislead entire countries.9

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NOTES


5. Glaser, Health Insurance in Practice, 249, 254, 421-423, 491-492. The “open-ended” option in traditional HMOs and IPAs is described in The InterStudy Edge, 1989, vol. 1. Many traditional health insurance companies now offer limited lists of doctors headed by primary care case managers—with lower out-of-pocket costs to patients—and the “open-ended” option with much higher out-of-pocket costs.

