Heterogeneity of Health Maintenance Organizations and Quality of Care

Sheldon M. Retchin*

Medicare beneficiaries have been permitted to enroll in health maintenance organizations (HMOs) (1) for more than two decades. There are now approximately five million beneficiaries who have enrolled in Medicare HMOs, and the Federal government is exploring new avenues to encourage more of them to join (2). This effort is principally intended to contain the spiraling costs of the Medicare program. However, there have also been those who have suggested that HMOs may be a more appropriate vehicle than the traditional fee-for-service (FFS) system for delivering health care to the elderly, many of whom find the present system fragmented and uncoordinated. Nonetheless, the merits of managed care for the elderly in either containing costs, or in delivering quality medical care, remain unsettled.

The article by Potosky et al. (3) in this issue of the Journal examines the process of care and the long-term survival of women with breast cancer in two HMOs and compares them with similar women from the same FFS market areas. The results were notable not only for the comparisons between HMO and FFS care of breast cancer but also for the dissimilarities between the two HMOs. For instance, in San Francisco–Oakland, the 10-year survival rate was substantially better in the HMO than in FFS, while the survival rates were indistinguishable between HMO and FFS in Seattle. Although recommended therapy (i.e., breast-conserving surgery and adjuvant radiotherapy) was more commonly performed in women in both HMOs, the differences were far more dramatic in Seattle. What factors account for these differences in two HMOs with apparently similar roots?

Influence of HMO and Market Characteristics on Practice Patterns

On the surface, the two HMOs studied in the report by Potosky et al. would appear to be indistinguishable. The Group Health Cooperative of Puget Sound (GH) is the largest and oldest consumer-governed health care organization in the United States, dating back to 1947 (4). Similarly, Kaiser Permanente has roots that date back to 1933. Both organizations are not-for-profit and began as staff or group model HMOs, where providers were full-time employees whose practices were solely devoted to the plan. Nonetheless, special features about these HMOs and the communities they serve have important implications for the type of care delivered in their organizations. These characteristics serve as useful reminders of the heterogeneity in the managed care industry.

There have been enormous changes in the HMO industry during the 1990s, including the growth of for-profit plans and the relative decline of not-for-profit plans. Moreover, there are wide variations in the characteristics of individual health plans. These characteristics are dynamic, since there has been perpetual reorganization throughout the industry. For instance, HMOs have different provider arrangements, or models, that can influence the quality of care. Staff model HMOs employ physicians and other providers directly, group HMOs contract with one or more group practices, individual independent practice associations (IPAs) contract with many individual physicians/providers who care for enrollees in their own offices, and network model HMOs contract not only with individuals but also with groups of physicians. In the article by Potosky et al., both health plans began as staff or group model HMOs, where providers were full-time employees whose practices were solely devoted to the plan. Preventive care, including mammographic screening, has been shown to vary by HMO model type, with staff and group model HMOs performing better in this regard than do IPA models (5). This follows organizational theory, which suggests that a more structured oversight will occur in health plans that employ or contract with large physician groups. Provider financial arrangements can also play a prominent role in practice patterns. While staff and group model physicians are often salaried, IPA and network model physicians may receive FFS remuneration (6). These arrangements are particularly important for specialty care services, since staff/group model HMOs could have more control over specialty physician practice patterns. However, because of the increasing challenges from competitive plans, there has been a shift from staff model HMOs to individual practice associations or network models (7). As a measure of the changes

*Correspondence to: Sheldon M. Retchin, M.D., M.S.P.H., Department of Internal Medicine, Virginia Commonwealth University, P.O. Box 980270, Richmond, VA 23298-0270.

© Oxford University Press
that are epidemic in managed care, both health plans studied in this article, Kaiser and GHC, have more recently explored other provider arrangements aside from staff or group model HMOs, such as IPAs.

Both the number and size of HMOs have grown considerably in the past 10 years, and this has increased the diversity in the managed care industry. As of January 1, 1996, 630 HMOs served approximately 60 million enrollees nationally (8). Although 63 new HMOs obtained licenses to operate in 1995, the managed care industry was also rapidly consolidating. The 25 HMOs with the largest semiannual net gains in enrollment during 1995 accounted for 35.5% of the total plan enrollment and 40% of the growth. For large markets, with 1 million or more eligible enrollees, the average HMO penetration was about 26% while small markets (<250,000 eligible enrollees) recorded an average HMO penetration rate of 11.5%. Of the two health plans studied by Potosky et al., the Northern California Division of Kaiser is larger than GHC and has a much greater market share. Kaiser has more than 4000 physicians, 17 acute care hospitals, and approximately 2.5 million enrollees in Northern California. In contrast, GHC has approximately 3200 physicians and about 640,000 enrollees. In 1993, Kaiser experienced a decline in membership for the first time and, in 1995, GHC experienced a negative operating margin after attempting to lower its rates to remain competitive. In response to these external pressures, these two HMOs recently agreed to form a new, not-for-profit organization called Kaiser/Group Health.

There are also contrasts in the local markets and market shares that may explain some of the observed differences between HMOs (9). For example, Seattle remains a loosely consolidated market, with a commercial HMO penetration of only 13%, as of early 1996. On the other hand, San Francisco is in a highly organized, more mature market, with a commercial HMO penetration of almost 50% in the same time period. These differences in local markets can lead to substantial geographic variations in health care utilization. For instance, in 1989 payments per Medicare beneficiary for health care services were almost 25% higher in Seattle than in San Francisco. Some of these variations may be explained by primary care to specialty physician ratios in specific metropolitan areas (10).

The structure of health plans may also influence their assessment of technology and their dissemination of medical innovations. This is especially important for diseases such as cancer, where newer screening techniques and therapies are introduced frequently. Often, a small group of plan administrators or physicians have authority over coverage decisions for new advances (11). These decision-makers say that evidence from published data is the most frequent basis for their decisions, but how a health plan evaluates a new medical technology for coverage varies with identifiable plan characteristics. Plans that welcome input from providers and consumers might be especially predisposed to offer novel advances. For instance, GHC’s focus on consumerism is more than cosmetic. It has led to the plan’s long-standing commitment to preventive care and health education, including a special foundation dedicated to research in these areas. This research has resulted in a 32% decrease in late-stage breast cancer among enrollees (12).

Conclusions

The aphorism ‘‘. . . if you’ve seen one HMO, you’ve seen one HMO . . . ’’ clearly holds true. No two health plans are alike. The growth of for-profit HMOs has dramatically altered the managed care industry. Therefore, individual HMOs are too distinct to be easily disparaged or applauded as a single industry. Local market characteristics and attributes of the health plans themselves are extremely influential variables in the quality of health care delivered in these systems.

References

(7) Gabel J. Ten ways HMOs have changed during the 1990s. Health Aff 1997;16:134–45.