The Development and Future Of Group Practice Prepayment Plans

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THE CONCEPT of group practice is not a new one, nor are the difficulties it seeks to solve. More than 30 years ago the Committee on Costs of Medical Care recommended group practice as a method for solving organizational and financial difficulties in medical service. Yet despite endorsements by this committee, and by many other authorities examining America's medical system, prepaid group practice has grown slowly over the years.

The number of persons covered by prepaid group practice plans increased from 3.3 million in 1955 to 4.2 million in 1965, but this growth represented no discernable increase in the percentage of the American people covered by these plans. Only three new prepaid group practice plans were established in 1966. But the capacity for growth is present, and the incentives for growth are increasing.

Despite the organized opposition, the subtle and overt pressures, the bitter legal actions, prepaid group practice plans have been established in every region of our country. The road to survival for these plans was rocky. But in recent years many of the road's bumps have been smoothed. Courts have struck down some of the laws which had previously prevented prepaid group practice plans from operating, and legislatures have repealed others.

On the positive side, recent accomplishments of group practice in providing comprehensive, high quality care, and at the same time, containing costs, have aroused attention and produced support. For today more than ever before, Americans appreciate and expect competent, complete health care; they are increasingly resistant to accepting anything less. More and more they recognize that access to high-quality medical care is a basic right for all Americans. More and more they realize that it is imperative to organize the delivery of health services, making the best use of the basic manager of these services—the physician—and using wisely the knowledge now available to prevent, to diagnose, and to cure. Prepaid group practice plans can meet these rising expectations.

Advantages

The advantages that group practice offers to those seeking access to high quality health care at a reasonable cost have been clearly documented in recent years. A careful assessment of the quality of care provided through group practice was conducted a decade ago by the American Medical Association's Commission on Medical Care Plans. The commission found that the quality of group practice care was at least as high as the care generally available in the

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communities studied (*1*). Considering the comprehensiveness of protection provided by prepaid group practice plans, this commission concluded that, "The benefits provided through various miscellaneous and unclassified plans are broader and more comprehensive than those provided through most other prepayment mechanisms" (*1a*).

Prepaid group plans can also control costs more successfully than other prepayment plans. A study was made of total costs of health services for the families of California State employees (*2*). A comparison of these costs indicated that health care under the Kaiser prepaid group practice plan cost 10 to 25 percent less than health care under nongroup practice plans.

The crucial shortage of physicians is another strong reason for accelerating the growth of prepaid group practice. Group practice plans permit better use of our existing health manpower, because many of the methods, techniques, and personnel that can make more effective use of physicians' capabilities are only economically feasible in settings where physicians work together. Such conservers of a physician's time as the use of automation in laboratories, the use of nurses to interpret orders or to instruct the patient on diet and drug usage, and the use of physiotherapists and other ancillary personnel are not readily available to the solo practitioner.

The nationwide shortage of health facilities is perhaps an even more important reason to promote group practice prepayment. Prepaid group practice plans demonstrate an ability to reduce significantly the strain on existing health institutions. Persons in prepaid group practice plans consistently use less inpatient hospital care. For example, in October 1964 a survey was made to determine the use of hospitals and services under the Federal Employees Health Benefit Program (*3a*). The results of the study showed that among people insured by prepaid group practice, hospital use was 40 percent less than that in other plans and that those insured in other plans had 2½ times the rate of tonsillectomies, 2 times the rate of appendectomies, and 1½ times the rate for gynecologic surgery.

In September 1960, the results of a study of a million and a quarter people showed that the 38,879 who elected the Kaiser prepaid group practice plan had similar experiences (*4*). Hospital admissions declined from 135 per 1,000 beneficiaries for those under the care of solo practitioners on a fee-for-service basis to 90 per 1,000 for group practice beneficiaries; hospital days per 1,000 went down from 1,032 per annum to 570; and major surgical procedures per 1,000 from 69 to 33.

Limiting Factors

Why then is prepaid group practice at an apparent standstill? Lack of broad public knowledge of, or experience with, prepaid group practice is one limiting factor. The public responds when it is exposed to these plans. The Federal Employees Health Benefit Program provides some valuable statistical insights. Some 13 percent of all Federal workers faced with a choice of plans in July 1960 chose prepaid group practice where such choices were available. At the end of 1962, enrollment had increased in proportion to the rate of increase of total employee enrollment. These figures are well above the national level.

The choices of auto workers in California between Blue Cross and Kaiser Foundation health plans provide some useful data. Originally all were enrolled in an indemnity insurance program. In 1950, when both Blue Cross and Kaiser Foundation health plans were offered, only 10 percent changed to the Kaiser plan. By 1960, however, 25 percent transferred to the prepaid group practice plan. Members of the longshoremen's union on the west coast, with a 100 percent enrollment in the Kaiser plan, maintained a 96 percent enrollment record over the past 10 years despite opportunities for another choice.

Despite the unanimous record of victories in the courts for group practice plans, legal opposition to their growth still exists in some areas. Seventeen States still prohibit the formation of consumer-sponsored groups; in 18 States the plans are neither approved, nor prohibited; five States have legislation specifically mentioning approval of consumer-approved plans; the remaining States have no codes covering health plans.

This is a problem that time seems to be solv-

ing. The precedent set by the 1964 New Jersey Supreme Court decision should serve as an example for eliminating restrictive legislation in other jurisdictions. But we should not allow decades to pass before these legislative restrictions are entirely removed. Immediate action must be supported.

Consumer reluctance and physician resistance certainly limit the growth of prepaid group practice. Some patients cannot be satisfied in the group practice setting, and some physicians cannot function under this arrangement.

Studies of levels of satisfaction among group health plan members show surprisingly similar results (*3b*). Of patients checked in the Montefiore medical group, the Permanente group, and the Labor Health Institute of St. Louis, only 7 percent expressed strong dissatisfaction; the remaining 93 percent reflected partial or complete satisfaction. But population studies by E. L. Koos (*5*) show that 17 percent of the general population were not satisfied with their private care. What emerges from these studies, and from a review of the specific complaints registered by those persons surveyed, is that a large proportion of the criticisms made of group health plans are actually imputed by patients to all medical practice, but that the nature of group practice tends to accentuate conflicts in expectations that already exist between some lay and professional persons.

It is important to remember that group health care is a relatively new experience for the consumer and the provider. Both physicians and patients have different expectations—differences which are accentuated in group practice. The patient, thrust into an impersonal setting, suffering from illness, and confused by the vastness of the medical center, needs more personal involvement and reassurance from his physician. From any objective standpoint, the group practice setting has a greater potential to satisfy the patient's health care needs—if the flexibility and warmth are achieved. It can and must be achieved if group practice prepayment plans are to expand.

Federal Participation

Communities must assume a major role in financing, organizing, and promoting the growth of group practice. But there is also a need for the Federal Government to participate in this effort if prepaid group practice is to play its important role in the delivery of high quality, comprehensive health care. Recent actions by the Congress and the Administration have encouraged the growth of these prepaid group plans.

Title V of the Demonstration Cities and Metropolitan Development Act of 1966 is one example of recent Congressional action in this area. This title, "Mortgage Insurance for Group Practice Facilities," is the culmination of many years of legislative effort to provide a financing mechanism for group health facilities. It says, in part, "It is the purpose of this title to assure the availability of credit on reasonable terms to units or organizations engaged in the group practice of medicine, optometry, or dentistry . . . to assist in financing the construction and equipment of group practice facilities."

This title is administered by the Federal Housing Administration in the Department of Housing and Urban Development, with the cooperation of the Public Health Service in the Department of Health, Education, and Welfare. The administrative regulations for this section of the act have been written. The responsibilities of the Public Health Service in this joint administrative endeavor concern the professional medical and health aspects of the program.

The Public Health Service and Federal Housing Administration partnership has already received about 500 inquiries from physicians, dentists, optometrists, hospitals, planning councils, welfare agencies, and others. At present, there are several dozen applications for FHA insured mortgages in various stages of development. While the actual operation of this title of the act is just beginning, these initial actions are promising.

Social Security Amendments

Similarly, both titles 18 and 19 of the Social Security Act will have far-reaching effects on group practice. Title 18, Medicare, specifically recognizes group practice, as did earlier legislation providing Federal employees with a choice among a variety of insurance plans in its program of health benefits. Congress, by these

actions, clearly indicated an intent to promote the use of group practice plans.

Recent congressional action regarding Medicare and group practice should be noted. The social security amendments (H.R. 12080) adopted by Congress in December, and signed into law by President Johnson on January 2, 1968, contain provisions for reimbursement experiments under Medicare, Medicaid, and the Child Health Program. Under the provisions in this law the Secretary of Health, Education, and Welfare is authorized to experiment with various methods of reimbursement to organizations, institutions, and physicians participating in these programs. The experiments would be designed to provide incentives for economy and efficiency while maintaining or improving the quality of health services.

The report of the Committee on Ways and Means on H.R. 12080 explained ways these experiments might relate to group practice plans. The report stated:

> Under the bill, the Secretary would be authorized to enter into agreements with a limited number of individual providers, community groups, and group practice prepayment plans which are reimbursed on the basis of reasonable costs, under which these organizations would engage in experiments with alternative reimbursement systems in order to lower the cost of providing services while maintaining their quality. Group practice prepayment plans that have elected to be reimbursed on a cost basis for physician services, and also provide hospital service, could engage in experiments under which a combined system of reimbursement could be developed for both physician and hospital services.

Under title 19, Medicaid, each State will administer its own programs and, eventually, there may be 50 different versions. It is clear, however, that the intent of title 19 also provided for the payment of services by a capitation arrangement. Several States have already put this principle into effect. Medicaid in New York State, for example, provides for contracting for care through prepaid group practice. The Health Insurance Plan of Greater New York has already enrolled more than 20,000 Medicaid beneficiaries.

Department Activities

The Department of Health, Education, and Welfare is encouraging the growth of prepaid group practice plans in many ways. The Department has engaged in these recent and current activities related to group practice:

1. Prepared and submitted to President Lyndon B. Johnson a report on medical care costs.
2. Convened the National Conference on Medical Care Costs in June 1967, which brought together leaders of the medical community and other groups to discuss ways to improve the efficiency of medical care delivery.
3. Is working, through the Public Health Service, with a number of medical schools interested in establishing group medical practice within their faculties. Such groups serve as a model to give medical students experience in clinically oriented, comprehensive family medical care.
4. Is preparing plans to support research in the organization, delivery, and financing of services through group practice. This support will be financed through the National Center for Health Services Research and Development.
5. Held a National Conference on Group Practice in October 1967 at the University of Chicago's Center for Continuing Study.

The importance of this National Conference on Group Practice must not be underestimated. Ten, or even five years ago, such a conference on group practice would have been impossible. But recently 150 conferees met to find ways to stimulate group practice. These conferees included deans of medical schools; private practitioners of medicine, of dentistry, and other areas of the healing arts; representatives of large insurance companies, the Blue Cross and Blue Shield, and other prepayment plans; union officials and management representatives; Federal, State, and county employees; lawyers and economists. Many recommendations were made by the seven discussion groups at the conference. A whole series of suggestions about how to overcome existing legal barriers were offered.

One group felt that the group practice setting allowed for the maximum use of part-time personnel. This conclusion has real meaning since part-time use of trained personnel is often suggested as a means for stretching our scarce health manpower.

Several discussion groups recommended that the dialogue begun in Chicago be continued through annual conferences on group practice. We must continue and expand this dialogue in order to realize the contributions that group practice can make to high quality, economical medical care.

Private Efforts

Companies writing private health insurance are indicating interest in the advantages offered by group practice. The president of the Blue Cross Association, Walter McNerney, at a news conference on April 27, 1967, expressed the hope that "the American Hospital Association and the American Medical Association will strongly sponsor studies and experiments in group health."

Americans are beginning to articulate a demand for more comprehensive health protection. The public is beginning to realize that there are other avenues to health service than the route which leads directly to the hospital bed. The whole spectrum of physicians' offices, group practice clinics, hospital outpatient services, extended care, and home care is gaining recognition and acceptance. The consumer wants his health insurance to offer more protection against all types of threats to health, and he wants alternative methods of health care to be covered by his insurance bill. He does not necessarily demand hospitalization for an illness.

Private health insurance is being challenged by a public demand for comprehensive coverage at a reasonable cost. This challenge, I believe, will provide a powerful incentive for private insurers to examine and support group practice plans.

Conclusion

The American people are displaying a greater concern than ever before about medical services. Americans have made it very clear that they want more and better health care and that they are willing to devote more of the nation's income to this purpose. We in the Department of Health, Education, and Welfare are committed to excellence in the delivery of health care. We are committed to the principle that such care shall be readily accessible to all.

Group practice is clearly among the most promising avenues for fulfilling these commitments.

REFERENCES

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