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Ten Ways HMOs Have Changed During The 1990s

HMOs and managed care organizations did not merely grow during the 1990s—they changed substantially too. Is America better off because of these changes?

by Jon Gabel

ABSTRACT: The same forces that encouraged the expansion of managed care also brought about change in health maintenance organizations (HMOs). Using data from annual surveys of the Association of American Health Plans and other sources, this paper examines ten major changes in the HMO industry during the 1990s, including the growth of for-profit plans and the relative decline of nonprofits; the shift from vertically integrated group/staff models to virtually integrated individual practice associations/network models; industry consolidation through mergers and acquisitions; increased patient cost sharing; and the shift to capitation payment of primary care physicians. Current research is unable to show whether these changes have led to improved quality of care or patient satisfaction.

INTRODUCTION

When the 1990s began, indemnity insurers, nonprofit community hospitals, and solo fee-for-service physicians had a commanding role in the financing and delivery of care. Health insurance premiums had increased by nearly 20 percent per year in the previous two years. By 1995, managed care plans had established their dominant role, while indemnity insurance covered fewer than one of three Americans with private health insurance. The growth of managed care plans stimulated a wave of hospital mergers and the formation of many large physician group practices. In 1995 and 1996 overall premium increases in employer-based plans were 2.5 percent and 0.5 percent, respectively—lower than any other years since researchers began measuring them.

Between 1990 and the end of 1995, the number of Americans enrolled in a health maintenance organization (HMO) grew from 36.5 million to 38.2 million. But HMOs and managed care organizations did not merely grow during the 1990s—they changed substantially too. The same forces that encouraged the expansion of managed care also brought about change within HMOs. The primary force was the heightened resistance of the nation’s employers to paying for double-digit premium increases. This paper draws on data from the American Association of Health Plans (AAHP) and other sources to examine ten changes that occurred during the decade among HMOs: (1) the rapid growth of for-profit HMOs; (2) the rapid growth of network and individual practice association (IPA) models; (3) the growth of mixed-model HMOs; (4) product diversification; (5) industry consolidation at the national and local levels; (6) the decline of community-rating methods; (7) altered payment arrangements with physicians; (8) increased patient cost sharing; (9) declining hospital use; and (10) increased use of clinical guidelines.

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Some of these trends began in the 1980s and accelerated in the 1990s. This paper aims to quantify the major trends and explain underlying factors that stimulated changes in the market. Because comparable data on HMOs are not often available from surveys over a precise ten-year period, the paper shows changes in HMOs over the period 1990–1994 or, alternatively, over the widest range of years that the data permit.

**INDUSTRY SURVEYS.** Two surveys are the primary data sources for this paper. The first is the Annual HMO Industry Survey conducted by the Group Health Association of America (GHAA) (now known as the AAHP), an industry group representing HMOs. From 1986 to 1995, the GHAA conducted this extensive mail survey, which asked about subjects such as premium costs, enrollment, product lines, rating methods, diversification, utilization, and patient cost sharing. The GHAA attempted to solicit data from all HMOs in the nation. Response rates rose from 45 percent in 1986 to 72 percent in 1995. HMOs with lower enrollments were generally less likely to respond to the survey. Since smaller HMOs are less likely to offer cutting-edge products, and since smaller HMOs were less likely to respond to the survey during the earlier years, the survey results may be conservative, perhaps underestimating the extent of change.

The second survey was the GHAA Membership Survey, which was conducted from 1989 to 1995. The GHAA collected data from HMOs’ filings with state regulators, and these data were the basis of the annual GHAA Directory. Data included enrollment, product lines, and model types.

**Ten Changes in HMOs**

- **The Rapid Growth of For-Profit HMOs.** Between 1988 and 1994, membership in for-profit HMOs increased by 91.6 percent, whereas nonprofit membership grew by 24.9 percent. Today the majority (58 percent) of HMO members are enrolled in for-profit organizations, whereas in 1988 the majority (53 percent) were enrolled in nonprofit HMOs. What is most remarkable about the rise of for-profits is that some states with major HMO enrollments, such as Minnesota, prohibit for-profits from operating within their states—an indication of how widespread the enrollment in for-profits has been in other states.

  Why did for-profit HMOs grow more rapidly than nonprofits? No conclusive evidence currently supports or refutes the proposition that for-profits grew more rapidly because they are more efficient than nonprofits. For example, there is little difference in the cost of monthly premiums or hospitalization rates between for-profit and nonprofit HMOs.³ However, three other factors may explain the faster growth of for-profits.

  First, for-profits were more aggressive in seeking growth. Many of the large established nonprofits had the resources to enter new markets but were less concerned about enrollment growth. One reason for this was that, unlike publicly traded HMOs, the equity price and value of their enterprise was not linked to Wall Street analysts’ reaction to their enrollment growth.

  Second, building provider networks in new markets, information systems, and other forms of infrastructure requires capital. As the sometimes darlings of Wall Street, for-profits had greater access to capital. This was the reason that many HMOs gave for converting from nonprofit to for-profit status.

  Third, and perhaps most importantly, many large nonprofits were committed to staff- or group-model HMOs. These models required greater expenditures in “brick and mortar” when entering new markets and a longer time to plan for entry. For-profits, in
contrast, preferred IPA or network models, for these very reasons. Employees found that switching to an IPA or a network plan involved less disruption in their care, particularly since many of the physicians who contracted with IPAs and network plans were the same physicians that employees were already using.

THE RAPID GROWTH OF NETWORK AND IPA MODELS. Increasingly, HMOs are “virtual organizations” or “organizations without walls,” built on contractual relationships with community providers. The traditional group- or staff-model HMO is a vertically integrated organization, which operates its own physical facilities in different geographic locations, and whose physicians work solely for the HMO. In 1988 group and staff models constituted about 42 percent of HMO membership (Exhibit 1). By the end of 1994 they constituted only 31 percent.

Why the greater appeal of IPAs and network models? First, virtual organizations needed less capital to enter new geographic markets than vertically integrated organizations needed. Second, employees could switch to an IPA or a network plan and, in many cases, retain their family physician and specialist. Third, many group and staff models, which were more likely to be owned by a nonprofit organization, were not as aggressive in increasing market share as were IPAs or network plans. For example, in the early 1990s, Kaiser plans in California suspended new enrollment during a period when the plans could not keep up with demand. Many Kaiser physicians regarded the expansion as a burden, and they resisted adding new facilities and physicians.³

THE GROWTH OF MIXED MODELS. As IPA and network membership expanded, staff and group models eventually responded by contracting with independent physicians and group practices. In doing so, many formerly staff and group models became mixed models in which, for example, one component of the plan was a staff model and another component was an IPA model.⁷

In 1990 about one-third of staff models were mixed models (Exhibit 2). By 1994 that figure had increased to 57 percent. Group models were less inclined to alter their arrangements. Network models increasingly contracted with independent solo practices, so that by 1994 more than one in three network models was a mixed model.

The transition to mixed models was often a painful process for group and staff models. Many plan physicians and executives genuinely believed that a group or staff model delivered higher-quality care than IPA or network models did. Deviating from this model seemed to them to violate the mission of the organization.

PRODUCT DIVERSIFICATION. Over the past ten years, employers increasingly

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EXHIBIT 1
Share Of HMO Membership, By Type Of HMO, 1988–1994

<table>
<thead>
<tr>
<th>Year</th>
<th>IPA</th>
<th>Network</th>
<th>Staff</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>42.8%</td>
<td>14.9%</td>
<td>12.4%</td>
<td>29.9%</td>
</tr>
<tr>
<td>1992</td>
<td>46.1%</td>
<td>16.0%</td>
<td>13.5%</td>
<td>24.4%</td>
</tr>
<tr>
<td>1994</td>
<td>50.4%</td>
<td>18.6%</td>
<td>10.7%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

SOURCE: Group Health Association of America Annual HMO Industry Survey.
NOTES: HMO is health maintenance organization. IPA is individual practice association.
have chosen to offer hybrid health plans: point-of-service (POS) plans and preferred provider organizations (PPOs). As more employees have enrolled in POS plans and PPOs, HMOs have responded by expanding their offerings to cover services provided outside the plan. Between 1990 and 1994 the percentage of HMOs offering open-ended plans (meaning POS products) increased from 36 percent to 61 percent, while PPO offerings rose from 35 percent to 50 percent (Exhibit 3). Today, most HMOs do not view themselves as HMOs but as managed care organizations that offer an array of managed care plans.

Two factors underlie the decision to diversify: the desire to increase the choice of plans and providers; and the desire to ease employees’ transition from indemnity to managed care plans. Most managed care organizations view choice as very important. Many managed care organizations, particularly investor-owned national companies, believe that diversification bestows an advantage in the marketplace with employers seeking carriers that can provide the triple option (HMO, PPO or POS, and indemnity offerings). These employers believe that the triple option will reduce administrative costs and biased selection across plans.6

Many large and midsized employers were self-funding their indemnity plans in the 1980s. In the 1990s greater numbers of employers sought to self-fund their managed care offerings, so more HMOs offered administrative-services-only products. Under this arrangement, the employer bears the financial risk for the cost of services. The HMO bills the employer on a discounted fee-for-service basis for medical services delivered. In addition, the HMO also charges the employer an administrative fee for “renting” the provider network and for using the HMO’s quality management and utilization review program. Between 1990 and 1994 the percentage of HMOs offering an administrative-services-only product increased from 40 percent to 57 percent. Based on KPMG Peat Marwick’s 1996 survey of 1,185 employers with 200 or more workers, about 20 percent of Americans with HMO coverage were enrolled in a self-funded plan, and about 86 percent of POS plan members were enrolled in a self-funded plan.7

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**EXHIBIT 2**
Percentage Of HMOs That Are Mixed Models, By Plan Type, 1990 And 1994

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>1990</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>All plans</td>
<td>60</td>
<td>50</td>
</tr>
<tr>
<td>Staff</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Group</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>Network</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>IPA</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

**SOURCE:** Group Health Association of America Annual HMO Industry Survey.

**NOTES:** HMO is health maintenance organization. IPA is individual practice association.
Administrative-services-only products held some distinct advantages for employers over traditional HMOs, just as HMOs had advantages over indemnity plans. Employers did not have to pay premium taxes and were not subject to state-mandated benefits or consumer protections. A multistate employer did not have to comply with numerous and sometimes conflicting state regulations. If an employer’s workforce was younger and healthier than the community average, expected medical expenses and, therefore, premiums were lower than when the HMO bore the financial risk for medical expenses.

HMO CONSOLIDATION. Mergers and acquisition activity among managed care organizations accelerated in the 1990s. The number of major acquisitions among publicly traded managed care organizations grew from five in 1993 to twelve in 1994 and fourteen in 1995. These acquisitions involved more than $4 billion in cash transfers in 1994 and 1995. In April 1996 Aetna purchased U.S. Healthcare for a record $8.8 billion in cash to form a managed care organization with fourteen million covered lives, including 4.4 million HMO members. Other major acquisitions and mergers, such as Anthem’s acquisition of the New Jersey Blue Cross plan, PacifiCare’s purchase of Family Health Plan (FHP), and WellPoint’s acquisition of MassMutual, made 1996 a record year for acquisition and merger activity.

When new entries into the market are fewer than the number of exits (through mergers and acquisitions), the result is a more consolidated industry. Nationally, approximately 600 state-licensed HMO plans served nearly sixty million Americans in 1995, compared with 675 licensed plans serving twenty-nine million Americans in 1987. Today approximately twenty-five managed care organizations account for an estimated two-thirds of national membership.

A better measure of consolidation is local market concentration. Two of the nation’s most mature HMO markets, southern California and Minneapolis, offer a glimpse of the future. In southern California, six HMOs hold 75

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**EXHIBIT 3**

Percentage Of HMOs Offering Diversified Products, By Product Type, 1990 And 1994

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>POS</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>PPO</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>Administrative services only</td>
<td>30</td>
<td>40</td>
</tr>
</tbody>
</table>

**SOURCE:** Group Health Association of America Annual HMO Industry Survey.

**NOTES:** HMO is health maintenance organization. POS is point-of-service. PPO is preferred provider organization.
percent of the market. In Minneapolis, three
HMOs account for 80 percent of the market. In recent years merger and acquisition ac-
tivity has strayed from its historical pattern. Small for-profit HMOs used to be at the cen-
ter of merger and acquisition activity. In their first four years of operation, these HMOs
were likely to be acquired, often by national and regional HMOs, or to merge with another
small HMO. Recent merger and acquisition activity often has involved two large organiza-
tions. Sometimes national companies merge with other national companies. PacifiCare’s
acquisition of FHP (which had purchased TakeCare one year earlier) is one such exam-
pie. More common is the acquisition of a large national company, often one that began as an indem-
nity insurer, by a regional HMO. For example, United Health Care purchased MetraHealth, a managed care organization that had been created one year earlier by the merger of former giants Metropolitan Life and Travelers. Other examples are WellPoint’s ac-
quision of MassMutual and Humana’s purchase of Emphesys. A third type of activity involves two large regional companies, such as Blue Cross plans. Four Blue Cross organi-
izations have created publicly traded subsidiaries, which have then searched for other Blue
Cross plans to purchase. WellPoint and An-
then are two of the most aggressive Blue
Cross plans; in the past few years Anthem has
purchased the New Jersey, southern Ohio,
Kentucky, and Connecticut plans.
■ THE DECLINE OF COMMUNITY
RATING. In 1988 Congress amended the
HMO Act and permitted HMOs to allow fed-
ernally qualified plans to adjust rates prospect-
ively for employer groups. During the next few years HMOs shifted from using forms of
community rating to using forms of experience rating (Exhibit 4). In 1988 standard com-
munity rating covered 47 percent of HMO
members; community rating by class ac-
tioned for an additional 38 percent; and the
remaining 15 percent of HMO members were subject to experience rating. By 1993 standard
community rating covered only 29 percent of
HMO members, and community rating by class covered 27 percent. Experience rating
covered 19 percent of enrollment. However,
adjusted community rating, a modified form of experience rating, accounted for 26 percent
of enrollment.
Standard community rating, where all
members of the community pay the same rate,
encouraged employers with older workers to
contract with HMOs. Community rating by class, in which rates are set according to age, sex,
and other demographic characteristics and all members of the same class pay the
same premiums, permitted younger members
of the workforce to purchase coverage at a
lower price. Adjusted community rating, in
which the HMO sets an overall community
rate and then adjusts the rate for individual

EXHIBIT 4
Percentage Of HMO Enrollees Covered By Various Methods Of Rating, 1988 And 1993

<table>
<thead>
<tr>
<th></th>
<th>1988</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience rating</td>
<td>15%</td>
<td>19%</td>
</tr>
<tr>
<td>Standard community rating</td>
<td>47%</td>
<td>29%</td>
</tr>
<tr>
<td>Community rating by class</td>
<td>38%</td>
<td>27%</td>
</tr>
</tbody>
</table>

*Adjusted community rating was not implemented until after 1988.

SOURCE: Group Health Association of America Annual HMO Industry Survey.
NOTE: HMO is health maintenance organization.
groups prospectively, allowed HMOs to lower their premiums for employer groups that used fewer medical care services and employed a younger and healthier workforce.

From a business perspective, the shift away from standard community rating served to improve the risk selection of individuals who joined HMOs, allowing HMOs to compete more easily with experience-rated PPO and indemnity plans. However, from a societal perspective, this shift increased inequities among individuals and employers in their efforts to obtain health coverage at similar prices.

ARRANGEMENTS FOR PAYING PHYSICIANS. Since the mid-1980s health plans have increasingly negotiated payment arrangements with physicians and physician groups, shifting the financial risk from health plans to physicians. The net effect is to change the economic environment in the health care system from a cost-plus system to one with budget constraints, more closely resembling traditional markets for goods and services. In this new environment, physicians are rewarded for practicing efficiently, or denying care, depending on one’s ideological interpretation.

Survey data on payment arrangements between HMOs and physicians are limited. However, Alan Hillman and colleagues provided baseline data on payment arrangements at the turn of the decade.15 In their 1989 survey of 260 HMOs, Hillman and colleagues identified two-tier and three-tier arrangements. Two-tier arrangements result when an HMO contracts directly with an individual physician. Three-tier arrangements involve a plan contract with a physician group, which in turn contracts with individual physicians. Hillman and colleagues reported that 36 percent of HMOs, accounting for 61 percent of enrollment, had three-tier arrangements. Examining both two- and three-tier arrangements, Hillman and colleagues reported that the major payment methods used to pay individual primary care physicians were salary (23 percent), capitation (35 percent), and fee-for-service (36 percent) (Exhibit 5).

In 1994 Marsha Gold and colleagues surveyed twenty-nine group/staff and fifty network/IPA HMOs.16 Although the methods used by Gold and colleagues were not identical to those used by Hillman and colleagues, they were similar enough to provide a basis for comparison. Gold and colleagues found that 26 percent of plans paid individual primary care physicians on a salary basis, 50 percent on a capitation basis, and 24 percent on a fee-for-service basis.17 The shift from salary and fee-for-service is not explained simply by the growth of for-profit and investor-owned HMOs. In recent years, some of the nation’s best-established nonprofit group and staff plans, including the Fallon Community Health Plan and Kaiser Foundation Health

EXHIBIT 5
How HMOs Paid Primary Care Physicians, 1989 and 1994

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee-for-service</th>
<th>Salary</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>36%</td>
<td>23%</td>
<td>35%</td>
</tr>
<tr>
<td>1994</td>
<td>24%</td>
<td>26%</td>
<td>50%</td>
</tr>
</tbody>
</table>


NOTE: HMO is health maintenance organization.
Plans, have switched from salary to capitation to pay their primary care physicians.

■ INCREASED PATIENT COST SHARING. With its historic antecedents in the labor and consumer movements, HMOs traditionally have offered comprehensive services with small out-of-pocket payments for patients. HMOs continue to provide more comprehensive benefits with less patient cost sharing than indemnity plans, PPOs, or POS plans provide. However, since 1990 HMO members have faced increased copayments, and sometimes deductibles, when they use health care services.

Exhibit 6 shows the increase from 1987 to 1993 in the average out-of-pocket costs for HMO members for selected services. These figures include plans that do and do not require patient cost sharing. Thus, in 1987 the average out-of-pocket cost for a physician visit was $1.18; in 1993 it was $4.51. Out-of-pocket costs for outpatient mental health services increased from $5.74 in 1987 to $12.24 in 1993. Copayments for prescription drugs increased from $3.90 per prescription in 1987 to $4.60 per prescription in 1993.

Why did patient cost sharing increase? One contributing factor was the growing presence of for-profit plans and diminished market share of nonprofit plans. Unlike many nonprofits, for-profits had no historic ties to the consumer and labor movements. But far more important was the imperative to control premium costs. By increasing patients’ out-of-pocket costs, employers’ costs for health care services were directly reduced; more importantly, the use and cost of health care services declined. In an analysis of a natural experiment at the Group Health Cooperative of Puget Sound, researchers found that the imposition of a $5 copayment resulted in an 11 percent reduction in primary care visits, a 3 percent reduction in specialty visits, and a 14 percent decrease in physical examinations.

■ DECLINING HOSPITAL USE. In a highly quoted review of the literature, Harold Luft noted more than sixteen years ago that a major source of savings for HMOs was their lower use of hospital inpatient services than was true in the fee-for-service sector. By

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**EXHIBIT 6**

Copayments For HMOs’ Best-Selling Benefit Package, 1987 and 1993

<table>
<thead>
<tr>
<th>Service</th>
<th>1987</th>
<th>1993</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health</td>
<td>$3.39</td>
<td>$14.51</td>
</tr>
<tr>
<td>Outpatient mental health</td>
<td>$5.74</td>
<td>$12.24</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$3.90</td>
<td>$4.60</td>
</tr>
<tr>
<td>Hospital day</td>
<td>$4.50</td>
<td>$24.90</td>
</tr>
<tr>
<td>Physician visits</td>
<td>$1.18</td>
<td>$4.51</td>
</tr>
</tbody>
</table>

**SOURCE:** Group Health Association of America Annual HMO Industry Survey.

**NOTE:** HMO is health maintenance organization.
In 1988 this was still the case. The elderly in HMOs used about half the number of inpatient days reported for the elderly population in the United States. The nonelderly in HMOs used about 36 percent fewer days per thousand persons than the entire nonelderly population used (Exhibit 7).

From 1988 to 1993, hospital use, measured as the number of inpatient days per thousand covered lives, declined by 15 percent for the elderly HMO population and 19 percent for the HMO nonelderly. For the general population, the elderly’s use of hospital services declined by 18 percent, while use among the nonelderly fell nearly 16 percent. Thus, by 1993, although hospital utilization rates declined throughout the health care sector, HMOs retained their advantage over the fee-for-service sector.

Similar factors contributed to the reduction in the use of inpatient hospital services in the fee-for-service and HMO sectors. Advances in medical technology reduced hospital lengths-of-stay and enabled physicians to perform more surgery in outpatient settings. Both the fee-for-service system and HMOs used preadmission certification and other utilization management techniques to reduce lengths-of-stay and admission rates.

CLINICAL PRACTICE GUIDELINES. The majority of medical practices are derived not from scientific studies but from “medical folklore,” with word-of-mouth and a practitioner’s past experience determining treatment patterns. Clinical practice guidelines provide scientifically based protocols to guide physicians’ clinical decisions. Proponents believe that these guidelines simultaneously promote lower costs and better outcomes. Critics view guidelines as an administrative mechanism to reduce utilization and cost. In 1989 there were an estimated 700 sets of guidelines developed by thirty prominent organizations nationally. Today, seventy-five national organizations have developed some 1,800 sets of guidelines, while individual hospitals, managed care organizations, private researchers, and pharmaceutical manufacturers have developed thousands of others.21

Because HMOs did not regard guidelines
as an important administrative tool during the 1980s, no surveys were developed to measure their use. However, two recent surveys of the HMO industry indicate the important role that clinical guidelines play today. In their 1994 survey of thirty group/staff plans and fifty IPA/network plans, Gold and colleagues found that approximately 75 percent of plans used formally written practice guidelines. Major sources of guidelines were national professional provider groups, plans’ medical staffs, and federal agencies such as the Agency for Health Care Policy Research (AHCPR), the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC).

The GHAA (now the AAHP) surveyed seventy-one HMOs in the fall of 1994. Eighty-two percent of responding plans indicated that they encouraged providers to follow clinical guidelines. Of those promoting guidelines, 85 percent reported assigning professional staff to formally develop and implement those guidelines.

Essential questions remain unanswered about the use of clinical guidelines in HMO settings. Most HMOs lack an information system that can measure physicians’ and patients’ compliance with specific guidelines. Nor are many HMOs able to determine the effectiveness of guidelines in improving medical outcomes and patient satisfaction or their impact on the cost and use of services for specific medical conditions. Many HMOs now pay primary care physicians and large group practices a capitated payment for services, rather than paying on a fee-for-service basis. Even if the HMO asks physicians to submit dummy claims, physicians have less economic incentive to submit these claims than they had under a fee-for-service system, in which claims were the basis of actual payment.

Without accurate paid claims data, these HMOs may capture less information about treatment patterns for specific medical conditions today than when they paid physicians on a fee-for-service basis.

**Is America Better Off Because Of These Changes?**

The HMO industry is clearly moving from its historic antecedents. Vertically integrated nonprofit organizations now play a diminished role, while publicly traded investor-owned organizations that offer a continuum of managed care products are on the rise. Enthusiastic readers of The Wall Street Journal’s editorial page will likely find this trend encouraging. Dedicated followers of The New England Journal of Medicine’s editorial section presumably will consider this development alarming. But what is the evidence?

Certainly, there are positive developments. Intense price competition among HMOs has led to a persistent decline in health care premiums that was unimaginable in 1990. For the past two years, overall health insurance premiums have increased at a lower rate than the overall rate of inflation, the medical care component of the consumer price index, and workers’ earnings.

There also are disturbing developments, however, which suggest that the new HMO market does not reward HMOs that deliver above-average quality of care. A cursory look at the nation’s best HMOs, as judged by data from the Health Plan Employer Data and Information Set (HEDIS), places largely nonprofit HMOs as the leaders—and these are not the HMOs that are growing most rapidly. Wall Street analysts accord no value to a plan that receives accreditation from the National Committee for Quality Assurance (NCQA). In 1996 fewer than one-third of employee benefits managers from the nation’s large and midsize employers indicated familiarity with NCQA accreditation, according to...
a KPMG Peat Marwick survey of 1,185 firms.27 Until recently, the consensus from studies comparing quality of care in HMOs and in fee-for-service settings was that HMO care was at least comparable.28 These studies, however, largely examined care in traditional staff and group models. More recently, John Ware and colleagues studied 2,235 patients with chronic conditions in three cities and observed changes in their health over a four-year period. They found no differences in physical and mental outcomes for average patients, but chronically ill elderly and poor patients had worse physical outcomes in HMO settings than in fee-for-service settings.29 No studies have assessed the quality of care provided by investor-owned managed care organizations in a deflationary market. During the past few years HMOs have experienced a decline in their patient satisfaction scores. No one knows to what extent these declines are attributable to the constant anecdotes and horror stories found in the popular press about denial of care in HMOs. Nor do we know how representative these individual cases are.

Current research does not provide answers about many other changes that have occurred in the HMO industry in this decade. For example, does capitation payment to physicians lower quality of care? How effective are clinical guidelines in improving the quality of care in HMO settings? Does increased patient cost sharing in HMOs reduce access and thus jeopardize health status for HMO members with poor health and low incomes? Is the reduction in hospital service use jeopardizing medical outcomes for specific diseases?

Unfortunately, while the research community is analyzing these issues, employers and employees must make choices about what health plans to select. Public opinion will force state and federal governments to consider so-called patient protection legislation that restricts managed care organizations’ ability to make business and clinical decisions. Advances in information and medical technology will bring about major changes in business and clinical practices. In the words of the legendary Yogi Berra, the one safe prediction is, “The future ain’t what it used to be.”

The author thanks Kelly Hunt, Tom Dial, Chris Bergsten, Heidi Whitmore, Tom Rice, and Marsha Gold for their helpful comments, and Kathie Moyer and Joyce Chin for their excellent secretarial support.

NOTES

2. KPMG Peat Marwick LLP, Health Benefits in 1995 (San Francisco: KPMG Peat Marwick, 1995), 26. Managed care is commonly defined as health plans that contract selectively with providers on a discounted basis and provide utilization management and quality assurance. This definition includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.
3. Ibid., 14–17.
7. Organizations that regularly survey HMOs term these arrangements as “mixed models” but continue to classify the core business as the HMO model type. For example, if a staff model contracts with community physicians, but the majority of HMO members continue to receive their care at the HMO-owned clinics and hospitals, then the HMO would be termed a “staff-mixed model.”

12. Findlay, “Will Big HMOs Stamp Out Competition?”


17. Ibid., 75. The figures were derived by the author of this paper.


22. Gold et al., Arrangements between Managed Care Plans and Physicians.


24. Specifically, in 1995 and 1996 premiums increased by 2.1 percent and 0.5 percent, while overall inflation rose by 3.2 percent and 2.9 percent, and workers earnings grew by 2.7 percent and 2.9 percent. KPMG Peat Marwick, Health Benefits in 1996.


29. J. Ware et al., “Differences in 4-Year Health Outcomes for Elderly and Poor Chronically Ill Patients Treated in HMO and Fee-for-Service Systems,” Journal of the American Medical Association (2 October 1996): 1039–1047.