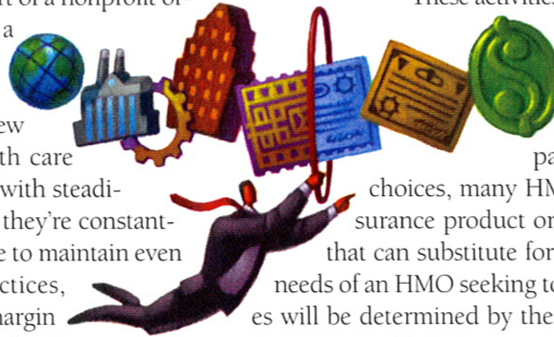
What Do HMOs Really Want?

MOST OF US ARE USED TO SEEING this question refer to something (or someone) other than HMOs. The answer, however, is the same no matter who you ask the question about: It depends.

For HMOs, it depends on regulation, litigation, ownership, growth goals, profit goals, media coverage, competition, public attitudes, and so on. In general, HMOs are in business to arrange, deliver, and finance health care for a specific region or service area. HMOs also need to sustain some level of financial viability—through either outside funding or profits—to continue in business over the long term. Some HMO plans have a stronger need to make money than others, but even if they're part of a nonprofit organization, they can't afford to be a long-term financial drain.

At one time HMOs were strongly encouraged to step forward with new and innovative ways to slow health care spending, and they were rewarded with steadily growing membership rolls. Now they're constantly faced with a public relations battle to maintain even the most basic managed care practices, while fighting to maintain a profit margin on a dwindling or stable HMO membership.



Of course, conditions are somewhat different for every plan, so it's not possible to identify a universal set of desires. The following, however, is a set of wants and needs that ring true for most plans in the current environment.

Most plans are intent on either moving to profitability or maintaining it. Most cannot continue in business without showing that they're a financially viable venture. In the past, provider-owned plans were willing to live with losses as long as membership was growing, but the folly of this philosophy has become clear to nearly everyone.

HMOs have always had strategies for making money, but these strategies have their limits. They can raise rates at a pace greater than the medical expense trend, but that often translates into a loss of membership. They can try to negotiate lower provider payment schedules, but provider resistance may reduce the size of their network at a time when choice is at a premium.

A more effective strategy may be to provide products with more choice, such as point of service (POS) or a preferred provider organization (PPO). These products can be priced appropriately in light of the demand for choice. The market has allowed such products to be priced at a profitable level when a traditional HMO product has been squeezed below acceptable margins.

Another effective strategy for health plans may be to establish themselves as providers of administrative services, including access to their network. This removes poorly performing insured business from their bottom-line losses to a basis where they can collect fees to cover administration and network access only.

As long as they cover their expenses associated with administration and access, they've now balanced an insured loss with a much more stable gain associated with administrative and medical management services only.

These activities are certainly not traditional for many HMOs, thereby creating a new set of wants—or maybe even needs. In order to participate in products with wider choices, many HMOs need to provide an insurance product or find reinsurance solutions that can substitute for an insurance product. The needs of an HMO seeking to broaden its product choices will be determined by the regulatory environment of the states in which they operate.

States have taken various positions with respect to HMOs' participation in these products, so HMOs' wants may range from an understanding of what the regulations allow, all the way to the ownership of an appropriately licensed insurance company.

When HMOs provide services to self-funded employer groups, they encounter a new set of rules they need to understand and apply to their organizations. Often this means building capabilities that might not otherwise be needed. A knowledgeable partner may be the best way for many plans to get started.

With both the product variation and self-funded strategies, there will be additional work in areas the HMO is

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already familiar with, such as provider contracting, benefit design, and pricing. But there are also new needs that hadn't previously existed (competitive administrative-services-only fees for self-insured groups and specific and aggregate average).

Health plans need a broad membership to support their various managed care programs. They also need to show providers an ability to direct care to them as participants in the health plan's network. In a somewhat circular relationship, health plans need membership to support their networks and need strong networks to foster membership growth.

Managed Medicare and Medicaid

What does a plan need to be able to show membership growth? As noted above, new products with expanded choice certainly help the cause. Also, plans need to be continually on the lookout for government programs that might expand their membership. Medicare has gone out of favor with most HMOs because making a profit on the government capitation rates is challenging.

However, in an effort to reduce their numbers of uninsured citizens, many states have looked for ways to move more of the Medicaid or Medicaid expansion programs toward managed care. Many actually mandate managed care. Managed care entities have consistently exhibited their ability to positively impact the health care delivery to these populations.

HMOs really want to get back to the business of managing care as they were originally chartered to do. They want to show how oversight and leveraging provider negotiations can provide better health care at a lower cost. But as society reduces its tolerance to oversight, the provider community sees the weakening leverage as well.

The balancing feature should be increasing costs, but as long as potential litigation continues to hover over some managed care tactics, the health plans feel helpless to offer a lower-cost alternative.

HMOs do have some hope for a shift back to managed care. It will likely come if health care financing moves away from the employer-employee relationship and becomes more an individual responsibility. This shift is taking place in some instances, as employers are unable to absorb the increasing cost of employee health care into their budgets in a tightening economic environment.

Individuals will be able to see firsthand the financial consequences for their health care choices. This shift will also help individuals look at their health care in the long term rather than making short-term choices. Then and only then will consumers welcome back the managed care programs that can lower their health care costs in both the short and long term.

Ultimately, HMOs should get what they want. They've been deprived long enough, but as with many other wanting parties, it sometimes takes a change in other circumstances before it's clear that what HMOs want is really what we all want. Just like any other product or service we purchase, we want the best possible health care at a reasonable cost.