Controlling health care costs a costly business for HMOs in US

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Features

Chroniques

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To Canadians "health care costs" are an intangible because the government pays the bills. But to Americans, these costs are very tangible. I realized this last month when I got the monthly statement from my health maintenance organization and learned that my premiums for next year are going to rise by 27%. Come January, our premiums rise from $402.94 a month to $511.59 for 2 people. And we're getting a bargain. My HMO, Foundation Health, offers small businesses and self-employed persons virtually the lowest premiums of any of the 35 HMOs available through a health care purchasing alliance sponsored by the Florida government. We could pay as much as $875 per month to get the same coverage from another provider.

Over the next few months, millions more Americans are going to get the same bad news about their premiums that we did. Some will be puzzled. Wasn't managed care supposed to restrain health care costs, keeping them affordable and allowing the bulk of Americans, who are not covered by government-funded plans, to buy private insurance? In a clear signal that managed care has exhausted its low-cost advantage, Kaiser Permanente, the nation's largest nonprofit HMO, is seeking double-digit increases from the large corporations it services in its home state of California, and slightly smaller ones in other states. This will affect not only its 9 million members in 19 states: as one of America's oldest group-practice prepayment programs, Kaiser sets premium standards across the country. Last year, it suffered losses of $270 million on revenues of $14.5 billion. Dr. David Lawrence, the company's CEO, says 1999 will be devoted to a re-evaluation: "[We are] scaling back on capital expansion plans and carefully evaluating underperforming operations."

In the US, most health insurance is purchased by employers, and although they pay the larger share of these premiums they don't pay them all. Thus, as premiums increase so does the amount being taken from employees' paycheques. Currently, 85% of American employees are enrolled in managed care programs, and increases for virtually all of them appear inevitable. Why the sudden inflation after 4 years of relative calm? The HMOs offer many reasons: exploding operating costs, increasing drug costs, older patients, higher expectations. As well, after several years of stagnation, HMOs are facing demands for increased fees from physicians. Added to the mixture is the continuing expansion of government regulations requiring insurers to provide more minimum services (such as 2-day hospital stays for new mothers) and more liberal Medicare benefits for the elderly.

The California Medical Association, a frequent critic of HMOs, recently found out the hard way how difficult it is to play the managed care game. In 1996 the association created California Advantage, a physician-owned company designed to compete with some of the state's big managed care organizations. It pulled together 7500 physician–investors, who put up $7.5 million. Dr. Jack Lewin, executive president of the 28 000 member association, said the company's goal was to put "patients first and profits second."

That proved to be easier said than done. It soon became clear that $7.5 million wasn't nearly enough to become a big-time player. The association had a 10-year goal of 3.3 million enrolees, and needed 40 000 to break even. It got 6000. After being in business for 30 months and losing $11 million, California Advantage filed for bankruptcy in June. Liquidation is under way. The bitter lesson is that it takes money — a lot of money — to be competitive in the managed care business, and in the end there's really only one source for that. And down here, it's not the government. ?