IMPACTING THE HEALTH CARE SYSTEM

THE ROLE OF THE HEALTH MAINTENANCE ORGANIZATION:

The Functional Autonomy of Administrative Organizations

by

Jeannie Commet

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First Reader Albert C Price

Second Reader Carl R Vaux

Personal Vitae

Jeannie Commet

Education

Masters in Public Administration from University of Michigan-Flint, December 1989.

Bachelors of Science from Michigan State University, (Multidisciplinary program with concentration in Health Sciences) June 1985.

Work Experience

The author is currently employed as an Administrator at the Greater Flint Sports Medicine Center.

ABSTRACT

The advent of HMO legislation has had a profound impact in the shaping of the American health care system. As an alternative delivery system, Health Maintenance Organizations promised cost containment with comprehensive and preventative medical services. This paper will focus on the structure and functioning of the HMO as a managed care system. Regulatory, economic and political forces and their impact upon the evolution of the HMO will also be reviewed.

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Introduction

Considerable debate has occurred over the years as to whether or not Health Maintenance Organizations have been effective since being introduced as an alternative health care delivery system in the early 1970's. Much of the controversy has centered on the HMO's prepaid capitation rate for medical services as opposed to the traditional fee for service reimbursement mechanism which had previously dominated the health care industry. (Luft, 1981, p.5) The inception of the HMO concept became part of the federal agenda at a time when America's health care system was in real crisis. Immediate attention had been focused on reducing Medicare and Medicaid expenditures which had risen dramatically since its beginning in 1965. Health Maintenance Organizations were unique for several reasons including an important emphasis on health maintenance and prevention. It was assumed that if you could prevent or at least minimize the risks, then there is a less likely chance that hospitalizations will occur. "HMOs income grows not with the number of days a person is sick but with the number of days a person is well." (Gobuschutz, 1986, p. 14) The budget is determined in advance and the health care provider is penalized for going over it and rewarded for staying under it. This was the first time any initiative had been proposed on a large scale challenging the traditional fee for service

model addressing cost containment. This was in contrast to the traditional system which focused on "sickness" care.

The overall scope of the program was to provide comprehensive health care for individuals. The HMO contracts with the enrollee for a fixed annual fee and agrees to provide a given range of health care services. With a fixed payment per individual, the HMOs income is inversely related to the number of services rendered. Thus, there is a financial incentive to reduce the number of unnecessary services.(Luft, 1981, p. 3) Since the enrollee pays a fixed annually or monthly payment which is not dependent on the number and type of services rendered, there is an incentive to offer preventive services that could potentially provide reduced expenditures in the future.

There are three main models of HMOs. First of which is the group model, this is where physicians of a partnership or service corporation contract directly with the HMO to provide services for a predetermined fee. Secondly, the staff model HMO is where physicians are direct employees of the HMO. An Individual Practice Association is another type of HMO, where the physician contracts individually with the HMO. There are many variations of this and depends upon the organization of the IPA. The HMO pays the IPA a capitated or per-member amount and the IPA reimburses the physician on a fee for service basis. With this model, the physician can work in his/her own office and can provide services to HMO patients as well as their own patients.(Orientation Manual for Board

of Directors, HPM 1989) Economic incentives within the staff model for the physician is based on his or her stake in the financial success of the organization. IPA physicians are rewarded by having the potential to receive 100 percent of the fees and a portion of any surplus funds at the end of the year. Studies have been done which indicate that staff and group model HMOs have lower hospital utilization than IPA models. Questions are raised as to the effectiveness of financial incentives since no individual incentive mechanism is present in the staff model HMO. (Health Maintenance Organizations, 1980, p. 123)

Legislative History

By 1970, only five short years after the enactment of the Medicare program, attention was drawn to rising health care expenditures that were increasing at an alarming rate. The enactment of the Medicare and Medicaid program had overrun estimated budgets and funding was drying up quickly. It was at this point that the federal government had become the largest single purchaser of health care. It was apparent very early in the Nixon Administration that attention must be focused on reform in health care policy. There was a great deal of pressure from Congress promoting a national health insurance policy. The Nixon Administration believed that a national health insurance policy was an inattractive and costly initiative that would only meet with controversy while

not addressing the real issues of cost containment in health care. (Brown, 1983, p. 206) It is because of this climate that the concept of prepaid group practices became part of the federal agenda.

It was of great surprise to many including the American Medical Association when President Nixon proposed as part of reform, reorganization of health care to include health maintenance organizations. This initiative resulted from a coalition of planners in the Department of Health, Education and Welfare under the direction of Dr. Paul Ellwood (who was a physician and policy analyst), the office of management and budget and the White House. The Nixon Administration supported this alternative delivery system arguing that HMOs increase the value of services a consumer receives for each health care dollar. (Falkson, 1980, p. 7)

The administrations bill offered a flexible approach to the development of HMO policy. It was the belief of the administration that there was a need for a policy that wasn't costly. The role of the federal government should be indirect and catalytic. The Individual Practice Association model and profit making HMOs should be encouraged. This is because it reduces the operational costs of the HMO since they don't have to assume the responsibility of the physician's salary. Also, if profit making HMOs were encouraged, the federal government wouldn't have to subsidize them. The more complex and costly HMO building became the more likely health care providers would be deterred from

participating.(Falkson, 1980 p. 107)

Senator Kennedy and Griffiths whose efforts supporting a national health insurance policy unsuccessfully, saw the development of Health Maintenance Organizations as an important first step in developing a comprehensive policy. It was the first time the government was attempting to become directly involved in the delivery of health care. Kennedy argued that the Nixon bill was not well founded or well defined. He didn't approve of granting federal aid to Individual Practice Associations with the fee for service concepts. (Brown, 1983 p. 226-28) He believed that larger sums of monies needed to be appropriated, ranging in excess of one billion to five billion dollars for HMO development. There must be strict guidelines that HMOs must comply with in order to receive funds. Kennedy also criticized the administration for not clearly spelling out which medical services a federally supported HMO would be required to provide. (Falkson, 1980 p. 115)

By the spring of 1972, Kennedy had rewritten a bill that was very comprehensive and proposed funding at five billion dollars over five years. (House Bill HMO Requirements, 1975, p.607) His bill, excluded the IPA model for federal funding. Only loan guarantees would be available for profit HMOs. The bill suggested that a separate national commission on the quality of health care be established. Provisions for health education for staff and members should be included. The Kennedy bill was an innovative bill that would create a

new health care delivery system that was not in existence anywhere.

In the house, Congressman Roy sponsored a bill which took the middle ground between the short and superficial administration's bill and the long and detailed Kennedy Bill. However, this bill mandated a substantialnumber of services to be covered under fixed -price premiums.(Brown, 1983 p. 237) The cost was too great to be able to compete in the market place. The Roy bill was scaled down and a clean bill was introduced. There was no legislation that passed in the Ninety Second Congress, however, immediate attention was taken by the Ninety Third Congress. The bills were reintroduced in congress on January 3, 1973 in the house and on January 4, 1973 in the senate. Several conferences were held throughout the year to reconcile differences between the house and senate.(Falkson, 1980 p.153-156)

Finally, By December 29, 1973, the HMO Act was enacted. (Public Law 93-222) The HMO act authorized expenditures of federal dollars, for the purpose of providing assistance and encouragement for the establishment and expansion of HMOs. The act required federally qualified HMOs to provide certain basic health services for all enrolled members. Included within these basic health services is physician care with consultations and referrals, impatient and outpatient hospital services, emergency services, short term outpatient mental health for crisis and evaluation, diagnostic such as laboratory and radiology services, and home health. Primary

emphasis was placed on preventive services including physical exams, well baby visits, immunizations, family planning, etc. Substance abuse programs were a part or the program requirements also. (Public Law 93-222) They must have the ability to offer a range of supplemental services including dental, vision, and physical medicine. The act authorized three hundred seventy-five million dollars from 1974-78 to help a limited number of new HMOs. (Boggs, 1986 p.46) It also included a provision requiring employers with more than 25 employees to offer the HMO option to their employees if they offered a standard health insurance plan.

It wasn't long after the legislation was enacted that problems began to arise. The acts requirements still made the benefit plans too expensive to market effectively. They had to charge too high of a premium to be competitive with other insurance companies. Already existing HMOs would have to raise rates just to provide the basic services required by the act. Requirements that an HMO community rate rather than experience rate like most other insurance companies again put them at a disadvantage. For instance, in community rating two families may pay the same premium even though one family requires more medical care, therefore, raising the cost of care for everyone, Whereas, experience rating is based on actual prior costs. It was also a requirement initially that HMOs have an enrollment period of at least 30 days a year where they must accept all applicants including the medically uninsurable until they reach their

limit. Needless to say the expectations of congress were a little overzealous and it was very difficult for HMOs to get started let alone reach a level of financial solvency. Amendments in 1976, 1978, and 1981 helped ease the burden of the strict HMO requirements and allocated additional funding to help in the development of these programs. It was upon completion of each of these amendments that there was renewed interest in developing Health Maintenance Organizations. The process started from a demonstration project and transformed into a policy for the promotion of Health Maintenance Organizations.

The concept of prepaid group practices is not new and has been around for a long time. The Ross-Loos Plan established a prepaid plan in 1929 with the Los Angeles water and power department employees providing comprehensive health care. Another prepaid plan that is fairly well known is the Kaiser Foundation Medical care program, it was initially formed in 1933 in Southern California. These plans are still in operation today and serve as models for prepaid group practices.(Kelly, 1984 p. 33)

Project grants were awarded for feasibility studies planning and initial developmental costs. The office of the Assistant Secretary for Health, Public Health Services, Department of Health, Education, and Welfare was the federal administering agency. Loans and loan guarantees were also given to assist in covering operational costs for a period of time easing the burden on the newly formed HMO. The

application process for becoming federally qualified was very detailed and it took a considerable length of time before approval was given to proceed with the developmental phase of the HMO.

While the presence of legislation for HMOs is fairly recent in Michigan the concept of HMOs is not. Early in the 1960's, the Community Health Association was developed by the UAW. The prepaid group practice was offered as an alternative to the traditional health insurance option that was provided by Blue Cross and Blue Shield of Michigan. (Falkson, 1980 p. 20) The CHA was at a later date taken over and managed by Blue Cross.

The first indication of regulation of HMOs came with the enactment of the Michigan HMO Act in August of 1974. The Act included provisions designating the Department of Public Health to assume responsibilities for regulating activities in the HMO as well as overseeing that quality of care was being maintained. It also became necessary for the HMO to be licensed by the Insurance Bureau of Michigan. The act also established a commission to make sure the agencies acted in the public's best interest when regulating HMOs. An HMO does not need to be federally qualified to operate in the state of Michigan, however, it must be licensed under Act 368 of Public Act of 1978 and Act 354 of Public Act of 1983 by the Michigan Department of Public health and the Michigan Insurance Bureau, otherwise it cannot conduct business. The federal monies available for HMO development have dried up

considerably under the Reagan Administration, and the states have had to assume a larger role in picking up the slack. Not all states have been able to bridge such a gap. (Chapney Interview, Nov. 1988)

While some HMOs have proven more successful than others overall the growth of HMO enrollment is continuing to rise. It is estimated that thirteen percent of the U.S. population participates in HMOs. (Peres, 1988 p.11) Reasons for their popularity consist of the following: consumers favor low out of pocket costs in HMOs opposed to those of traditional insurance plans, subscribers are attracted to a broad range of services as well as the centralization of services, employers view HMOs as a positive response to rising health care premiums, a surplus of physicians has attracted individuals to participate and the wide range of models offer physicians a choice in tailoring their practices. (Black, 1985 p.551)

The advantages of being federally qualified may not be as beneficial to the Health Maintenance Organization as was previously expected. The grants, loans and loan guarantees were helpful in establishing HMOs but it was a very detailed and lengthy process in order to receive such monies. There were many restrictions placed on HMOs that may have ultimately inhibited their success. The HMO act not only provided financial support for HMOs but it also tried to increase the competitiveness by increasing the access to potential subscribers. The act required that employers with

twenty-five or more employees offering health insurance must offer the federally qualified HMO as an option. The intent was to open the HMO market up to those employers who were reluctant to do so. This was effective, however, the community rating system imposed by the legislation placed restrictions affecting the competitiveness of the plans premiums.

The advantage of being federally qualified according to Mike Mark, President of HealthPlus, is that it offers a stamp of approval, much like the USDA. This approval by the federal government has been interpreted by employers as an endorsement of the HMOs ability to provide quality medical care with an assurance of financial viability. Mr. Mark also added that there was legislation in the works to give greater flexibility in pricing strategies, corporate structure and delivery of medical care. (Mark Interview, Oct. 1988) The proposed legislation would allow HMOs to restructure their rates based upon the group's utilization experience. It would allow the HMO to become more competitive with their premium setting in the marketplace. The provisions for a relaxed corporate structure would eliminate the need for HMOs to set up independent subsidiaries to operate non federally qualified health plans. HMOs would also be able to diversify and increase their options to include a PPO, and indemnity plan, or a self-insurance administrative arrangement. The bill would also offer benefit packages where ten percent of the physicians services could be obtained outside the plan

and a deductible could be charged for this. (Alternatives, 1988 p. 1)

Considerable attention has been focused on the debate over the delivery of "quality" medical services. There is little doubt that an HMO meets the requirements necessary when the grant is given. However, there is no guarantee that standards are maintained once the HMO has been in operation over time. Patricia Harfst, director of the Office of Prepaid Health Care's office of qualification (HCFA) told a business group on health that ongoing monitoring of federally qualified HMOs consists exclusively of reviews of financial reports. This is done only periodically and the only time quality of care review occurs is where there are Medicare risk contracts involved. (Peres, 1988 p. 13)

Literature Review

There has been a vast amount of literature written discussing the incentives leading HMOs to provide more preventive services and their ability to reduce the cost of medical care. Significant efforts have been made by researchers to address the question of whether or not HMOs do save money and contain costs. It can be proven that HMOs are successful in reducing health care expenditures at least where hospitalization rates are concerned.

Studies have been conducted that suggest on an average that prepaid group practices reduced per capita cost some 10

to 40 per cent for health care. This is largely a result of 25 to 45 per cent reduction in hospital admissions.(Enthoven, 1984 p. 1528) Further findings in the literature suggest that the overall number of hospital days is lower for HMO subscribers, however, there is no difference in the length of stay once an HMO patient is admitted. It appears that those physicians involved in the individual practice association have a tendency to be less effective in keeping patients out of the hospital and sending them home a little sooner. (Enthoven, 1984 p. 1529) The primary difference according to Harold Luft, whom has reviewed the research extensively has suggested that the difference lies in the number and mix of services provided. (Luft, 1978 p. 1339) Observed changes are seen in hospital costs rather than ambulatory care. It is much easier for the physician to control hospitalization rates. Many plans require physicians to seek prior approval to hospitalize a patient except in an emergency. The consumer can initiate an ambulatory care visit whereas only a physician can admit patients to the hospital. (Luft, 1978 p. 1337) It is the philosophy of the HMO to perform a procedure on an outpatient basis whenever possible. However, this is also in line with conventional fee for service trends which provide economic incentives for health care providers who provide outpatient services when possible over inpatient services. It is interesting to note that there is an increased number of ambulatory care visits for HMO enrollees as compared to traditional fee for service plans. While it

is not significantly higher, it does stand to reason that HMOs do not save money by reducing ambulatory care visits. (Luft, 1978 p. 1338)

Based upon these findings, one can interpret the results in a variety of ways. First of which, is a belief supporting the concept that HMOs have been successful in developing sufficient initiatives preventing the need for subscribers to be hospitalized. Another view might suggest that the group as a whole enrolled in the HMO is healthier and does not require as much hospitalization. While another view may suggest HMOs have a tendency to "overtreat".(Luft, 1978 p. 137) HMOs negotiate with hospitals for lower room rates and for discounted fees on other patient services.

It is apparent that HMOs have a strong financial interest in preventing illness. Those in favor of the prepaid health care delivery system would agree that the existence of preventive and educational services in HMOs will lead to long-term savings in medical care costs. Preventive care is "any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease of detecting it in an asymptomatic stage." (Luft, 1978 p. 144) Thus, reducing the need for more expensive treatment at a later stage. From a theoretical perspective, the concept of prevention and maintenance appears to make sense on the surface as a foundation in the HMO philosophy.

There is some uncertainty as to what is meant by "preventive" services. It is the general assumption that

prevention or detection in the early stages will catch a problem eliminating the need for curative services in the future, however, little is mentioned about which mix of preventive and curative services leads to the optimal output.(Luft, 1978 p. 143) Whatever the optimal output, a reallocation of resources is required.

Under the fee for service system, providers have a tendency to offer services that yield the greatest profit. The prepaid plan would have a tendency to support whichever costs least in the long run.(Relman 1985 p. 751) It may be preventive or therapeutic care. Some of the common procedures we generally would assume to be preventive in nature may not provide any benefit in early detection. The executive physical is an example. It can be argued whether or not there is long term benefit, however due to the number of procedures performed this may be very profitable for fee for service providers. The direct costs that the patient bears has an impact on the number of services provided. The more out-of-pocket cost incurred by an individual, the less likely one is to request services as when it is covered by insurance.

Other noneconomic factors affecting decisions in preventive services involve the influence of the physician. The style of medicine practiced is one focusing on diagnosing and treatment of disease. It is usually the decision of the physician that determines which services are rendered. However, it is in preventive care that the consumer can exert

the greatest influence. The absence of specific symptoms makes the preventive visit more postponable. The current economic structure of HMO's has discouraged physicians from promoting preventive care. In the prepaid system, which is based on capitated rates, once the fund is used up there are no additional monies available for disbursement.

The organizational and financial structure of HMOs varies from one to another but the basic arrangement consists of a primary care physician who acts as a gatekeeper. The job of this gatekeeper is to provide the patient with comprehensive medical care in a coordinated manner. Financial incentives are used to entice the primary care physician to make decisions based on cost containment. The primary care physician controls all referrals for the patient. Gatekeepers are also encouraged to arrange for outpatient procedures whenever possible.

Fifteen years after the HMO act was enacted the role of the government has diminished considerably. The early goals of promotion through regulation has given way to that of competition. HMO's must compete with other managed care groups such as Preferred Provider Organizations and Exclusive Provider Organizations for enrollment of employee groups. These alternative delivery systems did not exist when the HMO act was passed. The products being delivered are changing while medical services are becoming more complex and resource intensive. Employers have become more sophisticated purchasers of health care and are for the first time building

coalitions that are tipping the balance of power away from the health care provider. (Peres, 1988 p.8)

Statement of Purpose

The purpose of this paper is to study the Health Maintenance Organization and its relationship to environmental influences. It is through studying these environmental factors that one is better able to understand the structure and functioning of an organization. Organizations are not isolated entities and they must exist with other organizations in a highly complex and constantly changing system. (Hall, 1987, p. 212) Some theorists have suggested that organizations are controlled by the environment while others have suggested that organizations control the environment. The more dependent an organization is on the environment the more vulnerable it is. (Hall, 1987, p. 230)

The very presence of HMO legislation was developed in response to economic demands of the environment. While prepaid group plans have been around for a long time, the pressures of spiraling health care costs gave this alternative delivery system national exposure. From the inception of the program, environmental influences have played an important role in the development of HMOs. Interactions with the environment are filled with change and uncertainty. The ability of the HMO to make decisions in

response to these constantly changing and highly complex external influences is the driving force which contributes to its success or failure.

The scope of this paper will not allow for examination of all of the environmental forces acting upon HMOs. However, this paper will focus on a review of regulatory, economic, and political forces that impact the management and decision making in Health Maintenance Organizations. HMOs have been forced to under go significant changes inorder to survive in a highly competitive health care environment. The importance of preventive services to the HMO will be discussed along with identifying the changes in the government's role now that federal funding is no longer available. The HMOs relationship with health care providers, employers, and consumers has not been without its share of controversy. Health care costs are still not under control and what attempts are HMOs making to work towards a solution to this problem.

METHOD OF ANALYSIS

Research methods used for this analysis consist of a review of secondary data sources obtained from library research and interviews with administrators and board members who are involved in the decision making and management of a local Health Maintenance Organization. The purpose of this research is to analyze regulatory, economic, and political forces and their influences on Health Maintenance Organizations. The research will include a combination of the cause and effect approach along with the policy prescription approach in an analysis of the administration of HMOs. The method of analysis chosen for this study is not only to examine these forces as they are presented within the literature, but to apply them to a local HMO in order to review more specifically the impact that these forces have.

The HMO under study, HealthPlus of Michigan was developed from initial efforts of a broadly based community task force which began operation in October of 1979 and is still in existence today. Interviews were conducted with administrators directly responsible in the decision making for the organization. Those individuals involved in the interview process include the Chief Executive Officer, Vice President of Legal Affairs, Chairman of the Medical Affairs Committee, and Director of Medical Services and Quality Assurance. Additional information was acquired from organizational documents. The documents examined consisted

of: annual reports, board and committee meeting minutes as well as correspondence with health care providers, the State of Michigan, and other HMOs.

The interview questions were designed from a review of the literature and consist of the following:

1. What impact has the growth and spread of HMOs had on the structure and functioning of the Nation's health care system?

2. How have the principle objectives of HMOs shifted and what impact has this had on the administration of these organizations?

3. What has happened to the government's role since the early development of HMO?
   A. Did the government program cause the impact for which it was intended?
   B. Did government intervention improve the situation or create additional burdens?

4. What is the HMO's relationship with health care providers, employer groups and consumers?

5. What are the major obstacles presently confronting Health Maintenance Organizations?

DISCUSSION

When the government introduced HMOs to the country there were great hopes that at least 50 percent of the population would be enrolled in this alternative delivery system. (Friedman 1988, p. 17) After all, it provided for comprehensive medical care with a price competitive feature. HMOs could offer many things to many people and the government could support a program which was less controversial then the highly debated national health insurance proposal. However, health care expenditures continue to rise and consume a large percentage of our GNP. Many HMOs developed from the 1973 legislation have failed while those that have survived have been forced to transform into highly competitive managed care systems.

There is little argument among researchers that studies have shown a decrease in health care expenditures resulting from reduced hospitalization rates. However, there is little debate over whether or not preventive services contribute to these reduced costs. At the present time, it is very difficult to show any correlation between the presence of preventive care and the reduction of hospitalization rates.

One of the more important questions that must be addressed is what constitutes prevention and what level of that prevention ought to be provided for in the HMO setting. There are several levels of prevention. Immunizations, well baby visits, and health promotion are examples of primary

levels of pervention. Screening for early detection of a disease is considered to be secondary prevention. Tertiary preventive services encompass the retardation of the progress of a disease after the detection has occurred. It can be suggested that with each level of prevention there are additional resources needed, often leading to increases in cost (Luft 1978, p.141). Further evaluation is necessary because in some cases there is little advantage to early detection. Thus, the determination of the optimal mix for a preventive or curative approach depends not on the HMO philosophy rather a cost benefit analysis. It is inherent within the capitated system that whatever costs least in the long run will be the one that is promoted.

Motives to endorse a policy promoting prevention are only as good as the support of the health care providers. While HMOs may promote prevention, physicians are the ones who are more influential in determining the services that a patient needs. Many physicians endorse the policy promoting wellness. However, they dedicate much more of their efforts to treating the sick. There is some controversy between the HMO and physician as to what good preventive care includes. The HMO may encourage a compete physical exam which is primarily focused on a social history. Whereas, the physician's view of a physical exam has a tendency to involve a more comprehensive workup consisting of lab tests, Xrays, EKGs in addition to the physical exam.(Piesko interview, May,1989). Inadequate reimbursement discourages physicians

from wanting to perform these services. All of this is very costly to the HMO, whose budget doesn't allow for such provisions. Presently, HealthPlus of Michigan is making attempts to increase reimbursement to physicians for practicing the art of medicine rather than increasing the reimbursement rate for tests or procedures.(Piesko interview Oct.,1989) The inability to find a middle ground can be attributed to the declining interest in prevention and maintenance in HMOs.

ADMINISTRATIVE CHANGES IN HMOs

The concept of Health Maintenance has given way to one of Health Management. The successful HMOs have evolved into highly sophisticated organizations whose primary focus is on managing care through the containment of costs.(Mike Mark interview, Jan. 1989) The HMO industry had little impact on increasing the access to health care benefits, however, they they have been the first to attempt to control health care expenditures. While utilization review programs had been established before the 1973 legislation, HMOs are credited with enforcing stricter guidelines which increased efficiency. Traditionally, hospitals have used an internal review process. HMOs established more structured criteria for utilization management and added a non bias analysis which had previously been absent. (Mark interview, Jan.,1989)

HMOs represented a major departure from traditional indemnity plans and have paved the way for a multitude of managed care plans. Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Third Party Administrators (TPAs), etc., are a few examples of managed care systems which have evolved as a competitive response to a rapidly changing health care environment. (Champney interview, Nov. 1988)

The primary objectives in HMO management have shifted from prevention and comprehensive service of managing care of the sick along with managed prevention. Most of the funds awarded to HMOs in the beginning went towards operating expenses. The remaining financial resources were used up on reimbursement of therapeutic and diagnostic services. In many cases, minimal funds were available for financing preventive services. The lack of allocated funds for preventive services has shifted the priority of this element of comprehensive care. Because of the HMO concept truly being an alternative delivery system, little was really known about what resources were necessary to finance such an operation.

Early problems resulted with HMOs having large administrative staffs consuming more than their allocated share of the budget. For the most part, HMOs lacked effective health care administrators and decision making was based strictly on cost principles. Since that time, successful HMOs have redirected their efforts and found

health care managers who could handle the delicate balance between quality of care and cost containment of that care. (Mark interview, Jan. 1989)

The early and mid 1980s were a time when enrollment in HMOs was increasing, however, many HMOs were operating with large financial losses. This inspired many HMOs to assess the needs and evaluate organizational growth, quality of service, cost effectiveness, pricing mechanisms and flexibility in changing market conditions. Shifts in health care supply and demand needed to be looked at carefully with emphasis on consumer demands for new technology, medical services and quality care issues. (Dawson interview, Nov.,1989) Amendments in the HMO Act eased some of the burden that the HMO faced with regard to competitive rate setting. Investments were directed toward improving Management Information Systems so important data could be obtained sooner. One of the major problems facing HMOs in the early days was the length of time it took to retrieve the valuable information regarding utilization management and costs. If the HMO doesn't know what the costs are until six months after the quarter has ended, how can it possibly know how to set its rates? (Group Health Institute,1988 p.11)

Administrators at HealthPlus have found the greatest challenges presently to be controlling outpatient costs. They believe that they have been successful in controlling hospitalization costs. The trend to perform everything on an outpatient basis has led to a shift in the cost structure.

They have enhanced their information system and are trying to establish a DRG pricing system for these outpatient services. Health Plus conducted a study of the costs of services rendered by local radiologists. The objective was to see who provided the most economical services and who overutilized services. For instance, certain radiologists did four view chest xrays when two views would have been appropriate based on their diagnosis. (Dawson interview, Nov. 1989)

One of the biggest issues concerning HMO administrators is the threat of being held accountable for the decisions made on behalf of the physicians and other health care providers. It has been suggested that the inherent incentives provided under the HMO structure can lead to a underutilization of services leading to future problems of greater consequence down the road. The risk associated in withholding care has forced HMO management to take a second look at the providers in which they contract with. (Group Health Institute, 1989, p.143)

Many changes are occurring within the HMOs quality assurance program. While regulations required HMOs to have a program in place it was not highly sophisticated and was not clearly defined. HealthPlus, like many other HMOs is placing greater emphasis on revitalizing their quality assurance program. Their belief in an effective quality assurance program is contingent upon developing and maintaining an effective and efficient monitoring system. It

is through the incorporation of superior MIS capabilities, sophisticated physician peer review, strong utilization review capabilities and dedication of resources that this can be accomplished. (Medical Affairs Committee Meeting HPM 10/11/89) A strong quality assurance program not only provides legal protection and is necessary for the credentialing process but it assists in controlling health care expenditures. Poor quality is very expensive because there is a greater likelihood that complications can occur. These complications can lead to potentially more serious problems and tend to impose higher costs. (Dawson interview, Nov.,1989) Additional difficulties are found with the IPA model HMOs because of the number of providers involved as well as the lack of control over their private practices.

GOVERNMENT'S ROLE

The government's role has changed considerably since the introduction of HMO legislation almost two decades ago. Several amendments to the HMO Act have occurred to meet the unrealistic expectations of the original program and assist in increasing the competitiveness with other plans. National policy makers were drawn to this alternative delivery system because of the attractiveness of financial incentives instead of regulation to contain health care costs. It was the major concerns over escalating health care costs that resulted in less emphasis by the government on primary considerations of

access and quality. (Group Health Institute. 1989, p.76) It was generally assumed that the comprehensiveness of the services would indirectly take care of quality issues. However, in the new health care environment the demand for quality has taken hold. It has been suggested that these financial incentives within the HMO structure have raised concerns that quality of care may be compromised. The shift in health care is from one of cost in the 1980s to one of quality in the 1990s. (Group Health Institute, 1989 p.219)

The goals of the HMO program have fallen short on many of the intended promises. One of the governments original objectives was to increase the access of individuals to health care. This goal was not achieved. It is apparent that much of the marketing efforts in HMOs are directed toward employer groups. It is this targeted group that already has access to medical care. The HMO just offers an additional option for the employee. There has been little effort on the behalf of HMOs to address the uninsured problem.

Supporters of the HMO legislation believed that due to the level of comprehensive services provided under the program, quality of care would be of a superior nature. Research has not found this to be true. It has been proven, however, that comparable levels of care is rendered in the HMO setting. Low out of pocket costs for office visits and preventive services may serve as incentives for consumers to enroll in these plans but there is little data

to suggest that these patients receive a higher quality of care than those with other plans. (Luft, 1988, p.147)

The structure of government contracts through Medicare and Medicaid have made it extremely difficult for HMOs to remain financially viable when treating a large number of these beneficiaries. (Champney interview, Nov. 1988 Health Plus, like many other HMOs have incurred large deficits when participating with Medicare contracts. They have taken losses of over $ 8.4 million from 1984-1987 in their attempts to provide services to the elderly population. (Board of Directors Orientation manual, 1989, p. 75)

In 1988, traditional health insurance premiums rose on average between 12 and 25 percent. (Group Health Institute, 1988 p.557) HMO premiums rose less than the tradition indemnity plans. It is apparent they have done little to keep health costs down. Research has indicated that inpatient expenditures have been reduced significantly. However, these costs have shifted to other outpatient settings, where HMOs have not shown they are any more successful at reducing expenditures. HMOs have not only been unable to contain these costs but they are faced with additional burdens of maintaining their own financial viability. Part of the HMOs failure to contain costs is attributed to an uncontrollable rise in the elderly population, new technological advances, and long term care for catastrophic illnesses. While this is definitely a national problem, the government is looking to HMOs and

managed care plans for potential solutions. Predictions in health expenditures are estimated to increase from 11% to 14% over the next five years and 22% by the year 2000. (Group Health Institute, 1988, p. 3)

The detailed and effective utilization management process is a direct result of the HMOs initiatives to contain costs. This has proven very successful and has helped the traditional indemnity plans to lower their utilization rates as well. Therefore, lower costs in traditional plans resulting from the managed care philosophy have allowed HMOs to lose their competitive edge.

The state's role has remained the same since the enactment of the 1973 Act. Until HMOs were in existence, the state had no way of accessing physicians' offices. There was no mechanism to inspect to see if these physicians' offices were clean, safe and sanitary environment for patients. The HMOs set facility standards which were monitored by the state in which the "whole" public was made better off. It would be impractical to meet these standards for HMO patients only.

RELATIONSHIP WITH SOCIETY

The advent of the HMO industry has not existed without controversy especially with regard to health care providers. The structure of the alternative delivery system has altered the Doctor - Patient relationship. No longer can physicians be exclusively concerned about the needs of the patient.

Medical decisions are frequently based on economic issues with respect to managing patients' care. The design of the HMO structure has made primary care physicians act as gate keepers of medical care. These gate keeper physicians are not only responsible for coordinating medical care for patients, they must also find the least costly place to have the procedure performed. Otherwise, the physician is held accountable and suffers the higher risk withholding rates. (Hillman, 1987, p.1747) The resistance by physicians toward the HMO movement has had a direct influence upon the success of the program. Those HMOs that have survived have dedicated many resources towards building strong provider relations. The implications of this managed care has moved providers toward wanting only to treat the young and healthy since this is most cost effective. The "sick" are financially unacceptable to treat. (Piesko interview, Oct.1989)

Additional problems have resulted for physicians with respect to malpractice issues. In 1985, a malpractice carrier in Michigan attempted to impose a surcharge against HMO and PPO physicians due to the increased risk for operating under utilization and financial incentives. The claim was based on the premise that there was an increase in risk for those physicians who had to deliver patient services in certain pre-set ways or at pre-set cost. (Group Health Institute, 1986, p.385) The Insurance Commissioner supported the managed care operation and asked the insurance company to

revoke the surcharge. Health Plus Administrators have indicated that the next few years will serve as a most critical time. Once the quality assurance programs, peer review activities and utilization management programs are soundly in place the potential risks will be greatly reduced.

Health Care spending in the U.S. is estimated to climb to $ 590 Billion in 1989. Employers are expected to pay some 32 percent of the bill for employee benefits covering approximately 190 million Americans. (Group Health Institute, 1989, p.237) While health care inflation is expected to continue to rise in the future, employers are becoming increasingly frustrated by cost increases that are occurring in light of cost containment initiatives promised by HMOs and PPOs. Typically, the HMO option has been so attractive because of the limited financial exposure of the employer. The employer's financial exposure is limited to the capitated rate and any exposure above this level becomes the HMOs responsibility. (Scanlon and Auston, 1987, p.15)

Employers as financial backers of health care must become more aggressive in cost containment otherwise their own financial viability will be threatened. Profit margins are being reduce with the greatest costs being associated to employee benefits. Additional pressures from unions fighting for better health care benefits for their members has forced management to a somewhat retaliatory position. While support is needed from all, typically corporations are not been allowed to govern the type and quality of medical care

rendered. General Motors has made it known to HMOs in Michigan that they expect to spend 20 percent less when dealing with this alternative delivery system. (Piesko interview, Oct., 1989)

The structure of HMOs has made it possible for consumers to purchase preventive services which they otherwise may not have been able to afford or willing to pay for. The original design of the program was to keep out of pocket costs low so that consumers will be more likely to utilize services. While this alternative delivery system has created a vehicle to promote increased benefits to medical care, they have dangerously created a situation in which consumers are not responsible for health care dollars spent. Managed care systems have found the greatest success when the consumer assumes some financial responsibility for their health care.

It is significant to note that HMOs have proven they have the potential to control costs with case management and quality assurance initiatives. If this is the case, questions of why haven't HMOs consumed a greater share of the health care market? One possible reason for this is that consumers don't really like budgeted care. The term implies that if careful planning does not take place money can run out. The underlying question becomes does society want an infinite amount of health care at an infinite price or a finite amount of health care at a finite price. (Group Health institute, 1988, p. 4) There is no doubt that the HMO does restrict freedom of choice and this philosophy can only work

when and if society is ready to accept it.

OBSTACLES CONFRONTING HMOs

The biggest obstacle facing HMOs is the biggest problem confronting all of America today. Increases in technology along with the cost of that technology is a major reason why national health expenditures continue to escalate. The aging population, costly catastrophic illness such as Aids, coupled with the malpractice crisis has greatly affected the HMOs ability to demonstrate successful cost containment objectives.

The HMO industry is dedicated to finding less costly alternatives in providing care. While increased technology is important, more is not always better. (Dawson interview, Nov. 1989) Increased technology is not only costly because of its presence, it often doesn't replace an already existing diagnostic procedure. For example, Magnetic Resonance Imaging is not a replacement for a Cat Scan, often times it is done in addition to the Cat Scan. Managed care organizations are analyzing whether or not these efforts become a costly duplication of services.

The management information systems set in place by HMOs have allowed them to explore less costly alternatives for catastrophic illness. It is believed that several alternatives can be explored when looking at what one hospital day can provide. In this light several potential

alternatives can be substituted at a lower cost including hospice care, home care, and/or admission to a step down facility. (Board Meeting Minutes August, 1988) Due to Union influences regarding health care costs in the Flint area, it is less expensive to send patients for specialized care at Mayo clinic in Minnesota or Cleveland Clinic than it is to provide hospitalization and subspecialized care in Flint. (Dawson interview, Nov.,1989)

Additional obstacles affecting the HMO are the lack of support from physicians. Physician resistance is due to the HMOs direct involvement in decreasing income. HMOs have been accused of altering the "Art of Medicine" through control mechanisms on how to practice and what therapies to use. (Mark interview, Jan.,1989) Managed care efforts are being directed toward building relationships with physicians so that mutual goals of quality patient care can be achieved.

Some of the problems HMOs have had with health care providers is due to the lack of good medical administrators with experience. The ability to balance pressures from providers wanting greater reimbursement and employer groups demanding increased benefits with lower costs is most difficult for even the very best. Consumers needs must be successfully met especially since disenrollment is directly related to consumer satisfaction. It is apparent that many administrators have been unable to balance these forces and maintain the financial viability of the HMO.

FUTURE TRENDS

Managed health care is an industry which is in its infancy. Many players are involved and there is a high emphasis on innovation. Future success will depend on innovations, flexibility, and administrative efficiency. (1989 retreat, p. 80) Enhancing the HMO by giving patients choices, reevaluating the compensation of physicians, diversifying the membership and creating new products are all ways Health Plus of Michigan believes they can continue to compete in this rapidly changing medical environment. (Board Minutes 9/29/89)

One of the hottest areas for diversity for HMOs is Third Party Administration. HMOs as Third Party Administrators assume the role of providing comprehensive benefit administration services to employer groups. Several different plans may be administered including traditional fee for service, PPO, and HMO options. The key administrative duties consist of claims processing, actuarial estimations of costs and utilization review.

In an attempt to realize this competitive environment, HealthPlus has taken progressive steps necessary for financial viability as well as benefiting the community as a whole. The Ford Motor Company, UAW Exclusive Provider program is a pilot program that is designed to ease the administrative burden for employers and continue to provide comprehensive care for patients while still focusing on cost

savings. It would be the responsibility of HealthPlus to process all claims allowing them to be able to capture cost and utilization data as well as keep track of quality assurance activities. (Employees could choose between an HMO, PPO, or traditional plan) The pilot program will focus on direct involvement by labor and management, providers and administrators in all phases of system design, finance, implementation and review. It would be the responsibility of HealthPlus to provide cost and utilization reports on a timely basis. The program appears so appealing because it offers the opportunity for direct involvement in determining the direction of health care, in establishing quality standards, and predicting future health care costs. If this program is successful, the result may draw national attention to this unique approach to system development and its attempt to promote communication, problem solving, and responses to this rapidly changing health care environment. (Mark interview Jan.,1989)

CONCLUSION

An atmosphere that was once filled with intense regulation is now giving way to an environment of fierce competition. HMOs that will succeed in the future will have excellent management and will be greatly diversified. Many HMOs will become part of larger health management companies. The decisions of employers and government as purchasers will determine the shape of the health care

environment in the coming decade. (Monthly Briefings, HPM, October 1989, p. 3) The short term focus will be on consumers wanting freedom of choice and employers along with the government needing to get a handle on health care expenditures. In the long run, choice will not only based on cost effectiveness but also on high quality.

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