

Blame Congress for HMOs

Twila Brase

Twila Brase is a Registered Nurse and is president of the Citizens' Council on Health Care in St. Paul, Minnesota (www.cchc-mn.org). This article is reprinted from Ideas on Liberty.

Only twenty-seven years ago, congressional Republicans and Democrats agreed that American patients should gently but firmly be forced into managed care. That patients do not know this fact is evidenced by public outrage directed at health maintenance organizations (HMOs) instead of Congress.

Although members of Congress have managed to keep the public in the dark by joining in the clamor against HMOs, legislative history puts the responsibility and blame squarely in their collective lap.

The proliferation of managed-care organizations (MCOs) in general, and HMOs in particular, resulted from the 1965 enactment of Medicare for the elderly and Medicaid for the poor. Literally overnight, on July 1, 1966, millions of Americans lost all financial responsibility for their health-care decisions.

Offering “free care” led to predictable results. Because Congress placed no restrictions on benefits and removed all sense of cost-consciousness, health-care use and medical costs skyrocketed. Congressional testimony reveals that between 1965 and 1971, physician fees increased 7 percent and hospital charges jumped 13 percent, while the Consumer Price Index rose only 5.3 percent. The nation’s healthcare bill, which was only \$39 billion in 1965, increased to \$75 billion in 1971. Patients had found the fount of unlimited care, and doctors and hospitals had discovered a pot of gold.

This stampede to the doctor’s office, through the U.S. Treasury, sent Congress into a panic. It had unlocked the health-care appetite of millions, and the results were disastrous. While fiscal prudence demanded a hasty retreat, Congress opted instead for deception.

Limited by a noninterference promise attached to Medicare law—enacted in response to concerns that government health care would permit rationing—Congress and federal officials had to be creative. Although Medicare officials could not deny services outright, they could shift financial risk to doctors and hospitals, thereby influencing decision-making at the bedside.

Beginning in 1971, Congress began to restrict reimbursements. They authorized the economic stabilization program to limit price increases; the Relative Value Resource Based System (RVRBS) to cut physician payments; Diagnostic-Related Groups (DRGs) to limit hospitals payments; and most recently, the Prospective Payment System (PPS) to offer fixed prepayments to hospitals, nursing homes, and home health agencies for anticipated services regardless of

costs incurred. In effect, Congress initiated managed care.

National Health-Care Agenda Advances

Advocates of universal coverage saw this financial crisis as an opportunity to advance national health care through the fledgling HMO. Legislation encouraging members of the public to enter HMOs, where individual control over health-care decisions was weakened, would likely make the transition to a national health-care system, where control is centralized at the federal level, less noticeable and less traumatic. By 1971, the administration had authorized \$8.4 million for policy studies to examine alternative health insurance plans for designing a “national health insurance plan.”

Senator Edward M. Kennedy, a longtime advocate of national health care, proceeded to hold three months of extensive hearings in 1971 on what was termed the “Health Care Crisis in America.” Following those hearings, he held a series of hearings “on the whole question of HMOs.”

Introducing the HMO hearings, Kennedy said,

We need legislation which reorganizes the system to guarantee a sufficient volume of high quality medical care, distributed equitably across the country and available at reasonable cost to every American. It is going to take a drastic overhaul of our entire way of doing business in the health-care field in order to solve the financing and organizational aspects of our health crisis. One aspect of that solution is the creation of comprehensive systems of health-care delivery.

In 1972, President Richard M. Nixon heralded his desire for the HMO in a speech to Congress: “the Health Maintenance Organization concept is such a central feature of my National Health Strategy.” The administration had already authorized, without specific legislative authority, \$26 million for 110 HMO projects. That same year, the U.S. Senate passed a \$5.2 billion bill permitting the establishment of HMOs “to improve the nation’s health-care delivery system by encouraging prepaid comprehensive healthcare programs.”

But when the House of Representatives refused to concur, it was left to the ninety-third Congress to pass the HMO Act in 1973. Just before a voice vote passed the bill in the House, U.S. Representative Harley O. Staggers, Sr., of West Virginia said,

I rise in support of the conference report which will stimulate development of health maintenance organizations. . . . I think that this new system will be successful and give us exciting and constructive alternatives to our existing programs of delivering better health services to Americans.

In the Senate, Kennedy, author of the HMO Act, also encouraged its passage:

I have strongly advocated passage of legislation to assist the development of health maintenance organizations as a viable and competitive alternative to fee-for-service practice. . . . This bill represents the first initiative

by the Federal Government which attempts to come to grips directly with the problems of fragmentation and disorganization in the health care industry. . . . I believe that the HMO is the best idea put forth so far for containing costs and improving the organization and the delivery of health-care services.

In a roll call vote, only Senator Herman Talmadge voted against the bill. On December 29, 1973, President Nixon signed the HMO Act of 1973 into law.

As patients have since discovered, the HMO—staffed by physicians employed by and beholden to corporations—was not much of a Christmas present or an insurance product. It promises coverage but often denies access. The HMO, like other prepaid MCOs, requires enrollees to pay in advance for a long list of routine and major medical benefits, whether the health-care services are needed, wanted, or ever used. The HMOs are then allowed to manage care— withhold access to dollars and service—through definitions of medical necessity, restrictive drug formularies, and HMO-approved clinical guidelines. As a result, HMOs can keep millions of dollars from premium-paying patients.

HMO Barriers Eliminated

Congress' plan to save its members' political skins and national agendas relied on employer-sponsored coverage and taxpayer subsidies to HMOs. The planners' long-range goal was to place Medicare and Medicaid recipients into managed care where HMO managers, instead of Congress, could ration care and the government's financial liability could be limited through capitation (a fixed payment per enrollee per month regardless of the expense incurred by the HMO).

To accomplish this goal, public officials had to ensure that HMOs developed the size and stability necessary to take on the financial risks of capitated government health-care programs. This required that HMOs capture a significant portion of the private insurance market. Once Medicare and Medicaid recipients began to enroll in HMOs, the organizations would have the flexibility to pool their resources, redistribute private premium dollars, and ration care across their patient populations.

Using the HMO Act of 1973, Congress eliminated three major barriers to HMO growth, as clarified by U.S. Representative Claude Pepper of Florida:

First, HMOs are expensive to start; second, restrictive State laws often make the operation of HMOs illegal; and, third, HMOs cannot compete effectively in employer health benefit plans with existing private insurance programs. The third factor occurs because HMO premiums are often greater than those for an insurance plan.

To bring the privately insured into HMOs, Congress forced employers with twenty-five or more employees to offer HMOs as an option—a law that remained in effect until 1995. Congress then provided a total of \$375 million in federal subsidies to fund planning and startup expenses, and to lower the cost of HMO premiums. This allowed HMOs to undercut the premium prices of their insurance

competitors and gain significant market share.

In addition, the federal law preempted state laws that prohibited physicians from receiving payments for not providing care. In other words, payments to physicians by HMOs for certain behavior (fewer admissions to hospitals, rationing care, prescribing cheaper medicines) were now legal.

The combined strategy of subsidies, federal power, and new legal requirements worked like a charm. Employees searching for the lowest-priced comprehensive insurance policy flowed into HMOs, bringing their dollars with them. According to the Health Resources Services Administration (HRSA), the percentage of working Americans with private insurance enrolled in managed care rose from 29 percent in 1988 to over 50 percent in 1997. In 1999, 181.4 million people were enrolled in managed-care plans.

Once HMOs were filled with the privately insured, Congress moved to add the publicly subsidized. Medicaid Section 1115 waivers allowed states to herd Medicaid recipients into HMOs, and Medicare+Choice was offered to the elderly. By June 1998, over 53 percent of Medicaid recipients were enrolled in managed-care plans, according to HRSA. In addition, about 15 percent of the 39 million Medicare recipients were in HMOs in 2000.

HMOs Serve Public-Health Agenda

Despite the public outcry against HMOs, federal support for managed care has not waned. In August 1998, HRSA announced the creation of a Center for Managed Care to provide

- . . . leadership, coordination, and advancement of managed care systems
- . . . [and to] develop working relationships with the private managed care industry to assure mutual areas of cooperation.

The move to managed care has been strongly supported by public-health officials who anticipate that public-private partnerships will provide funding for public-health infrastructure and initiatives, along with access to the medical records of private patients. The fact that health care is now organized in large groups by companies that hold millions of patient records and control literally hundreds of millions of health-care dollars has allowed unprecedented relationships to form between governments and health plans.

For example, Minnesota's HMOs, MCOs, and nonprofit insurers are required by law to fund public-health initiatives approved by the Minnesota Department of Health, the state regulator for managed care plans. The Blue Cross-Blue Shield tobacco lawsuit, which brought billions of dollars into state and health-plan coffers, is just one example of the you-scratch-my-back-I'll-scratch-yours initiatives. Yet this hidden tax, which further limits funds available for medical care, remains virtually unknown to enrollees.

Federal officials, eager to keep HMOs in business, have even been willing to violate federal law. In August 1998, a federal court chided the U.S. Department of Health and Human Services for renewing HMO contracts that violate their own Medicare regulations.

The Ruse of Patient Protection

Truth be told, HMOs allowed politicians to promise access to comprehensive health-care services without actually delivering them. Because treatment decisions could not be linked directly to Congress, HMOs provided the perfect cover for its plans to contain costs nationwide through health-care rationing. Now that citizens are angry with managed (rationed) care, the responsible parties in Congress, Senator Kennedy in particular, return with legislation ostensibly to protect patients from the HMOs they instituted.

At worst, such offers are an obfuscation designed to entrench federal control over health care through the HMOs. At best, they are cynically deceptive. Congress has no desire to eliminate managed care, and federal regulation of HMOs and other managed-care corporations will not protect patients from rationing. Even the U.S. Supreme Court acknowledged in its June 12, 2000, *Pegram v. Herdrich* decision that to survive financially as Congress intended, HMOs must give physicians incentives to ration treatment.

Real patient protection flows from patient control. Only when patients hold health-care dollars in their own hands will they experience the protection and power inherent in purchasing their own insurance policies, making cost-conscious health-care decisions, and inciting cost-reducing competition for their cash.

What could be so bad about that? A lot, it seems. Public officials worry privately that patients with power may not choose managed-care plans, eventually destabilizing the HMOs Congress is so dependent on for cost containment and national health-care initiatives. Witness congressional constraints on individually owned, tax-free medical savings accounts and the reluctance to break up employer-sponsored coverage by providing federal tax breaks to individuals. Unless citizens wise up to Congress' unabashed but unadvertised support for managed care, it appears unlikely that real patient power will rise readily to the top of its agenda. Ω