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ABSTRACT

Prepaid group practice as a concept for providing health care is now over 25 years old in the nation and in New York City. It has overcome initial opposition by the medical profession and has been adopted by government as a healthy strategy under the acronym HMO or "Health Maintenance Organization". The author asserts that on two major criteria for evaluating the health care system--accessibility to the health care system and cost of treatment--prepaid group practice compares most favorably with other types of Insurance plans. There are presently estimated to be 170 operational HMOs throughout the country providing service to some eight million enrollees. An additional 262 HMOs are in various stages of planning and development, although only 66 of these have the assistance of government funds for feasibility and planning surveys under the Federal HMO Act of 1973. The HMO is substantially an urban phenomenon requiring large concentrations of population and large initial sums of money. The HMO Act of 1973 was a Federal Law designed to promote and encourage the growth of prepaid group practice plans. Before and after the Act passed Congress, criticism began to develop and major problems began to emerge. The author advocates definitive and timely Congressional action to amend the Law in order to ensure its success. (Author/JM)

PRIMARY HEALTH CARE IN THE URBAN COMMUNITY: THE ROLE OF THE PREPAID GROUP PRACTICE PLANS

by Allan Kornfeld [1]

Prepaid group practice as a concept for providing health care is now over 25 years old in the nation and in New York City. It has overcome initial opposition by the medical profession and has been adopted by government as a health strategy under the acronym HMO or "Health Maintenance Organization". Do HMOs provide ready accessibility by consumers to good quality health care at a reasonable cost?

It is tempting for those of us who operate plans to point to prepaid group practice as the solution to the endemic "crisis" perpetrated by the fee-for-service non-system. The arguments for prepaid group practice are persuasive. Prepaid plans conceptually and organizationally do have the ability to contain costs, provide continuous good quality care, and to remove the barriers to care inherent in the fee-for-service system.

From a cost standpoint, prepaid plans, while requiring substantial capital expenditures, exhibit more efficient use of the medical care dollar. Existing plans have consistently demonstrated a statistically significant lower hospital utilization which produces substantial savings since hospital costs account for the largest portion of the medical care dollar. In addition, since physician reimbursement is fixed on a capitation basis (arrived at through arm's length negotiations) without regard to the number of services provided, the incentive for providing unnecessary services is removed. From a delivery standpoint, the subscriber is assured of continuity of care, 24 hour a day coverage, and the convenience of receiving all ambulatory medical care in one location. The prepaid system can more easily develop mechanisms and impose quality controls, and screen the qualifications of physicians. Since there is little or no dollar outlay at the times services are received, financial barriers to receiving medical service are removed and a favorable atmosphere for the practice of medicine is created.

Let's look at the plan I represent to see how well it provides accessibility to consumers while containing costs and delivering good quality care.

HIP and New York City have a unique and special relationship. HIP is a creature of the urban environment in many significant ways. Created 27 years ago under Mayor La Guardia in recognition of the need to pro-

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vide medical care to City employees, HIP today serves the health needs of about 10% of the City's population. It is the major source of ambulatory care on an organized prepaid group practice basis with 28 independent groups of physicians in the metropolitan area operating out of 45 medical centers and subcenters which contract with HIP to provide care to HIP enrollees.

HIP is a health system with many component parts providing medical care to a diversified, but mainly middle class population including City, State and Federal employees, labor union groups, and Medicare and Medicaid recipients.

HIP policy is set by a 24-man Board of Directors representing contractors, providers, consumers and the public. The HIP corporation undertakes to market, enroll, pay capitation to the medical groups, monitor the quality of care, dispose of claims and complaints, and account for funds. It provides and supervises ancillary care through social workers, health educators and nutritionists. Presently over a thousand physicians are either partners or contract physicians in the 28 medical groups. About 400 are full-time with HIP and provide over 50% of all medical services. Although the medical groups provide a substantial part of care to patients, HIP has over the years undertaken to deliver directly various aspects of care. For example, our Emergency Service Program operates when the medical groups are closed, on a seven day, 24 hour a day basis providing emergency care throughout the City. HIP operates a Mental Health Program providing care to about 150,000 persons. Our Drug Program presently fills 1,000 prescriptions per day. Through a subsidiary corporation, HIP operates the La Guardia Hospital in Queens County which is presently, with the aid of a State loan, expanding to over 300 beds. When completed, this hospital will take care of all HIP's hospital needs in Queens County. In addition, HIP and the medical groups share responsibility for a Centralized Laboratory, presently delivering some 2 million laboratory services per year, and a Special Services Fund which spends over 2 million dollars per year to provide, on referral, super-specialty services beyond the scope and capabilities of the medical groups such as heart surgery, radiation therapy, neurological surgery and many others.

HIP attempts to assure quality care through a variety of means. Physicians entering the HIP system must be approved by a Medical Control Board consisting of outside distinquished physicians. This Board also sets standards and qualifications for manpower needs, facilities, and other aspects of the delivery of care.

The HIP Medical Department monitors contractual standards. A Peer Review system is in place and operational this year. HIP has a well-developed system for handling subscriber complaints through several

channels: 1) a Subscriber Service Department, 2) consumer councils in each medical group, and 3) a final appeal to an independent Ombudsman.

Access to the system by the consumer is on an individual appointment basis through a single primary care physician in the medical group chosen by the consumer. This primary care physician makes necessary referrals to specialists and other health services.

This thumbnail sketch is brief, but it will give you some idea of the complexity and scope of the HIP system.

In 1973, physicians affiliated with HIP medical groups provided a total of 3.2 million face-to-face office services; 3,500 babies were delivered by HIP physicians; 16,000 operations were performed in hospitals; 1.8 million specialty services were provided. HIP physicians provided an average of 4.3 services per enrollee. In addition, many thousands of ancillary services were provided through the Centralized Laboratory, Emergency Service Program, the Drug Program and the Mental Health Program.

I recite these statistics to show you that, despite any bureaucratic red tape necessarily inherent in such a large and complex system, thousands of HIP enrollees, on a daily basis, are able to have ready access to all components of medical care.

Over the 27 years of its history, HIP has many pioneering achievements to its credit and continues to come up with creative programs and mechanisms which serve as a role model for other HMOs around the country. For instance, the Peer Review Program and the independent Ombudsman established in the HIP 1973 contract with the medical groups are landmarks in an ambulatory care system.

In 1973 per capita expenditures for personal health care in the United States were $441; for a family of three this would amount to $1,323. Per capita costs of the Medicaid Program in New York City were $1,338 (exclusive of nursing home care). Comparable HIP premium for a family of three or more was $302. To this amount must be added approximately $356 for Blue Cross hospital benefits making a total in and out of hospital package of $658.

The average cost of an office visit delivered by a HIP family doctor in 1973 was about $10 including cost of X-rays and injectable drugs and the average cost of an office visit to a HIP specialist (who deliver almost half of all physicians services) was about $20. We believe that this is about 90% of the cost of comparable indemnity plans, and can be compared to the average cost of an out-patient service in a hospital emergency room which ranges from $35 to $50.

Hospital utilization of HMP enrollees is 15 to 20 per cent less than the utilization of the average Blue Cross enrollee. Yet neither HMP nor the medical groups receive any financial advantage or incentive from the million of dollars in hospital cost savings that have accrued over the years.

Thus on two major criteria for evaluating the health care system which are mentioned in the draft outlined for this symposium, namely accessibility to the health care system and cost of treatment, I believe prepaid group practice compares most favorably with other types of insurance plans.

There are presently estimated to be 179 operational HMOs throughout the country providing service to some 8 million enrollees. An additional 262 HMOs are in various stages of planning and development, although only 66 of these have the assistance of government funds for feasibility and planning surveys under the Federal HMO Act of 1973. Sponsors of HMOs include insurance companies, Blue Cross affiliates, hospitals, medical schools, unions and consumer groups. The HMO is substantially an urban phenomena because of the large concentrations of population and large sums of money needed to establish facilities and to make the plan operational.

Only a few of the plans presently in operation can be considered giants. Kaiser on the West Coast with well over two million enrollees has expanded westward to Hawaii and eastward to Denver and Cleveland. The next largest is the Health Insurance Plan in New York City with about 750,000 enrollees. After that comes the Group Health Co-Operative of Puget Sound, Seattle, Washington, with about 150,000 enrollees. All the rest are fairly small. An operative plan with thirty to fifty thousand enrollees is considered a good sized HMO.

Let's examine the HMO Act of 1973, a Federal law designed to promote and encourage the growth of prepaid group practice plans. Passage of the Act was heralded by its proponents as a long-awaited and necessary leap forward to a more rational health delivery system which could also contain runaway costs. The Act contains several key provisions believed to be essential to HMO development including, 1) the authorization of $375 million to be distributed over a five-year period in the form of grants and loans for HMO development and expansion, 2) a mandatory dual choice option requiring that employers of over 25 employees offer a choice of an HMO along with other health insurance, and 3) the pre-empting of State laws which discourage development of HMOs.

Before and after the Act passed Congress, criticism began to develop and major problems began to emerge. These problems are especially critical as they affect established operational plans. For instance,

the Act mandates a benefit package that is so rich and comprehensive that it will be most difficult to market competitively. This is becoming more acute in a sagging economy. For HIP to become a certified HMO would mean a 15% premium rise which in turn would mean that the City of New York, our largest contractor, would have to agree to the payment of $4 to $5 million additional dollars the first year to cover costs for its HIP and City enrollees or large co-payments by the consumer. You've read today's newspaper - under present fiscal extremity this is not very likely. There are other serious problems with the bill.

What is needed at this time is definitive and timely Congressional action to amend the law in order to assure its success. I suspect that the Administration is shedding no tears over the standstill pace of development of the Act and prefers not to spend the money for implementation. This is consistent with the Administration's thinking in recommending no action be taken with respect to consideration of National Health Insurance at the present time.

Before closing I should mention one of the major problems that urban governments on every level are grappling with and that is the huge cost of providing care to the Medicaid population. During the 10-year period 1960 to 1970, over a million middle class individuals moved out of New York and were replaced by an equivalent number of disadvantaged, frequently under-educated people without job skills for whom medical care must be provided by government subsidy. This shifting population pattern continues and has a profound effect upon HIP which has remained mainly an urban, inner-city oriented system. The original concept of HIP was to provide care for employed people. In view of this vast shifting of people the fact that HIP's population has remained relatively stable is remarkable. HIP has not shirked its responsibility to the less fortunate. Starting in 1962, HIP began a welfare demonstration project to provide medical services to welfare recipients integrating this population with its regular case load. After the Medicaid law came into being, HIP at one point enrolled some 93,000 Medicaid recipients. This number has now dropped considerably. The Medicaid population has two major problems. The first is that according to present eligibility rules, Medicaid recipients have to be re-certified every month; therefore, they go in and out of the Medicaid system so fast that it is almost impossible to keep track of them for enrollment purposes. Secondly, an extensive outreach program is necessary to properly educate the new enrollees on the services available and how to use the system. Without placing blame, HIP and the Department of Social Services of the City of New York have never been able to agree on an enrollment system that brings large numbers of

Medicaid enrollees into HMP. Instead, Medicaid enrollees are receiving sub-quality care from the Medicaid mills that have sprung up in ghetto areas where they are ping-ponged through the fee-for-service method resulting in high costs to the government. On the other hand, Medicaid patients in HMP are charged only the basic fixed premium. This is a great injustice to prepaid group practice and ought to be rectified if we are serious about providing good quality medical care at reasonable costs to our indigent population.

Is it feasible to reorganize the present health delivery system so that all or most Americans will receive their care through prepaid group practice on a capitation basis? The broad consensus of people for whom prepaid group practice is "a cause" think this is not feasible at the present time and do not expect that it will become feasible in the foreseeable future. HMOs are not looking for exclusivity. In fact one of the standards by which HMOs are judged for eligibility to become members of Group Health Association of America is that a dual choice option period be extended to all enrollees. Many Americans for a variety of different reasons will continue to use the fee-for-service system. What prepaid group practice wants is a fair governmental and legislative climate and a fair chance in the competitive market place. Given that opportunity we have no doubt that prepaid group practice will continue to grow and will become through growth a viable alternative to the fee-for-service system in all urban communities.