

Health maintenance

The third sector which promises to impinge on the core inpatient market of the nation's hospitals is comprised of those hybrid health insurance plan/delivery systems popularly known as health maintenance organizations (HMOs).^{*} As will be established below, the principal economic consequences of the HMO involve lowering hospital utilization and rates through brokering of health care for HMO enrollees. As such, HMO development is targeted at restraining hospital use and costs. The strength of the health maintenance concept may be its flexibility-the ability to adapt to different physician, employer, and community perceptions and needs. Fee-for-service medicine, private office practice, and third party insurance, as well as free physician choice, can all be encompassed within the alternative delivery system, while still retaining certain core features of health maintenance.

The health maintenance organization is a controversial enterprise. Like group practice, it has been subjected to attack by organized medicine and for many of the same reasons (compromising physician autonomy, threatening quality of medical care, etc.). It has equally zealous supporters who claim that this model, if supported by changes in tax and insurance laws, can help solve the nation's health cost crisis. It is difficult to make an objective assessment of the HMO without being accused of bias by at least one side of the debate. However, the debate itself is one of the healthiest developments in health care, and the results may influence national health policy significantly during the 1980s.

WHAT IS A HEALTH MAINTENANCE ORGANIZATION?

The health maintenance concept grew out of successful models of prepaid group practice, the largest and best known of which is the Kaiser/Permanente Group Plan of California, founded during the 1930s. Health maintenance organizations are prepaid a fixed fee by enrollees which covers a full range of medical services from routine office visits to hospitalization. Because the HMO encompasses ambulatory as well as inpatient care, it is a vertically integrated health enterprise. The same entity which collects the fees from enrollees provides them -care. In a few cases (notably Kaiser), this integration may extend to ownership of the hospitals in which HMO patients receive inpatient care. More typically, HMOs contract with hospitals in their communities for care. In the vast majority of HMOs the concept of insurance, or third party payment, plays a much reduced role. Physician services are provided by groups of physicians who are either incorporated separately as a group practice and sell their services to the HMO on a per capita basis (the group model), or by staff physicians who are salaried employees of the HMO (the staff model).

The essence of health maintenance is that the health care provided to the enrolled population is managed, within fixed predictable resource limits, by the HMO. Enthoven has likened the management role of the HMO to that of a prime contractor in arranging comprehensive care for its patients. The HMO thus assumes at least part of the role traditionally occupied by the physician under traditional fee-for-service practice. The prime contractor feature of health maintenance organizations is at the economic heart of competitive health care proposals put forward by health maintenance advocates. HMOs will seek out the most efficient providers of

^{*} Advocates of HMOs have urged relabelling them "alternative delivery systems," an unendearing expression intended to encompass more types of organizations than the closed panel staff or group HMO.

care, often through competitive bidding. HMOs thus become economic brokers for their enrollees, offering hospitals and other providers large blocs of utilization in exchange for a good price.

Competitive models rest upon the growth of this brokering function to compel established providers to be more efficient. In this competitive system, hospitals will not necessarily be paid their "reasonable costs" for rendering care to groups of plan enrollees; rather they will be paid what they can get. How much "brokering" is required in a given hospital market to effect overall costs is a subject of ongoing research, and is the "\$64,000 Question" about health maintenance.

At the same time, since sickness is a cost to the HMO the financing mechanism contains incentives both to improve health status (through screening, physical examinations, and other preventive health measures), and to minimize use of expensive health services such as hospital care, HMO proponents believe that the fee-for-service system encourages cost increasing behavior by rewarding the physician for each intervention. Because HMOs reverse this incentive, proponents argue they save money. Physicians participating in HMOs are unquestionably subject to stricter oversight of their practice than private practice colleagues, including, in many cases, prior authorization of hospital admissions.

Several variations on the prepaid group practice model have emerged in response to market and, some speculate, political pressures. The most popular variation is the Independent Practice Association (IPA), which contracts with physicians who practice in their own offices to render care to enrolled patients. As with the conventional prepaid group practice HMO, the IPA is responsible for providing a comprehensive range of health services for its enrollees. Its physicians comingle enrollees with their private patients (typically not more than 15 percent of an IPAs physician's patients are enrolled in the plan), and are compensated for their services on a fee-for-service basis. However, the fees may be paid on the basis of a negotiated fee schedule limiting maximum reimbursement. Fee reimbursement may also be reduced below these negotiated levels if the plan experiences financial difficulty. Physicians are also subject to peer review of their hospital utilization practices. The principal attraction of the IPA for potential enrollees is that they typically involve a large enough percentage of the physicians practicing in an area to guarantee potential enrollees their choice of physician or, implicitly, the continued services of their family doctor. As will be seen later, this feature may be pivotal to the ultimate market prospects and penetration of the HMO.

A third variation is the primary care network (PCN). This type of organization pioneered by the SAFECO Insurance firm is a coalition between a private health insurer and contracting primary physicians (internists, family practitioners). The participating physicians, who are reimbursed for their services by the insurance company on a capitation (per capita) basis, are responsible for arranging all care for their patients. What services they cannot supply themselves they arrange through referral. The cost of referral services and hospitalization are picked up by the insurance company from the pool of fees paid by enrollees. If the pool runs a surplus it is split with the physician. If it runs a deficit a portion of the deficit is reduced through reduced fee payments, putting the physician at risk financially for routine care. Catastrophic hospitalization costs are paid by the insurance company. Here the physician becomes a financially responsible intermediary for the insurance company in arranging care.

All these methods have in common an alteration of the economic relationship between the doctor and patient in such a way that the physician is encouraged to avoid, to the extent medically and ethically permissible, using expensive medical services in caring for the patient. The spectrum of control ranges from the physician being a salaried employee of the plan (staff-type HMO) to the physician being a mildly constrained independent contractor (IPA). In all these arrangements peer or corporate control is exercised to some degree over the practice habits of participating physicians. In all cases such participation by the physician is voluntary.

HMO AND COST CONTROL

An extensive body of research has established that the total health cost to the consumer of HMO care, at least under the prepaid group practice mode, is lower than can be rendered under competing fee-for-service insurance plans. It is important to realize that these results relate not to premium costs (the cost of insurance benefits) but to the total cost of care, including out-of-pocket outlays. This is an important distinction because enrollment fees for HMOs are often higher than for conventional group health insurance premiums. But because they cover more services and do not contain deductibles or co-insurance, overall outlays for care are lower in HMOs.

According to Harold S. Luft, who summarized about 50 comparative studies of HMO costs relative to conventional group health insurance, total health costs to HMO subscribers range from 10 to 40 percent below those of subscribers to comparable group insurance plans.¹ This specific finding ties to research conducted in California, where the HMO cost data derives from the very large, established Kaiser HMO network. Whether these cost reductions will be duplicated by the large cohort of newer HMOs started up during the 1970s remains to be determined.

With regard to IPAs, Luft could find no evidence that costs to enrollees in them were lower than for conventional insurance.² This latter finding is potentially significant since it could be argued that the IPA concept has traded away cost reducing features of prepaid group practice to accommodate the fee-for-service system. That is, physician behavior may not be sufficiently altered by the IPA to influence his or her pattern of use of expensive services.

Luft's review establishes conclusively that HMO cost savings are attributable directly to lower rates of hospitalization of enrolled patients. Specifically, research has found that hospital inpatient days are from 25 to 40 percent lower for HMO enrollees and from 0 to 25 percent lower for IPAs than for comparison groups of the conventionally insured.³ The National HMO Census taken in 1980 estimated that HMOs nationwide generated only 418 patient days of care per 1,000 population. This compares to a nationwide average of 1,235 days per 1,000 population. The relative degree of hospital use varies according to HMO type, with "group" HMOs below the mean and IPA's 20 to 30 percent above the mean.⁴

Inpatient bed days are the product of two factors: admissions and length of stay. While Luft found that length of stay does not appear to be shorter for HMO patients, the rate of hospital admissions appear to be lower for HMO patients. However, the AMA study of 15 HMOs did find systematically lower lengths of stay in HMOs compared with the same community's Blue Cross plan.⁵ In attempting to tease this problem apart a little further, Luft searched for evidence that HMOs reduce discretionary admissions, such as elective surgery, and found no support for this hypothesis.

Luft established that HMOs do not achieve savings by reducing ambulatory care. In fact, 10 of the 17 non-IPA HMOs surveyed experienced higher rates of ambulatory use than paired groups of the conventionally insured. Of five IPAs in the studies Luft reviewed, all had substantially higher rates of ambulatory usage relative to conventionally insured group plans.

Though research has established the reasons why HMO care appears to result in lower health care costs, e.g., lower hospitalization rates, the underlying causes of the lower hospitalization rates are still a subject of controversy. HMO advocates claim that these lower rates are the results of a better organized system of care, more prevention, and other factors. HMO detractors claim that it is because the people who enroll in HMOs were unlikely to require hospitalization or expensive care in the first place, and that the system of care cannot claim responsibility.

These critics point to the fact that HMOs enroll only about 1.5 percent of the nation's more than 50 million Medicaid and Medicare recipients. Both of these groups are high risk medically and consume more (in the case of the elderly, much more) hospital care than the national average. The Interstudy HMO Census found that people over 65 comprised only 4.6 percent of total HMO enrollment. The average proportion of elderly enrollees among the AMA study sample of 15 HMO plans was 6.1 percent.⁶ The elderly have a hospitalization rate more than triple that of the national average.

Proponents of the HMO concept agree that as the HMO enrollment base broadens the average rates of hospitalization will probably rise, and costs will rise along with them. Where this ultimate rise will place HMO costs relative to conventional health insurance plans such as Blue Cross remains to be seen.

THE MARKET FOR THE HMO

The most recent estimate of total HMO enrollment in the United States is the federal government's 1980 National HMO Census. As of June 1980 there were 9.1 million Americans enrolled in HMOs, 72 percent more than in 1974. Of this group, 1.3 million were enrolled in IPAs.⁷ There were 236 HMOs, according to the survey, of which 34 percent were IPAs.⁸ The Louis Harris poll regarding national attitudes toward HMOs conducted during the summer of 1980 established that approximately 6 percent of adult Americans were then enrolled in HMOs, but that there is sharp regional variation in HMO penetration. While 20 percent of all adults in the West are enrolled in HMOs, only 4 percent in the Midwest, 3 percent in the East, and 1 percent in the South are enrolled. The Harris poll also found that enrollments are higher in cities and suburbs than in rural areas and small towns.⁹ The 1980 HMO Census conducted by the federal government also established that HMO enrollment is unevenly distributed in the national market. Nearly 59 percent of all HMO enrollment is in the West and 44 percent in the state of California.¹⁰

When one looks behind the enrollment data to the organizations themselves, one can see that, despite impressive growth in the number of HMOs since 1970, in enrollment terms, the market can still be characterized as "Kaiser/Permanente and everybody else." Kaiser plan enrollments, which are heavily concentrated in California and other western states, totaled 3.9 million in 1980, 42 percent of all HMO enrollment. Kaiser accounts for approximately 75 percent of the enrollment of all HMOs which have met federal requirements for financial and marketing assistance. Of the 12 HMOs with enrollments over 100,000, five are Kaiser plans. Blue Cross is also a significant institutional presence in the HMO field. Local Blue Cross sponsors 44 HMOs

nationally and is assisting some 27 others.¹¹ The significance of this degree of involvement by large health insurers will be discussed below. See Figure 4-2.

The Harris poll found no significant differences in rates of enrollment by race, sex, marital status, or number of children in family under age 18. Those with college level education, income over \$25,000, and those who work for very large organizations were over-represented in the enrolled population relative to other groups. Professionals are over-represented in the HMO enrollment data, while executive /proprietor and skilled labor groups were underrepresented.

Annual enrollment in HMOs grew by only 5 percent from 1976 to 1977, but increased by 18 percent from 1977 to 1978 and by 12 percent annually during the subsequent two years. Interestingly, 56 percent of the sharp 1977-78 growth in HMO enrollment occurred in IPAs. The IPA share of the HMO market appears to be growing relative to the other types of HMO. The proportion of HMOs that were IPAs grew from 25 to 34 percent from 1975 to 1978, while the proportion of HMO enrollment accounted for by IPAs grew from 6.5 to 14.1 percent from 1976 to 1978.¹²

The public opinion data gathered by Harris provide a clue to the underlying market issues responsible for the above pattern. Harris established that approximately 10 percent of the nonenrolled U.S. population was very interested in possible future HMO enrollment. However, this percentage *more than doubles* (to 26 percent) if non-members are informed that it may be possible to retain their family doctor.¹³ The Harris survey concluded that the market for future HMO growth is limited (more than 58 percent of those polled were hardly or not at all interested¹⁴) and that the problem of breaking private physician ties (e.g., inability to choose the HMO physician) may be a major impediment to growth.

However, a more fundamental problem faces those who wish to expand HMO enrollment. That problem is that the vast majority of the general public simply does not understand what an HMO is, let alone what benefits it is likely to confer upon its members. Fully 79 percent of the general public indicated that they are either not very or not at all familiar with the HMO concept, while only 5 percent said they were very familiar with the concept.¹⁵ This is not surprising since the concept itself and the differences between HMOs and conventional health insurance are quite complex. As Harris points out, it is difficult to market something to a population that does not understand the product or its potential benefits.

The key intermediary in HMO enrollment is the employer, not the consumer of health care. The vast majority of enrollees participate in HMOs as part of an employee health benefit package. Thus the real market for HMOs is the employer and the competition is other health insurance plans. HMOs are already at a disadvantage in this competition because, as Enthoven points out, premium costs (to the employer) of HMOs are likely to be higher for the first several years of an HMO than competing group health insurance plans. Only established plans like Kaiser are able to enter this competition on a relatively good footing.

The Federal HMO Act of 1973 requires employers to offer qualified HMOs as a benefit alternative if available in their area. This requirement has engendered isolated but angry resistance from some firms who resent federal mandates driving up their health benefits outlays. Harris correctly points out that the employer will have to bear much of the burden of educating the employee about the benefits of HMO membership relative to enrollment in more conventional health insurance plans. To the extent that employer vested interests in lower health care costs are

a more prominent feature of the marketing effort than how HMOs can benefit the employee, these educational efforts may be rejected as “company medicine,” much as industrial health care clinics have been in the past. This has been a particular problem with company based HMOs such as those advocated by Paul Ellwood in his well-known 1973 article "Health Care: Should Industry Buy It or Sell It?"¹⁶ The employer in such instances is hardly a disinterested participant in the process.

The Harris public opinion data provide some valuable clues to effective marketing strategies for the HMO manager. Figure 4-1 compares product attributes of HMO care relative to fee-for-service care according to users of each mode of care. Cost bulks the largest among the factors favoring HMOs—a complex issue since, as pointed out earlier, the cost differences may reflect much lower out of pocket outlays due to the comprehensiveness of HMO coverage, but higher upfront premium costs. The additional features of health education and prevention programs are unique attributes of HMO care which fee-for-service medicine is not well organized to provide (except through some hospitals).

The negative attributes, unfortunately, relate to the core product—medical care. The perceived differences between HMO and fee-for-service care relative to both quality of and access to physicians are significant. Fully 30 percent of HMO users were dissatisfied both with the waiting time for a physician appointment and the waiting time once in the facility to see the physician. Perceived quality and attitudes of physicians in HMO settings were also significantly less favorable than in the fee-for-service settings. Unfortunately, this data did not differentiate between HMO users who saw their physicians in an IPA setting as against a group/staff HMO setting.

**Levels of satisfaction with various aspects of available health care service.
net difference between members and nonmembers**

Q.: I would like you to tell me how satisfied you are with various elements of the health care services that are available to you and your family. Please say for each one whether you are very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied.

	Net difference between percentage of members and nonmembers saying "very satisfied"
The cost to you and your family—not met by insurance—of health care services	+27
The Total cost—whether you pay for it yourself or not—of health care services	+23
The availability of doctors and medical services 24 hours a day, 7 days a week	+17
The availability of adequate preventative health services	+15
The availability of health education for your family	+10
The amount of time you have to wait to see a doctor after you have called for an appointment	- 5
The helpfulness and general attitude of your doctors	- 8
Your ability to see a doctor whenever you need to	- 9
The quality of doctors	-12

Source: Reprinted with permission from Louis Harris and Associates, Inc. "American Attitudes Toward Health Care Maintenance Organizations" (Menlo Park, California: The Henry J. Kaiser Family Foundation, July 1981).

This consumer perception contradicts research findings, summarized by Frances Cunningham and John Williamson, which suggested that the quality of health care in HMOs, measured by a variety of empirical techniques, is superior to care rendered in other settings.¹⁷ The difference between "objective" measures of quality and consumer perceptions suggests that HMOs have not done an effective job of differentiating their product from conventional modes of health care and, perhaps, have not paid as much attention to the amenities of care as they should.

The problems of accessibility and quality must be addressed forthrightly by HMO marketers because they represent two areas where HMOs are likely to have image problems in the future. The IPA has an obvious competitive advantage over the closed panel group or staff HMOs since patients are permitted to remain with physicians in whom they have confidence. In terms of accessibility, HMOs may be compelled to commit to maximum waiting times for appointments and to allocate appropriate resources to keep these commitments. They may also be bucking a consumer unwillingness to permit non-M.D. allied health personnel to assume a larger role in their health management. HMOs have been more aggressive in substituting nurse practitioners and physician assistants for physicians where possible (taking histories and conducting physicals, for example). The AMA study estimated that approximately 30 percent of all medical encounters in half of the non-IPA HMOs they studied are handled by allied health personnel.¹⁸ As consumers accept the role of these personnel, demand for physician contact may subside somewhat.

Keeping management attention focused on the core issues of the perceived quality of service is difficult in many cases because most HMOs are new business ventures. Like all new ventures, HMOs are fragile, and maneuvering them out of the take-off phase is a complex, anxiety-ridden enterprise. Fourteen federal qualified HMOs have gone bankrupt in the last eight years, and many times this number may follow if the Reagan administration limits loans for HMO development.¹⁹ These problems are aggravated by certain federal requirements for HMOs desiring federal support, such as required periods of open enrollment and the use of community rating for premiums rather than ratings related to individual health status. It may take \$3 to \$5 million of deficit and five to six years' time before a staff or group HMO reaches the break-even point.^{*20} Depending on the mix of services offered, it may take an enrollment of 30,000 to 40,000 to reach breakeven. IPAs usually take much less capital and a lower enrollment level to break even.²¹ Financial management and marketing to employers may crowd out managing for consumer acceptance.

Estimating the likely rate of enrollment is the most complex methodological problem encountered in planning for the growth of the HMO. The most effective method of doing this is by estimating from a base of sponsoring institutions which may have themselves have studied the enrollment potential of their employee groups as part of their benefits planning process. Community surveys are not a cost-effective method of estimating potential markets, because they ignore the key mediating role of the employer in the HMO choice. Accurate estimates of enrollment are critical to the financial management of the HMO since these rates determine the projected revenue flow within which the HMO must live, given the level of upfront funding expected (federal loans, etc.). Available revenues govern staffing and other resource allocation decisions, in turn affecting the mix of services the HMO can offer. The problem which HMOs face in their first several years is in managing the deficit. Since these facilities are simultaneously struggling to gain consumer and employer acceptance, it is important that some type of feedback mechanism (patient satisfaction surveys or other less formal devices) be built into evaluation to assure that consumer needs are not sacrificed during the start-up period.

The growth rate of health maintenance organization enrollments in the future is uncertain. The Harris data suggest two reasons why growth will not be necessarily be rapid. The first is public ignorance of the HMO concept. The second is the relatively limited appeal of the HMO in a health care system where the vast majority of consumers have satisfactory physician relationships under fee-for-service. The loss of freedom of physician choice, and the implicit loss of choice of hospital which follows, is a significant market impediment to future growth. Finally, the consumer jury is still out on the implicit trade-offs in access and, possibly, quality of care. Since the HMO is still a relatively unknown quantity in the health care market, consumer skepticism will have to be countered by solid achievements in providing quality patient care.

As mentioned earlier, the rates of hospitalization within HMO populations are likely to rise as the base broadens. If the HMO is not able to reduce significantly the rates of utilization among newly recruited populations, including the medically indigent and the elderly, the cost advantage between the struggling community-based HMO and the established insurance plan will narrow and could disappear. Open enrollment and community rating (which inhibit selective enrollment of low-risk groups) will probably pull HMO medical care use and costs up, all other things being equal. The rate of increase in utilization and cost as HMO enrollment broadens will test the theory behind the HMO. The results of the test may bear directly on the marketability of the HMO.

Perhaps recognizing these significant uncertainties, HMO advocates have begun to analyze the competitive framework within which health insurers operate. A major feature of this competitive environment relates to the federal income tax exclusion of employer contributions to health benefits. This tax exclusion encourages employees to demand, through their unions, that employers pay the full cost of health insurance premiums, regardless of the total cost of care delivered under the plan. HMO advocates recognize that it may be difficult to reach the market share they seek if the groundrules for enrollment in health insurance programs are not tilted in the direction of greater employee choice (e.g., multiple plans) and greater economic "neutrality" respecting the type of plans offered.

Thus, rather than offer a single health benefit plan, Enthoven argues that employers should offer several, including prepaid health plans. Because of the tax exclusion mentioned above, however, Enthoven believes that multiple choice alone will not suffice to encourage competition among plans. He argues that the federal government should also establish conditions for continued exclusion of employer health benefit contributions from federal taxation. Specifically, only those plans which provide certain cost containment features should be permitted to receive the exemption. Finally, the employer contribution should be *fixed* at some level below the total premium cost of care so that the consumer, in choosing between competing health plans, is to some extent at economic risk in allocating his or her portion of the premium.

Under the present system the employer, not the employee, reaps the benefits of the employee's choice of a less expensive health care plan. Under a system of fixed contributions, the employee would bear the responsibility for economic choice and participate in the rewards. It is presumed that the changes in federal tax and employee benefits policies proposed, which are substantial, would create the correct mix of economic incentives to further growth of HMOs. Right now, the employer-group health insurance nexus is perceived by HMO advocates to be the principal barrier to the growth of alternative delivery systems.

Whether the far-reaching changes proposed by HMO advocates will be enacted by Congress remains to be seen. If HMOs are permitted to compete in the consumer rather than in the employer marketplace, some of the economic and product benefits of HMOs can enter more directly into the consumer decision, and HMOs may be able to achieve greater market penetration than under the current groundrules. Without the changes, the market for alternative delivery systems is likely to remain limited, and probably will not exceed 10 percent of the U.S. population before 1990.

COMPETITIVE IMPLICATIONS OF ALTERNATIVE DELIVERY SYSTEMS

The health maintenance organization was endorsed by the Nixon administration as an innovative device for restraining health care cost increases by providing an alternative to the fee-for-service physician and the cost-reimbursed hospital systems. To the extent that HMOs are successful in penetrating the health care market, they will reduce the number of patients who are treated under fee-for-service reimbursement. Through brokering hospital care for large panels of enrollees through economic competition, as well as restraining aggregate hospital utilization, HMOs may also pull down hospital utilization and revenues and narrow profit margins. For these reasons, the HMO is a competitive problem for both the physician and the hospital.

When HMOs were first developed they were subjected to intense opposition from local medical societies. Participating physicians were sometimes censured or expelled from their local medical

societies or denied hospital admitting privileges. Since the specter of antitrust has raised its head in the health care field, many overtly public anticompetitive practices of the past have gone underground or been abandoned. Rather, physician groups and medical societies have increasingly flocked to the IPA as an alternative to the closed panel, group, or staff HMO. Many IPAs are formed as a defensive measure by local physicians to assure their ability to keep their patients while permitting them access to prepaid care. Some HMO advocates have argued that there are antitrust implications of IPAs with 80 to 95 percent of the physicians in a county or city participating.

The research findings available so far suggest that the increased freedom of choice afforded the consumer by the IPA has economic trade-offs. Specifically, the fee-for-service system remains in place. Findings which indicate higher levels of physician visits in IPAs relative to HMOs as well as higher rates of hospitalization, suggest that IPA cost reduction mechanisms and, implicitly, peer pressures, are not as effective as in closed panel HMOs. The IPA and the closed panel systems may be generically different. With growing physician supply, and multiple IPAs, these physician groups may begin competing among each other, tightening cost and utilization controls as a consequence. Recent marginal growth in HMO enrollment has been among IPAs.

The fee-for-service system, and the high level of consumer satisfaction with the care received under that system, is well entrenched and accepted by patients. Advocates of HMOs may be compelled by market realities to temper their desire for structural reform by encouraging pluralism among different methods of organizing prepaid care which incorporate fee-for-service practice. Under the type of system Enthoven advocates, however, the ultimate competitive outcome will be determined by the consumer, responding to systems of care which do the best job of meeting economic and medical needs.

The implications for the hospital are less clear. As discussed above, it is still not certain how much the HMO actually reduces the hospital utilization of its enrollees, as opposed to enrolling people who use less care already. To the extent that HMOs actually reduce the need for hospitalization, increased enrollment of HMOs in a community or market area will reduce the demand for hospital utilization in that area.

The impact on the hospital, and the posture the hospital takes toward the HMO, will depend on the strength of the hospital's market position. Hospitals with strong medical staffs and high utilization can probably ignore the HMO. Hospitals with marginal utilization are faced with two choices-ignore the HMO and hope that lost utilization will be absorbed by other institutions, or work with the HMO to sell its services. Depending on the financial circumstances of the hospital, it may be appropriate to bargain with the HMO to offer hospital services to its enrollees at a discount below the hospital's prevailing charges for services. Communities with a sufficient penetration of HMOs will probably experience bidding wars between hospitals attempting to secure HMO hospital utilization. How much the hospital system can "absorb" via competitive bidding without eating away net incomes will depend on the degree of management control over costs and on the collective market power of prepaid plans in the community.

Some larger hospitals have been involved in sponsoring health maintenance organizations as outreach strategies. Several of the larger teaching hospitals in the Chicago area have sponsored HMOs and established branches throughout the metropolitan area, including areas they may not have penetrated through their voluntary staffs. There are several good reasons for a hospital to

sponsor an HMO, including possible reduction of its own health benefits costs and helping to participate in reform of the health care system.

However, hospital executives must understand the implications of the inherent conflict of interest between the HMO and the hospital before embarking on such a course. If a captive HMO is to meet its economic objectives and minimize its fee levels, there are powerful incentives to minimize reliance on the parent hospital and seek out less expensive hospital settings closer to the patient's home or to the HMOs outlets, as well as to bargain aggressively for lower rates for the services the captive does choose to purchase from the parent institution.

In addition, because the HMO delivers most of its care in an ambulatory setting and deals with a great amount of self-limiting disease, and because of the utilization controls the HMO imposes on hospitalization, the rate of admission of patients per quantum of HMO visits is likely to be far lower than from the hospital's own emergency room or outpatient clinics. Ellwood's estimate that it takes an HMO enrollment of 100,000 persons (which only 12 health care plans have yet achieved in the United States), to support a 200-bed hospital suggest that HMOs may not be an effective method of sustaining or increasing hospital use.

As far as the major actors in the HMO markets, there have thus far been four-hospitals, physician groups, community/employer based groups, and insurance companies. Many HMOs started during the early 1970s were sponsored by community and employer organizations, though as mentioned above, IPA growth has increased in the last five years, as have insurance company sponsored plans. With the exception of insurance company based plans and Kaiser, these groups have tended to be under-capitalized, requiring reliance on federal grants and loan guarantees, and undermanaged, reflecting their inability in many cases to recruit competent personnel. Managing the start-up phases of any new venture is a difficult undertaking. For reasons mentioned above, hospitals are unlikely to form many additional HMOs. Federal funding is more likely to be withdrawn than to grow. To the extent that the field is to grow, it may be the insurance companies, including Blue Cross, and the hospital management firms that will be the dominant presence in the HMO market. These organizations have extraordinary access to capital, as well as extensive marketing expertise and access to corporate benefits programs.

HMOs owned or operated by large national firms currently account for about 60 percent of all HMO enrollment. A listing of HMOs owned or managed by national firms may be seen in Figure 4-2. If the federal government caps its loan guarantee program, as has been proposed in the fiscal year 1982 federal budget, further infusion Of capital into this market will come from the private sector. In this case, penetration by the national firms will increase, making them the dominant force in the HMO sector.

FIGURE 4-2
HMOs owned or managed by national firms

	Number of plans	Enrollment
Kaiser	8	3,876,000
Blue Cross	39*	782,000
INA	6	391,000
American Medical International	4	110,000
Charter Medical	5	103,000
Connecticut General	2	67,000
Prudential	4	48,000 ⁺
CNA	2	43,000
SAFECO	4	38,000
Total	<u>74</u>	<u>5,447,000</u>

* Does not count 30 which receive extensive technical and management assistance from Blue Cross.

⁺ Includes 11,000 in joint venture with Kaiser in Dallas, Texas.

Source: *Interstudy*, telephone conversation with Research Department.

This movement by the national firms, while a defensive strategy primarily, reflects sound corporate planning and a belief that the future profitability of their conventional lines of group health insurance may be compromised by growing employer resistance to passing through escalating health care costs. Insurance companies may be willing to diversify into alternative delivery systems to protect their market share and enrollment base, even at the price of substantial initial subsidies. They are by far the best capitalized potential actors in the system. Since HMOs deliver care as well as finance it, insurance industry entry into the health maintenance market moves them into the business of organizing and delivering health care. How far the insurance firms are willing to tread along this possible path of integration will be one of the most interesting developments to watch in the next 15 or 20 years.

NOTES

1. Harold S. Luft, "How Do Health Maintenance Organizations Achieve Their 'Savings'?" *The New England journal of Medicine*, June 15, 1978, p. 1337.
2. *Ibid.*, p. 1336.
3. *Ibid.*
4. American Medical Association Council on Medical Service Information, distributed as background data for the Council on Medical Services Report A (A-80): "Study of Health Maintenance Organizations," (Chicago: American Medical Association), p. 16.
5. *Ibid.*
6. *Ibid.*, p. 15.

7. *Interstudy*, "July 1980 Survey Results: HMO Enrollment and Utilization in the U.S." (Excelsior, Minnesota: *Interstudy*, July 1980).
8. Ibid.
9. Louis Harris and Associates, "American Attitudes toward Health Maintenance Organizations" (Menlo Park, California: The Henry J. Kaiser Family Foundation, July, 1980, p. 13.
10. United States Department of Health and Human Services, "National HMO Census, 1980" (Washington, D.C.: Public Health Service, 1980),
p. 2.
11. Blue Cross/Blue Shield Association, telephone conversation with Department of Alternative Delivery Systems, July 24, 1981.
12. John K. Iglehart, "HMO's-An Idea Whose Time Has Come?" *National journal*, February 25, 1978, p. 314.
13. Harris and Associates, "American Attitudes toward Health Maintenance Organizations," p. 4.
14. Ibid.
15. Ibid., p. 20.
16. Paul M. Ellwood, Jr. and Michael E. Herbert, "Health Care: Should Industry Buy It or Sell It?" *Harvard Business Review*, July-August, 1973, p. 99.
17. Frances Cunningham and John Williamson, M.D. "How Does the Quality of Health Care in HMOs Compare to That in Other Settings? An Analytic Review of the Literature, 1958-1979," *Group Health journal*, Winter 1980, pp. 2-23,
18. American Medical Association, "Study of Health, Maintenance Organizations," p. 20.
19. Geisel, Jerry, "25% of HMOs Could Die of Thirst if Congress Turns Off Funding Spigot," *Modern Healthcare* (June 1981), p. 106.
20. American Medical Association, "Study of Health Maintenance Organizations," P. 125,
21. Ibid.