Implementation of Legislative Requirements for Emergency Medical Services in Prepaid Group Practice Organizations

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THE EXISTENCE OF TWO DISTINCT PIECES of legislation regulating health care delivery organizations within a community—prepaid group practice organizations (PPGP) and emergency medical services (EMS) systems—has created potentially antagonistic systems; each could increase the fragmentation of the other. The PPGP is a single organization that answers all of a person's health care needs and the associated financial risk. The regional EMS system centralizes the delivery of all emergency care. A PPGP that insists on being the focal point for all its members' requests for emergency care is in conflict with the basic tenets of the EMS laws.

An examination of the implementation of legislation affecting the delivery of emergency services in the group practice organizations indicates that the PPGPs are actually a threat to the regional EMS systems rather than being components of the systems (*1*). The Health Maintenance Organization Act of 1973 (Public Law 93-222) (*2*), the Emergency Medical Services Systems Act of 1973 (Public Law 93-154) (*3*), and other pieces of legislation are examined for their effects on the organization and management of emergency services in seven prepaid group practice plans.

This report was developed as a component of a descriptive study by the Group Health Association of America (*4*) for the National Center for Health Services Research. The data were gathered through interviews with the executive and medical directors, other administrators, and providers of emergency services of seven PPGPs and with leaders of health planning agencies in their communities, as well as through reviews of internal documents and a 1-month utilization survey of the emergency and urgent care services in each of the PPGPs. The seven health plans participating were Genesee Valley Group Health Association (GVGHA) in Rochester, N.Y.; Kaiser Foundation Health Plan (Kaiser) in San Diego, Calif.; Health Insurance Plan of Greater New York (HIP); Group Health Association (GHA) in Washington, D.C.; Harvard Community Health Plan (HCHP) in Boston, Mass.; Group

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Health Plan (GHP) in St. Paul, Minn.; and Metro Health Plan (MHP) in Detroit, Mich. Kaiser and MHP are hospital-based plans; the others operate their own health centers and use community hospitals when necessary.

Executive directors of other PPGPs were interviewed informally during the study. Since their PPGPs were not participating in the project, these health plans are not identified. Detailed statistical analyses were not undertaken because of the limited number (seven) of study sites and the descriptive nature of the information.

Several characteristics of PPGPs that relate both to the delivery and financing mechanisms should be kept in mind. First, the facilities used for emergency care also function as after-hours, acute care clinics. The utilization survey of patient complaints for a calendar month for each plan indicated that less than 10 percent of all requests for emergency or urgent care were for problems judged by providers to require immediate attention. Most demands on the PPGPs' emergency services systems are for urgent medical problems, rather than for surgical or life threatening conditions.

Second, the health plan functions like a private physician when presented with conditions requiring immediate care. Both direct the patient to the most appropriate sources for definitive care, manage the problem by telephone, or provide the necessary direct treatment. One difference, however, is that within a PPGP the source of health care is related to the reimbursement mechanisms.

Third, insurance coverage for emergency medical treatment is much the same for a PPGP as for an indemnity insurance carrier. Expenses incurred as a result of life-threatening emergencies are always reimbursable. However, in a PPGP, costs for treatment of other problems will be covered only if the care has been rendered by a health plan provider. In such circumstances, the PPGP might require the patient to use specified facilities and notify the PPGP before seeking care.

The PPGPs' premiums must remain competitive with indemnity insurance plans to insure their survival. As a result, the market dictates premium levels without regard to the benefits included. As with all types of insurance, any additional costs for administrative control mechanisms or additional coverage must be borne by the subscriber in the form of increased premiums.

The HMO Act of 1973

Few provisions of the HMO Act (*2*) relate to emergency services (*5*). For a prepaid group practice orga-

nization to be qualified as an HMO, it must meet the act's requirements as judged by a thorough review of its policies and operations. When this study was conducted in 1974–75, none of the seven organizations had been qualified; therefore, they are referred to as PPGPs. The legislation requires that emergency and related transportation services must be available as appropriate 24 hours a day, 7 days a week, at locations accessible to members.

Section 110.104 (a) defines a medically necessary emergency service as treatment involving traumatic injury or illness which requires care that cannot be postponed (*2*). Explicit printed information about these services must be given to members, instructing them on the appropriate use of HMO and non-HMO services. The instructions specify that all emergency care should be obtained through an HMO provider, either directly or by referral to non-HMO services. Members must be referred through an HMO professional to whom authority has been delegated. The instructions should also explain procedures for handling any associated claims.

The regulations stress that if the member obtains emergency services outside the HMO when the plan's services are not reasonably available, the member must notify the HMO and is expected to return to the care of the HMO provides as soon as transfer is possible without jeopardy to the patient. The HMO is not financially responsible for the care provided in a non-HMO affiliated facility "if the member could reasonably have given the HMO providers the opportunity to provide the service, or if the member is retained in such facility beyond the date it is reasonable to transfer the member to a facility with which the HMO has arrangements. The test of reasonableness is that of giving the HMO provider the opportunity to provide the service, or that the transfer would not jeopardize the member's condition or unduly prolong recovery or convalescence" (*2*).

The legislation has already had an impact on 85 percent of all persons enrolled in PPGPs; by November 1976, a total of 69 organizations had applied for qualification, attesting to their compliance with these requirements for HMOs.

For medical problems requiring immediate attention all plans provided coverage through plan-operated facilities or by referral to a hospital emergency room. The methods for meeting the demand for nonscheduled care of acute problems depended on whether the PPGP is hospital based. If the PPGP operated its own hospital, as do Kaiser and MHP, nonscheduled visits to their emergency rooms were acceptable, although not encouraged, without regard to the patient's problem. The PPGP member might request treatment as desired, but guidelines existed, as with all insurance companies, as to which types of visits would be covered by his plan membership.

Nonhospital-based plans attempted to limit emergency room use to treatment for emergency conditions or upon referral from the plans' providers. Kaiser provided care for acute and urgent problems through its emergency room, although its use for routine problems was discouraged. HCHP maintained a walk-in clinic for new subscribers who had no primary care physician-nurse team, allowed time for the primary care teams to see nonscheduled patients during health center hours, and operated the walk-in services for limited periods during weekends and evenings when patient demand was the greatest. GVGHA, GHP, and HIP operated evening acute care clinics to provide definitive care and to reduce the demand for emergency room use. At all study sites, some physicians were available for management of problems by telephone at all hours. However, in the smaller plans, a telephone operator often made the decision as to whether the patients' requests for assistance would be relayed to the physician.

Coverage for out-of-area emergency treatment was provided at all PPGPs for problems considered to be emergencies. All plans had developed guidelines as to what problems the PPGPs considered emergencies. Kaiser had recently implemented a policy stating that, in addition to being "out of the service area," the patient must be 20 miles from his home. This decision was directed at Kaiser members, technically residing outside of the service area, who continually requested reimbursement for treatment of problems not requiring immediate attention. This restriction is within the provisions of the legislation, since although the PPGP must provide physician services without limit to time or cost, the law has no specifications requiring location.

Ambulance transportation was a covered expense as required by the HMO legislation. Except in life-threatening situations (when the patient might directly request assistance) a PPGP provider had to authorize ambulance use. At all plans studied, ambulance services were provided if the patient was admitted to the hospital. The test of whether the ambulance costs would be covered occurred after the request for reimbursement had been made, unless a PPGP provider had previously authorized it. This practice is similar to indemnity insurance coverage in which the patient assumes the financial

risk unless a physician has ordered the treatment. All plans covered transportation costs, by ambulance or taxicab, to return the patient to his home or transfer him to the hospital, if the PPGP providers believed it was necessary.

The risk of treating a patient in a setting that lacks necessary support equipment and facilities has become an issue. The PPGPs have found that, by offering home care services, especially in communities where home calls were not the norm, they were increasing the liability of the physician. However, HIP and GVGHA still provided home visits when absolutely necessary, generally in conjunction with their early discharge surgery program rather than in emergencies.

Continuity of care is facilitated when a unified medical record is available. However, this survey revealed that medical records were seldom obtained when emergency treatment was needed except at HCHP, which used an automated medical record system with terminals at the providers' stations. Most of the time when out-of-plan care was received, the record of treatment remained in the plan's business office and was never entered in the patient's medical record. Kaiser, GVGHA, and HCHP have developed procedures to alleviate this problem, although they are not always followed.

Followup care was available through plan providers. When out-of-plan emergency treatment was obtained, the patient was responsible for notifying the PPGP and securing followup care. Six sites had provisions to determine if additional followup care was obtained, even when it had been ordered by a plan provider. HCHP, because of the automated patient medical record system at one health center, was an exception. HCHP had an automated procedure for notifying the primary care provider when followup care had not been obtained. If the prescribed followup visit had not occurred, a computer-generated listing was automatically sent to the primary care physician.

Procedures for the assurance of quality care differed among the PPGP emergency settings. Despite the intent to examine the quality of care in the emergency encounters, it was seldom done. At Kaiser and MHP, the emergency room records were reviewed by the emergency department chief only when the patient did not have a primary care physician. Otherwise, the treatment record was sent directly to the patient's primary care physician. At all study sites, audit procedures were used only if the emergency unit had departmental status and was subject to the PPGP's quality assurance measures. The work of the non-PPGP emergency room physician was seldom reviewed, except when a hospital was under contract to the health plan.

The identification card for members of all plans requested that the health plan be notified in the case of emergencies so that the care could be rendered by a plan provider, either in the emergency facility or at the health center. The nonhospital-based plans attempted to control the quality of care received by referring patients to selected facilities. Hospitals with contractual relationships with HIP had agreed to let the emergency service program administrator review the qualifications of prospective physicians and interview them. For small and newly developing PPGPs, such influence is limited. It should be reemphasized that the strengths and weaknesses of the HMO arise from a combination of health delivery functions and insurance mechanisms. An HMO can become financially viable only by carefully controlling utilization of non-HMO services.

Emergency Medical Services Systems Act

The EMSS Act of 1973 (*3*) authorized grants totaling $185 million to be awarded for 3-year periods to State and local governments and other nonprofit organizations to plan, create, or expand emergency medical services systems. An EMS system is a linkage of personnel, facilities, and equipment for the effective and coordinated delivery of health care services in an appropriate geographic area under emergency conditions. The system is administered by a nonprofit entity which has the authority and resources to administer it (*6*).

A brief description of the elements of the system and their relationship to an operational PPGP follows.

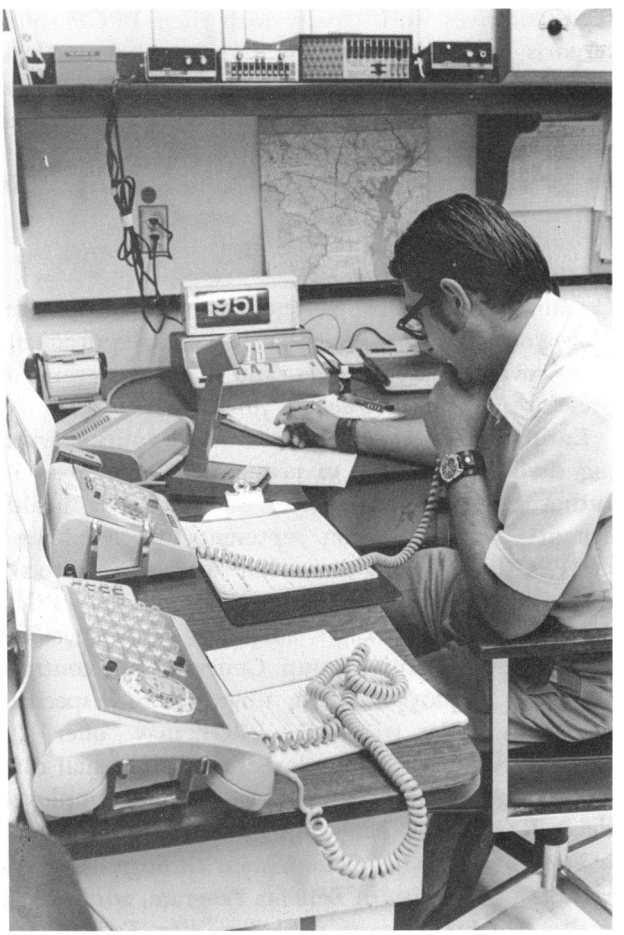
1. Adequate teams of health professionals including ambulance personnel with appropriate training and experience must be available on a 24-hour basis. However, since treatment is provided within the PPGP facilities or through fee-for-service arrangements at nonplan facilities around the clock, both facilities and available manpower are duplicated. Patients' demands for after-hours health care are addressed through the operation of acute care centers, the availability of problem management by telephone, and the insured coverage of treatment at established emergency facilities.

2. Appropriate clinical training and continuing education programs must be coordinated with similar programs in the EMS system's area. All seven study sites relied on community training programs for upgrading providers' knowledge. GHP and

Kaiser additionally sponsored inservice training programs for their providers.

3. The personnel, facilities, and equipment of the EMS system must be joined in a central communications network so that requests for emergency care will be handled by a communications facility that screens medical emergencies by telephone, uses the universal 911 emergency number, and is in direct communication with the personnel, facilities, and equipment of all providers in the system and with other EMS systems. Participation by a PPGP is a function of its size, the type of facility, and the extent to which the community network has been developed. The only study site that participated in the community communications network was Kaiser, which maintained telecommunications equipment, linked to the San Diego system, in its emergency room.

4. Each EMS system is required to have sufficient vehicles that meet standards of location, design, performance, and equipment and are manned by appropriately trained and experienced personnel. PPGPs generally contracted for ambulance services rather than operating their own and used ambulances more for transportation than for life support. The administrators of GHP, HCHP, GHA, GVGHA, and MHP believe that members, as taxpayers, should use community transportation facilities. HIP and Kaiser, however, seldom used the community ambulance because they were not able to specify the treatment facility to which the patient should be brought. They found it was less expensive to pay an ambulance bill than to lose the right to exercise this control.



5. An adequate number of easily accessible emergency facilities must collectively be capable of providing continuous services which meet standards relating to personnel, equipment, location, and capacity and are coordinated with other health care facilities. Generally, the acute care centers within the PPGPs had the ability to handle all but a few emergencies, and the PPGPs insisted on controlling the referrals to other facilities.

6. Access and appropriate transportation must be provided to existing specialized units such as intensive care units, burn centers, spinal cord centers, detoxification centers, coronary care units, high-risk infant units, and drug overdose and psychiatric centers. The structure and objectives of a PPGP dictate a preference for continued involvement of the PPGP physician. The fact that some specialized care facilities restrict or prohibit the primary physician from assuming an active role in the patient's care strengthens the PPGP's tendency not to refer patients to these facilities.

7. There must be effective utilization and integration into the regional system of appropriate personnel, facilities, and equipment of each public safety agency in the area. Emergency service providers at the study sites were familiar with public safety agencies, primarily because they are frequently the first respondents in an emergency, but they did not reciprocally share their resources with those agencies.

8. Community residents with no professional training or experience must have the opportunity to participate in policymaking for the EMS system. PPGPs have a responsibility to provide both consumer and clinical leadership to EMS systems through membership on community EMS councils, but because of their struggles for survival, the plans are more concerned with their internal problems than with community relationships. Their primary objectives are to provide health care to their members and become financially viable. Once the PPGP matures as an organization, it can look at societal obligations and responsibilities. Participation in EMS planning bodies is not considered unimportant, but

this role does not receive high priority. Kaiser and HIP, the more established PPGPs, have representatives on the local EMS council. Persons at the other study sites who participated in these organizations did so as consumers.

9. All necessary emergency services must be provided without inquiry as to the patient's ability to pay. The PPGPs had a similar policy. Nonmembers requesting emergency care at study site facilities were treated and billed on a fee-for-service basis.

10. The EMS system includes provisions for the transfer of patients to facilities and to programs for followup care and rehabilitation. The PPGPs often operated such programs but relied on the existing community facilities when necessary. However, they operated their own referral system, often duplicating existing community resources.

11. Standardized recordkeeping systems, which follow treatment from the patient's initial entry through discharge, should be consistent with the patient records kept by the dispatcher, ambulance, and emergency department. Kaiser and MHP, located in communities where guidelines have been issued, have adopted the standardized recordkeeping format.

Unified patient medical records incorporated data on emergency care, from transportation through followup, whenever the care was given or ordered by plan providers. This information was used for fiscal review of out-of-plan utilization, quality of care review, and clinical care. One HIP-affiliated hospital shared bed census data daily with the EMS coordinating agency and more frequently, when necessary, so that ambulance crews knew where to refer patients when overcrowding occurred.

12. Educational programs to inform patients how to obtain emergency care, as well as instruction in self-help and first aid methods, is a required component of the EMS. The PPGPs' efforts again paralleled the EMS requirements. GVGHA supplied patients with printed instructions as a component of treatment. At telephone information centers operated by Kaiser and GHP, prerecorded cassettes cover the care of various medical conditions, first aid topics, and how to access the plan's resources. However, these recorded messages do not describe community resources.

13. Periodic comprehensive, independent review and evaluation of emergency health care services and of the quality of care provided in the system's service area is required by the EMS legislation. Only GVGHA participated in these activities. The experience of PPGPs in internal quality assessment, through peer review, prepares their staffs to lead such activities.

14. The EMS system must have a plan to assure that the system can provide emergency services during mass casualties, natural disasters, or national emergencies. Kaiser was the only plan in the study to have participated in a community disaster exercise. In addition, the Kaiser hospitals in California had treated nonmembers after a recent earthquake. All PPGPs routinely established an internal plan for handling disaster casualties.

15. Appropriate arrangements must be established with EMS systems serving neighboring areas to provide reciprocal emergency services. The PPGPs developed mutual aid agreements independently of any existing within the community.

In the guide for developing EMS systems prepared by the Division of Emergency Medical Services, DHEW, (*6*) it was noted that HMO administrators felt that transportation in medical emergencies was a community matter and that they should not be involved in the solution. They expressed similar feelings about comprehensive health planning efforts. The report's (*6*) authors urged that the EMS regional representatives work closely with their PPGP counterparts in securing the plans' participation. With certificate-of-need authority recently having been delegated to the health systems agencies and the impact of this action on PPGP activities, there will be greater impetus for HMOs to participate in activities of the health systems agencies.

Additional Influences

Certain enrollee groups, such as unions and employee organizations, often have special requirements as to coverage, accessibility, and so forth. Several of these are briefly discussed in this section.

Enrollment in a PPGP is achieved as its marketing divisions attempt to persuade an employer to authorize the health plan as one source of health benefits. When a union represents the employees, the PPGPs deal with the union rather than directly with the employer. In many situations, the PPGPs develop benefit packages adapted to the specifications of the particular group. Generally, the contract with the employer or the union merely specifies the terms under which the PPGP may "offer" its health services to the employees. An individual contract or agreement must be issued when an employee elects PPGP coverage.

The Civil Service Commission, through the Federal Employees Health Benefits Program, administers health benefits to more than 8 million Federal em-

ployees and their dependents through one of five alternative sources, one of which is enrollment in a PPGP. Another alternative is membership in a prepaid independent practice association. The remaining three alternatives are different types of health insurance programs. The Civil Service Commission has established a number of requirements that must be satisfied before a health plan is permitted to offer its benefits to Federal employees; for example, the plan must assume financial responsibility for the first $5,000 cost of emergency services (*7*).

Numerous State and local statutes affect the administrative structure of both the health plan and the emergency service component (*8, 9*). Potentially important areas are briefly listed to suggest topics for a more detailed analysis.

- Many States and cities require that every patient requesting treatment at an emergency room be examined by a physician. This examination must precede referral to other facilities. In response to this requirement, HIP had arrangements with hospitals that patients who were not critically ill not be allowed to register at the emergency room until an HIP provider had approved the treatment. Providers are available around the clock for telephone consultation, and urgent care centers are open until 9 p.m. for in-person treatment. However, the patient still has the option of seeking treatment without a guarantee that the incurred expenses will be covered.
- State EMS and HMO laws impose additional requirements about community coordination, licensing of facilities and providers, categorizing of facilities, and availability of care. Several States' laws limit patients' stays in nonhospital facilities, generally to a 24-hour period, although it is less in some places. As a result, clinic-based plans with urgent visit and surgi-centers can retain patients for observation in their facilities only for a limited time.
- Workmen's compensation legislation in some States requires that a patient be treated by specified providers designated by the State when a work-related injury occurs. If a member goes to the PPGP, he may be denied coverage of the injury under workmen's compensation disability because the provider specified by the State legislation was not used.
- Since few PPGPs operate their own hospitals, they must contract for emergency and other hospital services. Each plan must obtain staff privileges for its physicians, and private hospitals have the right to exclude any licensed physician from the use of their facilities for any reason whatsoever. The decision, supported by case law, is entirely within the discretion of the hospital's managing officials. (*Hughes v. Good Samaritan Hospital,* 289 KY. 123. 159 SW2d 159.) (*7*). In 1971, physicians from the Mathew Thornton Health Plan in Nashua, N.H., were routinely denied privileges in the community hospital, the only hospital facility. The Department of Health, Education, and Welfare had to intercede and threaten to withhold Hill-Burton funds before the matter was resolved. This issue is currently a problem in Daytona Beach, Fla.
- The State licensure laws for medical personnel affect the staffing of emergency facilities and, as a result, the cost of operation. The Joint Commission on the Accreditation of Hospitals and several State hospital licensing regulations specify that medical records be kept for every patient receiving emergency services (*10*). Information about the time and means of arrival, patient's condition at that time, diagnosis and treatment of the problem, and disposition of the patient must be included. These standards must have been incorporated into the medical record-keeping system of those hospital facilities which are operated by the health plans.
- State laws on the ordering of prescription medication also affect the staffing of emergency rooms and acute care centers. If the State requires a physician to examine a patient before ordering medication, physician time is increased and, subsequently, costs rise. In addition, the recent HMO amendments require that if an HMO offers a prescription drug benefit, a drug profile on the patient must be maintained (*11*).

Conclusions

An analysis of the implementation of the legislation relevant to PPGPs and EMS systems indicates that the two organizations may merely be located in the same region. Furtherance of the PPGP concept, that a person's entire health care is provided and financed by one organization, detracts from the ability of a centralized body to coordinate the delivery of all emergency services. The requirement that patients channel all requests for care through the PPGP subverts any attempt at a coordinated community system for delivery of emergency services if the system is based on a thorough study of demand patterns, problems, and outcomes. The PPGP requirement results in duplication of effort and threatens the stability and viability of the EMS body.

PPGP and EMS proponents disagree about the PPGP's responsibility for providing emergency care services. PPGP advocates insist that they have the responsibility to operate a screening process and main-

tain a triage-referral system. The EMS leadership objects because this responsibility prohibits integration of PPGP members into their education and health care activities in the community. PPGPs which operate hospitals are well integrated into the community EMS system, while health center-PPGPs vary in the degree of cooperation and integration.

Legislation has had minimal effects on the design of emergency services in PPGPs. Change comes through the insistence of subscriber groups before signing a contract and from demands of dissatisfied members. Their emergency services are perhaps the most transitional aspects of prepaid group practices and the one most amenable to change. The PPGPs' activities are constrained by costs but, with further study, recommendations for mutually beneficial systems may be developed.

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SYNOPSIS

SOLOMON, MARIAN A. (Health Resources Administration, Public Health Service, Hyattsville, Md.): *Implementation of legislative requirements for emergency medical services in prepaid group practice organizations. Public Health Reports, Vol. 92, July-August 1977, pp. 307–314.*

The Health Maintenance Organization Act of 1973, the Emergency Medical Services (EMS) Systems Act of 1973, and other laws are examined for their effects on the organization and management of emergency services in prepaid group practice plans (PPGP). The study was conducted in 1974–75 by the Group Health Association of America. The data were gathered through interviews with administrators and providers of seven PPGPs and with leaders of health planning agencies in the same communities, as well as through reviews of internal documents and a 1-month utilization survey of emergency and urgent care services in each PPGP.

Effects of the laws were found to be limited, with the health maintenance legislation appearing to have the greatest effect on the design of emergency service models. In most localities, two parallel systems may operate in offering round-the-clock emergency care and programs to educate members and the public about the appropriate use of emergency facilities.

The EMS legislation has had minimal effects on the design of emergency services in the PPGPs. The emergency services component is the most transitional aspect of the PPGS and the one most amenable to change. Revisions have come through changes in internal management policy and from demands of subscribers.

A regulating inference in the operation of the PPGP, in the area of emergency services as well as in the delivery of primary care services, is that the plans must compete, both in costs and benefits, with available indemnity insurance coverage. The market dictates premium levels without regard to associated benefits. Additional costs for broader coverage and administrative regulatory mechanisms must be borne by the subscriber in the form of increased premiums. As a result, the utilization of expensive emergency care must be carefully controlled, and this restraint is often accomplished by requirements specifying which health problems are appropriate for the provision of emergency care, rather than by delaying assistance until the plan's office hours.

The furtherance of the PPGP concept, that the entire health care of the individual person is provided and financed by one organization, detracts from the viability of a central body charged with the coordination of the delivery of all emergency services in the community. It results not only in duplication of effort but often in the establishment of potentially antagonistic organizations.