ABSTRACT

The Evolution of Health Maintenance Organizations

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This thesis focuses on the development of Health Maintenance Organizations (HMOs) in the twentieth century. While the origins of the movement in the 1930s and 1940s are discussed, emphasis is also placed on the early 1970s and the 1990s, when HMOs proliferated at the national level, altering the spectrum of healthcare provider models in the United States. By 1999, the number of HMO enrollees in the U.S. had grown to its peak of approximately 80 million. In addition to its historical background, the overall philosophy of HMOs is studied and subsequent flaws in both HMO structure and function are examined. This last part focuses on the ethical and moral questions of HMO patient care. In examining the evolution of HMOs, cases of patient neglect and treatment shortcomings are evaluated and found to be the result of a business model designed for treating patient populations with an economically efficient remedy, rather than a treatment that is the most medically effective.

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TABLE OF CONTENTS

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CHAPTER ONE

Introduction: The Notoriety and Problems of HMOs

Opening Cases

For many individuals who regularly cannot afford healthcare, HMOs are a godsend. They offer a simple range of health services that usually cover all basic fields such as regular physical checkups and dental work. The inevitable flaw with HMOs, however, is that they lack the proper organization to deal with special cases involving unique circumstances. Rules and regulations are established to provide basic services on a scheduled basis, but the unfortunate truth is that they are inadequately designed to deal with emergency situations or cases that require specialists and long term care. The stories of the following people are a testament to that deficiency.

In the first case, Beautrice Luna, a forty five year old auto worker, came into a Detroit hospital complaining of chest pain one day. A cardiac catheterization and an angiogram were immediately proposed to analyze her problems and to monitor her condition to see if an angioplasty would be necessary. Beautrice, however, hesitated and sought approval from her HMO before proceeding. The delay took some time, but finally an out of plan cardiologist was brought in to do an angioplasty. In the last hour, as her cardio condition began to worsen, the procedure was approved and carried out. Beautrice Luna, one of the lucky ones, had escaped catastrophe (Anders 1996, 143).

Stephen Cummins was a thirty five year old engineer working out of Atlanta, and married with two children. One day, while working in the yard he complained of chest

pain and numbness in his right arm. His wife, Janis, called Kaiser Permanente and the on-call staff first advised her to give him an antacid. Granted his age and the statistical rarity of individuals under the age of thirty-five suffering from heart attacks, the call had initially been dismissed as an over-reaction. Later on, however, the operator called back and advised Janis to take her husband to Northside Hospital, 16 miles away for treatment. Unfortunately, just after that, Stephen vomited, collapsed, and stopped breathing. At that point Janis called 911. A fire department unit came to the scene, but it was too late. Attempts to revive David Cummins were unsuccessful and he was pronounced dead at a local hospital a short time later (Anders 1996, 140-141).

Christine de Meurers, a California school teacher, was diagnosed with breast cancer. She had been told by her oncologist at UCLA, that a bone marrow transplant posed the best chance for saving her life. It was thought, however, that her HMO, Health Net, would deem such a procedure as experimental and, subsequently, would not grant funding, which eventually proved to be the case. Even after a rigorous fight between the oncologist and the HMO, the latter still would not pay for the procedure. In the end the oncologist's department at UCLA had to pick up the tab. Although Christine did get her treatment, many other people in similar situations would not have been as fortunate (Anders 1996, 125-127).

Perhaps the most daunting case, which provides a more comprehensive view of the flaws of HMOs, is the case of the infant James Adams III. Lamona and James Adams were a couple living with their infant son, James III, in the suburbs of Atlanta during the early 1990's. Their lives were seemingly ordinary. James had left the army and taken up a civilian job as a security guard at night, while his wife remained at work during the day

at a civilian post in the army. One night, Lamona found her son panting and moaning with a fever of 104°F (Anders 1996, 1).

The child's illness had first appeared the following day with a minor fever for which Lamona stayed home from work and scheduled a doctor's appointment through her HMO, the Kaiser Plan of Georgia. The pediatrician did a standard diagnostic, checking for ear infections and listening through the stethoscope. All symptoms indicated a case of influenza. One fatal flaw was made early on. While an examination was given, it was of the most peripheral in nature with no tests being administered to rule out other illnesses. Although medical negligence by the physician was ruled out in the later trial, as there were a number of symptoms that indicated the flu, it can be argued that a good doctor would have considered all possibilities, and carried out additional tests to rule out other probable causes. The physician prescribed Tylenol to be taken every four hours and made a note that her husband should refrain from smoking in the vicinity of the baby; this was a standard Kaiser Permanente "cookie cutter" solution to a specific scenario, such as this one, and was expressly laid out in their manuals. The unfortunate truth was that the infant's ailment was not viral but bacterial. The baby had meningococcemia, an infection that was fatal if not treated immediately, yet could have been detected by taking a simple blood culture (Anders 1996, 7-8).

Despite all efforts, the Tylenol had served only to relieve the fever temporarily. Lamona phoned the Kaiser after-hours hotline to seek instructions for approved medical treatments. She relayed the child's information and symptoms over the phone to the nurse on call that night. Like most managed care providers, gaining this approval was necessary before embarking on any treatment. The HMO would then provide directions

to the cheapest and most cost effective doctors and hospitals available. If outside medical services were sought without prior approval, the HMO would not be required to pay the bill. Only in the gravest of emergencies could this protocol be violated. The nurse did not believe this to be the case. Although Kaiser's on call pediatrician was consulted, a lack of information led her to believe that the situation was less serious than it was, and no emergency was declared, leaving the problem to be dealt with by standard protocol. Lamona was instructed to take her child to the only place available, Scottish Rite Hospital, a remote pediatric center that was forty two miles away. For the Adams, this was even more difficult, since they had moved to the area only a few months prior. Regrettably, the hotline could not offer anything further, no directions, only the hospital's phone number. Subsequently, Lamona called the hospital to get directions and then quickly called her husband to come home from his night shift with the car (Anders 1996, 1-2).

Upon her husband's return home, they departed for Scottish Rite. The journey was hectic to say the least. As they were driving towards their destination, at speeds of eighty mph, they were met with torrential rains and after hydro planning across the highway, had to slow down. On slick roads and in poor visibility they had missed the turnoff to Scottish Rite. In the meantime, their son's condition began to deteriorate to the point of losing consciousness. Finally in desperation they sought out the nearest institution available, Kenestone Hospital at Windy Hills. Upon arrival, however, the child's heart had stopped beating. As the emergency staff pulled out the crash cart and began resuscitation maneuvers, Lamona broke down into a state of hysteria and had to be escorted away. A heartbeat was reestablished, but by that point substantial damage had

inevitably occurred. It had taken more than twenty minutes, and by that time the trauma from both the meningococcemia and the heart stoppage had caused severe damage to the infant's physiological systems. The team of doctors worked around the clock assessing his condition, but most did not believe he was going to make it and the parents decided to take him off life support, if the situation did not improve. Fortunately, baby James showed signs of recovery at the last minute and he subsequently survived (Anders 1996, 2-3).

Good fortune saved the Adams' baby, but not without serious repercussions, the lack of blood flow in James extremities and subsequent asphyxiation of tissue had caused irreversible damage. Subsequently, his hands and feet would have to be amputated in order to avoid further infection of gangrene. Although he had survived, he would be marred for the rest of his life. In time, he would be fitted with prosthetics and therapists would teach him how to walk. Handling pencils, dressing, and other normally simple tasks would be more complicated to learn (Anders 1996, 5).

In comparison to other cases, the Adams were fortunate to collect compensation. A lawsuit against Kaiser Permanente found the HMO guilty of negligence and granted the couple several millions of dollars to take care of their son. With their settlement, James Adams could quit his night job to provide full time care for their son, while Lamona could stay employed to maintain her family's health benefits from the army. Although their son had been permanently crippled, the family at least had been able to come out of it with financial security to take care of him (Anders 1996, 11).

How did this happen? How could such negligence have infiltrated the medical field? Most importantly, how is it that life and death decisions went from being made by

doctors and patients to corporate healthcare providers? At the very least, in these cases, HMOs have demonstrated practices reflecting limited healthcare with poor ethical standards.

How did this Happen? The Problems with HMOs

In essence, HMOs represent a contradiction in healthcare, because they combine two very different philosophies: the preservation of the health and welfare of the patient, and the increase of economic efficiency through cutting costs. Although a mutualism between treatment of the patient and good business had existed under the traditional fee for service medicine, the potential for doctors taking advantage of their patients by charging for unnecessary service was exploited by managed care advocates. The system that followed was one which sought to lower expenses by regulating the types and amounts of services that physicians could provide to the patient.

HMOs have been reprimanded from various sources, from both the patients, who are subject to their policies, and from the doctors and other healthcare personnel, who are forced to abide by their rules. For the latter of these two groups it is against their duties, specifically, the oaths they took to do no harm, to administer inferior treatments, simply because of business practices. One physician wrote "To me it matters a lot whether a four year old is in pain … [b]ut to the HMO it's just money. They don't see the child and they don't care" (Anders 1996, 87). The lack of concern for wellbeing of patients is a generally disturbing topic.

By undermining the work of the physicians, managed care has effectively risked undermining the physician – patient relationship, itself. Doctors, who stay true to the

oath to do no harm, will ultimately do whatever is in their patients' best interests. The policies of the HMOs, however, favor overall efficiency in treating a population of individuals rather than just case by case, as seen in traditional fee for service medicine. One group, the Kaiser group of Georgia stated that "We can practice good medicine without spending as much money." What works for a majority of the population is assumed to work universally for all patients. The individuality of the patient and his or her special circumstances are liable to be overlooked, which violates the ethics of traditional medicine. Richard Dean Smith, M.D. makes an observation that the term Managed Care is an oxymoron in itself, in that management requires "rules and rigidity," whereas care requires "good judgment and flexibility" (Smith 2000, 47). His words are both insightful and perceptive of the antagonistic relationship between giving good care and managing costs. The HMO is an inadequate mechanism to deliver the best quality healthcare for the individual, because it was designed more or less to see people as merely components to a larger system. Components subsequently can wear out over time and need replacement. Although HMOs will highlight compassionate and humanistic care, cases have indicated that this is not always the level of care given, especially in situations where the onset of health problems are unexpected and that the organization is unprepared to deal with financially and in regard to other resources. Long hospital wait times to persuade patients to seek care elsewhere and prescribing less effective treatments or denying potentially life-saving operations are merely a few of the problems that have highlighted the attention of the public over time to the questionable ethics and nature of HMOs. Furthermore, incentives and regulations are placed on the patient's primary physician, intended for him to regulate the amount of extraneous services granted to the

patients. This effectively turned the persona of the physician from one of care giver to one of "gate keeper." Incentives to deny care undermine the fundamental principle of medicine - to do no harm - and inhibit the patient's trust in the medical treatment process.

How the United States arrived at this point is an interesting study. For all purposes, the HMO is a business practice first and a medical provider second. Its origins can be traced to the heavy industry of the early to mid 20th century. Abiding by the idea that healthy workers are productive workers, their upkeep was important for preserving a functional employee population, much like maintaining equipment is crucial for production. Therefore, an "assembly line system" of healthcare was necessary to keep employees in working condition.

Commercialized managed care made its debut in the years following World War II. A cornerstone of this new variant was the denial of service in the interest of overall efficiency. Ultimately, this has led to the emergence of the most severe problem of the HMO, the incentive not to provide care. The intention was to decrease expenditures by weeding out costly procedures that were deemed unnecessary or experimental. Richard Dean Smith, M.D., a physician who has had several years of experience dealing with managed care believes that the best terminology to describe HMO service is "institutionalized mediocrity" (Smith 2000, 132). Often times, this simply led to the use of the cheapest alternative, when multiple treatment options were available. While this was effective from a business standpoint, to the consumer, in later years as medical practices and technology evolved, this would culminate in the denial of services considered risky, experimental, or unnecessary. Subsequently, financial incentives were

put into place for participating institutions and personnel that saved the HMO significant amounts of money.

In addition to businessmen, the HMO gained the interest of ambitious politicians, particularly on the federal level. Providing healthcare to the masses was an increasingly popular social idea, and politicians sought innovative health policies to gain public support. During the Johnson Administration, attempts were made to institute some form of nationalized healthcare. The HMO, itself was selected as a delivery system for such healthcare by the Nixon Administration, and later on, unsuccessfully, by the Clinton Administration. Seeing the success of the managed care movement in California, many officials wanted to replicate it on a national scale. The one problem was their perspective. They were looking at it as employers had done decades earlier, when they acquired managed care services to maintain their worker populations in the same way as their capital. Subsequently, between the 1970's and 1990's the number of HMOs increased nationwide by exponential proportions.

The publicity regarding the questionable HMOs policies in the 1980's and 1990's brought to life the question of how American healthcare got to this point. It was at this point, in the midst of public anger and the questions of further reforms that the issue of what to do about HMO's is addressed and that in order to do so, a retrospective study is needed first.

CHAPTER TWO

The Development and Birth of the HMO from the 1930s to the 1970s

Overview

In discussing the rise of the HMO model it is necessary to study briefly the early models as well as the environments that fostered them. This chapter focuses on the spawning of the HMO by key players Paul Ellwood and the Department of Health, Education, and Welfare under the Nixon Administration. From there, the HMO debate in the both legislative houses will be examined, as well as the evolution of various bills from several factions into the Health Maintenance Act of 1973. Emphasis is placed on the ideologies of Sidney Garfield and Paul Ellwood.

History of Early Prepaid Health Plans

Although the HMO did not become established on a national scale until the 1970s, prepaid health plans were a product of the early twentieth century. Prepaid group practices began appearing sporadically in the 1930s during the Great Depression. Two developments in particular proved essential in the coming of the prepaid health plans: Blue Cross – Blue Shield and Kaiser Permanente.

Though there have been records of experiments with prepaid health plans early in the twentieth century, these instances were largely isolated and traditional fee-for-service (FFS) remained the standard model for healthcare providers. This model, however, experienced financial difficulties in the 1930s. Owing to the Great Depression, the compulsion of the U.S. population to conserve money resulted in hospitals and physicians

experiencing inconsistencies in demands for their services. The lack of a steady flow of patients was potentially disastrous for private practices and hospitals alike. In 1929, The Ross Loose Clinic in Los Angeles and the Elk City Cooperative in Elk City Oklahoma were founded as the first prepaid group practices. The American Hospital Association responded by adopting an experimental concept of prepayment specifically for hospital services, introduced by Blue Cross –Blue Shield. Blue Cross was a health plan initially designed to allow schoolteachers in Dallas, Texas, to receive services from Baylor Hospital for fixed prices. By the late 1930s, the plan had been accepted in many hospitals across the country (Falkson 1980, 116-18).

The place where the development of prepaid healthcare advanced the most was in California. Physician Sidney Garfield was crucial in the creation of the progenitor for all HMO's, Kaiser Permanente. Garfield's work began early in the midst of the Depression. In 1933, he established a group practice that provided prepaid health services to construction workers building canals between agricultural and urban areas in the deserts of Southern California. In this setup, workers voluntarily gave up five cents of their daily wages in order to be provided with a basic set of medical services. Garfield's initial success in creating managed care practice made him well renowned. He constructed three hospitals in Southern California, each carrying many of the most modern amenities of the time, such as X rays, advanced laboratories and operating rooms, and even air conditioning (Kruif 1943, 28-32).

The success of the operation drew the attention of industrialist Henry Kaiser, who subsequently hired Garfield to design a group practice mechanism to facilitate the labor force working on the Grand Coulee Dam in Washington. The plan was based on

prepayment, which would provide workers compensation coverage, in addition to medical and hospital services to all Kaiser employees. The prepaid health plan for the Grand Coulee Dam project proved successful enough that it was used again to provide healthcare for workers in Kaiser shipyards across the West Coast during World War II, and was christened Kaiser Permanente (Falkson 1980, 19).

After the war, however, the decrease in workforce necessitated that Kaiser Permanente seek customers outside the company. At its height, the plan had covered 90,000 workers, with the war over and mass production in decline, Kaiser was left with empty facilities built up along the West Coast. In order to alleviate this problem, Kaiser opted to offer the services of Kaiser Permanente to outside companies in order to make up for the loss of enrollees and keep the plan going (Garfield 2000, 50; Luft 1983, 10). This marked the emergence of the first commercial HMO. It was during this time period, roughly from the1950s to the 1970s, that Sidney Garfield's model for the distribution of managed care began to take shape.

Garfield's overall model was to simplify the nature of healthcare provision by consolidating multiple services under one healthcare provider. The use of prepaid group practices allowed patients to seek help from physicians without concern of overtreatment. Garfield credited the increased specialization of medicine and the rising number of different services available as the primary cause for the increase in healthcare costs (see Figures 1a and 1b). Following the FFS model, the patient would first go to the primary care physician. From there, the patient could either be treated and sent home or be referred to a specialist and other services. This latter option meant the addition of substantial expenses to the overall cost; often times, specialist service rates were higher

than those of the primary physician. By consolidating as many services as possible to minimize covered visits to outside specialists, overall costs could be conserved. Garfield also believed that a significant percentage of patients entering the system were hypochondriacs or "worried well," and in reality there was nothing physically wrong with them. He believed it was the primary physician's responsibility to identify and sort out these individuals so that they would not advance further into the healthcare system (Garfield 2006, 52-53).

Furthermore, emphasis was placed on preventative medicine, particularly on health testing and screening. Focus was also made on educating patients on how to live and stay healthy (see Figure 2). By preventing the progression of disease the idea was that future illnesses could be stopped from developing into larger problems, and, subsequently, excessive and expensive treatment would not be necessary later in time (Garfield 2006, 53).

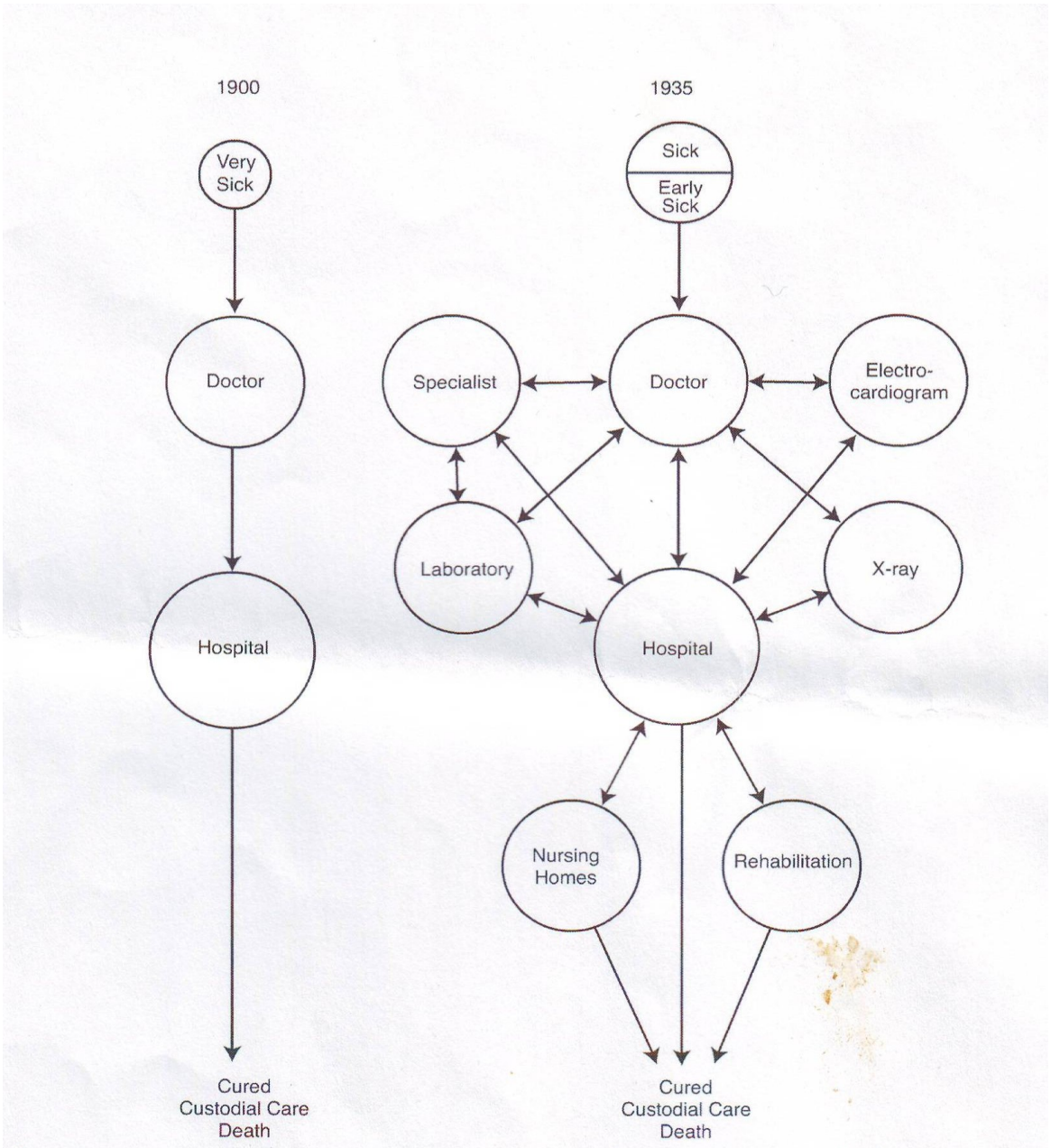

Figure 1a. As medical care evolved over the twentieth century, the organization became more complex with specialized fields emerging. This was primarily due to new technological and research developments (Garfield 2006, 53).

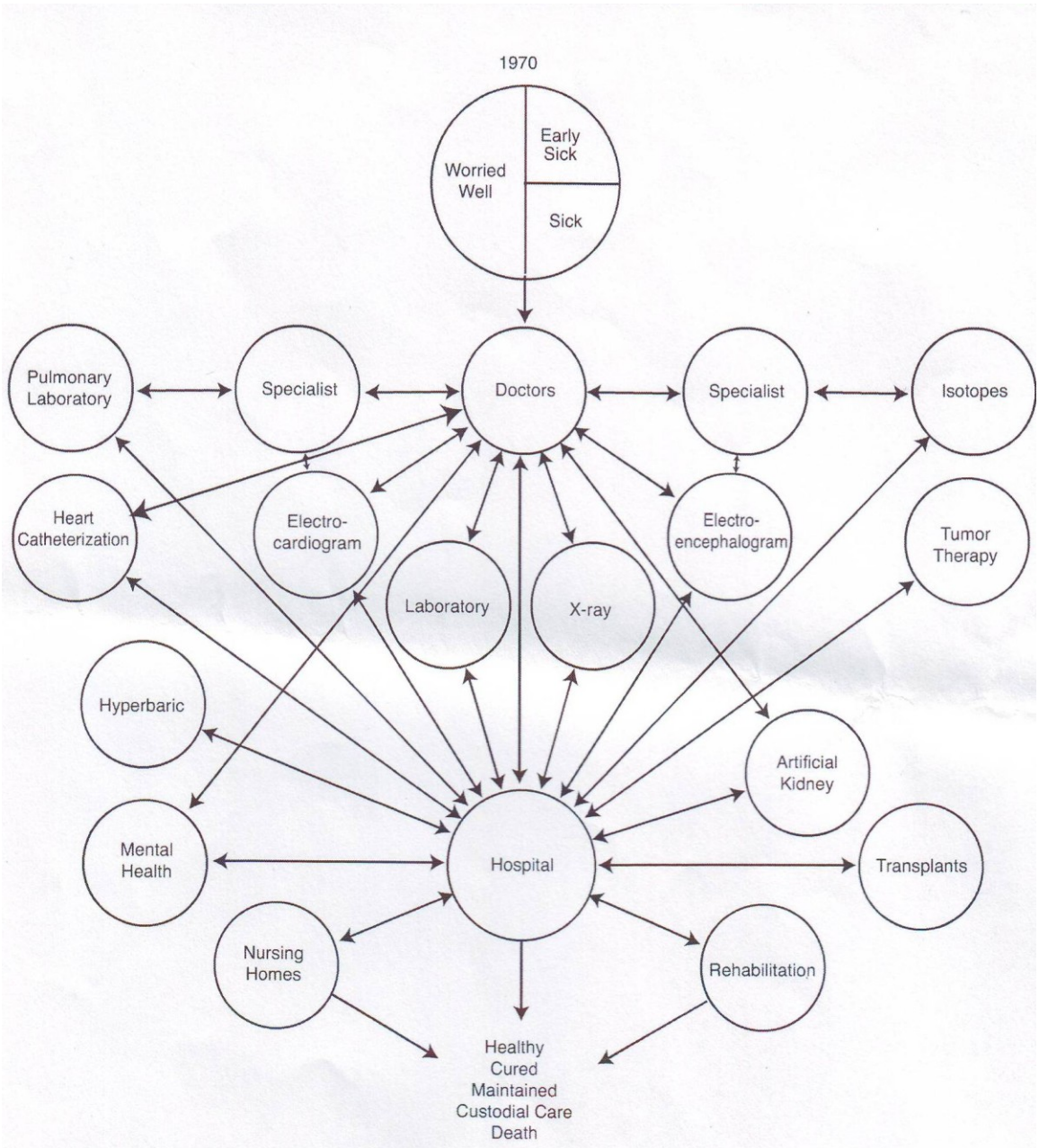

Figure 1b. By 1970, the level of organizational complexity had grown substantially. Garfield attributed the rising cost of medicine with the constant migration of patients between the primary doctors, the hospital, specialists, and various other services (Garfield 2006, 53).

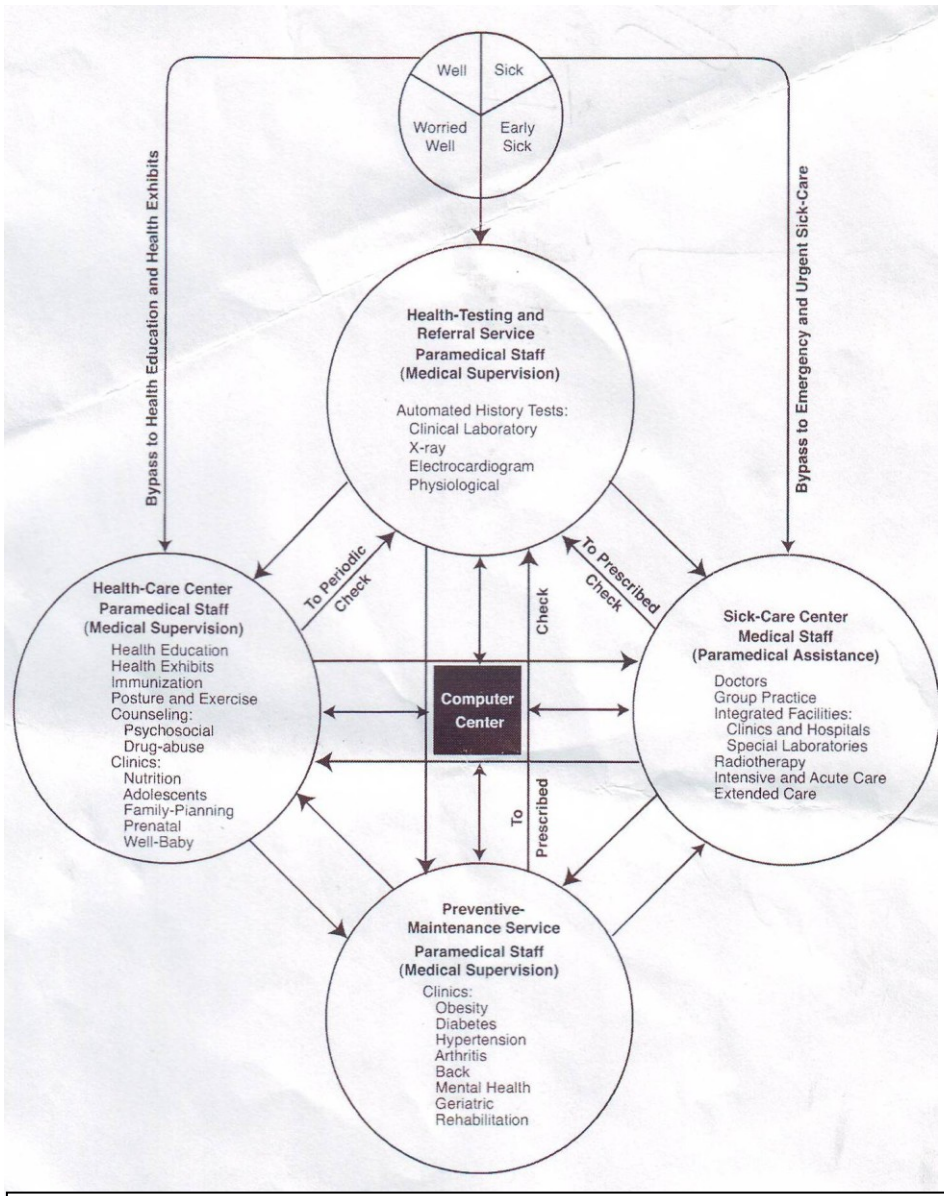

Figure 2. Garfield's plan for organizing managed care called for patients to be screened for illness upon arrival into the system. Those who were found to be ill were sent into sick care, while the healthy and worried well were sent to a healthcare center to be educated. The early sick went to preventative maintenance for early treatment (Garfield 2006, 54)

Despite the revolutions in creating a model for industrialized healthcare, prepaid health practices were met with significant opposition from proponents of FFS medicine. Many FFS physicians feared that the "contract medicine" from prepaid health groups would present steep competition. The Elk City Cooperative was faced with constant opposition for twenty years, from 1934 to 1954. Several of their physicians were expelled from local medical societies and numerous failed attempts were made to have their licenses revoked. Many FFS advocates pushed for state legislative reforms to hinder prepaid health plan groups. By 1971, twenty-two states had laws prohibiting the creation of organizations intended to conduct specifically "corporate medical practice, conjointly with non physicians" (Falkson 1980, 20). A further response was the creation of foundations for medical care (FMCs) by FFS physician. The FMC was intended to be a countermovement to prepaid group plans. It incorporated the cost efficient features of prepayment plans with the autonomy of FFS care. The first of these, essentially the prototype, was established in 1954 in the San Joaquin Valley as a response to the spread of Kaiser Permanente on the West Coast. The organization used Blue Cross as a fiscal intermediary, and developed a fee schedule so that all participating physicians would charge uniform prices. The program also utilized peer review to ensure that all physicians were practicing with maximum efficiency. Despite the success of the FMCs in many regions, it was criticized from both sides of the healthcare system. The American Medical Association, in particular, disapproved of it, because the FMC bore too many similarities with prepaid plans to hold true to the values of FFS (Falkson 1980, 20-23).

The Politics of the 1960s

To understand the reasoning for HMOs' establishment, it is necessary to introduce the situation that catalyzed their growth nationwide. The first organizational steps towards socializing medicine indicated the need for a means of reducing costs. The 1960s saw the emergence of health care on the federal level, for the masses. The political initiative of Lyndon B. Johnson's "Great Society" started a movement to provide healthcare to a broader spectrum of people across the United States. This era saw the emergence of the two notorious public insurance programs: Medicare and Medicaid. The former was introduced to cover medical services for the elderly over age sixty-five, while the latter was to provide the economically disadvantaged with access to healthcare. Though the programs were popular, criticism immediately arose over the skyrocketing cost of the program and interests began to shift towards a method of reducing operating expenses and subsequently the cost of medicine in general (Falkson 1980, 24-27).

Throughout history every major movement has had a leader. This individual often plays a pivotal role in either its direct creation or as a catalyst for its activity and is subsequently held up as a symbol of the movement itself. The man who would rise to be the figurehead of the HMO movement was Paul Ellwood, a neurologist and Stanford graduate working out of Minnesota. Practicing for seventeen years in both pediatric neurology and psychiatry, he believed that medicine was too differentiated into various specialties and subsequently lacked synchronism and coordination. Due to this setup, patients were often over treated. There could be more practical courses of treatment that could be equally effective without the excessive use of resources. In one case, Ellwood believed that listening to a radio could be just as successful for teaching stroke victims to

speak as time spent in therapy and other means of rehabilitation. As early as 1967, he advocated reforming the structure of the healthcare system with this sort of pragmatic approach in order to manage the cost and quality of services (Emling 2007).

In 1965, Ellwood served as the executive director of the American Rehabilitation Foundation (ARF). One of his tasks was reforming the Sister Kenny Institute Rehabilitation Hospital in Minnesota. With improvements in rehabilitation, the number of in-house patients dropped and subsequently reduced the revenues of the institution. By its very nature and design, the institution was suffering financial losses due to its own success in treating patients. After reading the views of physician, Robert A. Levine, Ellwood and his associates came to believe that excessive expenditures and lack of incentive to conserve resources were the primary causes for financial loss. Levine identified a number of deficiencies believed to be responsible for cost inflation. He emphasized, specifically, the lack of centralization and planning in the economy. He also noted that, as independent physicians, many doctors are self employed and are motivated by "pure economic self interest." In practice, Ellwood focused on and subsequently achieved success in increasing efficiency with his plan for prepaid healthcare with Sister Kenny Institute (Falkson 1980, 14-16).

During the late 1960s, Ellwood was a proponent for the healthcare corporation idea. In 1969, he was appointed to advisory groups under Assistant Secretary for Health and Scientific Affairs, Roger Egeberg, M.D., and the director for the National Center for Health Research and Development, Paul J Sanazaro, M.D. In December, Ellwood presented his idea for a healthcare organization to both groups, but neither showed

interest (Falkson 1980, 25). Although his idea had merit in some views, society lacked the proper legal environment to foster such a reform.

The Introduction of the HMO into Politics on an Experimental Level by the Department of Health, Education and Welfare

In 1969, the Nixon Administration came to office. Improved healthcare was one of Nixon's campaign promises and had been proclaimed one of his top priorities. On July 10, Nixon made a public address in which he stated that the healthcare system was in crisis. He furthermore, emphasized the need for both executive and legislative action to alleviate the problem; otherwise the health system could face complete and total collapse within two to three years. That same year the Democrats, led by Senator Ted Kennedy and by United Auto Workers chief Walter Reuther, had advocated and were working on the creation of a National Health Insurance program for introduction in 1970 and the administration was in need of its own healthcare initiative, which would be tasked to the Department of Health, Education, and Welfare (HEW). It was not, however, until six months after Nixon's inauguration that the executive body of HEW was established and the new group could begin exploring more effective and efficient delivery systems for the Medicare and Medicaid programs (Falkson 1980, 3-9).

On February 5, 1970, Under Secretary John G. Veneman, Assistant Secretary for Planning and Evaluation, and Lewis Butler of HEW met with Ellwood to discuss his proposal for a solution to the health crisis. They agreed that the problem in traditional FFS medicine was that there were no incentives for doctors or hospitals to conserve money. The current system was rewarding bad behavior. Patient spending was profitable for FFS providers and was a negative incentive to conserve costs.

Subsequently, increased expenditures were passed on to Medicare which drove up the price of healthcare in general. It was decided that a prepaid provider model would reduce costs; all of them were familiar with Kaiser Permanente and the San Joaquin Experiment. The federal government would actively sponsor healthcare corporations intended to provide comprehensive healthcare to the consumer. It was expected that members would prepay through Medicare and Medicaid. Fixed price contracts would be offered to eligible customers for inpatient and outpatient care. There would also be structural alterations to correct negative incentives which caused inefficiency and allowed for the creation of group practice prepayment plans. Although HEW had taken interest in implementing the reform, it had little interest in how they functioned. Ellwood had specific criteria for the program, such as the number of doctors needed, the number of enrollees, relationships with hospitals, and details on benefits packages. Assistant Secretary Butler believed that specifics were not necessary. The government should only dictate the requirements it wanted, and outside corporations would provide a variety of methods to make them work. It was decided that the proposed groups would be referred to as HMOs, specifically to emphasize the use of early diagnosis and early treatment and the maintenance of health instead of simply treating the illness. All of these services were to be carried out by a neutral party. Legislation was currently being drawn up in the House Ways and Means Committee to add an amendment to Title XVIII of the original Medicare – Medicaid legislation, which was focused on reforming costs. The group decided to add an HMO proposal on an experimental level to establish Part C which would create a "prepayment option" for Parts A and B, already in existence. Not

surprisingly, Butler assigned Ellwood the task of writing up the initial proposal (Falkson 2000, 32-33; Brown 1983, 205-208).

Ellwood spent the next three weeks with the ARF Staff drawing up a plan which he submitted as "The Health Maintenance Plan Reform" on February 25, 1970. After passing initial inspection, Ellwood and the health bureaucracy of HEW held their first formal meeting on March 7. In the course of discussions, concerns over the emphasis on free market competition and lack of accountability were discouraging to the present membership. Members of the Social Security Administration (SSA) were especially concerned about the lack of details and the loose definitions. Venemon countered, however, that these were advantageous because they encouraged self regulation so that government interaction and tinkering were unnecessary. These deficiencies would later incite more resistance in the Congress, however. Despite some doubts, this concept of looseness was compatible with Republican ideology and would become a cornerstone for the HMO. Despite initial setbacks the proposal was uniformly accepted, and by March 9, the "Health Maintenance Plan" was ready to go to the White House for final executive approval.

After inspection, the White House authorized HEW to submit the final bill to the Ways and Means Committee. The assimilation of the initial HMO proposal met little resistance, due to Venemon waiting until the end of the Ways and Means Committee's three-month session on health reform. On March 23, Venemon discussed the feasibility of incorporating the proposal into the amendment for Medicare. The following day, in the last fifteen minutes of the final session, Venemon's request for approval was granted and the proposal was added. Following the success of the meeting, HEW announced in

the interest of cutting costs that it was going to offer an HMO contract option for Medicare.

Overall the original proposal was to achieve the following: (1) it was to permit annual Medicare contracts with HMOs; (2) it tore down the legal barriers, which prevented HMOs from functioning in twenty-two states; (3) it suggested that governments should finance development of the HMO; and (4) cost control mechanisms were to be mandated and it was recommended that the government should attempt to get rid of "cost plus" hospitals and excessive physician fees.

On March 31, 1970, HEW established the Health Finance and Delivery Reform Project Group to explore options for healthcare delivery systems with a particular emphasis on HMOs. The group was essentially a conglomeration of MBA holders led by James McLane, an assistant to HEW Secretary Robert Finch (Falkson 1980, 45). Two different tracks emerged for implementing the HMO. One in particular, which was supported by McLane, called for the federal government to take action by implementing the HMO itself without seeking legislation. On July 31, McLane submitted the "Work Plan for Implementing the Health Maintenance Option" which essentially dictated and allocated tasks and assignment to various government groups in order to have a Medicare HMO option available by January 1971. McLane like the rest of HEW, however, underestimated potential opposition in Congress. Although HR 17550 passed in the House during May of 1970, it got caught up in the Senate. As a result of this and the departure of McLane in August, the implementation plan would never be enacted (Falkson 1980, 48-49).

Though HEW had been preoccupied devising healthcare reforms, the White House had paid little attention to the issue. Following increasing public pressure to revise its methods of financing health services for the underprivileged, the White House finally decided to turn its attention towards healthcare reform. Following a request to HEW to provide strategies for devising Health Options for 1971, they further tasked them with preparing a comprehensive analysis for each. This result was the creation of two movements in HEW: the Health Option process and the Family Health Insurance Plan (FHIP) process. Ultimately these proved to be diversions away from HMOs. On February 2, 1971, Richardson submitted the final copy of the health decision paper and, despite objections from Vice President Spiro Agnew, approved it during the final council on February 11 (Falkson 1980, 64).

On February 18, 1971, the President announced his health agenda before Congress. He emphasized that the primary problem with healthcare was the high cost as a result of structural flaws in the healthcare system, and he recommended a new, six-point national health strategy to combat these flaws. Its first point focused specifically on HMOs, calling for four measures. First, it demanded that public and private health insurance plans allow members to participate in HMOs. Second, $23 million in planning grants should be awarded to help potential private and public HMO sponsors. Third, a system of federal loan guarantees should be established to allow private sponsors to raise up to $300 million in private loans. Fourth, legal barriers preventing the operations of HMOs in twenty-two states should be removed. This last measure was to be achieved either through the states voluntarily adopting model statutes to alter their legislation or the federal government contracting HMOs to deliver service for Medicare patients,

forcefully overriding any state law with the Supremacy Clause of the U.S. Constitution (Falkson 1980, 65).

The Legislative Debate in the House and the Senate

The key process in the HMO movement proved to be the legislative action. While the executive had been successful drawing up a Medicare-compatible HMO model and administering experiments in establishing them to certify its viability, it failed to create a national program to foster the creation of HMOs. In stimulating HMO development, HEW had acted outside its authority by budgeting departmental funds for HMO grants. Furthermore, it was incapable of overruling state legislation forbidding local HMO establishment in twenty-two states. Therefore, the movement to establish the HMO as a part of Medicare Part C could simply not precede any farther without proper legislation.

In both houses during the early 1970s, a number of bills on healthcare strategies were drafted that used HMOs in some application. Out of these, three significant sets of bills were developed to implement the HMO: H.R. 5615 and S. 1182, developed by the Nixon administration; Representative William Roy's (R) and his assistant, Joseph Bile's bill H.R. 11728; and Senator Ted Kennedy's (D) Health Security Act, S. 3327 (originally S. 935).

Of all the bills, the Nixon Administration bills were the first to be introduced formally. Following the February 18 health address, H.R. 5615 and S. 1182 had been drawn up in the House of Representatives and the Senate, respectively, to implement President Nixon's health strategy. They authorized the secretary of HEW to establish

services by using either contracts or issuing grants with public and nonprofit HMOs and contracts with profit equivalents. They further authorized HEW to establish new HMOs and expand preexisting ones. Loan guarantees were provided to new HMOs to provide newer health service and to help reduce initial operating costs. Direct loans could also be issued to alleviate the latter of these two issues. One drawback to these loan guarantees, however, was that they limited construction of outpatient and ambulatory care facilities and only covered operating costs for the first three years.

In the House, H.R. 5615 was introduced. The bill listed criteria for defining an HMO. A prescribed range of services was to be provided, based on prepayment. The individual services, however, were not specified and were only listed in general categories (Falkson 1980, 125). Physician services were to be obtained by contract, employment, or arrangement with group or individual practice organizations. Access to prompt service with quality was also mandated. It also dictated an open enrollment period, which kept HMOs from barring admission to individuals with preexisting conditions. For all these strengths, however, the Administration neglected to include a clause to override opposing state legislation. The HMOs project manager also believed that the bill underfunded public HMOs and subsequently made it difficult for them to afford modern hospital and ambulatory care facilities. Funding only covered their development in underserved areas (Falkson 1980, 108-109).

Not all Republicans backed the administration's bill; it was particularly unpopular with fiscal conservatives. Representative William Roy objected to the bill because it lacked enough specific details and responded by drafting his own legislation. His bill, H. R. 11728, sought to define more stringently HMO characteristics and functions. It was

drafted by Brian Biles. In terms of background, both were familiar with the issues at hand and were well suited to devise appropriate legislation. Roy was a lawyer and a doctor, and Biles was a physician himself. They began their discussions with Group Health Association of America (GHAA), which represented prepaid group practice plans nationally. In the group's opinion, the administration bill was too vague to allow HMOs to function on their own and subsequently needed more guidelines and regulations. Between June and November 1971, Roy and Biles consulted policy analysts and administrators, academicians in the medical administration specialists, representatives of several interest groups, and even members of Ellwood's staff (Falkson 1980, 111 - 12). The result was a bill better designed to address the specific needs of the HMO and their patients.

Roy and Bile's bill, H.R. 11728, had five key improvements in comparison to the administration's H.R. 5165. First, definitions of services were highly specific with the types and quantities listed. Second, funding was specifically budgeted for HMO planning, development, and initial operations. Third, participating organizations were limited to private and nonprofit groups only; for profit HMOs were excluded. Fourth, it was designed particularly well to include the consumers in the process and ensure them quality by establishing grievance procedures to give HMOs some measure of accountability. Furthermore, there were mandates to ensure quality, provide open enrollment (like the Nixon bill), community ratings, and health education for providers and participants. Finally, the bill carried an override clause to supersede current state laws prohibiting the formation and operation of HMOs (Falkson 1980, 114).

Although the bill shared many of the same support mechanisms as H.R. 5165 and was complemented for having a state override provision, it was opposed by the Nixon Administration because it had too many specific details and criteria. H.R. 11728 required too broad of a benefits package and the lack of participation of for-profit HMOs, made this burden increasingly more difficult for HMOs to bear (Falkson 1980, 114-15).

At approximately the same time that Roy and Biles began drafting H.R. 11728, Senator Edward Kennedy (D) began drafting his own healthcare bill that made extensive use of the HMO. Kennedy assimilated the HMO (referred to in the bill as comprehensive health service organizations) into his proposed Health Security Act. Like his Republican counterparts, he saw prepaid healthcare groups as efficient mechanisms for delivering healthcare to the masses in a cost conserving manner. Although the HMOs served the same function as in the administration bills, they were serving in two completely different systems in the larger picture. While H.R. 5615 and S. 1182 aimed to establish HMOs as independent contractors in the Medicare system, Kennedy's goal was to have them serve as integral components in a nationalized healthcare system. The bill adopted a strict definition, limiting HMOs specifically to group practices that worked under prepayment of fixed premiums and delivered a dozen specific services. Many people had concerns that the premiums would be too high. In order to alleviate this fear, the bill called for the creation of a health maintenance trust fund, which would make up the difference of the premium prices and what customers could afford. By doing this, many critics believed that Kennedy had incorporated a National Health Insurance (NHI) concept into the bill. Furthermore, the bill prescribed the establishment of the Commission on Quality Health Care to focus on the overall outcome of cases, to ensure quality; this idea had originally

been conceived by Ellwood. Kennedy used two prepayment practice models for specific areas, depending on population density. For urban areas, he kept the classic HMO prepaid group models. In rural areas, he developed the Health Service Organization (HSO), which was a prepaid solo practice (Falkson 1980, 121-22).

Out of the three sets of bills, this one faced the greatest amount of opposition as many FFS advocates perceived it as a plan to replace FFS practices with HMOs. Several groups opposed the HMO concept altogether, among them was the American Medical Association (AMA). They argued that if HMOs were self sustaining, then they would not require such excessive government funds, and to use funds on an untested delivery system was reckless (Falkson 1980, 146).

Kennedy's bill proceeded without significant opposition in the committees. On June 15, S. 3327 went before and passed in the Labor and Public Welfare Committee. In order to eliminate the necessity of debate and to ensure that it would speedily pass through the Finance committee, the Health Maintenance trust fund was removed from the bill. In the Senate, however, the bill met significant opposition from AMA proponents which delayed the appearance of the bill on the floor for nearly two months. After some delay it was deliberated on and finally passed (Falkson 1980, 153).

Although they were introduced in November 1971, hearings did not begin on either of the administration's bills (H.R. 11728 and H.R. 5165) until April of 1972. The session proceeded from May until September 21, when both bills were merged and were ready to go before the Interstate and Foreign Commerce Committee as H.R. 16782. In design, the new bill was a scaled down version of H.R. 11728. In the subcommittee, the fundamental change was the number of grants. Roy and Rogers had called for 250

grants, while conservative Democrats and Republicans pursued a smaller number of 150 that was eventually approved. In the committee, the members were overwhelmed by discussions on multiple bills in a limited time period. At the same time, committee chairman Harley Staggers was facing pressure from AMA lobbying to block the bill and HEW's lack of interest to go forward with the bill. This resulted in the bill getting tabled, where it subsequently died (Falkson 1980, 154-55). The comprehensive HMO bill had failed to pass and would have to be run through Congress again the following year,

The 1973-74 Congress saw considerable progress and success in the development of an HMO bill. Following the failed attempts to get a joint bill passed in the ninety-second Congress, all the bills were resubmitted very early in the ninety-third Congress. S. 3327 was introduced as S. 14 and H.R. 782 as H.R. 51in January of 1973. Once again the administration introduced the bills, S.972 and H.R.4871, into both houses (Falkson 1980, 156).

Alterations were made to grant the bills more political viability in these rounds. Among them, the budget for Kennedy's bill was reduced from $5.1 to $1.5 billion. Funding was broadened for supplemental HMOs. There were also limitations on annual awards for quality of healthcare and capitation grant subsidies. Finally, authorization for a National Institute of Healthcare Delivery was siphoned off into a separate bill and funding in all other areas was reduced to meet the new budget (Falkson 1980, 156-57).

In the Senate debate a number of amendments were added. First of all, authorized funds were further reduced. For HSOs, funding was dropped to $865 million and quality assurance and capitation grants were reduced by $355 million. Furthermore Kennedy dropped his stringent definitions that differentiated forms of HMOs based on

location or open and closed medical practices. The Quality of Care Commission was transferred to HEW control and an additional $100 million was authorized to rural HMOs after the HSO concept was removed (Falkson 1980, 158-59).

At the same time the Kennedy bill was passed, the House was also working on two bills. In the Health subcommittee of the House Commerce Committee, once again the administration bill (H.R. 4871) and the Roy-Rogers bill (H.R. 51) were being merged. This time the number of HMO projects was reduced further from 150 to 100, and authorization level was reduced from $346.4 million to $280.7 million. The final bill was H.R. 7974 (Falkson 1980, 159).

Despite the new bill's progress, it was delayed in the subcommittee. The AMA proponents objected to the federally subsidized capitation supplements for economically disadvantaged individuals and the state override provision lacked sufficient limitations. In order to bring the bill forward, Democrats and Republicans compromised with the Hastings Amendment, which eliminated both the capitation supplement subsidy and the state override provision and limited the dual choice provision to employers with more than twenty-five employees. After some further "political arm twisting," the bill was approved by the subcommittee and then moved to the House floor, where it was adopted August 1 and passed September 12. It authorized $240 million for loans, grants, and contracts for HMO planning, development, and initial operating costs over a five-year period (Falkson 1980, 160-61).

The two bills, H.R. 7974 and S. 4, were merged into P.L. 93-222. In it, the dual choice initiative that originated in the House was approved by Senators in conference. It kept open enrollment and community ratings. Grants and loans would be distributed to

100 HMOs in a five year period. The benefits package was less extensive than the Senate version and more than the House version, but it would ultimately be too much for the infant HMO industry to handle. The primary flaw was that the bill had neglected to provide crucial financing provisions to counterbalance the effects of open enrollment, community ratings, and the sizable service package. Despite its significance, this flaw was overlooked; and on December 29, 1973; Nixon signed P.L. 93-222, the Health Maintenance Act, into law (Falkson 1980, 162-63).

The 1970s marked a crucial turning point in the spread of the HMO model across the U.S. Although the passing of the Health Maintenance Act was not the end of federal legislation that helped to establish the HMO, it had served to catalyze the development of the healthcare model at the national level. Attempts to assimilate HMOs directly into the federal healthcare system through Medicare Part C and Kennedy's national health program had been unsuccessful, but reforms aimed at establishing an environment preferable to the fostering of HMOs had come through. State legislation hindering the development of managed care groups had been overturned and a system of grants was put in place to help establish new HMOs. All obstacles had been cleared for the proliferation of the new model.

CHAPTER THREE

HMOs in the 1990s

Synopsis

In the 1990s, the movement to establish HMOs reached the pinnacle of its achievement. The 1993 Health Security Act proposed the HMO as one of several possible delivery systems for instituting national healthcare for the American public. This was the most significant proposed use of the organization model on a federal level to go before the Congress since Senator Ted Kennedy's attempt to establish national healthcare in the 1970s. The bill's failure to pass signaled the rise of opposition to the system. As the healthcare model reached its record rates of expansion in the mid 90s, allegations of mistreatment and unethical behavior more frequently arose among the public media, leading to a general resentment of HMOs in the American public. This rising distrust and backlash against managed care led to HMOs increasing the number of services. Subsequently, premium rates increased to compensate for this. This increase in premiums ultimately resulted in the HMOs reaching the pinnacle of their enrollment nationwide in 1999.

Growth Peak in the 90s

From the 1970s to the 1990s, the level of enrollees in HMO health plans increased substantially. While the level of enrollees increased moderately throughout the 1980s, by the 1990s the rate of change became exponential, resulting in a peak number of HMO

enrollees at 80 million in 1999. The jump alone from 1989 to 1999 saw the addition of 50 million enrollees, which was a remarkable accomplishment.

The enrollment of an increasing number of public and private corporations beginning in the late 1980s served as a catalyst to the growth of HMO enrollment. Companies and businesses that had offered full and unlimited healthcare coverage to current and former employees via FFS medicine found themselves incurring significant cost in order to maintain health benefits for them and their families. For instance, by 1987, healthcare costs for the Allied Signal Corporation were climbing 39 percent annually. Much of the expense was attributed to endless rounds of test, therapy, exams, and other procedures (Anders 2000, 16-17). In truth, the rising cost of healthcare was also largely due to increased technological achievements in medicine (such as more advanced equipment, and innovative procedures), but this was largely overlooked. The opinion of many corporate executive and politicians had turned against FFS medicine. Neither the physician, nor the patient, nor the hospital could be trusted to mediate the flow of healthcare. Politicians and businessmen were calling physicians "unscrupulous" and "greedy bastards" (Anders 1996, 24). Since doctors and hospitals charged fees for the same services which they prescribed, they were perceived to be intentionally over treating patients in order to make financial gains. Patients would also take advantage of the system, if allowed to. Like Paul Ellwood, fifteen years earlier, employers came to believe that a third party healthcare provider was needed to supervise and relegate the distribution of healthcare. Subsequently, many companies turned to HMOs. Southwestern Bell began offering HMO plans in 1987 and Sears Roebuck followed in 1990. A large number of well known companies followed (Anders 1996, 29-32).

A point of interest in the growth of HMO enrollment was the positive correlation between premium rates and growth rate of HMO enrollee populations. As the HMO premiums increased less, enrollee populations increased in size (see Figures 3 and 4). Subsequently, when premium rates rose more quickly, the number of new enrollees declined and overall population growth leveled out – as was the case in 1998 and 1999. It can be suggested that premium growth rate determined the number of annual enrollees. This is probable, since the 6 percent rate increase in 1998 coincided with a substantial decline in population growth rates which had been increasing exponentially during previous years. The following year witnessed a further 7 percent rate increase accompanied by a further decrease in growth. This time, population growth ceased and the number of enrollees began to decline for the first time in over a decade (Managed Care).

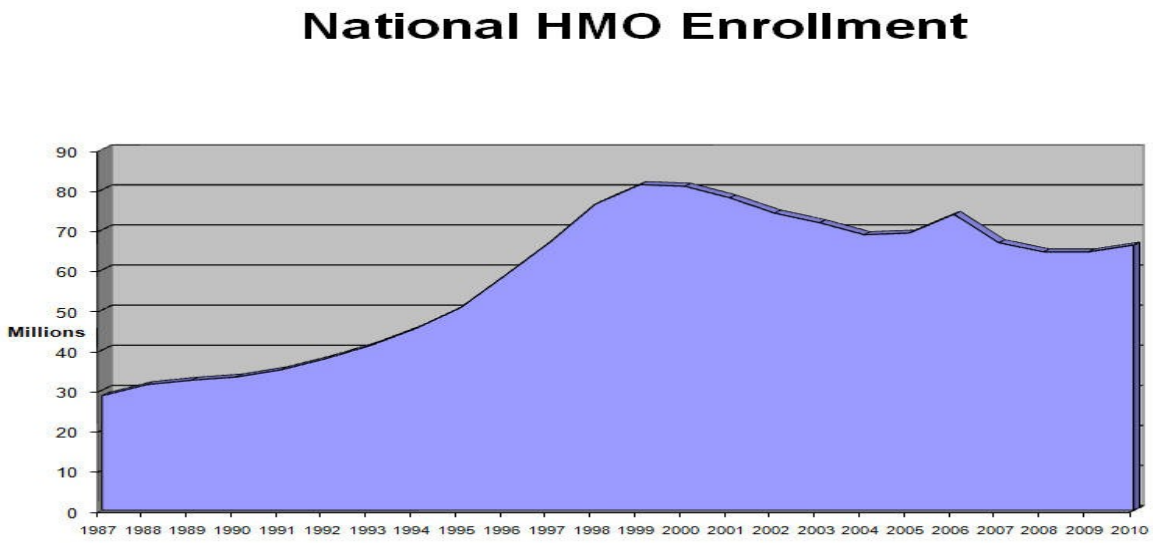

Figure 3. HMO enrollment rapidly increased throughout the 1990's, to reach its peak in 1999 (Managed Care).

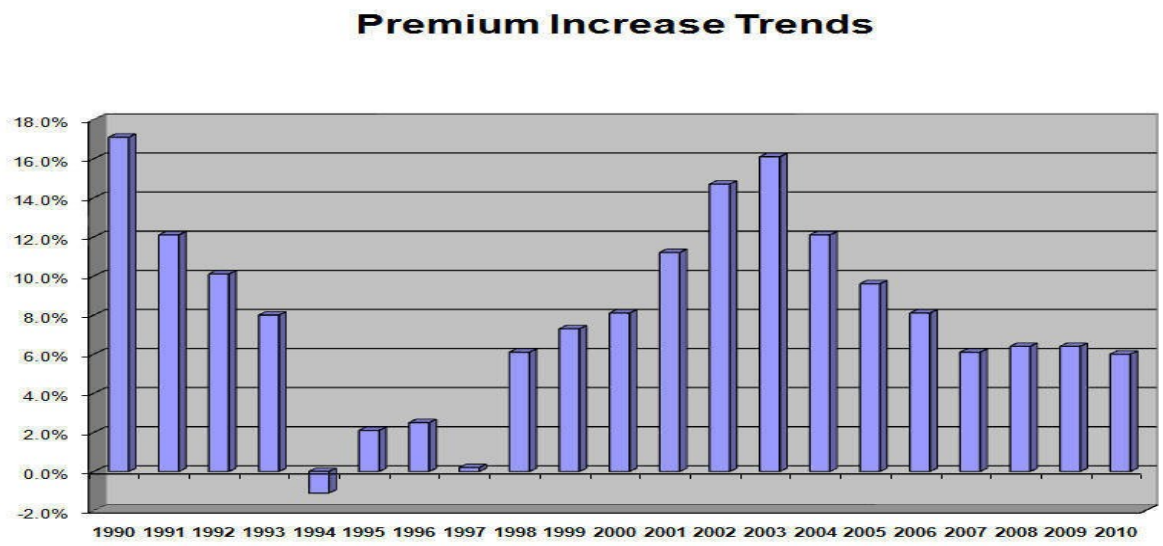

Figure 4. During the early to mid 1990's the rate of premium increases began to decelerate. This trend changed in 1998, when rate of premium increases began accelerating again (Managed Care).

The reasons for general premium increases are somewhat difficult to determine. There is speculation on whether number of health services provided by HMOs on average has an effect on premiums. It is logical to assume that additional services in plans incur greater operating expenses, which can be best compensated through increases in premium rates. One certainty does exist. The influence of new legislation regulating the services provided by HMOs had an effect on premiums. State and federal laws passed towards the end of the decade paid more attention to the manner by which HMOs treated their enrollees, specifically special needs cases. Some bills mandated that specific services be covered regardless of circumstance. One service in particular that was often mandated to be covered, whether it was inside or outside of the managed care system, was emergency services, which alone carried significant cost increases that could only be compensated with increased premiums (Smith 2000, 269-71).

An alternative theory suggests the opposite causality: population size determined premium rates. Managed care groups make their primary profit on younger enrollees because these individuals do not require as many specific services as older adults. Although population size plays a pivotal role, so does mean age of enrollee. The younger the age, the lower average expenditures required and subsequently the lower the premiums. Owing to this, it is in the best financial interest of the HMO to enlarge their populations by recruiting younger enrollees (Smith 2000, 272).

In the greater scheme, the number of health services seems to have the greater influence on premium, than population size, although the population size does play a role itself. From here, premium rates determine the overall number of population enrollees.

The Clinton Healthcare Plan

With the election of President Bill Clinton in 1992, a new national initiative for universal healthcare was begun. In the midst of his presidential campaign, Clinton rallied for the healthcare rights of every U.S. citizen. He emphasized the difficulty of average citizens being able to afford health insurance in the absence of employment. This healthcare initiative gave him a campaign edge. Although not revealed to the public, Clinton's support staffer, Ira Magaziner, who would eventually become senior policy advisor to the president for healthcare, was already investigating a plan that could free market competition and regulation, and would be more compatible with the ideologies of Republicans and Democrats alike. In January of 1993, he proposed in a memo to Hillary Clinton, cabinet secretaries, and the president's political advisors, that managed

competition with limits, should be the delivery system for healthcare reform (Well-healed 1995, 439).

Following Clinton's inauguration in 1993, First Lady Hillary Clinton was made chair of a joint task force intended to research and draw up a plan for implementing Clinton's healthcare initiative. For months the group toured healthcare facilities around the country and interviewed numerous healthcare professionals, developing a proposal in the process. One notable feature was that the group was comprised entirely of senior politicians, such as former cabinet and secretaries. The group's credibility in the public eye suffered from the suspicion of being involved with corporate interests. In general, all of the consulting and planning was done behind closed doors. This was not unusual for a group creating a bill. The nature of the meetings was so informal that disclosure of all matters was not deemed necessary under current laws. The amount of media attention, however, gave the public a false impression of deceitful practices. Subsequently, a general distrust of the group's intention in the public eye began to take shape (Well-healed 1995, 439-40).

The Health Security Act of 1993 was designed to foster a hybrid system featuring a balance between competition, based on quality and prices, and a series of government regulations and price controls. This ensured that cost efficiency could be improved, while ensuring that consumers' rights were also protected. A unique feature was the proposed alliances, regional health plans intended to cover approximately one million people each. Essentially, the idea was that the larger the population of enrollees in a health plan, the lower the risk of financial losses. Businesses with less than 5,000 employees would be required to join one of these pools, while those with more

employees still had the option to join a pool if they wanted (Well-healed 446). While the plan did not solely specify uses of HMOs, it did demonstrate favoritism towards non-FFS delivery systems. The bill specified that at least one FFS option had to be provided, while a minimum of two non-FFS options also had to be provided by every alliance (H.R. 3600).

Generally speaking, resistance to the Health Security Act was significant. Among groups, the Health Insurance Associates of America (HIAA) led a propaganda campaign opposing the plan. The group sponsored a series of notorious commercials starring a duet of characters, "Harry and Louise." The slogan - "If we let the government choose, we lose" - became emblematic of the fight against Clinton's healthcare reform. They also opposed community ratings, various pieces of demographic data used to determine rates, stating that they only resulted in elevated insurance rates and more individuals ultimately dropping their plans and becoming uninsured (Harry and Louis). Overall, these efforts served to undermine the image of the health plan (Well-healed 1995, 446).

Ultimately, the bill failed to pass for a variety of reasons. In the later months of the 1993 Congress, the Clinton Administration was distracted with a number of different issues such as the foreign policy crisis in both Bosnia and Somalia. More importantly, the administration was also trying to pass the bill for the establishment of the North American Free Trade Agreement (NAFTA). The passage of this bill was considered to be of greater importance, and all Clinton's efforts were focused on getting this done before the end of the year. Subsequently, there was little time for the president and the administration to gather and organize support for their healthcare plan and as a result the

ad campaigns of the opposition went unopposed. Ultimately, this culminated in the bill being shelved for the Congress to decide the following year (Well-healed 1995, 444).

The bill was finally considered the following year, but dissension amongst Democrat congressmen created many delays. In addition to alliances, the employer mandates met significant resistance along with community ratings. Throughout numerous committees, several adjustments were made; some features, such as committee ratings, were dropped altogether. In July 1994, versions of the bill successfully reached the floor of both chambers. This was a truly historic moment. No healthcare bill of this significance had been debated on the floor, since Medicare and Medicaid of the 1960s. The congressmen, however, were unable to reach a consensus on an appropriate bill, and it preceded no further (Well-healed 1995, 446). Following the 1994 congressional elections, the Democrats lost their majority in the Senate and any hope for Clinton's healthcare bill died. The Health Security Act along with Clinton's vision for healthcare had made significant headway, but in the end was unable find the support necessary to become law.

Incidents of Bad Ethics and the General Response

By the 1990s, new problems with HMOs were beginning to appear, most notably incidents of negligence on the part of the HMOs resulting in either death or severe trauma to enrollees. In the first chapter, the Adams (the Georgia couple and their infant who was crippled by a preventable bacterial infection due to negligence) were introduced (Anders 1996, 5). Their plight was an example of the worst possible scenario, in which a patient's specific needs were not met. This was due to the overall design of a system intended to

meet only the needs of individuals with more common and usually nonemergency problems.

Another notorious problem were the cases of individuals who were denied treatment every year. Often times, these treatments offered the only possible positive outcome in a life or death situation. In the eyes of the HMO, experimental procedures were not guaranteed to work anyway and represented an unnecessary waste of scarce resources. To the people who were denied treatment, this was the HMOs means of making profit at the expense of their wellbeing.

Kaiser Permanente was a pristine example of an HMO gone wrong during the 1990s. As a result of overestimating future enrollee population growth (a side effect of new competition in California) and subsequently overbuilding their healthcare infrastructure in the 1980s, the company was experiencing net losses in revenue during the early 90s, even though their enrollee population was still increasing significantly. In order to correct these deficits, a system of cuts in healthcare services was enacted. These cuts went from simple examination tests to shutting down entire departments at hospitals. Effectively, this resulted in Kaiser providing substandard treatment in several cases (Smith 2000, 273-80).

Kaiser watered down many of its services, while still maintaining high premiums. Pap tests which were crucial for detecting cervical cancer were reduced from being carried out as annual checkups to checkups every other year. Prenatal visits for pregnant women were reduced from sixteen to nine visits. In some hospitals, intensive care units were shut down if there was a shortage of patients. Furthermore, in some areas, hospitals were operating with antiquated equipment, as a side effect of Kaiser being unable to

modernize all of its facilities to keep up with new innovations in healthcare technology. Other hospitals were closed altogether, in order to cut net regional costs (Smith 2000, 278).

Over the years, a number of healthcare reviews cited deficiencies in Kaiser's healthcare system as a result of their cutbacks. A 1993 federal investigation found Kaiser Permanente representatives to be noncompliant with contractual obligations to provide services to 45,000 Medicaid enrollees 15 percent of Kaiser's enrollee population. In 1995, Kaiser was found guilty of offering bonuses to doctors who denied services to patients (Smith 2000, 278.

Kaiser's guidelines for healthcare provisions in 1996 contained a number of short-comings. Hospital stays for normal births were reduced from thirty-six hours to less than twenty-four hours. Ninety percent of knee and hip replacement patients were to be released without receiving rehabilitation. Screenings for colonoscopies were to be carried out only once every ten years instead of every three to five years, as recommended by the American Cancer Society (Smith 2000, 279).

Following the deaths of three Kaiser Permanente patients in 1997, the California Nurses Association filed a complaint stating that the emergency rooms in Kaiser Permanente's Richmond hospital were not properly equipped to deal with serious injuries and illnesses. This problem was traced to the hospital's intensive care unit being shut down three years earlier (Smith 2000, 275).

In 1998, several negative reports emerged from the chairperson of the Kaiser Permanente nursing negotiating team of the California Nurses Association. Complaints included the backup of emergency room patients in hallways, due to lack of staff and

beds, patient wait times in emergency rooms lasting as long as twenty-three hours; nineteen patients leaving the ER without seeing a doctor, and up to five ER visits before being admitted to the hospital. Other issues were: a mastectomy patient being discharged on the day of the operation, a patient and newborn infant roomed together due to lack of nursery personnel; understaffing in labor and delivery departments, shortages of nursing staff for critical care patients; nurses being over worked and subsequently being unable to provide assistance to other nurses, and nurses who were forced to work overtime or face the threat of being charged with patient abandonment by hospital managers (Smith 2000, 279-80).

The abuse of patients by HMOs to conserve expenses triggered a response from federal and state lawmakers and other government officials to protest the interests of patients. While the federal government had little success passing bills due to failure to come to a consensus, several states were successful in passing legislation that protected the rights of patients under an HMO. In April 1997, Pete Wilson, Governor of California authorized the creation of a task force to develop legislation for correcting the abuses of managed care. More than one hundred bills were introduced in the California state house to protect consumer rights (Smith 2000, 269-70). Among other things, this eventually led to specific essential services, including coverage of emergency services anywhere, to be mandated. Several other states, including Texas and Arkansas also proposed legislation to protect consumer rights.

Conclusion

The 1990s saw the HMOs reach the pinnacle of their success in the United States. Magaziner's support of managed care and the subsequent Clinton Health Plan emphasized HMOs because of their economic efficiency. The plan's failure to become law, however, reflected the American public's lack of faith in the new system. At the same time, reports of negligence and cases of denial of treatment for patients represented the short comings of the HMOs for individuals with special needs. The overall result was the number of HMOs and HMO enrollees reaching its peak by the end of the decade and then going into a gradual decline.

CHAPTER FOUR

Conclusion

Now that the history of the HMO has been discussed, it is now possible to evaluate its performance and to figure out where and why it went wrong. In carrying out an evaluation of the HMO's impact on healthcare, it is important to note the benefits, as well as the drawbacks of the HMO. For those who could not afford traditional healthcare, the HMO provided a viable option that covered a set of basic medical services, such as routine physicals, diagnostic tests, and basic corrective procedures (surgeries). In its earliest form, it allowed for healthcare to be provided on site in the industrial workplace. As a delivery system, the managed care vehicle drastically changed conditions in industry by providing a means to alleviate sickness and ailments brought in from outside and within the working environment. As it evolved, pioneer entrepreneurs - such as Henry Kaiser and Sidney Garfield - realized that it could be harnessed for use in the industrial work-place. Subsequently this led to the development of Garfield's unique philosophy for how to regulate healthcare cost properly, based on cutting out unnecessary services (Garfield 2006, 53).

Garfield's cost efficiency philosophy can be credited with the origin of the ethical problems associated with the HMO model. By altering the role of the primary physician to filter out those who were deemed not truly sick, Garfield established the precedence for the primary care doctor as a regulator of services in the managed care model rather than a simple care provider. The repercussions of this would be felt in decades to come.

The flaws of the HMO model became more evident when the managed care providers themselves were experiencing financial hardship. As examined in chapter three, Kaiser Permanente was desperate to make up for losses incurred from overexpansion, and competition from other HMOs during the previous decades. It is also important to remember that managed care arose in a period when medical technology was evolving at an exponential rate. That said, new technologies often came at a price and HMOs were faced with the dilemma of updating their facilities and procedures to keep up to at least a limited extent with the standards of the time. Altogether these conditions drove Kaiser Permanente to reduce drastically key functions of their operation, ranging from annual checkups and screenings to entire departments and hospitals being shutdown (Smith 2000, 278).

The allotment of resources and services has had a tendency to be minimalist in nature. These HMO practices can be compared to the classic Ray Bradbury short story "Cold Equations", where a stow-away girl is condemned to die by ejection into the void of outer-space because only enough fuel and air are provided for the pilot. No surplus resources were provided in this time period because conservation of resources was considered necessary to maximize overall efficiency. HMOs relied on a similar philosophy in order to minimize costs. The Adams case was symbolic of the worst HMO response in a crisis. In theory or on paper, the HMO model could work to handle an emergency quite effectively. Most HMOs have an after-hours hotline to call for emergencies and have hospitals setup with emergency departments to handle these sorts of issues. In reality, however, HMOs have had a reputation for not being able to come through in the worst case scenario. Murphy's Law states that if something can happen, it

will most likely occur at some point in time. Although many HMOs allow for visits to a non-affiliated institution in a critical situation, many individuals have trouble distinguishing between what constitutes a life threatening emergency and what justifies a trip to the doctor at a later time. Subsequently, many people have taken the latter course of action until the point where they realize that more immediate care is necessary. This exact problem has also been evident with hotline nurses. As was the cases with the Adams and other patients, lack of proper information and relying primarily on check lists of symptoms, resulted in a lack of sufficient information to determine accurately the severity of the situation.

The lack of adequate testing served as a further example of the flaws of providing the bare minimum. Garfield filtered out those who he believed were not truly sick in order to avoid excess spending. The core value of the HMO is ultimately to conserve healthcare costs by excising excess services that are deemed unnecessary. This ultimately results in system intent on allocating the bare minimum of resources necessary to help patients. In business and factory settings, this works with high success because a degree of near total control is acquired. Regrettably medicine does not follow this model. The very nature of human disease and pathology can be very unpredictable. Subsequently, the strategy that seeks to accomplish only the bare minimum is more likely to fall short of achieving the desired goal, because more resources and efforts are needed. Medicine is complex and even with modern diagnostic procedures and equipment, there can and will still be instances of misdiagnoses. Caution must be taken in assessing patients' conditions and it must be assumed that although one prognoses seems probable,

it may not be entirely accurate and subsequently more tests may be required to, if for any reason, exclude the probability of another disease of significant severity being present.

The use of the term "Health Maintenance Organization" emphasizes the upkeep of individual people as if they are components or units in a much larger machine, rather than just simply the health for the welfare of the patient. In a patient population, commercial managed care providers generally draw profits from the youngest enrollees typically because these people suffer from few health problems and only require minimal care. Garfield himself acknowledged that covering the sick would significantly drain financial resources unless a steady population of working healthy enrollees could be maintained (Kruif 1943, 57). The high cost of treating illness is the primary incentive for restricting critical, but expensive, procedures and services to patients. The services of primary care doctors are less expensive than those of specialists, and it was intended to have physicians minimize specialist referrals at all costs to conserve resources spent on patients, in addition to weeding out those who were deemed not sick. This is not to say that doctors were uncaring for their patients' well being or that they were entirely forbidden to go the extra mile to ensure their patients were receiving the best care possible, but spending such resource was discouraged often through financial incentives and other means.

Kaiser Permenante's financial troubles and subsequent cut backs in services during the 1990s gave the HMO a reputation of being deficient in vital areas of healthcare and offering substandard services. This perception sharply contrasted with Garfield's early managed care plans from the 1930s and 40s, which had been known for excellent standards in care and technology and generous arrays of services provided by

well paid and qualified physicians and nurses. Garfield's hospitals had been renowned for being state of the art; some of their amenities, such as air conditioning, were not even present in many big city hospitals. Although loans had been taken out to cover the initial start up costs, the profits generated were significantly large. Assuming five cents per worker every day times approximately 5,000 workers over a period of five years would have resulted in roughly $450,000 in profit. By project's end, however, enrollment was up to 12,000 workers, raising the profits substantially. When the aqueduct project was completed in 1938, Garfield had paid off all three of his hospitals, all of his equipment, and amassed an additional $150,000 in net profit (Kruif 1943, 36-43). The success of Garfield's prepaid health plan in its early years can be attributed to two factors: the age and background of his population of enrollees and the simplicity of medical technology of the era. In Garfield's early years, medicine had not specialized to the degree that was seen later on, and was easier to manage financially due to greater simplicity. A more decisive factor to this success, however, was the limited variation of the enrollee population. From 1933 – 1938, Garfield's care plan had catered only to workers. Coverage for workers' families and retirees would not be added until the Grand Coulee Dam Project and after World War II, respectively. Following pressure by workers, coverage of children was established for an additional twenty-five cents a week to the weekly thirty-five cent fee per worker (Kruif 1943, 57). Overall, Garfield's managed care models prior to 1945 have been representative of the success of the HMO in carrying out its original task, the treatment and upkeep of industrial workers. This forever emphasizes the choice population of HMOs as younger working age individuals. Since this age group did not carry the higher expenses of older retirees, profits were fairly high.

Subsequently, the net profits were high enough that reductions and restrictions of resources and services on individual patients to conserve costs was not necessary; this practice appears not to have become prominent until the years following World War II.

Like the early industries, politicians sought to use the HMO model to serve their own political gains. It was seen as the ideal means to cut costs on Federal healthcare programs which were generating far greater expenses than originally anticipated. Although a specific HMO option was not established for Medicare or Clinton's National Health Plan later on, the legislation of the 1970s - specifically the Health Maintenance Act - allowed the HMO model to proliferate on a national level. Besides removing state laws against managed care, the bill mandated that all businesses with twenty-five or more employees provide an HMO option (Falkson 2000, 162-163). While the federal government proved crucial to allowing the HMO to spread nationwide, it accomplished little in its attempts to regulate them. On a federal level, the Congress was plagued by a lack of consensus and patients' rights bills were for the most part passed up. The states had greater success in these areas and managed to pass a number of bills that regulated HMO behavior and ensured specific patient protections.

It is difficult to ponder what will happen to the HMO in the future. The 1990s saw the movement reach its peak in enrollment as premiums began increasing and the state legislatures began acting to regulate the HMOs' treatment of patients. Although the movement is no longer at its pinnacle, over 60 million Americans are stilled enrolled in a HMO managed care plan. While it would seem the model has lost popularity as the preferred healthcare provider, it is unlikely the movement will ever die out since it caters to those individuals, who cannot afford FFS medicine. Given its use in the politics of

national health strategies, such as those under the Nixon era healthcare reforms and Clinton's National Health Plan, it will most likely be used again in future healthcare propositions.

In summary, the HMO is a unique phenomenon that is the byproduct of twentieth century industrialism and entrepreneurship. From its origins as simple managed care groups providing a range of service to prepaid enrollees in the 1930s and 40s to its rebirth as a commercial entity, its spread nationally, and its proposed use as a vehicle to deliver affordable healthcare nationwide, the HMO has undergone significant evolution to become one of the most influential model in comparison to FFS for healthcare provision in the United States. At the same time, however, the movement has reached its peak. A few foreshadowing questions remain: where did those enrollees go? Is there a newer preferred model for healthcare delivery?

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National HMO Enrollment. Graph.

Premium Increase Trends. Graph.