What’s Not To Like About HMOs

A managed care maven struggles with an HMO runaround at a vulnerable time.

by Sara J. Singer

It’s a girl! My doctor’s long-awaited pronouncement heralded one of the most joyous moments of my life. More surprising for this first-time mother was the extent to which so many people shared in our enthusiasm. Not just family and friends but my employer, banker, the owner of the local Chinese restaurant, even the farmers at the local farmer’s market. They sent gifts, cards, and messages to demonstrate their affection for the precious addition to our family. The notable exception in this celebration was my health maintenance organization (HMO). When an HMO representative called, it was to deny financial responsibility for my daughter’s care.

I have devoted the past ten years of my career to working on ways to make a private, employer-based health care system work more effectively. I believe that HMOs can be part of the solution. From 1997 to 1998 I directed the staff work for the chair of the California Managed Health Care Improvement Task Force. The following year I led a study aimed at improving health coverage decision making in California. To learn that I had been denied health care services was personally disappointing and, considering my professional expertise, ironic. We all hear stories of coverage and claims denials, but when it happened to me, I understood the intense anger people feel about these episodes. My experience resulted in a clearer understanding of why HMOs are so widely disliked.

Finding The Right Doctor

Before Audrey’s birth I undertook the daunting task of arranging for a pediatrician for my baby. After hours of research and interviews and on the recommendation of my obstetrician, I selected a doctor with whom I felt comfortable. The pediatrician’s office suggested that I confirm coverage with my

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HMO. A potential problem stemmed from the fact that my daughter’s doctor was part of one medical group under my HMO, and I received care from another. The doctor’s office explained that some HMOs require parents initially to select a pediatrician for their child from the same medical group. If this were my HMO’s policy, then after thirty days I could enroll my child as a dependent on the HMO coverage policy, at which time I would have the option to choose any pediatrician in the HMO’s network.

I would have understood if my health plan required me to choose a pediatrician within my physician’s medical group. But requiring me to select a doctor only to switch after thirty days seems unreasonable; changing doctors so abruptly would disrupt care and could have an adverse impact on my baby’s health.

The problem I encountered stems in part from the fact that many HMOs in California contract with large medical groups and hospital organizations to deliver care to patients. HMOs delegate financial risk to medical groups by capitating them for professional and often for hospital services. The HMOs retain ultimate legal responsibility for care but generally delegate to the medical group initial decision-making authority about coverage. Most consumers are unaware of these contractual relationships and hold the HMOs accountable for care received and decisions rendered.

**False Sense Of Security**

Still several weeks before my due date and right after speaking to my pediatrician’s office, I phoned my HMO to inquire about its policy. A customer service representative told me that my policy allowed me to choose any pediatrician within the HMO’s network for my child, regardless of my own medical group affiliation. The HMO would cover expenses for services incurred as of my baby’s date of birth as long as I completed certain forms through my employer within thirty days after the birth.

I felt reassured, but to follow this course meant that until my baby was born, only the pediatrician and I would know which doctor I had selected. When my baby was born, I would notify the hospital of my baby’s pediatrician, the hospital would contact the pediatrician, and the pediatrician would come to the hospital to check on her new patient. My HMO would find out thirty days or so later. No one would inform my own medical group.
That is just what happened. The morning after my baby’s birth—more than two weeks early—I was trying to find a replacement for the health policy lectures I was supposed to deliver, choose a name for my baby, and learn to feed and change her. In the middle of all this, the hospital’s admitting department called to tell me that my medical group had denied coverage for my pediatrician’s fees because she was not affiliated with that group. This was not supposed to happen, according to the HMO representative. My medical group should not have been involved in determining coverage for pediatric services for my daughter.

**No Welcome**

The call left me frustrated at one of the most vulnerable moments in my life. The HMO was getting a new member who would likely become very low cost and would remain that way for many years. HMO representatives could have let me know they appreciated the business. They did not. Rather than welcoming my baby, the HMO lacked adequate administrative processes to track new members and their doctors, to notify contracting hospitals of their benefit policies, and to transfer eligibility information to affiliated medical groups in a timely manner.

I called my employer’s human resources department and was told that all should be well if I filled out the appropriate form within thirty days. Ten days and three pediatrician visits later, I received a letter from my obstetrician’s medical group. Again they informed me that they were denying coverage for professional fees for my infant and that I could formally appeal this decision.

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I knew enough about coverage decision making in HMOs to expect this denial to be reversed once the paperwork was processed, as indeed it was. But I was annoyed. I had complied with the rules of my coverage policy. Phone calls and letters from my HMO suggesting significant financial liability were stressful, coming on the heels of my baby’s birth, when I had neither the time nor the emotional reserves to deal with such matters. When the same thing occurs to someone with a serious illness, it’s not just aggravating, as in my case. It could be life-threatening.
A Broken System

My obstetrician’s group was involved with the coverage decision for my daughter’s pediatric services because I was the primary member on my insurance policy and had specified a medical group for myself to which my HMO had delegated both financial risk and decision-making authority. The coverage denial was consistent with my medical group’s coverage policy; since the group lacked prior notification about my choice of pediatricians, this outcome was predictable.

The hassle over my baby’s health care coverage was not tragic, but it could have been avoided. My medical group and HMO need to create processes that allow the group’s doctors to understand and act upon the HMO’s policies. The hospital also should know the appropriate party to contact for authorization under these circumstances. HMOs should many of the complaints about such systemic lapses, but all parties share the responsibility.

HMOs should also demonstrate to consumers that they value their patronage. No successful business ignores the needs of its customers. The owner of my local Chinese restaurant and the farmers at my farmer’s market figured out this key to business success. The hot soup and fresh tomatoes they offered as an expression of their affection for us made a lasting impression, one that will serve them well in the long run.

I have not changed my opinion that HMOs are a necessary part of our health care system. Health care costs are straining public finances and pricing coverage out of reach for moderate-income families. Market-based competition is the best shot we have at controlling health care inflation and is a better way to rein in costs than having government impose price controls. Individual choice among competing managed care plans can foster variety and innovation.

Multiple choice at the consumer level also would improve the incentives of HMOs to serve consumers as well as employers, the purchasers of care. HMOs need to get much smarter, fast. They need to be more consumer focused. They need to create administrative processes that work and to simplify them so that their customers and their contractors can understand them.

My postchildbirth run-in has not changed my belief that competing HMOs are the best route toward making high-quality health care affordable in this country. It has just reminded me that they have a long way to go in serving their customers well.