SELF GUIDE

Confused about all the health care options being thrown at you? Let us help. Herewith, everything you need to know to choose the right plan for you. *by John Sedgwick*

WELCOME TO THE WORLD OF MANAGED CARE

photographs by David Levinthal

each visit to the doctor's office. And there is no paperwork for the client: no claim forms, no waiting to be reimbursed.

What about the PPO? PPOs are basically a cheaper version of the FFS system. They began as an effort on the part of some large insurers to keep the FFS system going by making some cost-cutting adjustments. The idea was to organize doctors into loose associations whose services would be available at a lower cost than individual practitioners'. The doctors in these PPOs look exactly like their independent-practice colleagues. They have their own offices, they have no direct connection to other doctors in the system, and they see patients who are not members of the PPO. If your company decides to buy its group coverage from a PPO, you will be required to use one of the member doctors. You would still have considerable discretion in picking a doctor—PPOs provide their clients with lists of all kinds of physicians—but there are limits.

So how do PPOs cut costs? By monitoring the amount of medical care any doctor or member hospital provides in treatment. This is done through a process known as utilization review. These reviews are the reason people think of managed care as being run by accountants instead of by doctors. In a utilization review, the doctor clears the procedures he wants to use in treating a patient through a central cost-accounting system to determine if they are justified. For the headache patient, a PPO would have to clear both the blood workup and the MRI. The physician could probably prescribe the aspirin on his own. One of the complaints about this system is that it standardizes illnesses, and most people think of their circumstance as unique.

PPOs, then, are little more than lists of doctors and hospitals that provide their services to the PPO at a discount in exchange for a steady stream of patients. As they say in retail (an occupation that medicine is increasingly coming to resemble), the doctors make it up in volume. PPOs are quite popular, since they are the closest thing available to the familiar indemnity plans of yore. Plus, some large corporations have taken to forming PPOs themselves, further economizing by cutting out the insurance companies altogether.

So, PPOs still operate under the old fee-for-service system, which is to say that for every service performed, be it a heart bypass or a CT scan, the provider of that service receives a fee. Just as with FFS, there is a financial incentive to provide more of those services, whether they are a good idea or not. It is because PPOs have few ways to control costs or maintain quality beyond the provider discounts and the strictly-by-the-numbers utilization reviews that most health experts don't expect them to stay around very long. "PPOs are a transitional phenomenon," says Paul M. Ellwood, M.D., president of the Jackson Hole Group, a major player in all health care discussions.

The Top 10 HMO firms

HMO company*	Year HMO started	No. of HMOs	No. of enrollees	Primary regions served
1. Kaiser Foundation Health Plan Inc.	1945	12	6,670,000	California
2. United HealthCare	1975	21	3,670,000	Midwest, South
3. CIGNA HealthCare	1929	44	3,500,000	All regions
4. U.S. Healthcare	1973	13	1,900,000	Northeast
5. The Prudential Health Care System	1973	50	1,800,000	All regions
6. FHP Health Care	1961	9	1,730,000	West, Midwest
7. Humana Inc.	1983	19	1,600,000	Midwest, South
8. Aetna Health Plans	1985	25	1,500,000	All regions
9. Health Systems International	1979	7	1,470,000	West Coast
10. PacifiCare	1978	6	1,400,000	California

*Rating based on membership

And the HMOs? By nearly all accounts, the true creativity in the managed care network is found in HMOs, the only organizations that are sufficiently integrated and comprehensive to keep medical costs down and quality up. HMOs very often provide their care through clinics. While HMO members may not see the same doctor on every visit, they do go to the same facility. And all members of a single family can have their medical care handled at the same location.

The fee structure is a system called capitation, by which the organization is paid an annual fee to maintain the health of each of its members, regardless of how many services the HMO performs. There are no fees for individual services. Not only does this discourage excessive treatment, it also encourages more preventive medicine. The healthier the HMO doctors can keep their patients, the fewer treatments they will have to deliver and the more money they will make.

More important, the payment arrangements themselves appear to have significant effects on health outcomes. A study in *The New England Journal of Medicine* recently concluded that patients in prepaid plans like HMOs had 20 percent fewer ruptured appendixes than did those in FFS programs. Why? Researchers theorized that, mindful of the large co-payments and deductibles, FFS patients tended to put off seeking help, whereas patients in HMOs felt free to see their doctors at the first sign of symptoms. "More than any other system of care, HMOs are organized to preserve and maintain health," says Helen Darling, health care benefits manager for Xerox. "That's their purpose. All the financial incentives are designed to keep you healthy."

But aren't HMOs basically second-class? HMOs still suffer from that image, but the truth is that they have produced remarkably innovative health care in recent years. Massachusetts' Harvard Community Health Plan, for example, was one of the first health care providers to store patient information electronically so that all of a patient's doctors would have quick access to his medical records. It has also started a violence prevention project to try to find ways for children to release their anger besides fistfights and gunplay, and a pediatric asthma outreach program that has reduced asthma-related hospitalizations by 79 percent. Kaiser Permanente, the nation's largest HMO, with 6.7 million members, even sells bicycle helmets to its members at a discount.

And HMO members are pleased. According to a June 1994 study by National Research Corp., 63 percent were either "completely satisfied" or "very satisfied" with their health plans, compared with 55 percent of FFS plan members and 50 percent of PPO members. HMOs seem to have a better handle on cost controls as well. A KPMG Peat Marwick report found that from 1988 to 1993 HMO premiums increased 40 percent less than FFS plans and 32 percent less than PPOs. And while the deductibles and co-payments for FFS care continue to rise, fees for HMO members have remained practically nonexistent. As a result, one study showed that HMOs provide $150 worth of benefits for what would be an equivalent $100 paid for FFS care. (During the debate over the Clinton health plan, the Congressional Budget Office released an analysis predicting that if all Americans were to shift to HMOs, the health care budget would drop by 10 percent.)

Although the term HMO was invented by the Nixon administration in the early

Will your managed care plan cover your diaphragm? How about the Pill?

In 1993, the nonprofit Alan Guttmacher Institute became the first organization to conduct a comprehensive study of private insurance coverage of reproductive health care. Perhaps surprisingly, it found that HMOs and other managed care plans have been doing a much better job of addressing women's needs than many traditional indemnity plans have. As an example, here's a look at how different types of plans typically cover women's five contraceptive methods.

	Indemnity plans (100 employees or more)	PPOs	HMOs
IUD insertion	26%	25%	86%
Diaphragm fitting	21%	23%	81%
Norplant insertion	28%	29%	59%
Depo-Provera injection	39%	35%	74%
Oral contraceptives	33%	41%	84%

Source: The Alan Guttmacher Institute Study of Private-Sector Insurance Coverage of Reproductive Health Services, 1993

Seventies (PPO is a product of the Carter administration), the actual concept dates back to a farmworkers' cooperative in Elk City, Oklahoma, in the late Twenties. Since those pioneering days, HMOs have spread across the country, with the heaviest concentrations on the West Coast, in the mid-Atlantic states and in the Southwest. As of spring 1994, there were 556 HMOs altogether. As their numbers have grown, so has their variety. One HMO, alas, is not like another. The industry divides itself into four broad categories, or "models" as it likes to say: group, staff, network and IPA, for Independent Practice Association. In truth, the only distinction that really matters to the client is the one between IPA and non-IPA. And it is the last important distinction you'll have to remember to understand managed care.

Okay, so what is a non-IPA HMO? The non-IPA might best be thought of as the "one large box" model: Its medical services are provided at relatively complete medical centers, where most, if not all, of the major specialties (gynecology, orthopedics, cardiology) are gathered in one space, often in combination with hospital facilities. Non-IPA doctors are paid a salary and work exclusively for the HMO.

How does it work? A good way to understand that is to visit one of the oldest and most successful: Kaiser Permanente, which has been operating in California since 1945. Almost a quarter of all northern Californians who have health insurance are Kaiser members, some of them third generation. For them, Kaiser is a way of life. Indeed, as California's elected government has become increasingly embattled, Kaiser has become a small government of its own, instigating programs to combat domestic violence, promote AIDS awareness and curb work-related injuries. In the last election season, it spent $70,000 opposing a California ballot question that would have weakened antismoking regulations.

Kaiser has more than 3,600 doctors, 2.4 million members, 15 medical centers and 29 offices or clinics sprinkled throughout the northern California region. Because of Kaiser's vast size, it is able to offer a remarkable range of services, including specialized programs for female AIDS patients, medical lending libraries, and a research division that is the envy of major universities. It was a Kaiser study that first showed the benefits of the birth-control pill in preventing ovarian cancer, and it is now taking part in the massive Women's Health Initiative study of the health risks faced by postmenopausal women.

Kaiser doctors pretty much run their clinics. Supervision comes not from administrators or accountants, but from other doctors within the system. "In our group, physicians have a large role in deciding which procedures are done and what's covered," says Mark Glasser, M.D. "We look at the total picture." The downside to this collegial, nonprofit approach is that Kaiser can't react as quickly to market pressures as the more nimble, for-profit organizations can. Total membership nationwide at Kaiser has been stagnant since 1992 as new entries into the market have undercut the larger, slower-moving Kaiser on price, and complaints are rising about the time it takes Kaiser to answer telephones or schedule appointments. Nevertheless, *Money* magazine has ranked Kaiser of northern California the best HMO in the country for the past five years in a row.

And the IPA, how is that different from a non-IPA? If the non-IPA is considered the "one big box" model, the IPA is the "lots of little boxes" model. An IPA HMO consists of smaller neighborhood clinics or practices offering primary-care physicians and just a few specialists. IPA doctors do not work exclusively for one HMO but are often signed up with a half dozen. They, too, are usually paid a set salary for treating the HMO's members for a year. But they have far less discretion over the treatment they offer patients. A central administrative office monitors quality and manages—micromanages, some doctors would say—expenditures.

IPAs are currently the faster growing of the two varieties, for two reasons. First, every time a non-IPA HMO like Kaiser wants to expand, it must build a clinic from the ground up and hire a new staff. An IPA, on the other hand, simply finds existing practices, interviews the doctors and signs them up. No heavy capital expenditures, no hiring and organizing, no supporting a clinic until its patient base builds up. Second, since IPAs often sign up doctors all over town, they are more likely to have an arrangement with a potential member's existing doctor, making the IPA more attractive to newcomers.

What is a typical IPA like? One of the better IPAs is U.S. Healthcare, based in Blue Bell, Pennsylvania. Founded by a onetime pharmacist named Leonard Abramson in 1973, it has grown phenomenally in the past 10 years to become the

largest IPA in the nation, with a total of more than 1.9 million members, most of whom are in the Northeast. Its stock price has grown even faster than its membership—twelvefold since 1988.

To visit its corporate offices is to understand its operating style. The bright and spacious quarters hum with perky, can-do energy. A state-of-the-art exercise room is located across from the hamburger-free cafeteria; a vast video screen plays an endless loop of U.S. Healthcare commercials in the lobby; and on the walls are such entrepreneurial bromides as "If we don't take care of our customers—someone else will." No patients, however, come to Blue Bell. They go to the 30,000-or-so physicians that U.S. Healthcare has contracts with throughout its 11-state (plus Washington, DC) operating region. The Blue Bell offices are solely for administrators, including the dozens of precertification nurses who must review a doctor's diagnosis before his patient can be admitted to the hospital for elective surgery, and the 40 medical directors who determine the policy guidelines that the doctors in the U.S. Healthcare system are obliged to follow.

U.S. Healthcare offers many of the health-improving inducements that are standard fare at all the better HMOs. It has a "Li'l Appleseeds" program for high-risk pregnancies, a $300 reimbursement on enrollment in any cardiac-fitness program, a smoking-cessation program and many others. While all care is normally routed through a primary-care physician (which means a patient can see a specialist only if he is referred by his primary-care physician), women are allowed one gynecological visit per year without referral. It is also one of the few HMOs to have earned a full three-year accreditation from the National Committee for Quality Assurance (NCQA) in all of the major regional markets in which it is eligible. The NCQA accreditation is important because it is the only objective nationwide assessment of HMOs currently available. And U.S. Healthcare is more advanced than most in monitoring its doctors' performances in ways that are meaningful to members. It publishes an annual report, which is available to both its doctor members and its patient members, grading each primary-care office on various measures of its responsiveness and courtesy.

But the command-central approach to health care, symbolized by those gleaming Blue Bell offices, has earned the resentment of some doctors. U.S. Healthcare spends about 11 percent of its annual revenues on corporate overhead, compared with Kaiser's 2 percent. And it is known to be quite strict in getting its doctors to follow the company line. Asked what would happen to a doctor who didn't, one medical director said, "It is unlikely that that particular physician would remain in our network." On the other hand, market forces, when fully unleashed as they are at U.S. Healthcare, can be very powerful in reducing costs and delivering the product that people most want.

One final caveat: The distinction between IPA and non-IPA HMOs is not so clear-cut as it may sound, since even non-IPAs like Kaiser and Harvard Community Health Plan have extended their networks into some geographical regions by signing up existing group practices as IPAs. And this trend is likely to continue.

What about the downside? Aren't there limitations on the services that managed care provides? That depends on the provider and your employer's arrangement with it. As a rule, you must work within your health provider's network of doctors and hospitals. That's the whole point of managed care, but there are exceptions. In an emergency, yes, you can go outside the system to seek the nearest available care and your HMO or PPO will almost always pay the bill. That is generally also true if you come down with turista on vacation. For some exotic illnesses or specialized procedures, some HMOs will arrange—and pay—for you to receive treatment elsewhere. Most HMOs and many PPOs will cover all your prescription drugs, making them available at their own pharmacies, so long as your employer has signed up for that option. (Indeed, many managed care providers now buy so many drugs that pharmaceuticals companies have taken over managed care drug distributorships to get in on the market, and the Food and Drug Administration has recently had to warn drugmakers not to abuse their position by

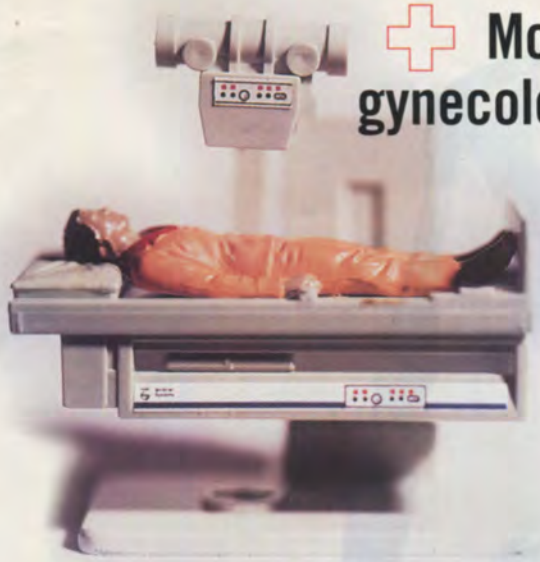
FYI

If you're looking for help in understanding the finer points of managed care, you might try:

Health Care Choices for Today's Consumer, 342 pages; $14.95; Living Planet Press, Washington, DC.

"Checkup on Health Insurance Choices," a 20-page pamphlet published by the U.S. Department of Health and Human Services Agency for Health Care Policy and Research. Free. Call 800-358-9295 to order.

For computer access, America Online offers a discussion forum. Go to the Health Reform and Insurance topic on the Better Health and Medical Forum (keyword: HEALTH).



Most HMOs routinely cover annual gynecological exams, mammograms and Pap tests.

pressuring doctors to prescribe their products.) The notorious issue of pre-existing conditions, however, is tricky. Most HMOs and PPOs will not pay for treatment of diseases that you had going in. But that can be subject to negotiation, so be sure to raise the issue with your provider before you sign up.

How do I choose the health care plan that is right for me? Despite a tremendous effort in recent years to develop standardized measures that would help consumers make sensible decisions about health care, it's not easy. Besides accrediting individual HMOs, the NCQA has been busy working up "report cards" rather like *Consumer Reports* guides. These reports include categories of information that the industry itself has devised, like the percentage of female patients who have gotten regular mammograms or the percentage of children who have received their immunizations. Such information certainly has the advantage of objectivity (although that might be somewhat undercut by the fact that the HMOs provide much of the information for these report cards themselves). Unfortunately, because managed care companies serve their clients in significantly different ways, the data aren't very useful for head-to-head comparisons between HMOs as different as, say, U.S. Healthcare and Kaiser, not that they compete in many of the same markets anyway.

Not everyone is convinced that these measures are indeed the ones that really matter in determining which HMOs actually provide the best health care. "We have to get beyond things like immunization rates and mammography screenings," Dr. Ellwood says. "What's important is whether the patient is likely to be successfully treated. Can he climb stairs again without pain? Can he go back to work?" Unfortunately, none of these questions is being addressed by the NCQA, although Ellwood notes that some of the better HMOs are already considering them on their own.

So, failing a national scorecard, how should I pick? To begin with, you have to consider what you want from your health care. Individual factors are important. One woman might want the maximum mental health benefit (where HMOs are inclined toward quicker pharmaceutical treatments); another, if she is single and childless, might want to forgo the HMO whose strong suit is maternity and pediatric care.

"There is also a psychic component to health care that is too often forgotten," adds Alan Hillman, M.D., director of the Center for Health Policy at the University of Pennsylvania. Many Americans, he notes, happily remain in FFS programs because they want to assure themselves that they always have the option of seeing another doctor for, say, a persistently aching knee. Plus, some people actually do want more medicine, not less, and might be frustrated by the less-is-more approach of an HMO. For this very reason, many HMOs have been moving into FFS territory with an option they call POS, for "point of service." It allows a member to go outside the HMO network if she wants to see a favorite gynecologist, for example, or consult an orthopedist. She would have to pay extra, but it would be less than the full fee charged by the outside physician. An increasingly popular option, it should be considered by anyone who is basically inclined toward HMOs but would like to have the choice of opting out if necessary. At U.S. Healthcare, customers choosing the POS option still end up staying in the network almost 90 percent of the time.

Are any of these types of health care plans particularly good for women? Actually, yes. The Alan Guttmacher Institute recently surveyed the various coverages on the subject of reproductive health, an issue of particular importance to women, and found that HMOs scored significantly better than PPOs, which in turn proved superior to traditional indemnity plans. Virtually all HMOs, for example, routinely cover an annual gynecological exam, but only 64 percent of PPOs did, compared with less than half of the traditional indemnity plans. The same ranking held for other aspects of gynecological care like chlamydia cultures, mammograms and Pap tests, and for coverage of reversible contraceptive aids like IUD insertion and diaphragm fitting. Confidentiality about these services is infinitely better in HMOs as well.

Any final tips? If you want to find a good HMO or to determine if the one your company offers is acceptable, there are some characteristics to look for.

- It is a good sign if it has full three-year accreditation by the NCQA, although keep in mind that the accreditation process takes a while and some HMOs that will receive accreditation simply haven't finished the process yet.
- It is also good if the HMO furnishes report cards, almost regardless of what the results actually say. (Most HMOs score above regional averages on most measures.)
- You might check to see what percentage of doctors are board certified in their specialty; it should be in the mid-eighties or above.
- Look over the academic backgrounds of the HMO's doctors to make sure a majority attended creditable schools.
- A good HMO should have an ample list of preventive medical programs like smoking cessation and substance abuse treatment.
- All things being equal, you're probably better off at an HMO that is growing rather than shrinking. Popular HMOs are usually doing something right. In general, though, you needn't worry too much about the financial health of the HMO, which is tightly regulated by the government.
- Probably the wisest course is to ask your friends for a recommendation. "That's what I'd do," says Ellwood. "It just happens that most of my friends are doctors."

But remember, the hardest part of any health care plan is picking one. Compared with that, actually being in a health care plan is a breeze. □