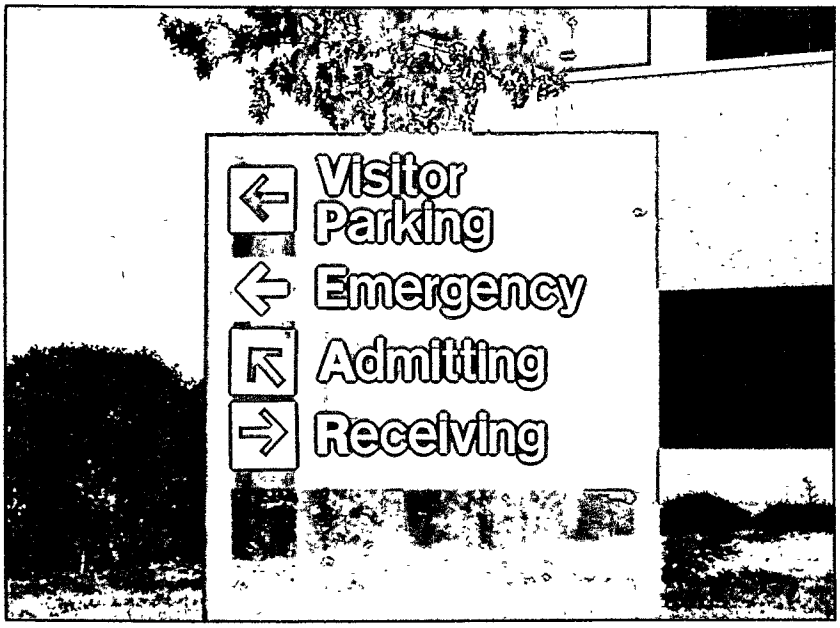

Carol Majors

Health Maintenance Organizations Arrive in North Carolina

What are Health Maintenance Organizations (HMOs) and where did they come from? What are the main differences in group practice and individual practice association HMOs? What are the advantages and disadvantages claimed by HMO supporters and skeptics? Specifically, do HMOs help hold down health care costs? Finally, what policy questions lie ahead for North Carolina policymakers and regulators? This article answers these questions in an effort to provide a primer on the HMO wave hitting the North Carolina health care scene.

by Robert Conn

Nearly five decades after it began in California, a prepaid approach to health care has finally taken hold in North Carolina and is growing rapidly. The approach is called a Health Maintenance Organization, HMO for short. HMOs aim at holding down costs while improving care. While critics have raised questions about whether HMO can adequately serve the entire population as well as traditional fee-for-service health care, HMO advocates point to the benefits for consumers, doctors, and businesses.

To the consumer, HMOs mean an end to nearly all medical claims forms, co-payments, deductibles, and other inconveniences Americans have come to expect in getting medical care. Instead, people who choose to become a member of an HMO pay a set monthly fee in advance for comprehensive primary health services—check-ups, routine tests, immunizations, treatment of illness and injury, and hospitalization.

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To the doctor, HMOs reverse incentives, from an approach in which more service means more money to an approach in which income can increase as costs are held down. HMOs accomplish this by having doctors share in the financial risk when their patients get sick. In other words, doctors can benefit by working to keep their patients well.

To the businessman, HMOs offer a chance of stanching the hemorrhage on their company's profits caused by ever-rising health care costs. HMOs can dramatically lower the use of hospitals and perhaps paperwork as well.

The wave of HMOs hitting North Carolina has brought added responsibilities to state officials. The growth of HMOs poses a threat to some hospitals because HMO members use hospitals far less often than people with traditional health insurance. Health policy planners will have to incorporate the HMO model into their long-range planning. In addition, and more immediately, HMOs offer new challenges to the N.C. Department of Insurance, which has the responsibility for licensing and monitoring the operation of HMOs in this state.

Currently, at least six different HMO plans are operating around the state, several of them in more than one city (see box on page 62). North Carolina has one veteran HMO, called Winston-Salem Health Care Plan, which R.J. Reynolds has operated for its employees for years. In the last two years, several major national HMO organizations have come into the state. And there is talk of more.

In 1982, Blue Cross and Blue Shield (BC/BS) of North Carolina started the first publicly available HMO in North Carolina. Called the Personal Care Plan, it has signed up, in Forsyth County alone, 50 percent of the employees of Forsyth County, 45 percent of those at Piedmont Publishing Co., and 60 percent at Unique Furniture Makers. "We're averaging 30 to 35 percent," said John Sharp, executive director of alternative delivery systems for Blue Cross and Blue Shield of North Carolina. "Normally 10 to 12 percent is very good."

In 1984, HealthAmerica, the nation's largest independent, investor-owned, operator of HMOs, began functioning in the state. In seven months, it has signed up 17,800 members. Among employee groups, the participation rate has reached as high as 66 percent (Durham city employees, 820 out of 1,250).

Three other major groups have laid the groundwork—getting licensed, signing up doctors, preparing the administrative base, etc.—and are scheduled to begin serving patients in early 1985: Kaiser Permanente, PruCare, and Carolina Medical Care. By January 1, 1985, an estimated 36,600 North Carolinians were enrolled in the five HMOs open to the public.[1]

The growth of HMOs in North Carolina trails the national trend. From 1977 to 1983, membership in HMOs nationally more than doubled, from 6.3 million to 13.6 million.[2] By the end of 1983, 290 HMOs were in operation, according to an analysis by InterStudy, a Minneapolis-based health policy research organization. The report shows 48 metropolitan areas have at least four HMOs. Boston, Los Angeles, San Francisco, Providence, Anaheim, and Philadelphia have at least 10.

In California, HMOs claim 21 percent of the population as members, followed by 17 percent in Minnesota, 12 percent in Oregon, 11 percent in Wisconsin, and 10 percent in Arizona. Nationally, InterStudy projects 50 million HMO members by 1993. At least six national HMO organizations—Kaiser Permanente, Blue Cross and Blue Shield, HealthAmerica, Prudential, CIGNA, and Maxicare—are rated by experts as strong enough to go into virtually any new market with assurance of success.

The gains have come despite a shaky period in the 1970s, when a number of HMOs failed. Today, complete HMO failures are rare, thanks in part to tightening state and federal laws and tougher supervision by state insurance departments around the country. In addition, national HMOs have been willing, even eager, to assist and perhaps take over floundering local HMOs. Usually, these weak HMOs become sound under new management.

In 1980, for example, HealthAmerica, a for-profit organization, came to the rescue of Penn Group Health Plan in Pittsburgh. Founded in 1974 and in financial trouble by the late '70s, Penn Group required shoring up by millions in federal loans. HealthAmerica offered capital, management, and marketing expertise to Penn Group in exchange for a long-term management contract and an option to buy. Since then, Penn Group has grown from 19,000 to over 50,000 members, and HealthAmerica has moved to exercise its option to buy.[3]

In another example, Kaiser Permanente Medical Care Program has taken over the operation of several financially troubled HMOs, one in Washington, D.C., and one in Hartford, Connecticut, and made them successful. Since Kaiser Permanente rescued the Georgetown Community Health Plan in Washington, its membership has grown from 50,000 to 140,000.

Yet all HMOs do not survive. The Moshannon Valley Comprehensive Health Care Program, sponsored by Pennsylvania Blue Shield and Blue

Cross of Western Pennsylvania, stopped operating last July.[4]

Experts express concern that most states, North Carolina among them, have not yet geared up insurance department staffing to properly monitor HMOs. And there is a more fundamental concern.

"As the HMO achieves a more pivotal role in the nation's health care delivery system, the responsibilities of state regulators become more difficult and more important," says a report by Aspen Systems Corp. prepared for the Federal Bureau of Health Maintenance Organizations.[5] "Officials must be aware of the delicate balance between too much or inappropriate regulation that impedes HMO development and operation and too little regulation which may endanger HMO subscribers. Clearly, some regulation of HMOs is necessary and desirable to protect the consumer of HMO services from fraud or financial loss."

How HMOs Work — the Basics

The HMO movement began in 1929 with the Ross-Loos plan in Los Angeles, where physicians formed a group practice prepayment plan. It is still in existence today, as are two other early HMOs—the Kaiser Permanente Medical Care Program, founded in California in 1934, and the Group Health Association, formed in Washington, D.C., in 1937. Today, Kaiser Permanente serves 4.6 million members and is signing up members in North Carolina.[6]

Numerous variations have evolved on the basic HMO theme, but there are two broad types: the Group Practice Model and the Individual (or Independent) Practice Association (IPA). Both types of HMOs deliver comprehensive health services for a fixed prepaid monthly fee. Under both systems, HMO patients are guaranteed specified services regardless of how many times they see the doctor, and the doctor gets paid even if the patient rarely needs attention. Joining an HMO is always voluntary, and a person has a choice, annually, whether to change plans. An HMO, the group practice or IPA model, might be for-profit or not-for-profit, and either model could be part of a national chain or a local, independent organization.

Group Practice Model. Group practice HMOs provide out-patient services in one or several medical offices owned or operated by the plan. All primary care is provided in those facilities, which usually offer extended hours and essentially one-stop service. With group practice HMOs, patients have fewer choices of primary care physicians than with the IPA model.

Three of the groups now either operating or

What is an HMO?

A health maintenance organization provides comprehensive health care under a fixed, prepaid fee arrangement. Patients are guaranteed care for this price, regardless of how many times they visit the doctor. Doctors contract with the HMOs and usually have some financial incentives to help keep patients well. HMO models range from single clinic sites with staff physicians (where patients have a minimum of choice as to doctor) to arrangements where most doctors in the city can affiliate with an HMO (allowing most patients to keep their same doctor). HMOs fall into two general categories: the group practice model or the IPA (Individual Practice Association) model (see main article for more).

If HMOs are "federally qualified," they probably achieve added credibility. In past years, federally qualified HMOs also could receive federal financial assistance. To be federally qualified, an HMO must offer these minimum servcies:

- Physician services—including primary care doctors, consultants, and referrals.
- Inpatient and outpatient hospital services.
- Emergency services, both in and outside the HMO's service area.
- Diagnostic laboratory services.
- Both diagnostic and therapeutic radiology.
- Home health services.
- Preventive health services, including periodic health examinations for adults, well-child care from birth, pediatric and adult immunizations, family planning and infertility services, and eye and hearing exams for children.
- Health education.
- Medical social services.
- Mental health services, including up to 20 outpatient visits.
- Diagnosis, treatment, and referral for alcohol and drug addiction.

in the planning stages for North Carolina are following the group practice model. The California-based Kaiser Permanente Program which is non-profit, is starting a group practice HMO in the Raleigh-Durham-Chapel Hill area.

Called the Kaiser Permanente Medical Care Program, the HMO will initially provide primary care by developing their own medical group (probably only four doctors in the beginning). This for-profit group, called Carolina Permanente Medical Group, will be responsible for all professional services to the HMO members and for contracting with local physicians for specialty care. The group physicians work entirely with HMO members, who may choose their personal doctor among the group's physicians.

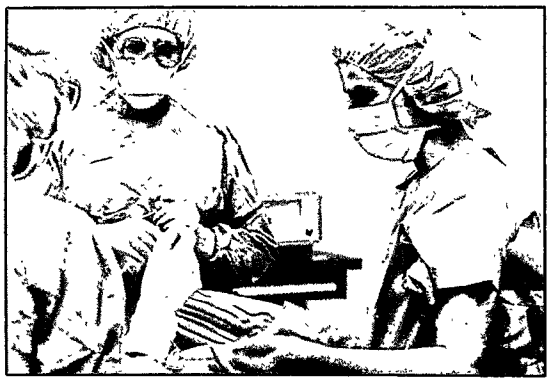
The Kaiser Permanente HMO will have enough doctors to take evening calls, said Alvin Washington, vice president and regional manager for the national Kaiser Permanente organization, and will contract with area specialists as needed. Eventually, the group will add specialists to the full-time staff and projects having 14 physicians by the end of 1985. Washington does not expect the group to operate a hospital, like some Kaiser Permanente units on the west coast, but rather to contract with existing community hospitals for in-patient care.

Another group practice model in North Carolina is PruCare of Charlotte, a subsidiary of the Prudential Insurance Company of America. PruCare is affiliating with the Nalle Clinic, a multispecialty group practice with more than 50 physicians at three sites. PruCare members will go to the Nalle Clinic for primary care, and for most specialty care.

The Winston-Salem Health Care Plan is an even more restrictive group practice arrangement. It uses a staff model with salaried physicians. It does make referrals for specialty care.

The Individual (or Independent) Practice Association (IPA). HMOs following the IPA model use existing primary care physicians who work in their own offices and continue to see their traditional fee-for-service patients. In most IPAs, the patient has a choice among participating primary care doctors—internists, family physicians, pediatricians, and sometimes obstetrician-gynecologists. Doctors may belong to more than one IPA group, as many have done in Charlotte. Three of the six HMOs in North Carolina are using the IPA model.

The Blue Cross and Blue Shield Personal Care Plan, the oldest IPA in North Carolina, has signed up about 900 physicians in the Research Triangle area, including primary-care doctors and specialists. So far, 15,000 people have enrolled as patients. The BC/BS plan has a similar track



record in Winston-Salem (140 doctors and 3,500 patients signed up) and in Charlotte (135 doctors and 250 patients).

A key element to the BC/BS HMO is its risk fund. Specialists agree to accept reimbursement from the plan as payment in full, with part of that payment going into a risk fund. If the program has a surplus, the doctors get back the money from the risk fund at year's end. In addition, doctors receive half of the year's overall surplus in the program, a further incentive to hold down costs.

The second IPA model to develop in the state is the HealthAmerica variation, where *primary care* doctors contract with the HMO. HealthAmerica refers to these physicians as the "gatekeepers" of the HMO members' health care needs. The primary care doctors determine when their patients need specialists and then arrange for that care on a fee-for-service basis. The primary care doctor has financial incentives to find a cost-effective specialist—one who offers the most appropriate care at the most reasonable cost. The specialist, for example, could charge more for his services but get the patient out of the hospital faster, making the overall bill lower than that from another doctor with lower fees. Unlike some IPAs, HealthAmerica does not restrict referral. Primary care doctors may use the services of any appropriate specialist.

The number of primary care doctors in HealthAmerica's network are: 41 doctors in 13 locations in Charlotte, 76 physicians in 26 locations in the Triangle area, 73 physicians in 32 locations in the Triad, and 28 doctors in 5 locations in Greenville, where the group began service in January.

The third IPA-type program is Carolina Medical Care in Charlotte, where primary care doctors will receive a fixed monthly fee. Specialists will be paid based on a set of uniform fees. All participating doctors will share in hospital savings. In all, 378 Charlotte doctors have joined Carolina Medical Care. When the overwhelming majority of a city's primary care doctors have

HMO Enrollment in North Carolina, January 1985

HMO	Location	Doctors	Enrollees
Blue Cross and Blue Shield of N.C.: Personal Care Plan	Triangle	900	15,000
	Winston-Salem	140	3,500
	Charlotte	135	250
	Greensboro	100	250
	Total	1,275[1]	19,000
Carolina Medical Care	Charlotte	128 (prim. care) 250 (specialists)	300
	Total	378	
HealthAmerica	Triangle	76 (prim. care)	6,300
	Triad	73 (prim. care)	8,900
	Charlotte	41 (prim. care)	1,300
	Greenville	28 (prim. care)	1,300
	Total	218 (prim. care)[2]	17,800
Kaiser Permanente	Raleigh	4 (prim. care)[2]	600
	Durham (March 1)	—	—
	Charlotte (July 1)	—	—
Pru-Care[3]	Charlotte	55	—
Statewide Totals		1,930[4]	36,600

FOOTNOTES

[1]This figure includes both primary care doctors *and* specialists. It includes medical school physicians who treat patients but not those who only teach or only do research.

[2]Both HealthAmerica and Kaiser Permanente do not plan to sign up specialists at the present. Kaiser Permanente will contract with specialists as needed; HealthAmerica expects its primary care doctors to arrange for specialty care as needed.

[3]As of mid-December, Pru-Care was still awaiting state approval, so had not enrolled anyone. The 55 doctors are members of the staff of the Nalle Clinic; only Nalle Clinic doctors will serve this HMO.

[4]The statewide total for doctors is artificially high, because many doctors in Charlotte, Winston-Salem, and Raleigh have signed up for more than one HMO.

Source: Telephone interviews by Robert Conn.

affiliated with an IPA, as is the case with Carolina Medical Care, the odds are great that a person can sign up for the IPA and go on seeing the same doctor.

Federal Regulations and State Responsibilities

The national corporations may use different models in different locales to suit the local situation. Blue Cross and Blue Shield has 57 HMOs nationally, with 1.8 million members. They include 8 staff models, 10 group practice models, and 39 that are classified under federal standards as IPAs, although 26 are variations.

Christina Bowesz of the federal office of HMOs points out that since federal law requires employers, if asked, to offer both an IPA and a group practice HMO, companies starting business against a dominant local HMO will nearly always opt for the other model.

The federal requirement stems from the HMO act, which Congress passed in 1973. The act encouraged the development of HMOs by providing money for new ones, overriding restrictive state laws, and granting federal qualification to any HMO that met specific requirements (see box on page 60). The 1973 law requires an employer of 25 or more persons to offer employees the option of joining an HMO *if*

the company provides conventional health insurance and if a federally-qualified HMO asks the company for access to the employees.

The Reagan administration has since eliminated the grants, but the rest of the program is intact. More and more HMOs, including most of those in North Carolina, say they are seeking federal qualification. Kaiser Permanente, for example, became federally qualified in the state, effective January 1985.

The entrance of HMOs into North Carolina came about as the direct result of the actions of the N.C. Commission on Prepaid Health Plans, which recommended the establishment of a nonprofit corporation to stimulate alternative health programs. The result was the N.C. Foundation for Alternative Health Programs, which not only has stimulated development of HMOs, but also encouraged other cost-cutting measures.[7]

Glenn Wilson of the UNC School of Medicine, who chaired the commission, is proud of another result—revision of the state's HMO act. He said the revisions made the act substantially better than the national model act proposed by the National Association of Insurance Commissioners.

North Carolina's HMO Act, Chapter 57B of the N.C. General Statues, is considered close to the national model HMO law, with some major exceptions. The law gives the N.C. Insurance Commissioner the job of granting HMOs a certificate of authority (i.e., a license to operate) and the task of monitoring their operations. The type and degree of monitoring depends in large part upon the skill of the Insurance Commissioner and his staff. The law allows for monitoring of virtually all aspects of an HMO operation, from its advertising to its contracts with doctors. The state law, unlike the federal law, does not, however, specify the minimum services an HMO must deliver.

Advantages of HMOs

In promotional literature, HMOs list at least five reasons why *employees* like HMOs:[8]

1. Comprehensive coverage that stresses preventive care. Because checkups, immunizations, and pregnancy care are provided under the single monthly fee, HMOs are far more comprehensive than traditional health insurance.

2. No hidden or surprise costs. The patient doesn't have to worry about taking a checkbook to the doctor's office, nor about deductibles or coinsurance.[9] Instead, HMOs turn medical care into a fixed monthly cost, rather than one of the scariest variables in a household budget.

3. Quality care. This claim is more difficult to document, and in fact is one area in which traditional health insurance companies challenge HMOs. But HMOs argue that since the primary care doctor becomes the patient's advocate in selecting specialists, higher quality specialists are chosen than when the patient is left to his own devices. In addition, HMOs point to their organized quality assurance system, a system that does not exist in most fee-for-service situations.

A recent American Medical Association study noted the difficulty in measuring quality, but found after studying HMOs, "The medical care delivered by the HMOs appears to be of a generally high quality." The comment is important because at one time, organized medicine opposed HMOs.[10]

In 1980, Dr. John Williamson of Johns Hopkins School of Hygiene and Public Health and one of his students analyzed 27 studies that compared care received by group practice HMO members with those in fee-for-service. In 19 studies, the quality of care in HMOs was superior, and in the remaining 8, it was rated as equivalent. None of the studies showed HMOs had lower quality. They concluded, "There is little question that facility-based HMO care [i.e., group practice] is at least comparable to care in other health care facilities, if not superior."[11]

4. No claims forms. They're not needed except in rare instances when a patient goes outside the prepaid system for a service that is included.

5. Guaranteed access to health care. A consumer always has a place to go—the HMO doctor. Under the traditional fee-for-service system, patients might have trouble finding a doctor.

The promotional literature says *employers* like HMOs because they:

1. Help control health care costs. Not only are hospitalization rates substantially lower than under traditional fee-for-service plans, but doctors are given incentives to increase efficiency and cut costs while maintaining quality of care.

2. Stimulate competition. The HMOs cite studies in New York, Minneapolis-St. Paul, Hawaii, and Rochester that show that traditional health insurance becomes more comprehensive when faced with HMO competition.[12]

3. Encourage good health habits, aimed at handling problems before they become expensive to treat. Because prevention is covered, members can justify annual physicals.

4. Reduce paperwork. They point to a hidden cost of most traditional insurance plans—the need for companies to have squads of clerks to cope with forms and claims and ques-

tions about coverage. Virtually all of this disappears with HMOs. Some national companies say those savings don't always hold, because they can deal with one insurance carrier nationally, while having to cope with a myriad of HMOs in each community.

Do HMOs Hold Down Costs?

The most important advantage claimed by HMOs is holding down health care costs. Though difficult to document, the evidence is mounting. "The evidence has been accumulating since the early 1960s that the out-of-pocket costs are significantly lower for persons involved in group practice HMOs than for persons with traditional health insurance," said Glenn Wilson of UNC.

... HMOs stress going to the doctor at the first sign of illness rather than waiting until you have to ...

All three major automakers now claim HMOs are saving them money. According to a report in *Business Insurance,* Ford Motor Co. says the 23 HMOs it offers employees will save it $7 million this year over the traditional health plans. The premiums are 16 percent less than those from traditional insurers, according to Ford officials. Last year, Ford documented $5 million in savings. Ford is planning to add HMOs in Florida, primarily for its retirees.[13]

According to *Business Insurance,* Chrysler is so supportive of its 12 HMOs that it gave away $50,000 to HMO members who signed up non-members, at the rate of a $50 savings bond for an individual, $100 bond for a couple, and $250 bond for a family. Delores McFarland, benefits administrator for General Motors, estimates GM's savings in the millions.

Other companies, like American Telephone and Telegraph and International Business Machines Corp., aren't so sure they save money, and are still studying the question.

Meanwhile, long-term research studies add to the evidence. The most convincing is a study by the prestigious Rand Corporation recently published in the *New England Journal of Medicine.*[14] This study represents a distinct departure from previous ones, because freedom to choose an HMO was eliminated. Healthy patients who had been getting traditional fee-for-service care were randomly assigned to continue fee-for-service care or go to an HMO. The HMO was the Group Health Cooperative of Puget Sound (GHC), a 37-year-old HMO in Seattle that has an enrollment of 324,000 people—roughly 15 percent of the Seattle-area population. The results were compared to a control group of regular GHC members. Under this study design, the Rand Corporation compared HMOs to fee-for-service systems while both were serving comparable populations with comparable benefits. The results were striking.

The rate of hospital admissions in both GHC groups was just over 8 for every 100 patients, about 40 percent less than in the fee-for-service group, which averaged nearly 14 admissions for every 100 patients. Overall health expenditures were about 25 percent less in both GHC groups ($439 per year in the GHC experimental group, $469 per year in the GHC control group) than in the fee-for-service group ($609 per year). But visits to the doctor's office occurred at roughly the same rate in both groups—a little over four visits per year.[15]

The two GHC groups turned out to be similar in the mix of health risks, which suggests there is no substantial difference between people going for traditional medical care and those who choose HMOs. The Rand team notes the overall results were in line with previous studies showing HMOs had 10 to 40 percent fewer hospitalizations than fee-for-service physicians. The Rand study concludes, "The style of medicine at prepaid group practices is markedly less 'hospital intensive' and consequently, less expensive."

An editorial in the same issue by a well-known expert on health care costs, Dr. Alain Enthoven of Stanford University, noted that about 40 comparison studies have been done. They found that prepaid group practices reduce per capita costs some 10 to 40 percent, "largely as a result of a 25 percent to 45 percent reduction in hospital use. Although these findings have been replicated in many different employee groups and in studies that controlled for age and sex and sometimes tested for measurable differences in

The Latest Wrinkle in Health Insurance: Preferred Provider Organizations

In a nutshell, preferred provider organizations—PPOs—agree to provide service to a specific pool of individuals, usually from an employer or group of employers, at a previously agreed fee. The individual can continue to go to doctors who don't participate in the PPO, but the plan usually pays a larger share of the bill if the patient goes to the PPO. The key is the discounted fees.

According to a report from the N.C. Medical Society, "This concept is attractive to the employers as a means of identifying cost-effective providers for their employees."

Three PPOs are in operation in North Carolina: the Triad Physicians Health Care Plan in Forsyth County, Health Point Preferred in Forsyth County, and Med-Select of Guilford County.

There's a question whether preferred provider organizations can or should be regulated, because they are still based on fee-for-service. Some argue they are sufficiently like HMOs to be regulated like HMOs. Regulation of PPOs is currently being debated around the country. They are not regulated in North Carolina.

FOOTNOTE

[1]"Alternative Delivery Systems in North Carolina: A Status Report," published in the *N.C. Medical Society Bulletin,* August 1984. This four-page report includes a glossary and a chart outlining the various components of four HMOs and three PPOs.

health status," he said, "the suspicion has always remained that somehow these savings might be explained by a self-selection of healthy people for membership in group practices."

Enthoven concluded the *New England Journal* editorial by emphasizing the practical implication of the Rand study: "The conclusion is now well established: the lower cost at GHC and others like it cannot be explained by differences in the population it treats."

The studies keep emerging, many of them focusing either on lower hospitalization rates or lower surgery rates—with both types addressing the overall issue of lower costs through HMOs. In Wisconsin last year, for instance, hospital admissions under the standard health plans averaged 124 for every 1,000 members, compared to 80 for Madison-area HMOs, and 83 for Milwaukee-area HMOs.[16] Sidney Wolfe, director of Public Citizen's Health Research Group, cites studies showing the number of operations performed is less under HMOs than under fee-for-service.[17] One study showed fee-for-service patients had 1½ times as many hernia operations, twice as many hysterectomies, gall bladder operations and appendectomies, and four times as many tonsillectomies.

Another cost-saving factor in all types of HMOs is prevention. Doctors try to head off illness through immunization, by promoting lifestyle changes, and by catching a disease early when it is still inexpensive to treat. This means, in contrast to most standard health insurance plans, that physicals and immunizations are free. Hence, HMOs stress going to the doctor at the first sign of illness rather than waiting until you have to go. Preventing illness may mean fewer employee absences, a hidden benefit of HMOs. The test is in the success of prevention. Early detection of clogging arteries may help doctors head off heart attacks and strokes. Indeed, one major crippling stroke easily could cost more to treat than the cost of annual physicals in an HMO with 1,000 members.

The American Medical Association's Council on Medical Services sums up the cost-saving issue: "HMOs appear able to provide care for their members at a lower total cost (premiums plus out-of-pocket) than most other health care delivery and financing systems."

Disadvantages of HMOs

Critics of HMOs include among their list of disadvantages the areas outlined below. Some often-stated disadvantages of HMOs are disappearing as laws and regulations change.

1. HMOs save money by enrolling younger, healthier people who don't need much care—a practice known as skimming the cream. People who already are sick are reluctant to change doctors in midstream. A switch to an HMO often requires a shift in doctors because the family

doctor isn't affiliated with the HMO.

Large corporations who have studied the matter challenge the cream skimming thesis. Xerox Corp. officials now believe, according to *Business Insurance,* that those who have had illnesses or anticipate hospitalization are more likely to join HMOs.

HMO officials say they can do little to influence selection. Most employers offer the choice of HMO or traditional health insurance to every employee, regardless of whether they are sick.

While the Rand study found no difference between these groups, the *New England Journal of Medicine* editorial took both sides. "In some Medicare experiments, it appears that the beneficiaries who were more willing to change doctors and join a prepaid group practice were those who had not been sick recently," said the editorial. "On the other hand, if the fee-for-service insurance plan has sizable coinsurance or deductibles or poor coverage of office visits, patients with chronic conditions will be attracted to the comprehensive coverage offered by a prepaid group practice."

2. HMOs fail to serve the elderly, whose medical expenses are often highest. If this has been true in the past, it is rapidly changing. Under the latest Medicare regulations—the so-called TEFRA Act, which is expected to take effect by year's end—Medicare recipients in areas where there are HMOs will get the chance to choose an HMO for medical care. This has the potential for opening up the large Medicare market to rapid penetration by HMOs or competitive medical plans. Margaret Heckler, Secretary of Health and Human Services, predicts 600,000 Medicare recipients will sign up with HMOs in the next three to four years.[18] Besides, some HMOs, such as HealthAmerica, already enroll Medicare members who have retired from a participating employer.

3. HMOs fail to serve the poor and medically indigent. Growing numbers of Medicaid recipients across the country are getting the chance to sign up with broad, community-based HMOs. All HMO members have access to the same care, whether their monthly fee is paid by an employer, Medicare, or Medicaid. (In the 1970s, some HMOs were made up predominantly of poor people, which meant services were not as comprehensive.) California has found that it costs 17 percent less to enroll low-income people in HMOs than it does to pay for care under its Medicaid program, MediCal. Furthermore, state officials say audits show the quality of care for low-income people is higher with HMOs than fee-for-service.

Barbara Matula, director of the N.C. Division of Medical Assistance, which oversees the Medicaid program, said, "We're ready to go once the HMOs are ready. We've had authority to buy in from the General Assembly, and approval from the [federal] Health Care Financing Administration to do it."

People who are already sick are reluctant to change doctors in midstream.

4. Patients don't have much choice about what's done to them. The primary care doctor, not the patient, often chooses the specialist. Sometimes, the HMO is so small that there's no choice at all, which means the HMO patient has little to say about which doctor operates on him or which specialist treats his most severe illnesses. "You often are not told what your options are," said Clark Havighurst of Duke University. "The HMO doesn't hospitalize as often, and that means you may be deprived of hospital care without it being offered to you. The HMO does what it thinks is best."

5. Doctors may stop treating patients when the money runs out. There's no evidence that happens, according to a number of experts, who cite both the quality of care studies and the studies showing that malpractice suits occur at about the same rate among HMOs as they do in fee-for-service.[19]

6. A number of HMOs have collapsed. This threatens patients with loss of medical care despite having paid for it. Anthony Buividas, a consultant for Carolina Medical Care from the American Health Management and Consultant Corp., said most HMOs that failed have been poorly managed. They made inadequate projections of expenses on which to base premiums. Sometimes, they simply didn't achieve the membership projected, or fell short of the break-even point, he said. Recent changes in the model law, largely adopted in North Carolina, attempt to head off any questions of insolvency.

7. HMOs are corporate practice of medicine. That charge has been leveled against HMOs from the beginning. But the argument probably

is not nearly so strong in North Carolina as it is elsewhere, because most HMO members in North Carolina belong to IPAs. Consequently, doctors are treating their HMO patients alongside traditional fee-for-service patients. Even doctors belonging to some group practice HMOs, such as PruCare, will continue to have fee-for-service patients.

The AMA's study found, "Some HMO members do express dissatisfaction with the perceived lack of personal physician-patient relations . . . . However, members generally appear to find the system more acceptable as they become used to it and balance 'impersonality' against availability of technical expertise and the HMO's perceived financial advantages."

But Havighurst is concerned that IPAs are too close to organized medicine, that often IPAs are formed under the auspices of the local medical society or by doctors who have been in medical society leadership. "Some of these plans were created to scare off other HMOs," he said.

Currently, N.C. law does not speak to this issue explicitly.

What Policy Questions Are Ahead?

In the months ahead, the state is likely to see increasing competition among HMOs, as they reach out to most employers in the state, as they seek a hand in treating the huge number of state employees, as they go after Medicare and Medicaid business. Furthermore, most HMO officials say the HMOs themselves do better when they compete, with increasing percentages of the population becoming involved with HMOs. One critical job of the state Department of Insurance is to make sure that competition is fair. But what does "fair competition" entail, as a practical matter, when it comes to state regulation, monitoring, and oversight? As the Department of Insurance begins coping with the HMO boom coming to the state, seven major policy questions will have to be addressed.

1. What should the Insurance Department do to properly monitor HMOs? HMOs are regulated by insurance departments in nearly every state.[20] The theory is that HMOs are like insurance companies because people buy care for a specified period of time. In some states health officials also are involved, particularly in examining quality of care. In North Carolina, the Department of Human Resources was involved in monitoring HMOs under the original HMO statute, passed in 1977.[21] In 1979, the legislature placed this responsibility under the Insurance Department.

Today, the Insurance Department appears more prepared for the licensing function than for other responsibilities regarding HMOs. Gordon Church, general manager of HealthAmerica of North Carolina, found the Insurance Department staff members "very thorough" in their review of the firm's application for a license to operate in the state. The license period took from September 1983 until March of 1984, a period more extended than in Virginia, Louisiana, and Alabama where HealthAmerica applied at about the same time.[22]

"In each case, the licensure process was less extended than it was here in North Carolina," Church said. But he added that the Nashville-based HealthAmerica was the first national organization to establish an HMO in this state.

Many analysts point out, however, that the key national problem is lack of adequate staffing in insurance departments trained to monitor HMOs, *once licensed.* People both in and out of state who had looked at the North Carolina law and the N.C. Department of Insurance repeatedly echoed that concern.

"The whole health end of the Insurance Department's staff need to be beefed up," said Jim Bernstein, president of the N.C. Foundation for Alternative Health Programs. The department has been too laissez-faire in the past on health matters, he said. But now, with HMOs, the health end is "taking on such importance it needs a whole bunch of new people."

The new Insurance Commissioner needs to add first class staff both to the HMO side and the health insurance side, continued Bernstein. Staffers "don't know things they should know." For one thing, no one knows the people who have been carrying health insurance and drop it because of a rate increase. "I see a real problem in a rural state with people going bare or with so little insurance it is meaningless."

Under the law, the N.C. Insurance Department has to review quarterly financial statements by HMOs, approve rates and changes in benefits packages, and approve advertising. Erling

Hansen, general counsel of the Group Health Association of America, the organization for Group Practice HMOs, said under present law, the N.C. Insurance Commissioner "does have sufficient authority to keep fly-by-night operations out of the state."

But he warned that as HMOs become successful in North Carolina, the state may see "an influx of less esteemed operators. It has happened around the country." Insurance Department staff members must be ready to cope with such HMOs, he said. Many states are "beefing up the quality and size of the HMO regulatory staff," added Hansen. In states like North Carolina, where HMOs are just beginning, understaffing is common.

The two really critical issues, as Hansen sees it, are the continuing financial solvency of the HMO and the protection of HMO members in the event of HMO failure so patients won't be billed for care they have not received.

Christina Bowesz of the federal office of HMOs said that many states have ineffective systems "to do the work that the statutes require." Oftentimes, state insurance examiners "don't know how to examine HMOs." Bowesz cited California, Illinois, New York, and Texas as states where HMO staffers are the best, and the most technically knowledgeable.

2. Should states monitor quality of care in HMOs? The question is explosive. To Hansen and other HMO defenders, the issue really boils down to equity—what does the state do to monitor quality in the fee-for-service sector of health care? "We should be regulated in an equivalent manner," said Hansen. "The industry believes that the quality of care in an HMO setting is equivalent to, if not better than, the fee-for-service sector."

The Institute of Medicine found no evidence that HMOs have provided a poorer quality of care than other components of the health care system, nor did the Johns Hopkins or AMA studies.

Federally qualified HMOs are required to have a quality assurance program. A state might consider whether similar standards should be established for HMOs that are not federally qualified. However, this raises the interesting question: Would the quality assurance program apply only to the IPA patients of doctors who see both IPA patients and fee-for-service patients?

3. Are major changes needed in the state HMO Act? Few people think so. Wilson, who chaired the N.C. Commission on Prepaid Health Plans, said the N.C. law is better than the national model law, because it focuses on fiscal responsibility, on meaningful contracts ("so HMOs deliver what they say they will deliver") and on honest straightforward information on rates and benefits. The national model law attempts to mandate measurement of health status and "nobody knows how to do that."

"My preference is for a fairly flexible law," said Bernstein, "and a first class administration of the law by the Insurance Commissioner."

National experts agree that the N.C. law is a good one. Erling Hansen said the law is not only good for monitoring HMOs but also is "good from the consumer standpoint."

4. Should there be minimum services required under state laws or regulations? There are no minimum standards now under the state law—certainly nothing like the list of minimums required under federal law (see box on page 60). Virgil Marsh, manager of alternative delivery systems for the national Blue Cross and Blue Shield Association, pointed out one important twist to requiring minimum services. Many insurance departments have a political connection, he said. State regulators who insist that HMOs must cover a broad range of services may be doing so to make the HMOs noncompetitive with traditional insurance plans. For instance, several states have recently attempted to require HMOs to cover prescription drugs, a step that could cause HMOs financial hardship. Then companies who support the commissioner could keep the bulk of the business. The issue is complicated, especially when linked with mandatory "dual choice" (see number 5 below).

5. Should state law be amended to require "dual choice"? Dual choice means that employers

Recommendations on HMOs

1. Supervision of Health Maintenance Organizations should remain within the Department of Insurance. Staff should receive increased training to deal with the vastly increased business expected. A task force should be appointed to determine whether enough appropriate statistics are being kept and whether department staffers are being properly trained.

2. The state should negotiate with some or all HMOs to enroll Medicaid recipients.

3. The state should quickly move to offer HMOs to all state employees, perhaps using the equal pricing system.

4. Private employers should pay the same premium to each available health-care option—HMOs and traditional health plans.

who offer health insurance must in addition offer HMOs, if the HMO asks to be offered. The federal HMO law already requires such choice (if 25 or more employees)—if the HMO meets the federal qualifications. Indeed, that's a major incentive for HMOs to become federally qualified.

But the issue is a tricky one, because of the lack of minimum services for state HMOs. HealthAmerica's Church said that "dual choice may be helpful, if the state law is amended." If a new state law does require dual choice, however, added Church, it must include a minimum benefits package, and that might make it tough to regulate.

Others argue strongly against dual choice, saying it removes the flexibility of HMOs to compete with traditional health insurance. A special industry advisory committee, for instance, recommended against the mandated approach.

The issue may be moot, anyway, since HMOs are reluctant to use the law to force an employer to give them access to employees. A business could bow to the law and permit the HMO to come in, while quietly sabotaging the HMO effort. "I used to think mandatory dual choice was important," said Wilson. "Now I wouldn't worry about it."

Instead, most HMOs seek federal qualification because it amounts to a federal seal of approval. But Hansen pointed out that some of the nation's best HMOs—including the Group Health Cooperative of Puget Sound, the one studied by Rand—are not federally qualified.

6. Should employers (or the government) pay an equal amount for each available health plan option—traditional health insurance, group practice HMO, or IPA—with employees picking up the difference? According to the Rand research team, many employers are actually paying more for traditional health insurance than they would for HMOs. "If employers did pay an equal sum, price competition between HMOs and fee-for-service insurance plans could well increase."

In Wisconsin, the state decided on that approach for state employees, beginning in October 1983, and the percentage of state employees opting for HMO coverage jumped from 15 percent to 66 percent. In Dane County (Madison) this year, the state pays $67.72 a month for individuals and $169.34 for families for health care, whether an employee chooses an HMO or the traditional insurance plan. But health insurance costs $76.33 a month for singles and $188.16 for families, which means single employees must add $8.61 a month and families pay $18.82. All the HMOs are cheaper, and one asks for nothing from employees.

The new arrangement was not successful everywhere in Wisconsin, however. In Milwaukee County, most of the HMOs were more expensive than health insurance, and the majority of state employees stayed with the standard health insurance.[23]

7. Should the state Medicaid program provide HMOs as alternatives to traditional care? The crux of the argument for HMOs is their effort to prevent illness, to find disease early, and to deliver a package of health care services efficiently. Traditionally, because poor people could not afford routine medical care, they waited to seek help until the problem was severe. That often meant visits to hospital emergency departments—one of the most expensive ways to get care—and long hospitalizations.

But states increasingly are using HMOs to try to hold down Medicaid costs while encouraging Medicaid recipients to get substantially better medical care. In Wisconsin, contracts have been signed with many HMOs to permit Medicaid patients to sign up. Enrollment is expected to reach 10,000 in Madison and 30,000 in Milwaukee by 1985. But Glenn Wilson points out that such an arrangement doesn't begin to deal with poor people who don't qualify for Medicaid.□

FOOTNOTES

[1]Figures based on telephone interviews by the author; see the chart that details where these people are enrolled.

[2]From "HMO Status Report, 1982-83," published by InterStudy, the Minneapolis-based Health Policy Research Organization. These figures also are summarized in the Sept. 28, 1984, *American Medical News*, which also includes a useful U.S. map showing state-by-state percentages of the population enrolled in HMOs. Blue Cross and Blue Shield publishes similar figures, showing national enrollment in all HMOs of 12.4 million in June 1983, of which nearly 1.4 million were in Blue Cross HMOs. By June 1984, Blue Cross HMO enrollment was nearly 1.8 million; total HMO national figures weren't available. (See footnote 4 for more on resources available from Blue Cross and Blue Shield.)

[3]See the extended discussion of the Penn Group Health Plan in HealthAmerica's 1983 Annual Report, page 8.

[4]"Blue Cross and Blue Shield Plan Activity in Health Maintenance Organizations, 1984 Mid-Year Report," a publication of the National Marketing Division of Blue Cross and Blue Shield Association in Chicago, page 10, contains a wealth of information on HMOs run by Blue Cross and Blue Shield, including overall enrollment, summaries on numbers by type of HMO, top ten HMOs by enrollment, by growth, by sponsor, as well as detailed information on each Blue Cross HMO.

[5]From the sixth edition of "A Report to the Governor on State Regulation of Health Maintenance Organizations," prepared by Aspen Systems Corp. for the Bureau of Health Maintenance Organizations and Resources Development of the U.S. Department of Health and Human Services, page 6. This report includes 12 major charts giving dozens of state-by-state comparisons, from whether a state requires consumer representatives on HMO boards to the size of required cash reserves to financial reporting requirements. It was prepared under the direction of Karen S. Greenwood, J.D., editor, HMO Law Manual.

[6]See the extended discussion of the history of HMOs in the "Kaiser Permanente Medical Care Program Annual Report 1983, a 50-year perspective on American Health Care," pages 7-24.

[7]See *Interim Report, Volume I* (1979) and *Final Report, Volume II* (1980), N.C. Commission on Prepaid Health Plans. The N.C. General Assembly created this commission in 1978 (see Chapter 1291 of the 1977 Session Laws, 2nd Session).

[8]See, for instance, the promotional literature put out by PruCare.

[9]Deductible is what you have to pay before insurance pays anything. Under many plans, that may be $100, or even $500. Coinsurance is the portion of the bill you have to pay once beyond the deductible. Under many plans, insurance pays 80 percent of the doctor's bill and you pay the other 20 percent.

[10]See the executive summary to "Health Maintenance Organizations," a 1980 report from the American Medical Association's Council on Medical Service. The main 183-page report studies 15 HMOs (5 IPAs, 5 group practice models, and 5 staff models), looking at numerous measures of performance, including cost of care, quality of care, and accessibility of care. There is also the formal report to the AMA's House of Delegates.

[11]From "The HMO Approach to Health Care" in the May 1982 issue of *Consumer Reports,* monthly magazine of the Consumers Union, which cites and details the 1980 Johns Hopkins study.

[12]From HMO promotional literature.

[13]See "HMOs, A Decade of Growth," *Business Insurance*, Dec. 19, 1983. Besides giving the figures from the automakers, the 10-page report says that employers find few gripes about HMO performance. The report also describes the various forms of HMOs, the advent of PPOs, and how the government has nurtured the growth of HMOs.

[14]"A Controlled Trial of the Effect of a Prepaid Group Practice on the Use of Services," by Willard G. Manning and five other members of the Health Sciences Program of the Rand Corp., *New England Journal of Medicine*, Vol. 310, No. 23, June 7, 1984, page 1505.

[15]The experiment was actually a bit more complex than that. From the report: "We compared four groups. The first three were samples of the Seattle-area population who were not enrolled in GHC in 1976.... Participants in the first two groups were assigned to plans that covered virtually all health services from fee-for-service physicians and ancillary personnel, such as speech therapists. In the first group, the services were provided at no cost to the participant; this plan is referred to as the 'free fee-for-service plan'." (Many N.C. employers now pay for health insurance for employees, and that insurance may cover virtually all costs—so this group is an important one.)

"In the second sample, participants had to share the costs of their medical care. They paid 25 percent or 95 percent of their medical bills, subject in most cases to a limit on out-of-pocket expenditure of up to $1,000 per family (less for the poor)...."

"Participants in the third group, the GHC experimental group, received free services at GHC.... The fourth group... was a random sample of GHC members in 1976 who otherwise met the eligibility requirements... and had been enrolled in the cooperative for at least one year."

Not surprisingly, once patients started paying for a hefty chunk of their bills, their admission rates dropped. Those paying 25 percent of their costs averaged 10 hospital admissions per year, though their bills average $620 per year; those paying 95 percent of their costs averaged $459 per year.

[16]"HMO Competition for Wisconsin's State Employees," by John Luehrs and Dale Hanson, *Business and Health*, September 1984, page 39.

[17]"Rating our Health Care Systems: You're better off with a health maintenance organization," by Dr. Sidney Wolfe in *Public Citizen.*

[18]See, for instance, the discussion on how new regulations open HMOs to Medicare beneficiaries in the Federation of American Hospitals Review, July/August 1984, page 9.

[19]The AMA analysis, for example, says, " 'Underutilization' has been suggested as a potential drawback of HMOs, resulting from their emphasis on cost-effectiveness. However, nothing in the literature indicates that HMO savings result from enrollees receiving less care than they need...."

[20]Aspen Systems Corp. report, page 6, see footnote 5.

[21]See NCGS 57A (now repealed) and Session Laws, c. 580, s. 1 (1977).

[22]HealthAmerica has introduced group practice model HMOs in these three states.

[23]For a complete comparison of the five HMOs in Dane County and the five HMOs in Milwaukee County, see "HMO Competition for Wisconsin's State Employees," by John Luehrs and Dale Hanson, *Business and Health*, Sept. 1984, page 37ff. Only one HMO, CompCare, is in both counties. Luehrs is senior staff associate for health policy studies with the National Governors' Association, and Hanson is deputy secretary in the Department of Employee Trust Funds for Wisconsin.

Other Resources on HMOs

In addition to the sources cited in the footnotes above, *Business Insurance* (December 19, 1983) lists these resources:

"Employer Attitudes toward Health Maintenance Organizations," available from the Division of Private Sector Initiatives, Office of Health Maintenance Organizations, Department of Health and Human Services, Rockville, Md. 20857.

The Group Health Association of America, Inc., the HMO trade association, has booklets and a library of HMO publications, Suite 700, 624 Ninth St., N.W., Washington, D.C. 20001.

"A History of Achievement, a Future with Promise," a report of the HMO industry produced by the National Industry Council for HMO Development, available from the Council at 5600 Fishers Lane, Room 17A55, Rockville, Md. 20857.

The National Association of Employers on Health Care Alternatives has booklets available at 1134 Chamber of Commerce Building, 15 S. 5th St., Minneapolis, Minn. 55402.

"The 1983 Investor's Guide to Health Maintenance Organizations," available from the Division of Private Sector Initiatives, Office of Health Maintenance Organizations, Department of Health and Human Services, Rockville, Md. 20857.

"The 1983 National HMO Census," which includes data through June 1983, is available through InterStudy, 5715 Christmas Lake Road, P.O. Box S, Excelsior, Minn. 55331, at a cost of $20. The annual census for 1984 should be available shortly.