Health Maintenance Organizations: Objectives and Issues

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There is a clear and significant climate for change in personal health services in the 1970's. Few people believe that the present health care system requires no change at all. The debate in Congress and in the nation generally is now enjoined as to what direction and how rapidly we will move.

The proposals for national health insurance range from the Administration's proposals to those of the Committee for National Health Insurance. Despite the wide variation in their financing provisions, almost without exception all the proposals recognize the need to bring some order, organization, and some new kinds of incentives to the delivery of health care. This Administration uses the term "health maintenance organizations" (HMO's) to describe its approach. Senator Edward Kennedy and the health security plan proposes "comprehensive health services organizations." The American Hospital Association uses the term "health care corporations." And Senator Claiborne Pell calls his reform measure "health services and health education corporations."

Objectives

Essentially, all these proposals have comparable objectives. They aim to provide investment in, and incentives to use, prepaid and organized comprehensive health care systems serving defined populations. There are several objectives of the proposals.

The first is to give the people a choice as to the type of health care system they may use. None of the proposals envisions a monolithic system of health care. None is intended to be a complete replacement overnight or in the future of the existing, traditional fee-for-service, private practice system. Rather the intent is to promote some alternatives to the existing system—alternatives which are believed to have certain advantages, so

that citizens can choose the kind of system they want.

A second objective is to attempt to reform the health care delivery system to bring about greater organizational efficiency together with more effective control of quality of care.

Third is the objective of cost control, including the provision of incentives for cost control by the delivery system itself, and of improving ability of Federal and State programs to control their health care expenditures with predictable prepaid contracts for beneficiaries.

Fourth is the objective to provide incentives for health maintenance rather than crisis-oriented medical care.

Last on the list is the objective of using HMO's as a mechanism to correct the maldistribution of health services. HMO's are not just a mechanism to serve the poor. While priorities will be given to HMO's in medically underserved areas, HMO's serving the more affluent population will also be eligible to receive support.

There are three reasons for so allocating support: (*a*) the entire population should have the HMO alternative which it does not have now, (*b*) the HMO is not necessarily designed to create new health services, but represents more a reorganization of those that already exist, and (*c*) most people are beginning to accept the judgment that the poor should not bear the brunt of supporting innovation in health care delivery. For years new demonstrations—new kinds of health manpower, delivery systems, and technological developments—have been tried out on populations that do not have much choice whether or not they want to participate. The poor either have had to accept being experimented on by physician assistants, or by neighborhood health centers, or with new techniques, or they went without care.

This Administration is saying that HMO's represent innovation in health care delivery which it wants to promote, generally. HMO's are not going to be forced on anyone, neither the poor nor the rich, but they will be available to everyone. If they turn out to lack advantages, then no one will use them and HMO's will have failed. But if HMO's are successful, they will be judged by all segments of the population and not just by those who usually have no choice and little voice in the debate.

I would like next to describe a bit more fully what HMO's are, to outline what the President has proposed to do in establishing and utilizing these organizations, and to summarize some of the major problems and issues which will need resolution in the months ahead.

What Is an HMO?

A recently published leaflet contains a brief definition of an HMO (*1*). Basically, an HMO is an arrangement between four elements.

1. An organized health care delivery system, which includes health manpower and facilities capable of providing or at least arranging for all the health services a population might require.
2. An enrolled population, consisting of individual persons and groups who contract with the delivery system for provision of a range of health services which the system assumes responsibility to make available.
3. A financial plan which incorporates underwriting the costs of the agreed upon set of services on a prenegotiated and prepaid per person or per family basis.
4. A managing organization which assures legal, fiscal, public, and professional accountability.

All four elements must be present in an HMO, and all must play an active role. Any one element may assume the corporate focal point for organizing and managing an HMO. For example, physician groups, medical societies, or hospitals may initiate HMO development, or consumers may sponsor them, or insurance companies or industrial or management corporations may take the initiative to organize the other three elements into an HMO.

Delivery System

The umbrella term "HMO" encompasses a variety of types of health care delivery systems. One can classify the systems along two dimensions: the relative degree of organization and centralization of health manpower and facilities and the relative extent of commitment to the enrolled population; that is, whether the system serves the enrolled population on an exclusive full-time basis or only part time.

Thus, the most highly organized and committed model of an HMO has multispecialty physicians and other health manpower organized into a closed-panel group practice, and this model uses health facilities which are owned and operated by the HMO. Both the group practice and the HMO are devoted to serving the enrolled population groups full time with minimal, if any, fee-for-service practice. This model is most closely identi-

fied with the Kaiser Foundation health plans and also the Group Health Cooperative of Puget Sound.

Lesser degrees of organization and commitment are represented by HMO's which utilize either full- or part-time physician group practices, but these have arrangements to purchase inpatient care from community health care facilities. The Health Insurance Plan of New York and Group Health Association of Washington, D.C., represent this type of organization.

The least degree of organization and commitment is represented by HMO's which utilize individually practicing physicians and community health facilities, bound together by contractual and professional agreements and serving the enrolled population side by side with a fee-for-service practice. The medical care foundation model exemplified by the San Joaquin Medical Care Foundation and other kinds of medical society plans adopt this approach.

While the HMO concept can embody these widely differing types of health care delivery systems, the organizations are not HMOs' unless they incorporate certain prerequisites. Thus, there must be an acceptance of responsibility by the delivery system to assure that services—not just payment for services—are available to the enrollees when and where they need them within the geographic service area. Services must be available and accessible on a 24-hour, 7-day week basis. The HMO must assure that each enrollee knows how and from whom services will be available; there must be an effort to assure an appropriate entry point for each enrollee into the HMO health care system. This effort may take the form of helping the enrollee select a managing physician or a particular clinic or office which he will use. There must be assurance, regardless of the type of HMO, that the patient, once in the delivery system, is assured some continuity of care through referral arrangements as well as some form of unit record system.

Finally, the delivery system element of the HMO must be capable of providing or arranging for whatever health services the enrolled population might need to maintain its health. Some populations may be able to purchase from the HMO the entire range of health services—primary care, emergency care, inpatient hospital care, as well as rehabilitation, dental, mental health, and other needed health care. Most population groups will purchase something less than this full range from an HMO. As a minimum, an HMO should be able to provide directly or arrange and pay for physician services, inpatient hospital care, emergency care, and outpatient preventive medical services. In any case, even if the HMO is not asked to provide all the needed health services, it should at least be able to refer patients to qualified health resources in the community.

Enrolled Population

The enrolled population, the second element in HMO's, are individuals and families in the population who make a conscious choice to join. They enter into a contract with the HMO, agreeing to pay, or have paid on their behalf, a fixed sum to the HMO in return for the HMO's assuming responsibility for providing the agreed upon set of health services.

The concept of enrollment needs some explanation, because many people talk about "enrolled" populations but mean something quite different from what would be required in an HMO.

Let me try to clarify by using three different terms: target population, registered population, and enrolled population.

Many use the term "target population" to describe the population residing in a geographic catchment area. The population in that area may be further limited by defining income or other eligibility criteria. A target population is one that an agency aims at serving as a maximum. Individual persons in the target population may or may not know that they are part of a target population. They may or may not use the health services. They may go elsewhere for services, but they are nevertheless counted in the target population. A target population is not an enrolled population in the HMO definition.

A registered population is one which a center, health department clinic, hospital, or physician's office for that matter, counts as the population which it is serving. The persons in the population may have been registered as they sought services. Or they may have been registered by outreach workers, who told them about the center and invited them to join. Generally, the registered population does not sign a contract that they intend to use the center services and only the center's services. Usually there is no real commitment or financial transaction on either side. A registrant may opt out at any time without notice to anyone and go elsewhere for care. For the most part, a registered population is a population of

users of services, and not descriptive of a population at risk. A registered population is not an enrolled population in the context of HMO.

In an HMO, enrollment happens before any service is provided. Enrollment takes place in the context of an agreement in advance that the enrollee will pay, or authorize to have paid on his behalf, a fixed sum to the HMO—in return for which the HMO is responsible for having services available.

The decision to enroll is made independently of any need for care. The enrollee may not need to use any services of the HMO during a month or a year. However, the enrollee knows the service is there if needed and the HMO knows it is responsible for the enrollee and includes the enrollee in its population at risk. The enrollee knows that the agreed upon set of services is paid for if obtained from the HMO and not paid for if obtained from non-HMO services.

Why is this enrollment concept important? First, it represents a significant change from the present fragmented system where usually no one locus of responsibility can be identified for the care of a defined population, either from the patient's viewpoint or the provider's viewpoint. Just having a comprehensive health center in an area and opening doors to all comers is not a concept of responsibility accepted or offered which is meaningful. With the acceptance of responsibility comes the ability to know the enrolled population and to be able to measure the effectiveness of services rendered—the satisfaction of the population, not just the patients—and other performance measures. Measuring is not easily done in any meaningful or valid way without a defined population.

Finally, the enrollment concept is significant because the need for health care resources and dollars can be predicted. Knowing or being able to predict how many people will be enrolled makes it possible to determine how many physicians, nurses, hospital beds, and so forth will be required.

Financing

The third essential element of the HMO is the financial plan. The plan includes capital financing to get started as well as capability to underwrite costs of services for the enrolled population.

Theoretically, one reason that there are few highly centralized and committed types of HMO's is the high cost of planning, development, and initial startup. It is estimated that the group practice model requires upwards of 30,000 enrollees before the plan breaks even and has as much premium income as expenses. Planning costs for this type of HMO can go up to half a million dollars. Operating costs, until the break-even point, can amount to $2–3 million, and capital investment in ambulatory care facilities for this population can amount to $1–2 million. The President's plan would provide grant, contract, and loan support to help defray these costs.

For organizations already in operation that have incurred the planning, development, and most of the capital costs, the costs of converting, in whole or in part, to HMO status would be much less. These costs might include, for example, costs of a population survey, management information systems analysis, capital development plans, actuarial studies, staffing plans and resource utilization studies, and marketing analysis and marketing campaign, among other items. Depending upon the stage of development, these costs might range from $25,000 to $250,000.

The other major element of the financial plan is the ability to underwrite the cost of services. For a fixed sum, negotiated and paid in advance on a periodic basis, the HMO must assume the risk of providing or paying for the agreed upon services. This arrangement avoids the open-end aspects of indemnity or a service-benefit health insurance plan which may pay on a fee-for-service basis for any services covered and provided. Under the HMO arrangement, if actual use of services under the plan are higher than predicted and costs are therefore higher than expected, the HMO must absorb any losses. Similarly, if utilization is less than predicted, there may be an element of profit which can be used either as profit or to expand services to enrollees or as a source of capital funds to expand services to additional enrollees.

The HMO concept also requires that the physicians, as a group, bear the risk for the costs of all physician services. While individual physicians may be paid on a salary or a fee-for-service basis, as a group they must be paid on a fixed sum or per capita basis.

Generally, unless there is some arrangement with an insurance company to assist with underwriting losses, an HMO must have a sufficiently large enrolled population (probably 30,000 or more) to allow a spreading of the risk to avoid being bankrupt, in the event of an epidemic or some catastrophic illness of a few individuals.

Management

Finally, to complete the four essential elements, the HMO must have a management vehicle which assures fiscal, legal, public, and professional accountability. As indicated earlier, this management vehicle may be under the control of a profit-making organization such as an insurance company or a medical group, a medical society, a hospital, or a consumer group. Regardless of the type of sponsorship or control, certain prerequisites must be present.

1. There must be a management information system capable of providing adequate data and reports to assure management, fiscal, and utilization controls.

2. If the HMO contracts with the Federal Government, under Medicare for example, it must be capable of reporting data which will permit performance monitoring and it must submit to medical and fiscal audits. (The Health Services and Mental Health Administration, the Social Security Administration, and the Social and Rehabilitation Service are now working on development of the monitoring system for HMO's.)

3. There must be internal quality and utilization review mechanisms for all types of care and for patients at all levels of care.

4. There must be a procedure to review consumer grievances, preferably through a consumer council.

5. There must be evidence of adequate fiscal viability to avoid bankruptcy by higher-than-predicted utilization.

6. And finally, it must be legally possible in the State to operate as an HMO; there are barriers in some States to the formation of some type of HMO's which the President's proposals would attempt to eliminate.

As I indicated previously, we are encouraging a variety of sponsorships and controls in order to make a wide variety of choices available to the population. One model we are encouraging is the consumer-cooperative control model. We are also encouraging physician-controlled models, medical school sponsorship, hospital sponsorship, and others. If a person does not want to enroll in an HMO which is profit-making or which is run by physicians, he has the choice not to. Eventually, such choices of type of plan will be available more widely, as we stimulate the development of HMO's. An HMO will not be permitted to have a monopoly in an area, so there will always be a choice, either between HMO's or between an HMO and the traditional fee-for-service system.

Administration Proposals

With this overview of the HMO concept, let me summarize the Administration's strategy as proposed in the President's health message. Basically, the HMO is the central element of the health message. There are four major provisions to foster HMO's in the message.

First is assistance in the development of new HMO's and the expansion of existing ones. For most models of HMO's, the planning, capital, and initial operating costs are quite high. To help meet these costs, the President has proposed a program of grants, contracts, loans, and loan guarantees.

Grants and contracts can be used to assist any organization in planning and initial developmental costs. For fiscal year 1972 the President is requesting $23 million for this purpose, estimating that about 100 organizations could be assisted with this phase of development.

Grants and contracts can also be used to cover initial operating costs of HMO's which serve medically underserved areas. An additional $22 million is being requested for this purpose for fiscal 1972, to assist about 25 HMO's in rural or poverty areas.

Finally, loans for public organizations and loan guarantees for nonpublic organizations would provide support for construction of ambulatory care facilities as well as operating capital.

These proposals have been introduced in the House as H.R. 5615 and in the Senate as S. 1182.

The second approach is an HMO option in public and private health insurance plans. Prepayment through HMO type arrangements is already being used in some State Medicaid programs. It is being proposed as an option under Medicare in House bill H.R. 1, which was considered in the last session of Congress as well. In addition, it is proposed to provide an HMO option under the new Family Health Insurance Plan and to mandate such options for private health insurance plans as part of the proposed National Health Insurance Standards Act (S. 1623). Under these provisions, a person eligible for the Family Health Insurance Plan or an employee covered by an approved health insurance plan could choose to use the actuarial value of his health insurance benefit package to purchase care from an HMO on a fixed-sum basis.

The third approach is part of the Administration's plan for health manpower education (H.R.

5614) and provides that medical schools which participate in developing and utilizing HMO's to train students would be eligible for special grants to help cover the costs of such training. Medical schools which want to form their own HMO's would, of course, be eligible for the planning and operating grants and contracts cited before.

Finally, the President has proposed to alleviate some of the legal barriers to formation of certain types of HMO's by using the supremacy clause of the Federal Constitution to preempt restrictive State statutes.

While this package of proposals represents the future, we in the Department of Health, Education, and Welfare are not marking time. The Secretary has clearly mandated that with or without legislation the HMO strategy will move forward. We are already supporting HMO developments under existing statutory authority such as 314(e) of the Partnership for Health Program and under the research and demonstration authority of the National Center for Health Services Research and Development. In addition, we are developing a cadre of informed Federal personnel, as well as consultants, in each DHEW Region who will be able to provide technical assistance and advice on developing new HMO's. We are actively working with the various Federal agencies interested in this concept to devise compatible approaches to contracting with HMO's for the purchase of services to Federal beneficiaries. We are developing approaches to standards and methods for monitoring HMO performance.

Problems and Issues

What roles would State comprehensive health planning agencies play in the HMO program? As a minimum, the legislation, if passed, would require the involvement of these agencies in helping to define and establish medically underserved areas, in reviewing and commenting on applications for grants, contracts, loans, and loan guarantees for development and operation, and in reviewing and commenting on HMO capital expenditures. These tasks, however, would appear to be the very minimum ones. A number of problems and issues have not been resolved to everyone's satisfaction, and they should be of some concern to the State agencies.

Provider acceptance. If HMO's are so efficient and advantageous, why haven't more physicians joined them or helped to establish them? What can be done to make the young physician more aware of the career choices available in organized health care settings? How can the HMO setting be made attractive to the physician?

Consumer acceptance. Why have not more consumers stimulated HMO development and joined these organizations where one was available? An HMO is a difficult concept to understand in terms of what is gained and lost by the consumer in joining one. What are the incentives to the consumer to join an HMO? We can recite the presumed advantages that the HMO will assume responsibility for his care, not just the payment for the care. Or that he can be assured of high-quality care, accessible on a 24-hour, 7-day-a-week basis. But is this very meaningful to the consumer? Would it be more meaningful to say that the HMO will keep him well and prove it by showing that HMO *X* has a good record of low mortality and morbidity. Or HMO *Y* is so efficient it is able to offer additional benefits, such as limited dental care, or special nutrition services, without additional premium costs. Or that HMO *Z* has no long waiting periods for appointments, that the nurses are pretty and pleasant, and that free coffee is served if you stay and watch the health education film. How can we help the consumer to understand the choices available to him and the implications of the choices he makes?

Benefit packages. The HMO may serve different populations with different packages of services. The Medicare population purchases one set of services; Medicaid another. A person covered by private insurance may have a still different package. Although the HMO must generically be capable of providing any range of services that might be necessary, it may never be called upon to provide the complete range because no population may want to buy it.

These organizations are largely geared to the payment mechanisms and the benefits the mechanisms will purchase. What happens to the person who has no coverage by insurance or otherwise? Unless he can pay his own premium, he is excluded. He is outside the present system as well, except on an episodic basis. The HMO concept will not solve his problem. Some sort of new insurance mechanism for this population may help to solve it.

Co-existence of prepayment and fee-for-service systems. What happens when prepayment exists side by side with fee-for-service practice? One can predict that, having a known advance income from the prepaid population, the provider would

have an incentive to increase the fee-for-service part of the practice at the expense of the prepaid part, since this would increase total income. To avoid this happening, both internal and external controls are needed. The best control, of course, is the consumer, for if he feels he is being slighted, he can withdraw from the prepaid plan.

How many HMO's how soon? The President proposes as a goal that 50 million more Americans be enrolled in HMO's by the end of the decade. This goal implies an intent to develop enough HMO's so that at least 90 percent of the population would have a freely available choice of joining an HMO or remaining in the present system. Whether this is an optimistic or pessimistic goal will remain to be seen. The fact is that current interest in HMO's around the country is high. We in the Health Services and Mental Health Administration have had literally hundreds of inquiries from interested organizations, including medical schools, medical societies, consumer groups, hospitals, planning agencies, and others. The level of sophistication of understanding of what is involved in developing an HMO is, of course, quite varied.

Health planning concepts. Is an enrolled population concept consistent with the geographic approach taken by most health planning agencies? What happens if an HMO feels it must build its own hospital in order to control the hospital utilization of its population, but the planning agency determines the area has a surplus of hospital beds?

Monopoly and competition. In communities or areas with single hospitals or single hospital systems, how can the potential for monopoly control by the hospital be avoided in bargaining with favored HMO's which need its beds? Similarly, with some HMO models, how can the potential for monopoly by the medical society be avoided? How much competition can we afford in an area?

Regulation. Who should regulate HMO's and for what purpose? Can regulation of quality aspects of HMO's be different from regulation of the present system? For example, the present system's incentives are toward overutilization, and thus review mechanisms are designed to detect abuse in overuse and overcharges. With the HMO, the incentives are toward underutilization and profit maximization. What new kinds of review and monitoring will be needed and who should do it? Can or should State or Federal regulation be used to control competition or monopoly situations and to assure the location of HMO's in underserved areas? What effect will tight or loose regulation of HMO's have on their expansion and development in general?

Payment levels. What should be the basis for payment of HMO's under Federal programs? What geographic base should be used to determine level of expenditures against which to place the 95 percent level of payment proposed for Medicare beneficiaries? Will HMO's operating in rural or poverty areas need ongoing incentive payments, in addition to the subsidy for development?

Conclusion

Health maintenance organizations deal directly with the organization of health services and the interface between the dollars and the delivery system. They may be one of the mechanisms that help to cure some of the ailments in our system of delivering health care. In his health message to Congress last February, President Richard M. Nixon stated:

"The most important advantage of health maintenance organizations is that they increase the value of the services a consumer receives for each health dollar. This happens, first, because such organizations provide a strong financial incentive for better preventive care and for greater efficiency.

"Under traditional systems, doctors and hospitals are paid, in effect, on a piecework basis. The more illnesses they treat—and the more service they render—the more their income rises. This does not mean, of course, that they do any less than their very best to make people well. But it does mean that there is no economic incentive for them to concentrate on keeping people healthy.

"A fixed price contract for comprehensive care reverses this illogical incentive. Under this arrangement, income grows not with the number of days a person is sick but with the number of days he is well. HMO's therefore have a strong financial interest in preventing illness, or, failing that, in treating it in its early stages, promoting a thorough recovery, and preventing any reoccurrence. Like doctors in ancient China, they are paid to keep their clients healthy. For them, economic interests work to reinforce their professional interests."

REFERENCE

(*1*) Health maintenance organizations. The concept and structure. Health Services and Mental Health Administration, Rockville, Md. Undated.