
DataWatch

HMOs And Managed Care

by Marsha R. Gold

During the 1980s, the experience of health maintenance organizations (HMOs) altered the way in which we think of health care in the United States and began to change how it is financed and delivered. These changes also blurred the lines between HMOs and more traditional insurance products and health care delivery schemes. The challenge for the early 1990s is how to interpret these trends and what they portend for the future of the HMO industry and the role HMOs play in the U.S. health care system. In this DataWatch, I review and analyze changes in the HMO industry and HMOs' role during the 1980s, the extent to which current HMO practices may be changing in response to employer and other influences, and the potential implications of these trends.¹

Data sources. Data cited here are largely from the Group Health Association of America's (GHAA's) National Directory of HMOs and GHAA's Annual HMO Industry Survey. Both sources are databases on HMOs, defined here as organizations that integrate financing and delivery of health services by offering comprehensive care from an established panel of providers to an enrolled population on a capitated, prepaid basis.² The first includes information collected from each HMO nationwide and is used for analysis on the current composition of the HMO industry and recent trends.³ Because GHAA data for the pre-1988 period are limited, benchmark data for earlier years are based on published analyses by InterStudy and others.⁴

Operational data on more specific aspects of HMO practice and perceptions are from GHAA's Annual HMO Industry Survey, a lengthy mail survey sent to all HMOs (including both GHAA members and nonmembers) with at least a year's operational experience.⁵ Because they represent more stable structures and include almost all of the nation's HMO enrollees (and now almost all HMOs), I focus here on plans over

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three years old (“established plans”). In the most recent survey, covering 1990 (1989, for use and financial data), 70 percent of established plans responded, encompassing 82 percent of the total national enrollment in established plans. While response rates varied somewhat by category of plan, data are reasonably representative of the industry, with 60 percent or more of all plans responding in each plan-characteristics category examined. Response rates are lower for some items, such as financial data or premium information. Survey response rates for previous years were somewhat lower (63 percent in 1989 and 55 percent in 1988). Respondents have become increasingly representative of the industry over time.

Changes In The HMO Industry During The 1980s

Industry growth and geographic dispersion. The HMO industry grew and became increasingly visible in most areas of the country over the 1980s. HMO enrollment increased fourfold, from 9.1 million in mid-1980 to 36.5 million at the end of 1990, while the number of plans—despite some recent consolidation—more than doubled, from 236 to 569. HMOs currently enroll 15 percent of the U.S. population and over a fifth (22 percent in 1989) of residents in the thirty largest metropolitan areas. HMO penetration varies by market. HMOs include a minority of the population in most markets but have come close to achieving majority status in a few markets, most notably the San Francisco Bay area and Minneapolis-St. Paul (Exhibit 1).

Regional disparities in HMO penetration lessened over the 1980s. In 1980, only ten states had ten or more HMOs, and only one (California) had as many as one million enrollees or more. By 1990, these figures grew to twenty-one and eleven, respectively. The share of HMO enrollment outside of California increased from 56 percent to 73 percent. HMO penetration remains lowest in the South, but, particularly in the South Atlantic region, it steadily increased in the 1980s (Exhibit 2).

The late 1980s were also a time of considerable growth in other forms of managed care. By 1990, 33 percent of all insured employees were estimated to be in either HMOs or preferred provider organizations (PPOs); a mere 18 percent were insured by plans with no utilization review features.⁶ While no definitive study exists, these changes—involving adoption of what may be viewed as elements of HMO practice into traditional insurance—arguably would not have occurred without the example and competitive pressure generated by an increasingly visible HMO industry. The experience of HMOs encouraged closer attention within the larger health system to the level and appropriateness of inpatient use and to the potential benefits of integrating financing with

Exhibit 1**HMO Market Penetration In The Largest U.S. Metropolitan Areas, In Rank Order, 1989**

| Metropolitan statistical area or complex and state ^a | HMO penetration rate | Number of HMOs serving ^b |
|---|----------------------|-------------------------------------|
| San Francisco-Oakland-San Jose/Sacramento, CA | 46% | 24 |
| Minneapolis-St. Paul, MN/WI | 44 | 8 |
| Milwaukee-Racine, WI | 35 | 8 |
| Portland-Vancouver, OR/WA | 34 | 6 |
| Los Angeles-Anaheim-Riverside/San Diego, CA | 32 | 28 |
| Boston-Lawrence-Salem, MA/NH | 28 | 15 |
| Denver-Boulder-Colorado Springs-Ft. Collins-Greeley, CO | 26 | 13 |
| Phoenix, AZ | 26 | 11 |
| Seattle-Tacoma, WA | 24 | 9 |
| Washington, DC/MD/VA/Baltimore, MD | 22 | 21 |
| Kansas City, MO/KS | 22 | 11 |
| Miami-Ft. Lauderdale, FL | 21 | 17 |
| Philadelphia-Wilmington-Trenton, PA/NJ/DE/MD | 21 | 24 |
| Detroit-Ann Arbor, MI | 19 | 9 |
| Columbus, OH | 18 | 8 |
| St. Louis, MO/IL | 17 | 12 |
| Chicago-Gary-Lake County, IL/IN/WI | 16 | 25 |
| Cleveland-Akron-Lorain, OH | 16 | 10 |
| Cincinnati-Hamilton, OH/KY/IN | 16 | 8 |
| Tampa-St. Petersburg-Clearwater, FL | 12 | 7 |
| Houston-Galveston-Brazoria, TX | 12 | 8 |
| Atlanta, GA | 11 | 7 |
| Dallas-Ft. Worth, TX | 11 | 10 |
| New York-Northern NJ-Long Island, NY/NJ/CT | 11 | 24 |
| San Antonio, TX | 10 | 4 |
| Norfolk-Virginia Beach-Newport News, VA | 10 | 5 |
| Pittsburgh-Beaver Vallev. PA | 10 | 7 |

Source: S. Palsbo, HMO Market Penetration in the 30 Largest Metropolitan Statistical Areas, 1989, GHAA Research Brief 13 (revised December 1990).

^aIncludes thirty metropolitan statistical areas (MSAs), representing twenty-seven areas in the statistical analysis because of consolidation among several MSAs. See source report for methods of allocating enrollment among plans serving multiple MSAs and specific limitations that may result in some small over- or understatement for particular MSAs.

^bSome HMOs serve more than one area, particularly in New Jersey and California.

delivery to potentially exert more influence over provider practice.

HMO enrollment statistics also reveal some cautionary notes for the industry. Most recently, HMO growth has been somewhat uneven geographically (Exhibit 2). HMO growth was basically flat in the Midwest from 1988 to 1990; in the South Central region, growth was entirely absorbed by population growth, meaning that penetration remained constant over this period. HMOs continue to be strongest along the two U.S. coasts, despite gains elsewhere. Market strength among plans in the

Exhibit 2

HMO Penetration Rate And Recent Enrollment Changes, By Region, 1980–1990

| Region | Regional penetration | | | | Percent change in enrollment | | |
|-----------------------|----------------------|-------|-------|-------|------------------------------|------|--------------------------|
| | 1980 | 1988 | 1989 | 1990 | 1989 | 1990 | Annual average 1989–1990 |
| United States | 4.0% | 13.3% | 14.0% | 14.6% | 6% | 5% | 6% |
| New England | 2.4 | 18.8 | 19.6 | 20.9 | 5 | 7 | 6 |
| Mid-Atlantic | 3.4 | 12.0 | 12.7 | 13.8 | 6 | 9 | 8 |
| South Atlantic | 1.3 | 8.3 | 8.8 | 9.3 | 8 | 7 | 8 |
| Midwest | 2.8 | 14.0 | 14.1 | 14.0 | 1 | -1 | 0 |
| South Central | 0.4 | 5.8 | 5.9 | 5.8 | 5 | -1 | 2 |
| Mountain ^a | 3.7 | 14.6 | 15.7 | 14.9 | 11 | -3 | 4 |
| Pacific ^b | 15.2 | 25.1 | 27.6 | 29.8 | 11 | 10 | 11 |

Source: GHAA's *National Directory of HMOs* database. U.S. population data from U.S. Bureau of the Census, *Statistical Abstract of the United States*, 1990, 110th ed. HMO data for 1980 from *National HMO Census*, 1980, DHHS Pub. no. (PHS) 80-50159.

^aGrowth in 1990 may be influenced by refinement in the definition of enrollee, which may have artificially reduced apparent growth.

^bPenetration rates exclude Guam.

industry continues, to vary: while 60 percent of plans gained enrollment in 1990, 39 percent lost enrollment (1 percent stayed the same). This suggests that further consolidation of HMOs is likely in the near term.

HMO penetration also remains considerably more limited in publicly financed programs than in the commercial sector for a variety of reasons, discussion of which is beyond the scope of this DataWatch. Only 6 percent of Medicare beneficiaries currently are enrolled under various Medicare HMO contracting options.⁷ A similar percentage of Medicaid beneficiaries are enrolled, although penetration is considerably higher in states that have actively pursued these arrangements.⁸ These patterns could change, assuming some spillover effect from the broader acceptance of HMOs in the health sector as a whole. On the other hand, the experience with public programs is not encouraging to HMOs at a time when some are advocating this approach for overall health system reform.⁹ While government officials recently have tried to modify this, both Medicare and Medicaid HMO contracting practices historically have been influenced by fee-for-service practices and mind-sets; this has created barriers to HMOs' participation in these programs both in reality and because of HMOs' perceptions. Unless this is changed, an expanded HMO role under a public insurance model could be problematic.

HMO provider networks. Over the 1980s, HMO provider networks tapped more heavily into more traditional medical practices and settings. Over half (53 percent) of all office-based physicians were affiliated with one or more HMOs in 1990; 68 percent of all medical groups had some

form of relationship with an HMO in 1988.¹⁰ Network and individual practice association (IPA)-model plans—which base their provider networks on physicians in office-based fee-for-service practice—increased from 97 to 433 between 1980 and 1990. Their share of HMOs increased from 41 percent to 76 percent, and of enrollment from 19 percent to 58 percent, although this share has remained relatively steady since 1988. Greater HMO penetration into fee-for-service practice also occurred with the growth in enrollment in prepaid group practice-model HMOs (group and staff models). To varying extents, these plans also rely on office-based physicians to complement their more committed full-time practitioners and, more recently, to expand service areas and markets through adoption of more “mixed” models. Exhibit 3 provides more detail on the kinds of provider networks used by each type of HMO model in 1990. The data show considerable variability among HMOs that define themselves as a common model type, an important point to note in drawing any kind of general conclusion about HMOs.

By expanding their provider base and involving in their systems physicians whose predominant practice probably is fee for service, HMOs have become less distinct, when contrasted against the original prepaid group practice model. However, HMOs also have increased their impact on overall medical practice. For example, the majority of networks and IPA models have moved away from fee-for-service payment for their primary care physicians, and almost all include some financial incentives as well as utilization review and management functions encouraging cost-effective practice.¹¹ On the other hand, these types of dispersed and potentially less committed provider networks are inherently more difficult for an HMO to manage; thus, fee-for-service influences also have intruded more heavily into the HMO experience.

HMO ownership. The organizations sponsoring HMOs also grew more diverse over the 1980s. In 1980, the HMO industry was mainly based around independent plans or multiplan organizations (generally non-profit) devoted solely to the HMO business. Current HMO ownership reflects historical roots but is considerably more consolidated and representative of the broader spectrum of health care and economic interests, which has made it more difficult at times for HMOs to maintain the unique regulatory treatment they have enjoyed in the past.

According to InterStudy, eight national HMO firms did business in 1980 with twenty-nine plans, or 12 percent of all HMOs. In 1990, excluding the Blue Cross/Blue Shield network, twenty-two corporate entities owning or managing multiple HMOs accounted for 242 HMOs, or 43 percent of all plans and 52 percent of all enrollees (Exhibit 4). Of the top ten companies (which account for 44 percent of national HMO

Exhibit 3
Profile Of HMO Provider Networks, By Model Type, Plans Over Three Years Old, 1990

| | Total | Predominant model | | | |
|--|-------|-------------------|-------|---------|------------------|
| | | Staff | Group | Network | IPA ^a |
| Other model types | | | | | |
| Percent yes | 24% | 59% | 20% | 49% | 12% |
| Percent enrollment in model (if mixed) | 27 | 77 | 68 | 63 | 74 |
| Physicians staffing | | | | | |
| Total number of physicians per average plan ^b | 1,189 | 399 | 517 | 1,816 | 1,326 |
| Average total physicians per 1,000 members | 28.6 | 3.2 | 5.0 | 39.7 | 36.9 |
| Average primary care physicians per 1,000 members | 10.2 | 2.5 | 2.7 | 9.5 | 14.4 |
| Average percent of primary care physician practice from that HMO | | | | | |
| 0–30 percent | 66% | 20% | 18% | 67% | 88% |
| 31–80 percent | 15 | 17 | 21 | 25 | 10 |
| 81–100 percent | 19 | 2 | 61 | 6 | 4 |
| Typical HMO medical network | | | | | |
| Multispecialty group practice | 37% | 74% | 84% | 42% | 10% |
| Alone | 15 | 60 | 42 | 7 | 1 |
| With others | 22 | 14 | 42 | 35 | 17 |
| Solo or partnership | 29 | 5 | 3 | 12 | 45 |
| Groups 3–7 or with solo | 10 | 2 | 3 | 2 | 15 |
| Other | 24 | 19 | 10 | 44 | 23 |
| Predominant payment method for primary care physicians | | | | | |
| Salary | 15% | 82% | 34% | 0% | 1% |
| Capitation | 56 | 11 | 66 | 81 | 59 |
| Fee for service | 28 | 7 | 0 | 19 | 40 |

Source: GHAA's Annual HMO Industry Survey.

^aIndividual practice association.

^bFrom GHAA's *National Directory of HMOs* database; all plans regardless of age.

^cNumbers do not add to 100 because of rounding.

enrollment), two—Kaiser and Health Insurance Plan (HIP) of Greater New York—represent what most regard as the traditional base of the HMO industry, three are commercial insurance companies, and five are publicly traded companies, most of which also offer other health care products. In 1990, 66 percent of HMOs were for-profit, with 47 percent of all HMO enrollees; however, there has been little change in their market share over the most recent period (1988–1990).

In 1990, insurers owned or managed 43 percent of all HMOs and enrolled 27 percent of all HMO enrollees. HMOs owned by commercial insurers represented 29 percent of all HMOs and 15 percent of all HMO

Exhibit 4
Largest Multi-HMO Companies, In Order Of Total Enrollment. 1990

| Organization | Number of HMOs | | | Total enrollment |
|---|----------------|---------|-------|------------------|
| | Owned | Managed | Total | |
| Kaiser Foundation Health Plans, Inc. | 12 | 0 | 12 | 6,525,574 |
| CIGNA Employee Benefits Company | 42 | 0 | 42 | 1,573,338 |
| United HealthCare Corporation | 7 | 8 | 15 | 1,186,291 |
| Aetna Health Plans | 19 | 7 | 26 | 1,163,032 |
| U.S. Healthcare, Inc. | 8 | 0 | 8 | 1,105,000 |
| Health Insurance Plan of Greater New York | 4 | 0 | 4 | 1,075,627 |
| Humana, Inc. | 14 | 0 | 14 | 997,511 |
| Prudential Health Care Plans, Inc. | 27 | 0 | 27 | 874,306 |
| FHP, Inc. | 6 | 0 | 6 | 864,768 |
| PacifiCare Health Systems | 5 | 0 | 5 | 688,504 |
| Sanus Corporation Health Systems | 4 | 1 | 5 | 641,863 |
| Lincoln National Admin. Services Corp. | 14 | 0 | 14 | 435,489 |
| Maxicare Health Plans, Inc. | 8 | 0 | 8 | 302,437 |
| Coventry Corporation | 3 | 0 | 3 | 265,500 |
| Independent Health Association, Inc. | 2 | | 3 | 252,162 |
| Qual-Med, Inc. | 5 | 0 | 5 | 245,064 |
| Metropolitan Life Insurance Company | 15 | 0 | 15 | 236,406 |
| Community Health Plan (CHP), Inc. | 5 | 0 | 5 | 178,800 |
| Principal Health Care, Inc. | 7 | 0 | 7 | 162,030 |
| Health source Management Company | 4 | 1 | 5 | 127,071 |
| Physician Corporation of America | 3 | 0 | 3 | 108,756 |
| The Travelers Health Network, Inc. | 10 | 0 | 10 | 102,984 |

Source: GHAA's National Directory of HMOs database.

Note: This list does not include the network of eighty-two Blue Cross/Blue Shield HMOs, which are affiliated nationally but owned and operated by individual Blue Cross/Blue Shield organizations. Together, Blue Cross/Blue Shield HMOs enroll 4.6 million members nationwide.

enrollees; the comparable share for HMOs owned by Blue Cross/Blue Shield plans was 14 percent and 13 percent, respectively. Two-thirds (65 percent) of HMOs sponsored by commercial insurers were started in 1985 or later, compared to half of HMOs sponsored by Blue Cross/Blue Shield organizations or by HMOs and others (48 percent each). This has contributed to the diffusion of HMO concepts but also to a growing indemnity influence on HMOs, for both insurer-owned plans and their competitors.

At the same time, despite the considerable changes over the 1980s, the HMO industry still has strong roots in its past. Kaiser Foundation Health Plan remains dominant in the industry, representing 18 percent of national HMO enrollment—a share larger than either of the insurance sectors and four times the size of the second-largest HMO company. A number of the largest individual HMOs continue to be more traditional plans; in addition to the two California Kaiser plans, HIP, Group Health

Cooperative of Puget Sound, Harvard Community Health Plan, and Health Alliance Plan all are among the ten largest individual HMOs.

The HMO industry also retains many elements of a “cottage” industry. Despite the fact that 64 percent of HMO enrollees were in the largest plans (100,000 or more members) in 1990, 39 percent of HMOs had fewer than 20,000 enrollees in 1990, and 31 percent, between 20,000 and 50,000—meaning that a full 70 percent of all HMOs (versus 88 percent in 1980) continue to be reasonably small. Some smaller plans with neither a strong community or market niche nor strong company affiliation may find it difficult to respond to current environmental pressures, another reason why further consolidation in the HMO industry is likely.

Problems with growth. The rapid growth of HMOs in the 1980s caused some short-term problems, which appear to be resolving as the industry matures. Growth was strongest from mid-1984 to mid-1987; the number of plans increased from 306 to an all-time high of 662, and enrollment essentially doubled, from fifteen to twenty-nine million. The result was that half of all HMOs were under three years old in 1987.

The financial effects of these patterns were predictable. New plans aimed to succeed by growing rapidly, leading to considerable price competition beneath that required to cover expenses. As with any business, some sponsors proved better managers than others, some plans proved better situated in the market than others, and profitability was eroded by start-up costs. In 1987, only 38 percent of established plans and 13 percent of new plans were profitable, with the industry losing an estimated \$1 billion, before taxes, on an estimated revenue base of \$24.9 billion. Seventy-six mostly small HMOs (median enrollment was 3,650) ceased operations between the end of 1987 and mid-1990; sixty-one merged or consolidated with other HMOs.¹²

There are signs that the HMO industry has matured and is in considerably stronger shape entering the 1990s. The recent consolidation of the HMO industry caused short-term dislocations but also increased the share of stronger, more competitive plans. In 1989, 66 percent of established plans (and 46 percent of new plans) were profitable; the HMO industry as a whole gained an estimated \$0.23 billion, before taxes, on \$38.3 billion in revenue. While this 0.6 percent gain is low in relation to optimum margins, it stands in stark contrast to aggregate losses of about -4.2 percent in both 1988 and 1987. Furthermore, improvements in financial performance appear to extend beyond profitability measures into operational performance; values for nine of the ten solvency surveillance indicators (developed by the National Association of HMO Regulators for monitoring HMO financial performance) improved from 1988 to 1989 (Exhibit 5). Preliminary data suggest that financial improve-

Exhibit 5**Trends In Solvency Surveillance Indicators And Selected Other Measures, HMO Plans Over Three Years Old, 1988-1989^a**

| Indicator | Sample size | 1988 | 1989 | Significance |
|--------------------------------|-------------|-------------|-------------|-------------------|
| Net profit margin | 128 | -0.0133 | 0.0160 | .000 ^b |
| Tangible net worth | 124 | \$7,432,241 | \$9,829,060 | .000 ^b |
| Current ratio | 124 | 0.9454 | 1.0135 | .000 ^b |
| Health care expense ratio | 129 | 0.9127 | 0.8951 | .000 ^b |
| Administrative expense ratio | 130 | 0.1209 | 0.1139 | .013 ^b |
| Tangible asset financing ratio | 121 | 0.9107 | 0.8167 | .000 ^b |
| Enrollment level | 134 | 129,406 | 135,832 | .000 ^b |
| Premium receivable turnover | 124 | 0.6957 | 0.6273 | .026 ^b |
| Cash flow to total debt | 113 | 0.0375 | 0.1702 | .000 ^b |
| Days claims and IBNR payable c | 122 | 46.58 | 46.99 | .778 |
| Other measures | | | | |
| Equity per member | 125 | \$37.66 | \$65.51 | .000 ^b |
| Assets per member | 126 | \$281.14 | \$330.50 | .000 ^b |

Source: GHAA's Annual HMO Industry Survey.

^aIncludes all plans over three years old in 1988 that also reported in 1989.

^bSignificant at the $p < .05$ level.

^cIncurred but not reported.

ments have continued in 1990, with fewer than 85 percent of established plans profitable, although some continue to have financial difficulties.¹³

HMOs attribute their improved financial condition about equally to increased revenues (largely through premium increases) and 10 improved cost controls (improved utilization review, more efficient administration, and renegotiated provider contracts). The duality of HMO responses reflects both the influence of overall inflationary forces on HMOs and the ability of HMOs to influence these costs through their organization and incentives. Among the 110 HMOs providing financial data for 1987-1989, the two-year average increase in revenues per member per month was 26 percent, while the average increase in expenses was 21 percent.

The HMO rate increase profile over the late 1980s presents a mixed picture. The Health Insurance Association of America's (HIAA's) Employer Survey results show that HMO premium increases appear to have been below those of indemnity plans over the most recent time period.¹⁴ However, HMOs did increase their premiums substantially over this period, generating concerns among some purchasers and policymakers. According to GHAA data, HMO premium increases averaged 11-12 percent in 1988, and 17-18 percent in both 1989 and 1990; preliminary data for 1991 indicate a moderation, with increases averaging about 12 percent.¹⁵ The slower growth rates for the HMO industry over the late

1980s (enrollment grew 6.4 percent in 1989 and 4.9 percent in 1990) may reflect an emphasis among HMOs toward solidifying their revenue base and enhancing their delivery systems to strengthen provider networks and internal systems to better absorb growth and restrain costs. To the extent that this has occurred, HMOs should be in a stronger position to expand over the 1990s.

Trends In HMO Products And Practices

Employer influences. Arguably the most significant influence on the HMO industry today is employers, who are responding to rapid escalation in health costs. Employers, particularly larger ones, have become more involved purchasers, actively engaged in assessing the value of each benefit option and in designing the overall mix and integration of their total benefit package. This has created an opportunity for HMOs but also has increased the demands upon them. In 1990, three-quarters or more of HMOs had requests from employers for data on utilization, demographics, quality of care, costs, finances, and consumer satisfaction. Employers also have become more assertive in influencing the structure of HMOs.

Exhibit 6 shows HMOs' perceptions of how these employer concerns translate into selected concerns with respect to the HMO benefit package, HMO rating practices, and the employer's overall health benefits design. I contrast perceptions in 1990 with those of 1988 and discuss them along with the HMO response in the sections that follow.¹⁶

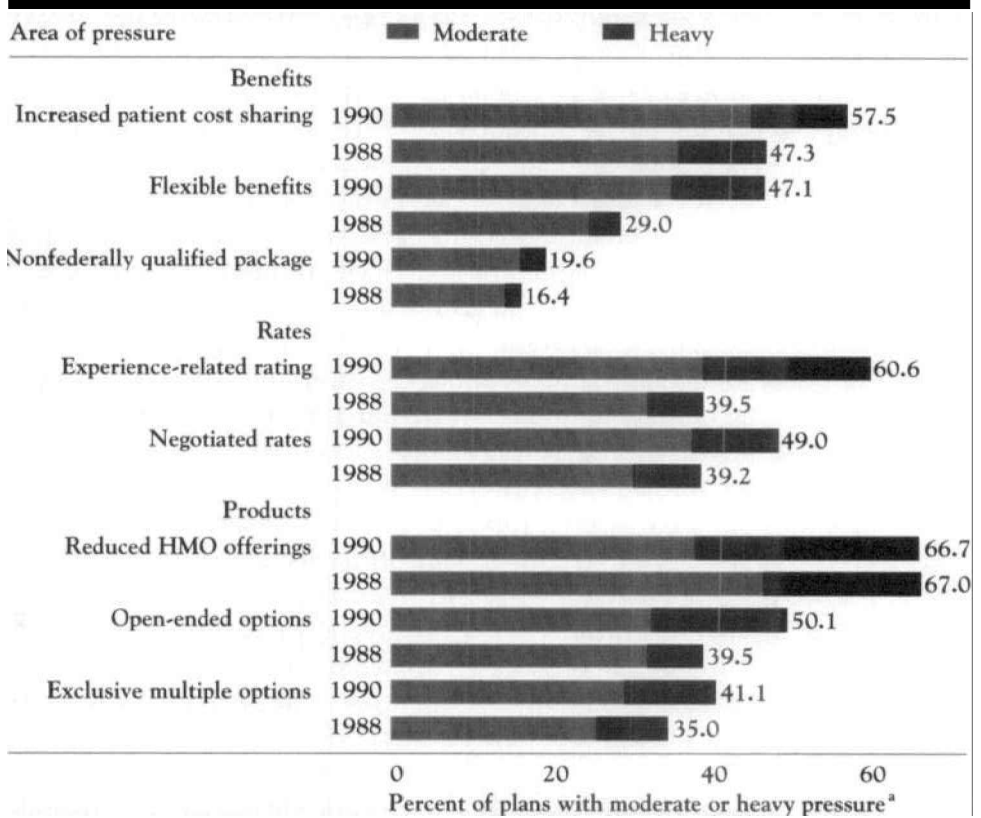
HMO benefit packages. Experienced with indemnity plans, employers tend to regard employee cost sharing as an important tool for controlling costs.¹⁷ Fifty-eight percent of HMOs perceived moderate to heavy pressure from employers to increase patient cost sharing in their benefit package in 1990, up from 47 percent in 1988. While HMOs have responded to some extent, major changes have not yet occurred in the most commonly offered HMO benefit packages.

Traditionally, HMOs have stressed comprehensive benefits with limited out-of-pocket costs, perceiving themselves as prepayment and insurance entities and relying on systems design rather than cost sharing to control costs. Hence, growth in HMO enrollment should have restrained growth in out-of-pocket spending and cost sharing in the health system as a whole, even if one makes no assumptions about spillover effects.

While HMOs have increased cost sharing to some extent, first-dollar coverage continued to be the pattern in 1990. The best-selling benefit package of most HMOs (which 66 percent of an HMO's enrollees purchase, on average) relies, where cost sharing is used, on fixed-dollar copayments rather than on the deductibles or coinsurance common in

Exhibit 6

HMO Perceptions Of Employer Pressures In Selected Areas, Plans Over Three Years Old, 1988-1990



Source: GHAA's Annual HMO industry Survey.

^aOther choices were "limited pressure" or "none."

indemnity plans. The most common HMO copayment for primary care visits was five dollars in 1990; under a quarter of plans (23 percent) had cost sharing for hospitalizations, with only 14 percent of HMO enrollees in such plans, since larger plans were less likely to apply cost-sharing requirements. Seventy-two percent of plans (with 56 percent of enrollees) charged copayments for primary care visits in 1990 (fewer for preventive services such as prenatal care), up from 48 percent in 1988 and 60 percent in 1989; there also was some growth in cost sharing for hospital services. Although 35 to 44 percent of plans increased average cost sharing in their best-selling benefit package in each of 1988, 1989, and 1990, 32 percent reported no net increase in cost sharing in any of the three years. Possibly some HMOs are responding to employer pressures through the development of alternative, less comprehensive pack-

ages (84 percent offered at least one less comprehensive package; 47 percent at least one more comprehensive package), but overall HMO benefits continued to be comprehensive in 1990 and to depart considerably from the structure of indemnity plans. Because this is an important selling feature for HMOs, major change in this area seems unlikely.

HMO rating practices. Employers are more closely scrutinizing the rates they pay HMOs and the methods by which these rates are set. Over half of all HMOs (more than in 1988) perceived moderate to heavy employer pressure for experience-related rating or negotiated rates; a larger share of HMOs characterized such pressure as heavy rather than moderate in 1990 than in 1988. The evidence suggests that employers increasingly are concerned with negotiating rates consistent with the anticipated cost experience of their employees (and dependents).

Traditionally, HMOs have used standard community rating, with no adjustment for the characteristics of particular employer groups, as these might bear on anticipated health care costs (that is, no group-specific rating). This is based at least in part on the notion that risk is best pooled over all enrollees to encourage affordable coverage for expenses that vary widely across a population. However, many employers believe this results in inappropriate cross-subsidies. Federally qualified HMOs were provided additional flexibility to respond to marketplace pressures in the 1988 amendments to the federal HMO Act through the allowance for "adjusted community rating," in which prospective group-specific rating was allowed, with restrictions to encourage affordable rates for small groups (100 employees or fewer) whose rates cannot depart by more than 110 percent from the community rate. (Prior to this, HMOs could partially address employer concerns by using community rating by class, in which separate planwide rates are established by demographic factors associated with costs, such as age and sex.) Nonfederally qualified HMOs are not subject to these restrictions, though they may be constrained by state law.

HMOs appear to be moving to meet employers' demands for group-specific rating, but most are using methods that retain the prospective nature of HMO rating, which many regard as providing the critical risk-bearing incentives needed for HMO success. Most also continue to use methods that encourage affordable coverage for small employer groups. In 1990, 56 percent of HMOs used some rating method involving an explicit adjustment for employer group experience. Indemnity experience-based rating typically involves a retrospective adjustment in rates for previous shortfalls or overestimates; under 10 percent of all HMOs used such adjustments. Because the larger and older HMOs tend to rely more heavily on traditional HMO rating methods, 90 percent of HMO enrollees in 1990 were rated using the three community rating methods

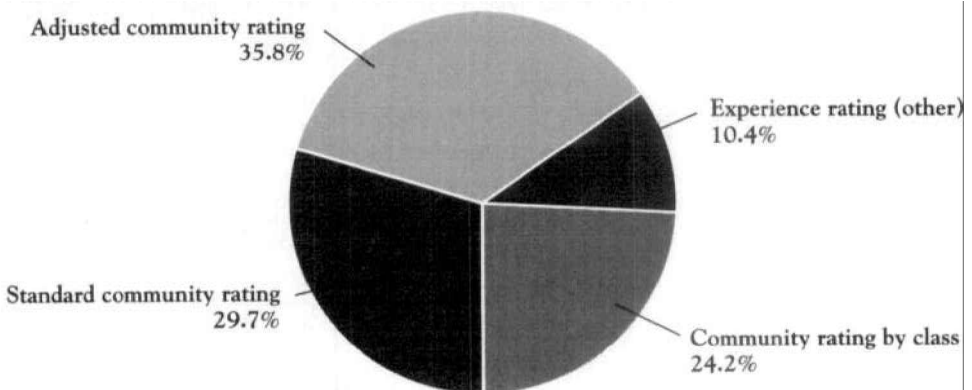
permissible under the federal HMO Act (Exhibit 7). Despite changes that move HMO rating closer to that of traditional insurers, HMO rating retained distinctive characteristics in 1990. Most notably, HMO rating is prospective and pays closer attention to equity considerations inherent in such issues as small groups or higher-cost accounts. Federal and state policy may play a large role in determining whether HMOs keep their distinctive policies. The Blue Cross/Blue Shield historical experience suggests that it is difficult for a single payer to maintain community rating practices if others do not, because of adverse selection effects.

Benefit package design. HMOs' perceptions confirm employers' more active involvement in the design of their health benefit programs. Two-thirds of HMOs perceived moderate to heavy pressure from employers to reduce the number of HMO options offered to employees in 1990. This percentage remained unchanged from 1988, but it included more plans perceiving heavier pressure. This does not necessarily mean that employers are less committed to HMOs in general, but it does suggest that many are becoming more selective in their offerings. The number of HMO plans grew rapidly over the 1980s; many employers appear to want to streamline the number of options they offer, based on the perception that numerous choices increase administrative burden, confuse employees, reduce employer purchasing power, and add to risk segmentation.

This has increased employers' interest in newer products oriented to this need. Between 1988 and 1990, employers showed greater interest in open-ended HMO products (under which an employee is enrolled in the

Exhibit 7

Distribution Of All HMO Enrollees, By Rating Method Used, Plans Over Three Years Old, 1990



Source: GHAA's Annual HMO Industry Survey.

Note: Plans that responded to this survey item account for 26.2 million enrollees.

HMO but may self-refer to providers outside the network, typically with cost sharing equivalent to traditional insurance products) and in exclusive multiple options (under which an HMO is part of an entity offering employers the ability to substitute a total replacement product for their current health benefits). Although these insurance products have not been tested over time, employers are interested in them for their ability to blend managed care features with the broader provider choice of traditional indemnity products, thus allowing employers to simplify their benefit offerings.

HMOs have not responded consistently to these pressures, and trends are somewhat unclear. To address the needs of national accounts or employers wishing to offer HMO options under a single umbrella, 42 percent of HMOs in 1990 had or were in the process of implementing agreements with other HMOs. In 1990, just under half (46 percent) of HMOs offered one or more of five types of diversified options. HMOs owned by commercial insurance companies were considerably more likely to offer diversified options than other HMOs (Exhibit 8). By model type, IPAs were most likely to offer diversified options (58 percent) and group models least likely (18 percent). An HMO's structure and legal basis of incorporation make it easier for some plans to diversify than others.

The most noticeable trend has been in the growth of open-ended HMO products, up to 20 percent of plans in early 1990 from 16 percent in 1989.

Exhibit 8
Percentage Of HMOs With Various Diversification Options, By Ownership And Model, Plans Over Three Years Old, 1990

| Option | All plans | Ownership | | | Model | | | |
|-------------------------------|-----------|---------------------|------------------------|------------|-------|-------|---------|------|
| | | Commercial insurers | Blue Cross/ BlueShield | All others | Staff | Group | Network | IPAA |
| Any of five specified options | 46% | 72% | 29% | 40% | 34% | 18% | 39% | 58% |
| Open-ended option | 20 | 39 | 10 | 16 | 25 | 9 | 7 | 26 |
| PPO option ^b | 27 | 61 | 10 | 18 | 21 | 13 | 22 | 34 |
| Indemnity option | 24 | 66 | 8 | 12 | 16 | 11 | 17 | 32 |
| Exclusive multiple option | 16 | 47 | 10 | 6 | 11 | 7 | 11 | 21 |
| Employer self-insuredoption | 25 | 49 | 16 | 18 | 16 | 7 | 11 | 35 |

Source: GHAA's Annual HMO Industry Survey.

^aIndividual practice association.

^bPreferred provider organization.

As noted, these options allow HMO enrollees to self-refer to providers outside the HMO network with cost-sharing requirements. Thirty-six percent of all HMOs in GHAA's National Directory of HMOs for 1991 offered such an option; sample GHAA surveys also indicate considerable recent growth.¹⁸ It is unclear whether these products will serve as a permanent feature of the health care landscape or more as a midway station to growing enrollment in more traditional HMO plans. Evidence on the performance of these kinds of options is limited; they have the previously noted attractive features but also draw more heavily on traditional insurance features and probably are more costly, depending upon out-of-plan use, than traditional HMO coverage.

This may explain why some HMOs are moving cautiously to expand these options; only 3.4 percent of HMO enrollees were in such options at the start of 1991.¹⁹ Some HMOs are proceeding rapidly to develop these options, while others are uncertain about how these options would affect their long-term position. In a cost containment environment, employers are concerned with both HMO cost-effectiveness and total health care costs—which also are influenced by the ability to attract individuals currently enrolled in indemnity or more loosely managed products into more tightly managed situations. HMOs differ in their philosophies, structure, market niche, and perspective on the importance of enrollment growth; it therefore seems likely that their responses to these pressures will continue to differ considerably, absent any overwhelming pressure from the environment to require broad-based change.

Trends And Future Implications

The HMO industry expanded considerably in the 1980s, resulting in a more geographically dispersed base and a more diversified industry and set of HMO sponsors. Even though most HMOs remain small and many are independent, the majority of enrollees are either in the largest plans or in plans sponsored by multi-HMO companies. Further consolidation is likely over the next several years, given the variability in both financial performance and market position across the industry.

Despite the industry's internal diversity, HMOs continue to claim certain unique properties: their absorption of prospective risk, comprehensive benefits, and integrated delivery systems with provider incentives for efficiency. At the same time, some of these distinctions have become more difficult to articulate, given the growth of other products—encouraged by HMO growth—that also use provider networks and enhanced coverage for primary care. HMOs' response to marketplace pressures by offering diversified products further blurs traditional distinctions.

With the growth of managed care, it has become virtually impossible to consider the future role of HMOs without simultaneously considering the complete spectrum of so-termed managed care products in which HMOs have become embedded. In considering trends, one can emphasize either the similarities or the differences between HMOs and the rest of the health care system. There clearly is a continuum of managed care products differentiated by varying degrees of management and health systems integration.²⁰ HMOs have served to encourage change in the organization and performance of traditional practice but may have sacrificed some uniqueness in the process. On the other hand, the overwhelming majority of the U.S. population continues to be enrolled in traditional insurance plans that overlay utilization review and guideline development over an essentially fee-for-service system. HIAA defines managed care as

health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangement with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.²¹

Yet, it is unclear whether all these features (which also are part of HMO design) currently are included in many of the newer and less highly regulated managed care organizations. The definition also excludes capitated payment and provider risk sharing, which are an important part of conceptual HMO design, as well as the integrated medical facilities some HMOs use (in particular, prepaid group practices).

Since there are many unpredictable factors, it is problematic to predict now how distinctive or important HMOs will be in the future, although many views exist. HMOs—acknowledging their internal diversity—could remain a distinctive minority player serving as an example. HMOs could become the dominant player if the further development of managed care organizations leads to adoption of more HMO features in the search for cost-effectiveness. Or, with the traditional disjointed incrementalism of U.S. policy, a managed care continuum of continuing pluralism could remain, in which the term HMO may or may not continue to be used. Which of these occurs could be influenced heavily by the current interest in health systems reform and universal coverage systems at both the federal and state levels. For the HMO industry, this creates a critical challenge to articulate effectively both the organizational form and its merits, including addressing the diverse issues that have been raised.

From a policy perspective, it probably is of less immediate relevance to predict the future than to influence it. In this regard, it is increasingly important to recognize the variability in current forms of “managed care,”

including variability within organizations of the same label. From my perspective, policymakers might be better served if the term managed care were dropped or at least deemphasized in favor of a conceptual framework to define better the key elements present in or absent from managed care plans or organizations on any point on any continuum. This could encourage greater clarity and content in the policy debates concerning managed care, better understanding of current trends, and an improved ability to interpret the meaning of any research and analysis on the effectiveness of various kinds of plans or organizations.

To accomplish this, statistical systems will need to provide a better empirical basis for assessing the extent of inclusion of these elements in the various managed care organizations or products. The current fragmentation of data collection and regulatory responsibilities for managed care plans impedes the ability to collect such data, even if consensus existed on what to collect. These difficulties are compounded because current national databases and reports, such as those produced by the Bureau of Labor Statistics and the National Center for Health Statistics, were developed in an earlier environment; they do not provide good measures of the managed care plans that now exist, the kinds of "insurance" coverage people have, or the features present in any plan. A thorough review of the existing national statistics to determine what new databases or modifications in current databases may be desirable given the needs created by the growth of managed care is well overdue.

The analysis and perspectives expressed in this DataWatch are those of the author and do not necessarily reflect those of the Group Health Association of America (GHAA) or its member plans. A number of GHAA staff contributed to the data analysis presented here. Dennis Hodges, a research associate at GHAA, is project manager for GHAA's Annual HMO Industry Survey and prepared much of the analysis from this source, including industrywide estimates of revenues and expenses. Susan Jelley Palsbo, a senior research associate at GHAA, provided the analysis of changes in financial performance and of statewide market penetration. Kevin Camerlo, research data coordinator, prepared statistics from GHAA's National Directory of HMOs database and assisted in overall data collection and analysis. Ingrid Reeves, Pamela Kalen, and Regina Cole of GHAA's Membership and Planning Department are responsible for developing GHAA's National Directory of HMOs database.

NOTES

1. For a benchmark and a more detailed look at these issues, see M. Gold and D. Hodges, "Health Maintenance Organizations in 1988," *Health Affairs* (Winter 1989): 125-138.
2. A review of HMO history and design is included in M. Gold, "Health Maintenance Organizations: Structure, Performance, and Current Issues for Health Benefits Design," *Journal of Occupational Health* (March 1991): 228-296.
3. Data collection methods and definitions are described in Group Health Association of America, Research and Analysis Department, *Patterns in HMO Environment*, 1991 ed.

- (Washington, D.C.: GHAA, June 1991). A member was defined as an individual who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the HMO has accepted the responsibility for the provision of basic health services. Plans were asked to exclude PPO enrollment. The definition would include enrollees in "open-ended HMO options" but exclude those in point-of-service options where the HMO merely "rents" its delivery system to another entity operating the insurance plan.
4. July 1980 statistics were collected by the Office of Health Maintenance Organizations, National HMO Census, 1980, DHHS Pub. no. (PHS)80-50159 (1980). For historical trends, see L.R. Gruber, M. Shadle, and C.L. Polich, "From Movement to Industry: The Growth of Managed Care," *Health Affairs* (Summer 1988): 197–208.
 5. Methods used to collect these data are further described in GHAA, HMO Industry Profile, 1991 ed. (Washington, D.C.: GHAA, 1991 [in three volumes]). Methods for collection have been essentially unchanged over time; prior years' editions review response rates as well as relevant statistics for the covered period.
 6. C. Sullivan and T. Rice, "The Health Insurance Picture in 1990," *Health Affairs* (Summer 1991): 104–115.
 7. Health Care Financing Administration, *Monthly Report, Medicare Prepaid Plans* (July 1991).
 8. HCFA, Medicaid Bureau, "National Summary of Managed Care Plans and Enrollment" (Health Care Financing Administration, 1 May 1991).
 9. GHAA, *Cautions for Prepaid Organized Health Care under a National Health System: Lessons from Canada* (Washington, D.C.: GHAA, February 1990).
 10. J. Norman, "The Flowering of Managed Care," *Medical Economics* (5 March 1990): 89–105; and P.L. Havelicek, *Medical Groups in the United States: A Survey of Practice Characteristics*, 1990 ed. (Chicago: American Medical Association, 1990).
 11. M. Gold and I. Reeves, "Preliminary Results of the GHAA/BC-BS Survey of Physician Incentives in Health Maintenance Organizations," *Research Brief 1* (Washington, DC.: GHAA, November 1987).
 12. N. Kraus, M. Porter, and P. Ball, *Managed Care: A Decade in Review, 1980–1990* (Excelsior, Minn.: InterStudy, 1991), 63–64.
 13. Unpublished preliminary 1991 estimates from GHAA's Annual HMO Industry Survey.
 14. J. Gabel et al., "Employer-Sponsored Health Insurance, 1989," *Health Affairs* (Fall 1990): 161–175; 1990 comparisons by type of plan are not yet available.
 15. Unpublished preliminary 1991 estimates from GHAA's Annual HMO Industry Survey.
 16. For more extensive conceptual discussion of employer concerns on such issues as selection, rating, and cost control, see Gold, "HMOs: Structure, Performance, and Current Issues for Health Benefits Design."
 17. "Business and Health's 1990 National Executive Poll on Health Care Costs and Benefits," *Business and Health* (April 1990): 24–38.
 18. M. Gold and D. Hodges, *HMO Market Position Report* (Results of an October 1990 Member Plan Survey) (Washington, D.C.: GHAA, November 1990).
 19. M.J. Porter et al., *The InterStudy Competitive Edge* 1, no. 1 (Excelsior, Minn.: InterStudy, 1991).
 20. For a discussion of the continuum of managed care, see R. Feldman, J. Kralewski, and B. Dowd, "Health Maintenance Organizations: The Beginning or the End," *Health Services Research* (June 1989): 191–211. This article also contains a good discussion of defining managed care and researching its effects.
 21. Health Insurance Association of America, *Source Book of Health Insurance Data, 1990* (Washington, D.C.: HIAA, 1990), 118.