

PN-ABP-003

MASTER COPY ISN 82166



# **HEALTH SECTOR FINANCING PROJECT**

---

Ministry of Health  
Republic of Indonesia

CONSULTANT REPORT SERIES



---

A USAID-Sponsored Project in Collaboration with  
The International Science and Technology Institute, Inc.

**TOUR AND REVIEW OF SELECTED US HMO's,  
AND BREIF OVERVIEW OF THE ONTARIO, CANADA  
COMPREHENSIVE UNIVERSAL HEALTH CARE SYSTEM**

**OCTOBER 16, 1988 THRU NOVEMBER 5, 1988**

**#10**

**Author:**

**George S. Goldstein**

**January 1989**

**Prepared for:**

**Health Sector Financing Project  
Ministry of health  
Republic of Indonesia**

**Under USAID Contract No. ANE-0254-C-00-8030-00**

**Prepared by:**

**International Science and Technology Institute, Inc.  
1129 20th Street, NW  
Washington, D.C. 20036  
Tel: (202) 785-0831  
Telex: 272785 ISTI UR  
FAX: (202) 223-3865**

Table of Contents

I. The Study Team

- A. Purpose
- B. Members
- C. Tutor

II. Aim of the report

III. Classroom presentations and discussions

A. Overview

B. Conceptual matters discussed during the tour

- 1. Definition of "managed health care"
- 2. Differences between HMO/managed health care and traditional health insurance
- 3. Definition of an HMO
- 4. Organizational concepts underlying the HMO definition
- 5. Different HMO models
- 6. Major factors necessary to organizing an HMO
- 7. Alternative methods of paying HMO providers
- 8. Assuring a high quality, cost-effective operation through utilisation review (UR) and quality assurance QA.
- 9. Major segments of current US and Indonesian medical care delivery systems

C. Federal and State legislative and regulatory issues

- 1. Classroom discussions
- 2. Programs visited

D. Federal programs discussed or visited

- 1. Medicare
- 2. Medicaid
- 3. Community Health Centers (CHC) program
- 4. Visit to Congress

E. State legislative and regulatory programs discussed

- 1. Massachusetts
- 2. Hawaii
- 3. California

IV. Selected programs observed during the tour

A. HMO's in the US

1. Staff models

- a. Group Health Assn (GHA) - Washington, D.C.
- b. Columbia Medical Plan - Columbia, Md.

2. Group models

- a. George Washington University Health Plan (GWUHP) - Washington, D.C.
- b. Kaiser Fdn. Health Plan - Los Angeles, Ca.
- c. Kaiser Fdn. Health Plan - Honolulu, Hawaii

3. IPA models

- a. Chesapeake Health Plan - Baltimore, Md.
- b. Hawaii Medical Services Assn. (HMSA)  
- Honolulu, Hawaii

4. Network model

- a. Health Net - Los Angeles, Ca.

B. Ontario, Canada

- 1. Comprehensive, universal health insurance program
- 2. Development of managed health care systems

V. Concluding, summary discussion, Friday, Nov. 4, 1988

A Introduction

B. Why proponents prefer HMO/managed care concepts,  
to traditional indemnity health insurance

C. Some major questions arising during the Study  
Team's review of the HMO/managed care industry in  
the US and Ontario, Canada.

---x---

The Report

I. The Study Team

A. Purpose

1. In order to improve health services available to the people of the Republic of Indonesia, the Indonesian government, working with the help of the US Agency for International Development (AID), has been developing, among other projects, a broad, multi-year initiative to increase the scope of social financing in health insurance programs in both public and private sectors in Indonesia. To further this goal, a Study Team of ten Indonesian officials who have major responsibilities for developing the health insurance industry, was sent on a study tour for the purpose of orienting themselves to health insurance programs in the US and Canada. The major aims of the tour were to help the members of the Team to gain an understanding of HMO and managed health care concepts as they are used in the US, to study how those concepts differ from traditional indemnity health insurance, to observe the operation of a number of programs functioning under managed care concepts, and to look at the legislation and regulations which govern the HMO/managed care industry.

2. Thus, the agenda of the tour aimed to: (1) introduce participants of the Study Team to concepts fundamental to managed health care systems; (2) provide an opportunity for the team to see how the components of a managed care system must interact to provide quality health care in a cost efficient manner; and (3) place emphasis on the key components of utilization review, quality assurance mechanisms, provider relations, effective management information systems, financial risk bearing, and effective organized health care delivery systems.

B. Members. The members of the Study Team include the following officials:

1. Dr. G. Rizali Noor, DDS - Director, Project Implementation Office, and Coordinator of the Study Team.
2. Dr. I.G.M. Brata Ranuh, MD, MPH - President, Civil Service Health Insurance Program (PHB).
3. Dr. Sri S. Setijana, MD, MPH - Civil Service Health Insurance Program (PHB).

4. Mr. Sentanoe Kertonegoro, MBA, MS - Ministry of Manpower and Labor, and Director, The Social Insurance System;
5. Dr. Oemy Syarief, MD - Ministry of Manpower and Labor, and Secretary, PKTK Coordinating Committee.
6. Drs. Chudri Burhanudin - Ministry of Health, Chief, Bureau of Organizations.
7. Dr. Erna Tresnaningsih, MD - Ministry of Health, Chief, Employees Service Section.
8. Dr. G.P. Wiadnyana, MD - Ministry of Health, Section Chief.
9. Mrs. Emma Suratman, SH - Ministry of Health, Chief, Bureau of Legal Affairs and Public Relations.
10. Mr. Budi Yahmono, SH - Ministry of Health, Chief, Division of Legislation Formulation.

C. Tutor.

1. In order to assure that the tour of the Study Team function as a "traveling seminar", the Team was accompanied by a tutor, Mr. George S. Goldstein, to serve as a facilitator. The role of the tutor was to help Team members understand and interpret what they saw and heard, to help raise and answer relevant questions, and to integrate and synthesize conceptual and operational matters as they occurred during tour discussions.

2. Mr. Goldstein is currently Adjunct Assistant Professor in the Dept of Health Services Administration, Graduate School of Public Health, University of Pittsburgh.

3. He served for thirty two years as Executive Director of prepaid group practice, HMO programs in the US. He has also devoted many years to active participation in the affairs of the Group Health Association of America, and is now an honorary, lifetime member of the Board of Directors of GHAA.

II. Aim of the report.

A. The aim of this report is to provide an organized basis for the Team members to review their experiences and learning, and to provide a supplement to their own records. The report will attempt to aggregate, synthesize, and summarize those aspects of what was seen

and learned, which were considered most relevant to the purposes of the tour.

B. The Tutor is indebted, for many elements of this report, without giving specific credits, to the large number of people who made presentations throughout the tour. This includes, in addition to GHAA staff and speakers from GHAA member Plans, the people who made presentations at each program visited, and the staff of ISTI.

### III. Classroom presentations and discussions

A. Overview - A major part of the first week of the tour, while in Washington, DC., was spent in classroom discussion of presentations by GHAA staff and other speakers from GHAA member HMO's, in two areas:

1. Conceptual and theoretical issues involved in the history, development, philosophy, organizational structure, financing, and operations of HMO's and managed health care systems in the US.

a) These discussions were aimed at developing the necessary theoretical clarity on the part of the study team members, for their consideration of adapting HMO and managed care concepts to the Indonesian context.

b) These conceptual and theoretical matters were repeatedly reviewed in the context of studying the specific programs observed during the tour.

2. Federal and state legislative and regulatory matters and programs in the US.

B. Conceptual and theoretical matters discussed during the tour.

1. Definition of "managed health care".

a) In the long historical development of HMOs in the US, "managed health care" is a new term which has appeared in the most recent eight to ten years, and spread rapidly and widely in use. The term, however, is frequently used interchangeably with the term HMO. This practice is inaccurate, and clouds a number of significant issues. Although the two concepts are closely related, and each can, and has been carefully defined, nevertheless there continues to be much loose, unclear usage of the two.

b) A good, usable definition of managed health

care has been offered by Interstudy. Commenting that the term suggests "the careful planning and delivery of health care services", Interstudy (paraphrased) defines a managed care plan as an organization that:

(1) markets a health program that integrates financing, management, and the delivery of care to an enrolled population, and

(2) uses an organized provider network which takes responsibility to deliver services, and which shares financial risk and/or has some other incentive to deliver efficient services, and

(3) uses an information system to monitor and evaluate utilization and financial outlays.

(4) (Source: From HMO Movement to Managed Care Industry - Interstudy, Excelsior, Minnesota, June, 1988, pp.17-18.)

c) In accordance with this definition, HMOs clearly come under the umbrella of, and can be considered the premier form of managed care. In recent years, however, in the competition between HMOs and commercial indemnity health insurance companies, many of the insurance companies, and employers as well, (the latter sometimes with the help of an insurance company, and sometimes on their own), have begun to use some of the mechanisms which an HMO would use, to manage the delivery and/or financing of some part of health care. Thus, while an HMO is a managed care plan, not all managed care is an HMO.

d) Thus, the term managed health care has come to be used much more loosely than in the above Interstudy definition. In this looser sense the term involves simply the use of some HMO methodologies - in one form or another, to one degree or another - for managing the outcome of some part of the delivery, the cost, the financing, the accessibility, or the quality of care.

e) Managed health care in this sense clearly does not imply the presence of an organization responsible for both delivering and financing health care, ie, an HMO, but merely the use by other entities of some of the methods HMOs use

to control or manage health care.

f) The use of managed health care in this looser sense has become very widespread indeed, in the past few years in the US, by health insurance companies and employers, so that today the combination of the continued growth of HMOs and the widespread adoption of some managed care methods by other entities, has had an enormous impact in changing the nature of the delivery system as a whole in the US.

2. The differences between HMO/managed health care concepts and those of traditional indemnity health insurance.

a) In the context of the above definition of managed health care, and the definition and underlying concepts of an HMO which follow below, it is important to emphasize the conceptual differences between HMO/managed care and traditional health insurance.

b) The basic difference lies in the nature of an HMO, or a managed health care system (as defined above), as an integrated system that takes on responsibility, in a framework of financial risk, for both the delivery and financing of care and responsibility for the cost and quality of that care. Traditional health insurance, on the other hand, has taken responsibility only for indemnifying, or insuring after the fact, for expenditures made by the insured in obtaining care. Traditional health insurance has taken no responsibility for delivering the care or for controlling its cost or assuring its quality.

c) In this context, an HMO/managed care program is a new type of organized health care system, as opposed to the traditional ffs "non-system" supported by the unrelated commercial indemnity health insurance. This is a new system in which management methods and concepts have become crucial, for both providers and administrators, because of the financial risk and the responsibility for cost and quality in a competitive framework.

3. Definition of an HMO. An HMO is:

a) An organized program, which

b) takes contractual responsibility to provide

- c) a fixed and defined package of services
- d) for a defined group of people
- e) who have enrolled voluntarily
- f) and who make a fixed periodic payment set prospectively,
- g) with HMO and providers sharing financial risk

4. Important organizational concepts implicit in this definition of an HMO:

- a) Prospective payment - cost to the member of the plan is known in advance and fixed, regardless of the quantity of services used.
- b) Cost-sharing - the prospective, periodic payment made is based on the idea of sharing the estimated cost of services to be provided to the entire group of people. A capitation (or per head cost) is calculated, and from that a periodic premium payment per person, or per member, for the fixed and defined package of services.

(1) Under the original HMO Act, federally qualified HMOs were required to use "community rating" in calculating premiums. This involves doing the calculation based on all of the groups (the entire "community") served by the HMO. By charging all of the HMO enrollees the same rate, the high costs of the high risk enrollees were shared with the low costs of the low risk enrollees, so that coverage was made equally available to all.

(2) This federal requirement, though obviously socially highly desirable, represented a competitive disadvantage for HMOs, because the ordinary insurance laws allowed commercial indemnity insurance companies to use "experience rating". This is a method of calculation in which a separate premium is calculated for each group of people covered. Thus, the indemnity insurance companies were able to charge low rates for low risk groups, and stay away from the high risk groups.

(3) In recent years, the HMO Act has been

amended so that the methodologies of community rating have been redefined and expanded in scope, so as to improve the competitive position of HMOs.

c) Responsibility for cost - the HMO plan and the providers (those responsible to both finance and deliver the care) jointly take responsibility for cost in return for the fixed, prospective, capitated, periodic payment.

d) Risk - the HMO, and the providers working within its structure, are at risk for keeping actual cost within the fixed premium payment per month collected in advance. "At risk" means they gain or lose, respectively, if actual cost is under or over the fixed periodic payment.

e) Competition - members are enrolled voluntarily, so that the HMO must provide a quality product at a competitive price, in order to prevent its members from disenrolling and joining some other HMO, or a commercial health insurance program, during the required annual re-enrollment period.

f) In summary, an HMO is a new, different type of organized system of delivering and financing medical care - as opposed to the traditional fee-for-service (ffs) "non-system" supported by traditional health insurance. In this new system, management methods and concepts have become crucial, for both providers and administrators. Thus, the organization of medical care delivery becomes more like other businesses functioning in a competitive economy.

##### 5. Different HMO models.

a) In the course of the historical development of HMO's in the US, especially since the passage of the federal HMO Act of 1973, a number of different models of HMO's have evolved.

b) These models are illustrated by the charts on the following pages:

(1) Staff model - see p. 11a: characterized by all employees, including physicians, being hired by the HMO; the MD's are paid by salary, and usually do not share risk, though there may be incentive bonuses; the HMO owns clinics, but only rarely a hospital, instead purchasing hospital as

well as referral physician services

(2) Group model - see p. 11b: the HMO hires all employees except physicians, instead having a contract with an independent, professional corporation, or group, of physicians (sometimes several groups) committed to serving the HMO members only (or primarily); the group(s) are paid by capitation, usually with risk sharing; the HMO owns clinics for the group practice of medicine, and sometimes hospitals.

(3) IPA model - see p.11c: a separate legal corporation (the IPA) is established by the physicians to contract with the HMO, on a capitation basis; the IPA contracts in a variety of ways, with different risk sharing arrangements or other incentives (such as a percentage holdback of fees), with individual MD's or groups, who practice in their own facilities, and also continue to serve their own ffs patients (usually a majority of their work).

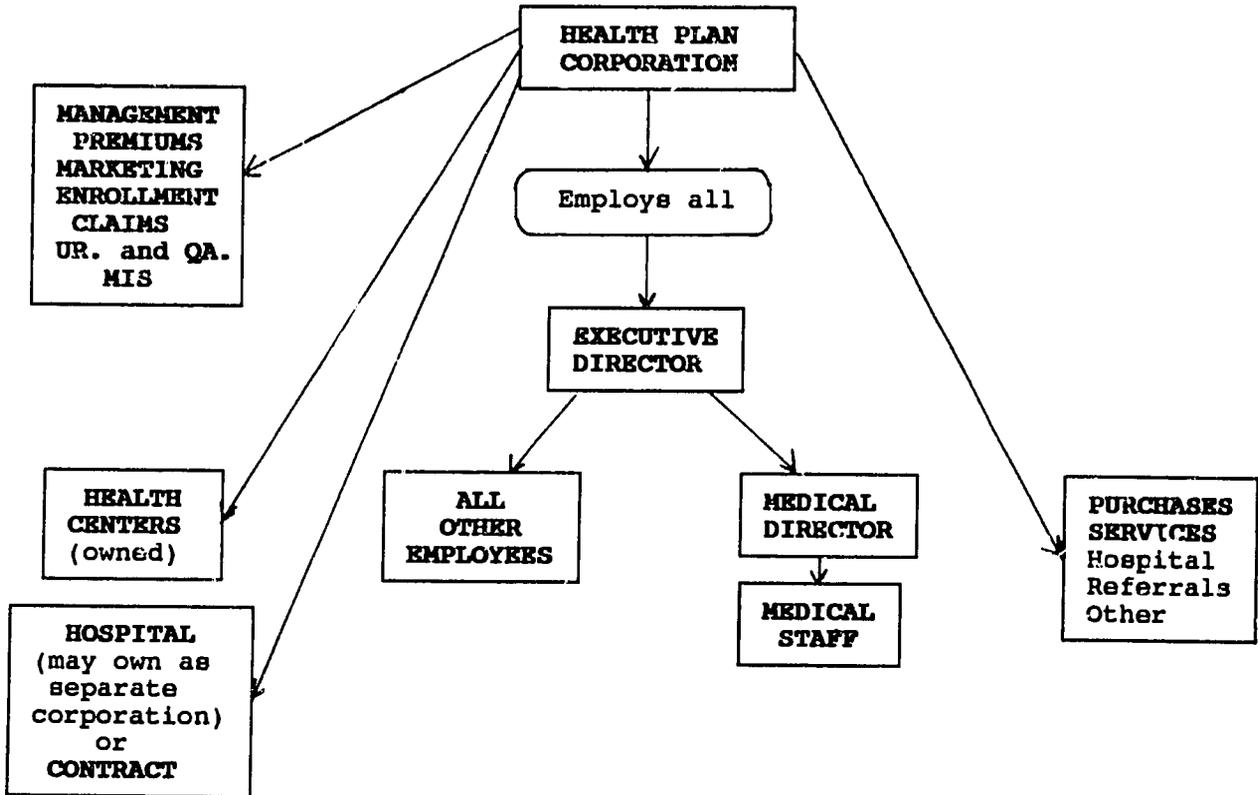
(4) Network model - see p.11d: the HMO contracts directly with a number of groups and also with some individual MD's (without an IPA); the groups and physicians also continue to serve their own ffs patients (usually a majority of their work); the contracts provide a variety of payment forms, including capitation and fee holdbacks, with risk sharing and/or incentive bonuses.

c) In recent years, the lines of differentiation among the different models have become blurred; many mixed models, in a variety of forms, have developed. For example: a group model could involve a number (a network?) of groups contracting with the HMO, with each group committed to serving only (or primarily) the enrolled members of the HMO; or an IPA model, similarly, could involve a number (or network) of IPA's contracting with the HMO; etc. Moreover, in many cases, one model HMO may operate another, different model HMO as a separate line of business.

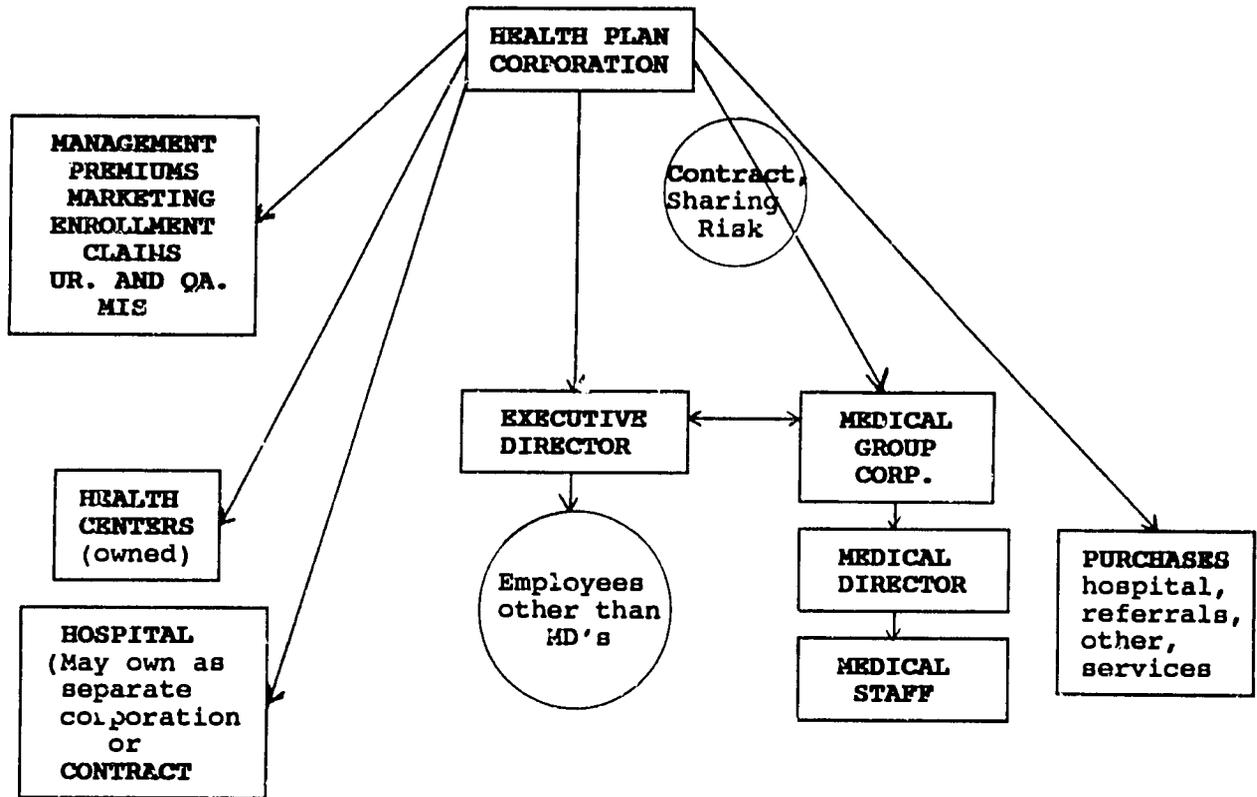
d) Major advantages and disadvantages of each model.

(1) Staff model. Advantages are mainly those

I. HMO  
STAFF MODEL



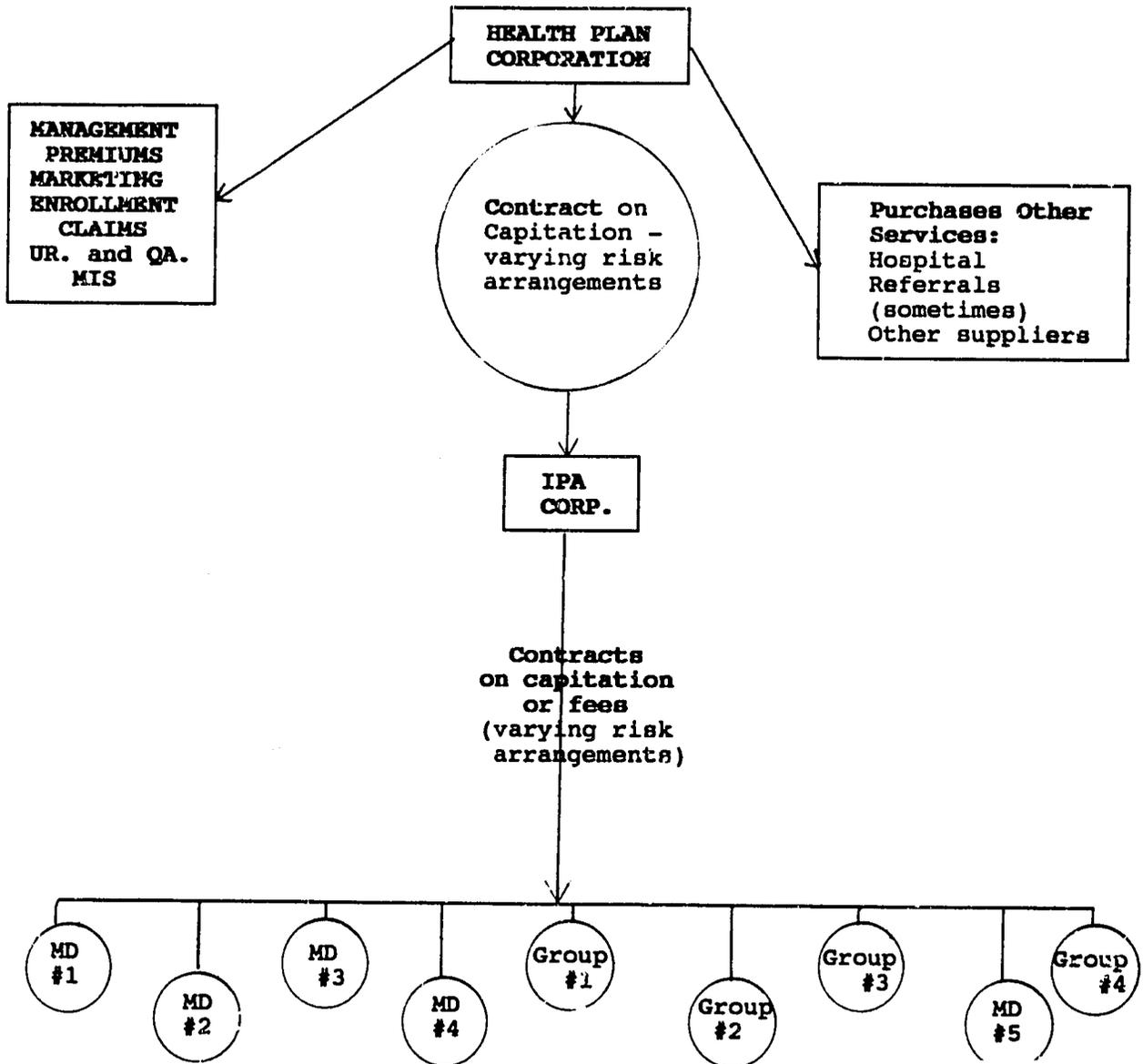
II. HMO  
GROUP MODEL



**III. HMO**

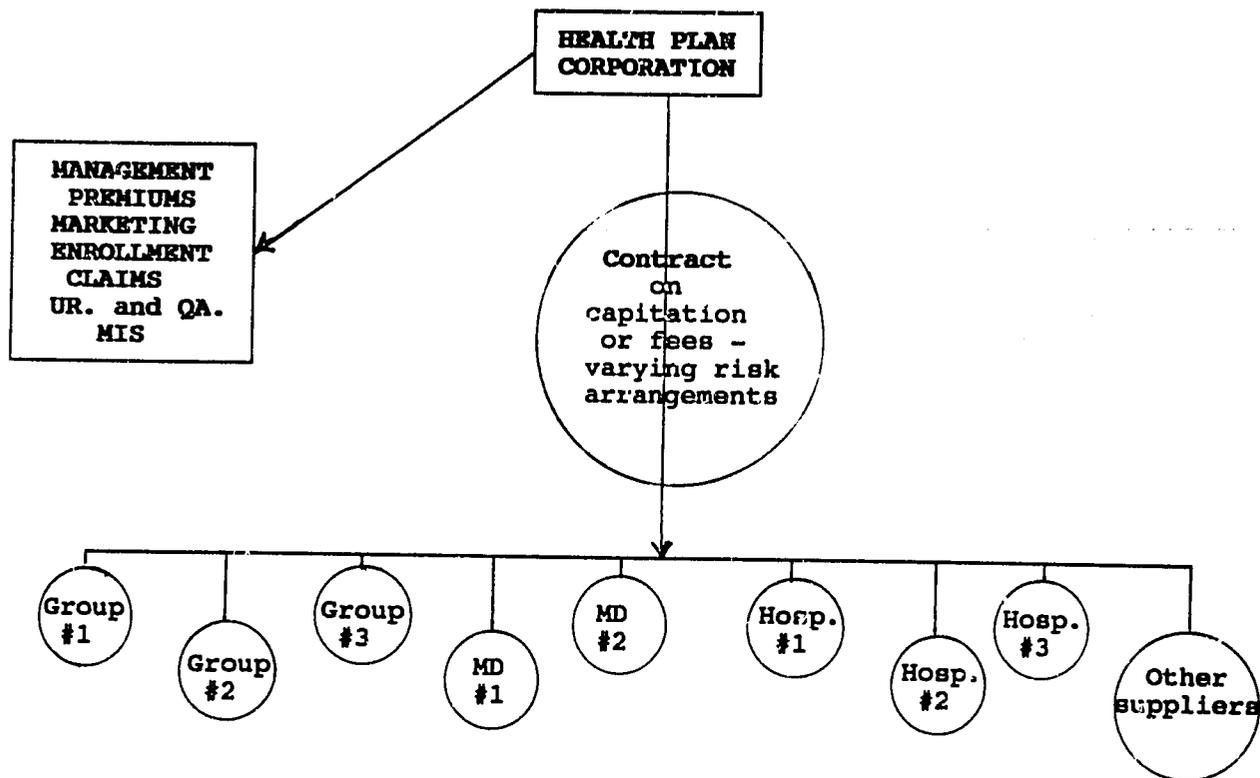
**IPA MODEL**

**(Independent Practice Association)**



IV. HMO  
NETWORK MODEL

(or PPO)



of the group practice of medicine, and the relative ease of implementing cost controls (especially utilization review, or UR) and quality assurance (QA). Disadvantages include the large capital investment needed for start-up and ongoing operation, marketing difficulties because members are limited to choice of physicians on the HMO group staff, difficulties in maintaining physician productivity in a salaried situation without risk sharing, and difficulties in recruiting medical staff because physicians generally prefer not to work for a lay corporation.

(2) Group model. Advantages are similar to the staff model, namely the group practice of medicine, and the ease of implementing cost controls and QA. A significant additional advantage with an independent but committed medical group, is the ability to create and maintain an effective cooperative relation in program management between management staff of the Plan and of the medical group. Disadvantages include the same need for large capital investment, and marketing difficulties because the choice of physicians is limited to those in the medical group.

(3) IPA Model. Advantages are mainly the significantly lesser need for capital investment because IPA physicians are already in their own facilities, and the relative ease of marketing to a large and accessible list of established primary care physicians. Disadvantages include the continued element of fragmentation of care carried over from the traditional ffs practice of medicine, and the significant difficulties of implementing cost (especially utilization) controls and quality assurance in a system of scattered, independent physicians.

(4) Network model - Advantages and disadvantages are a mixture of some of those of the Group and IPA models. With a number of groups of physicians involved in the network, the advantages of the group practice of medicine are present, as is the relative ease of implementing cost controls and quality assurance procedures. Also, with a number of groups and individual physicians

as well involved, there are the advantages of relative ease of marketing and the lesser need for capital because each MD or group practices in its own already existing facilities. However, to the extent that there are a sizable number of individual physicians included in the network, the disadvantages of continued fragmentation of care, and difficulties of implementing cost controls and quality assurance procedures remain.

(5) Preferred Provider Organization (PPO). (See the chart for the Network model (p.11d). Strictly speaking, a PPO is not an HMO. A PPO is an organization which contracts with a list of "preferred providers" (hospitals, physicians, and others) who have agreed to provide services to the PPO's enrolled members, at discounted fees; the PPO markets this list of preferred providers to the employees of participating employers; the employers get a major part of the cost saving of the discounted fees. In fact, however, a PPO in this elementary form does little to change the system of delivering and financing medical care. Thus, in order to be more effective, PPO's more often than not adopt some of the managed care methods of HMO's, such as utilization review and other cost control measures, quality assurance procedures, and elements of risk sharing. Having done this, the PPO acts and looks like a Network model HMO. Thus, we may classify the PPO, in its more developed form, as a Network model HMO.

6. Major factors necessary to organizing an HMO.

Four major organizational factors must be considered in the practical process of organizing an HMO as a functioning provider of medical care. The same basic factors are necessary, regardless of the model HMO, although there is, of course, much variation in how those factors apply in a given situation, with the different model HMOs. The factors are, in order of priority:

a) Market - Since an HMO takes responsibility to provide or arrange for a package of services to a voluntarily enrolled population, and must invest a large amount of money and resources to do that, the HMO must be assured in advance that there in fact exists an adequate market. An adequate market is one that contains enough

people who potentially can be enrolled and who have the ability to pay, either on their own or through some other source, the agreed premium for the services, so that the HMO can attain and maintain the necessary flow of revenue to reach financial viability.

b) Medical staff - It is self-evident that the HMO cannot provide the agreed package of services without being able to assure the availability of the appropriate medical staff and necessary support staff.

c) Management - It should also be self-evident, but often is not, that skilled management staff, both administrative and medical, is necessary to develop and guide the program. All too often, the major reason for failure of an HMO has been lack of such skilled management personnel.

d) Money - A large amount of up-front and continuing capital is necessary to support the developmental stages of a program, until sufficient total enrollment is reached to produce adequate revenue flow to attain financial self-sufficiency.

7. Alternative methods of paying providers.

a) The question of alternative methods of paying providers, especially paying physicians, who control almost all decisions on how and when to treat patients, is a key one in the theory and practice of HMOs and managed care.

b) In considering this question, for physicians, points to emphasize are:

(1) Inclusion of risk sharing and appropriate incentives enhances achievement of what is wanted, namely, quality care provided in a cost effective manner;

(2) Paying the physicians fairly will encourage cooperation; and

(3) Keeping the system as simple as possible, will minimize later differences.

c) Education of physicians is a necessary supplement to the risk sharing and incentives. However, such education is much easier to implement, with a reasonable chance of success, in staff and group models, where physicians are

easier to reach, and much more difficult in IPA and network models, where physicians are much harder to reach.

d) Methods of paying physicians vary by HMO model.

(1) Staff model - The staff (or "inside") physicians are almost always paid by salary, usually plus or minus (+/-) an incentive bonus based on the overall financial performance of the HMO. In a staff model, risk is only indirect, that is, limited to whether the HMO can continue to meet its payroll commitments. "Outside", or referral, physicians are usually paid by discounted fees, and occasionally by capitation, with risk limited to a corridor of maximum gain or loss.

(2) Group model - While the medical group itself is almost always paid a capitation from the Plan, the individual group physicians are paid, by their own group, by a variety of methods, depending largely on whether the group is dedicated solely or mostly to Plan members, or only partially to Plan members (less than, say, 50% of the group's patients). The former (like Kaiser) are usually paid salary +/- a bonus, similar to staff model MDs, except that the element of risk is greater and more direct. The latter, ie, groups only partially devoted to plan members, will have many different, more complex methods involving one or a mixture of salaries, fees plus sharing an incentive pool, productivity percentages, etc. Outside, or referral, physicians, are usually paid as they are by staff models, by discounted fees, or sometimes a capitation +/- a corridor of risk.

(3) IPA model - The IPA is almost always paid a capitation by the HMO, and individual physician members of the IPA are usually paid fees less a percentage hold-back, evaluated annually for payback, and sometimes plus a bonus based on overall or individual doctor hospital utilization. Capitation payment by the IPA to individual physician members is sometimes used, with varying risk sharing arrangements for the physician and IPA. Referral physicians are usually paid by negotiated (discounted)

fees.

(4) Network model - A mixture of the methods of group and IPA models is used.

e) Alternative HMO methods of paying hospitals.

(1) Usually, HMO hospital payment methods do not include risk sharing. Although a three-way sharing of gains or losses among HMO, physicians, and hospital is possible, in practice it is uncommon. The various payment methods, used by all HMO models except the few owning a hospital, include:

(2) Straight billed charges - no hospital risk.

(3) Discounted billed charges - no risk.

(4) Per diem cost - no risk.

(5) Capitation - risk for the hospital.

(6) Out-of-area hospitals are mostly paid straight charges, since HMOs have no clout with them.

8. Assuring a high quality, cost effective operation - utilization review (UR) and quality assurance (QA).

a) A crucial element of the theory and practice of HMOs and managed care is that the goals and the specific organized measures of cost control, must be accompanied by organized quality assurance measures, especially where there is risk sharing by physicians. Utilization review (UR) and quality assurance (QA) measures are two sides of the same coin.

b) UR and QA must occur with both outpatient and inpatient care.

(1) In the hospital, the major mechanisms for both UR and QA are: prior authorization for admission and surgical procedures; second opinions where appropriate; concurrent, ongoing patient review, while in the hospital, for quality issues and length of stay, by nurse/MD personnel specially trained for UR/QA; appropriate discharge planning; and retrospective review after discharge.

(2) For outpatient services, especially, a key to both UR and QA is the provision of adequate information on individual physician practice patterns, in a usable form; the same data is useful for both UR and QA.

c) The elements of the QA process include:

(1) structure - the system within which the care is given;

(2) process - what is done;

(3) outcome - the effect on the patient's health.

d) Clearly, the types and methods, and the extent of UR and QA, will vary widely with the model HMO and the type of managed care.

e) For a more detailed review of QA, the members of the Study Team were referred to the document handed out by GHAA at the Team session in Washington DC: "Overview of the QA Process", by Catherine Cleland; federal Office of Prepaid Health Care, and GHAA Medical Directors Division, Aug 25, 1988.

9. Major segments of the US and Indonesian medical care systems - current program financing and/or health insurance coverage.

a) United States.

(1) Government - federal, state, local

(a) Medicare (65+) ----- 30 M

(b) Medicaid (welfare) - state sponsored; state/federal financing- 20 M

(c) Federal employees health program - government/employee financed ----- 10 M

(d) Military (federally paid) ----- ??

(e) Special federal programs (CHCs, VA, etc) ----- ??

(f) Local (County, City) programs, health departments, hospitals ----- ??

(g) All of the above, except the VA and some County and City programs, use private sources of care.

(2) Private health insurance ----- ??

(a) Commercial, indemnity health

insurance programs

(b) Blue Cross/Blue Shield programs

(3) HMOs/managed health care systems - 32 M

(a) Mostly private financing by employees/employers

(b) Much overlap with all of the above, especially government

(4) No health insurance coverage ---- 37 M

b) Indonesia

(1) Government, central

(a) Central government civil servants program (including retired) - (PHB) - financed by 2% wage tax ----- 15 M

(b) Military ----- ??

(c) Both use government system of hospitals and clinics

(2) PKTK and ASTEK - central government sponsored, for some private employers, and for government owned corporations --- 70,000

(a) Financed by 7% employer-paid wage tax

(b) Mostly use government hospitals and clinics, but some employers provide own system of care; some use of private sector providers.

(3) Private health insurance

(a) For some private employers, and for general public

(b) Four life insurance companies offer indemnity health plans- but very small numbers enrolled

(c) A few provider-sponsored plans - also very small numbers.

(4) Dana Sehat

(a) Independent, private local (rural and urban) cooperatives.

(b) Some medical care (and other) programs now provided and financed - but Dana Sehat, with mostly poor, rural members, have very limited resources.

(c) Use central government system of hospitals and clinics, and some private sector providers.

(d) Large potential - since some 60% of total labor force in the country is rural, agricultural.

(5) No health insurance coverage ----- ??

C. Federal and state legislative and regulatory issues concerning HMOs.

1. In the US, the general division of powers between the federal government and the fifty states, places HMOs under a combination of regulation by both federal and state governments.

a) The powers of the federal government are derived from the US Constitution, which gives it jurisdiction over such matters as Defense, Commerce, Health, and Social Security.

b) The federal Department of Health and Human Services, under its Health Care Financing Administration (HCFA), covers the following health care programs:

- (1) Medicare
- (2) Medicaid
- (3) HMOs
- (4) Various public health programs

c) The Constitution also designates certain powers to the states, including the regulation of insurance and health. Thus, both State Health and Insurance Depts regulate HMOs. And State Health Depts also regulate the key elements of the delivery of medical care: hospitals, clinics, physicians, nurses, and other providers.

2. The federal HMO Act of 1973.

a) The basic ideas of HMO are essentially so simple, one wonders why the law didn't come sooner. Actually, the lobbies of organized medicine (the AMA), the traditional indemnity health insurance companies, and the

pharmaceutical companies, succeeded in getting state legislatures to outlaw those ideas and principles in most states. These state laws, however, started to break down in the 1960's.

b) The basic purpose of the federal HMO Act, which followed, in 1973, was to accept the principles of HMO and their effectiveness in controlling health care costs, and to provide support for the fledgling HMO industry.

c) The fundamental principles of HMO were built into the 1973 federal Act, after overriding any remaining state prohibitions, including the following:

(1) Mandatory, comprehensive basic coverage;

(2) Community rating - sharing cost among low and high risk persons;

(3) Mandatory dual choice for employees, between HMOs available, and the employer's current plan (usually a traditional commercial indemnity health insurance plan, or Blue Cross/Blue Shield). Interestingly, employers have never challenged in court either the law in general or this mandatory dual choice section;

(4) Equal employer contribution toward premiums of the HMOs and the competing insurance plans;

(5) Quality assurance requirements;

(6) Solvency requirements, including reserves of modest size, and reinsurance against unusually high risks;

(7) Consumer grievance procedures;

(8) Supporting funds, in the form of grants for start-up purposes, and loans for early operating losses until economic self-sufficiency is reached.

3. Federal regulation, including the major criteria for federal qualification. In the early years after 1973, federal qualification was considered essential for success; in recent years however, greater public knowledge of HMOs and greater influx of private sector funds have made qualification much less necessary. The criteria include:

- a) Financial soundness of the HMO;
- b) Presence of appropriate capital amounts;
- c) Appropriate pricing (not too low or too high);
- d) Adequacy of benefits;
- e) Appropriate marketing methods, particularly concerning information provided and honesty;
- f) Adequate quality assurance procedures; and
- g) Adequate consumer grievance procedures.

4. State regulation. State certification, which reviews criteria similar to those reviewed for federal qualification, is necessary for the legal right of an HMO to operate. A model state HMO Act has been developed by the National Assn of Insurance Commissioners (NAIC); although use of this by the States is not required, it has been highly influential in affecting the current form of most State Acts, although many significant differences remain among the states. The major areas of state regulation include:

- a) Oversight of contracts for services to be covered;
- b) Approval of premium rates established;
- c) Solvency issues, or financial responsibility to assure provision of and payment for care covered in the contracts;
- d) Availability and accessibility of providers and facilities necessary to produce services covered in the contract;
- e) Adequacy of quality assurance procedures;
- f) Adequacy of consumer grievance procedures; and
- g) Details of marketing plans and materials.

5. The federal HMO Act of 1973 created competitive disadvantages for HMOs, with respect to traditional indemnity health insurance companies. These include:

- a) The costs of the broad mandatory benefits coverage required of HMOs, in relation to the level of premium rates.
- b) The effect of mandatory community rating, in increasing premium rates.
- c) And the costs of more stringent regulation, especially with respect to regulations for quality assurance, which are not required of indemnity health insurance companies.

6. Gradual amendment of the HMO Act of 1973. As a result of political pressures generated by the disadvantages listed above, as HMOs took hold in the marketplace in the 1970s and 1980s, as enrollment expanded rapidly from 4.5 million in 1973 to 31 million in 1988, and as private sector funds began to flow into the industry, a gradual process of amendment of the Act took place. Especially significant amendments were made by Congress in 1976, in 1986, and most recently in 1988. These amendments had major impact chiefly in the following areas:

a) The methodologies of community rating for HMOs were redefined, so as to provide flexibility to introduce some elements of group specific experience. The intention was to improve the competitive position of HMOs vis-a-vis the use by indemnity health insurance companies, of experience rating. Whether the changes will in fact achieve that goal is currently a matter of some debate.

b) The language of the law requiring equal employer contributions has been redrawn to meet employer problems.

c) As private sector funding has expanded rapidly in recent years, for establishment of new HMOs and for expansion purposes of old HMOs, federal funding has come to be considered unnecessary. Thus, the availability of grants and loans began to dry up in the early 1980s, and finally the grant and loan provisions of the law were ended in the 1986 amendments to the Act. The law now has almost entirely a monitoring role in the industry.

7. In order to enhance their understanding of this legislative process, part of the Study Team spent a half day in Washington, DC, visiting staff and members of Congressional Committees having jurisdiction over HMO and other health legislation. (The Tutor did not participate in these visits).

D. Federal programs discussed (in Washington), or visited.

1. Medicare.

a) This is an "entitlement" program (all persons meeting eligibility criteria are entitled to coverage) - mainly for persons 65 years and over.

b) Coverage (especially with recently enacted, catastrophic coverage), is substantial, but not comprehensive.

c) Financing is by a complex mixture of wage taxes nationally on all individuals, supplemented by deductibles, copays, and coinsurance charges on the beneficiaries.

d) There is a special "risk contract" HMO program for Medicare eligibles, on the basis of risk sharing between the HMO and the federal government, with advantages to beneficiaries, government, and the HMO. However, a number of problem areas have made HMOs reluctant to participate in this program, including:

(1) Difficulties of controlling utilization, and the high cost of miscalculation, for the high risk elderly;

(2) Uncertainties concerning the level, and the methodologies for calculating, capitation payments;

(3) The HMO's right to withdraw from its commitment to the program (with appropriate safeguards to protect enrollees), creates uncertainties for the beneficiaries; and

(4) The need to educate beneficiaries on how HMOs operate.

## 2. Medicaid.

a) This is also an entitlement program, for persons eligible for local (County) welfare.

b) Coverage is substantially comprehensive.

c) Financing is from federal general taxes, but the program is administered by the states.

d) Many states now have special capitation risk contract programs with HMOs.

e) Major problems in Medicaid HMO contracting, which have made many HMOs reluctant to participate, include:

(1) Frequent on-and-off eligibility for welfare beneficiaries, because of frequent changes in family incomes and other

eligibility criteria - all of which present major administrative and cost problems;

(2) Difficulties with respect to methods of calculation, and adequacy and uncertainty of level, of capitation payments;

(3) Difficulties with respect to attitudes towards each other, among beneficiaries, providers, and state bureaucrats;

(4) Complexities of administration, with respect to data requirements, quality assurance procedures, and inconsistencies in practices across state lines; and

(5) Questions concerning mandatory vs voluntary enrollment, and especially with differences among states.

3. Community Health Centers program (CHC).

a) This is a federal program to serve the underserved, those who are too poor to pay for care (mainly the inner city poor), and/or have limited access in rural areas. There are about 600 such CHC programs (half and half inner city and rural), serving about six million people.

b) The program provides limited coverage, including primary physician care and lab and xray services, but not specialist care and hospital services.

c) Financing comes from a mixture of sources: 60% federal grants (from general taxes); 15% state Medicaid (but federal tax money); 15% special federal programs (eg, childrens aid, Aids, drug abuse, etc.); and 10% from fees paid by beneficiaries.

d) The CHC programs have not been able to get into HMO development mainly because they provide only partial financing and coverage, and because of inability to get (afford) the necessary skilled personnel in all areas of management.

e) In recent years, the federal government has been restricting funds available, so that this program has been shrinking.

f) Part of the Study Team visited one of these CHC programs in a rural area in the State of Virginia, near Washington. (The Tutor did not

take part in that visit.)

E. State legislative and regulatory programs discussed.

1. Massachusetts. Since the federal government is doing nothing about providing health coverage for the currently uninsured in the US, the legislature of the State of Mass. recently passed a bitterly contested compromise bill, which draws up a general blueprint on how to proceed to get coverage for the 600,000 now uninsured in the State, by 1992. This law is essentially enabling legislation; it does not yet organize or provide for financing a program. It is merely a step in the direction of the goal.

2. Hawaii. Hawaii's Prepaid Health Care Act, originally passed in 1974, requires all employers to provide health coverage for their employees, but not dependents. Minimum benefits are mandated, including hospital, medical care, surgery, and home and office visits. The employer must pay at least 50% of the cost, but can, and often does pay up to 100%.

a) The program is unique, being the only one in the US, since the new Mass. law is only enabling legislation, and does not take effect until 1992.

b) This mandatory act in Hawaii is considered more easily attainable by Hawaii, because its relatively more prosperous economy permits financing through combined employer/employee contributions.

3. California. The Study Team was presented in Los Angeles, by Calif. State officials, with a very informative description of the State laws concerning health care, and especially those dealing with the Medical (Medicaid) program, and with the operation and regulation of HMOs.

IV. Selected programs observed during the tour.

A. HMO's in the US. - Our purpose in this section is not to describe the elements of each Plan in a manner that simply duplicates the standard HMO model description in section III.B.3., but instead to emphasize only special characteristics of each Plan, and ways in which it differs from the standard model description.

1. Staff models.

a) Group Health Ass'n.(GHA) - Washington, DC.

(1) This staff model HMO is one of the country's few consumer cooperative sponsored HMO's; it is governed by a Board of nine elected by the consumer coop members (70,000 Plan subscribers plus their spouses each have a vote). The HMO has 140,000 enrolled members from the greater Washington, DC metropolitan area, which is dominated by federal government employees.

(2) The HMO operates a network of its own health centers, and contracts to purchase services from several hospitals.

(3) The Chief Financial Officer who spoke to the Study Team, emphasized that the Plan illustrates why a consumer coop sponsored HMO must develop an operating attitude based on a compromise mix between business caution to cover all costs with adequate revenue, as opposed to the natural consumer demands for more services. Although a non-profit consumer-controlled plan, he pointed out, it nevertheless must operate as a business, to compete and grow. For example, cost savings implemented in 1987 to reverse losses of 1986, included increasing premiums, reducing rates paid to hospitals, and reducing staffing.

(4) For similar cost control reasons, and to help control utilization as well, the Plan has adopted mix 1, but meaningful deductibles and copays.

(5) The need for a sophisticated Management Information System (MIS) was also emphasized, not only for financial and cost information and controls, but also for medical services utilisation controls and for quality assurance purposes.

(6) It was particularly emphasized that in this program, financial risk is not directly shared by the physicians; their only financial risk is indirect, ie, whether there are resources to pay salary and/or give salary increases. Education of the MD's to accept the Medical Group's values and the Plan's objectives, is emphasized to replace the whip of direct financial risk.

b) Columbia Medical Plan (CMP) - Columbia, Md.

(1) This HMO was established in 1969 as a for-profit staff model, sponsored by the Johns Hopkins University of Baltimore, Md, to serve the new, planned community of Columbia, Maryland, located near the federal capital of Washington, DC. In 1975, when the University withdrew from the Plan, the program became a Group model. But in 1982 and 1986, the Plan and Medical Group were bought by Blue Cross/Blue Shield and restructured again as a staff model, remaining on a for-profit basis, even though the parent BC/BS is a non-profit entity.

(2) The Blues objective, in buying, was to protect their market share from the growing threat of competition: the HMO itself has about one-third of the Columbia market of 80,000 total population; and the other competition of commercial indemnity insurance companies was growing. The objective of the HMO and the Medical Group in selling, was to obtain a needed organizational base and access to capital, both of which the Blues offered, to protect their market share, and to strengthen future growth.

(3) This HMO is now again technically a staff model: the MD's, although employees of the Group, are in fact indirectly employed by the Plan, which owns the Group. Nevertheless the HMO functions more like a Group model, in that the Medical Group appears to play a very strong role in overall Plan management (similar to the Kaiser Plans). For example, the physician who spoke to the Study Team is President of both the HMO and the Medical Group, and there appears to be a very close cooperative relationship between the HMO management and the Medical Group management, in running the program.

(4) Interestingly, although owned by BC/BS, the HMO continues to compete with both of the Blues other programs: a separate IPA model, and their traditional ffs indemnity insurance plans.

(5) The physician President of the HMO and Medical Group expressed the program philosophy that financial risk for

physicians directly related to utilization control should be avoided. Instead, there should be indirect financial risk, via sharing in the overall financial gains and losses of the program as a whole, through the use of an incentive bonus system.

(6) In this program (similar to the Kaiser Plan), emphasis is placed in addition, on education of the Group and medical staff to commitment to the overall welfare and goals of the program.

## 2. Group Models.

### a) George Washington University Health Plan (GWUHP) -Washington, DC.

(1) This group model HMO was started in 1972 without federal government grant funds. It was sponsored and supported by the George Washington University Medical Center, for purposes of providing education and research resources for medical students and residents, with service to Plan members as a byproduct. A major part of the education intent, was to provide input aimed at overcoming the historical lack of concern for cost on the part of physicians - that is, training in an HMO setting, aimed at making MD's cost-conscious.

(2) The Plan is owned and controlled by the University, which appoints a majority of the governing Board, although five of the thirteen Board members have to be consumers, and four of those five, HMO members.

(3) The University intended from the beginning that the Plan be financially self-sufficient, as it has been, except for a few years in the early 1980's.

(4) The Plan currently has 33,000 members. It provides ambulatory services in its major Clinic in downtown Washington, and three suburban satellite Centers, and hospitalizes in the University Hospital Center plus a few suburban community hospitals.

(5) In recent years, for purposes of expansion and greater accessibility to potential enrollees, elements of a network model have been added, in the form of a

network of some small primary care groups and individual MD's, and a number of referral specialists. It is intended that more of this occur as the Plan grows.

(6) Financial arrangements with providers reflect a mixture of those kinds of arrangements typical of both group and network model HMO's:

(a) The University Hospital is paid on a per diem basis, while the community hospitals being used are paid billed charges (sometimes discounted).

(b) For group physicians, a capitation is paid to the HMO's own Medical Group, and individual physicians in the group are paid a salary plus an incentive bonus (to maintain productivity), based on a complex formula using volume of patients seen, time spent, length of stay for hospital patients, and participation of the physician in educational and research programs; utilization rates are expected to be added to the formula later.

(c) The network physicians are paid instead, on the basis of negotiated, discounted fees, with a ceiling on the total dollars available, to put a cap on the extent to which increased volume can be used to offset fee discounts. Thus, network physicians are at risk to some extent, for controlling utilization. It is planned to capitate network MD's as soon as possible.

(d) Thus, on the issue of financial risk, this Plan also prefers not to use direct risk for physicians, in relation to control of utilization. Instead, the bonus system is felt to work better, supplemented by education and socialization of the physicians to function in a cost-effective manner.

(7) The Medical Director of the program reported there has been no specific study of the impact of the program on the medical education process, but it is his impression that an increased number of medical students are going into HMO's for their life's

practice.

(a) In the discussion, Study Team members observed that in Indonesia there will be great interest in HMO's based in the University Medical School, because of the potential teaching impact in changing the patterns of the practice of medicine, although it is recognized that the volume of service of such HMO's would be small relative to the total Indonesian population.

b) Kaiser Foundation Health Plan. - Los Angeles, California, and Honolulu, Hawaii.

(1) The Kaiser Foundation Health Plan, Inc., usually referred to as "Kaiser Permanente", is the country's premier prepaid group practice health care program (or group model HMO), and also its largest HMO.

(2) With a history going back to 1933, the program was opened to the general public in 1945 on the West Coast, and today operates a national program for well over five million enrolled members, in twelve organizational operating units called Regions - in Southern California, Northern California, the Pacific Northwest, Hawaii, Ohio, Colorado, Texas, the Mid-Atlantic states, Northeast, North Carolina, Georgia, and Kansas City.

(3) For the financing and delivery of health care, the Kaiser Permanente program maintains a non-profit organizational structure and the uniform use of prepaid group practice. Its unique operational style emphasizes a strong collaboration in plan management between the Medical Group and the Health Plan. The programs' two national corporate entities, Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals, function in a strong cooperative relationship with each of the independent regional Kaiser Permanente Medical Groups, in each of the twelve Kaiser Regions in the US, with an emphasis on regional management of prepaid group practice medical care delivery.

(4) This national organizational structure differs from the HMO group model structure illustrated in the chart on page 11b. In the

typical group model HMO, the HMO contracts with one medical group. In contrast, the Kaiser Foundation Health Plan contracts (separately) with each of the twelve independent Kaiser Permanente Medical Groups in its twelve Regions.

(5) The Study Team visited some of the Kaiser health center sites in two of the twelve Regions - in Los Angeles in the Southern California Region, and in Honolulu in the Hawaii Region.

(6) The emphasis in these visits, however, was on specific sessions devoted to three major service elements of the Kaiser program: in Los Angeles, the extensive Kaiser pharmacy program; and in Hawaii, the Senior Plan and the Quality Assurance programs. These major service elements are all illustrative of the kind of consumer-oriented services that can be provided by a large, well organized, well managed group model program. Nurse staff of the Senior Plan in Hawaii emphasized their program's "member driven perspective", and the pharmacologist staff in Los Angeles emphasized the mission of the Kaiser drug program as "service to members, not selling to the public for profit".

(7) The pharmacy program, as presented by one of the program's top pharmacologists (also an attorney), was of particular interest because of its scope and potential adaptability to other large medical programs with large membership, such as in Indonesia.

(a) The pharmacies are not independent, instead functioning under the Health Plan and Hospital corporations, although with technical control by each of the regional medical staffs.

(b) The program has a dual mission: (1) to service the members, not to sell to the public for profit; and (2) to optimize drug therapy through direct cooperation with the medical staff, reducing risk, and controlling cost via use of a formulary and efficient purchasing and distribution methods.

(c) Scope of the program includes 71

pharmacies with 1200 employees including 561 pharmacists, with an output of about 4 prescriptions per member per year in 1987.

(d) Small copays are used to promote the members' sharing in cost and to motivate them toward more complete and appropriate use of prescribed drugs.

(e) The pharmacy staff plays a major role in providing new drug information and education for the medical staff, and in using a sophisticated information system to provide drug utilization patterns, drug interaction information, and error prevention.

(f) The formulary process is not a mandatory one, instead depending on use of an active pharmacy staff assigned to work on drug therapy education of the medical staff, while maintaining a policy of flexibility for special patients with special problems.

(g) Quality assurance in drug therapy is an integral part of the overall program's QA procedures, as required both by law and by program policy.

(8) The second service element presented to the Study Team was the Kaiser Hawaii Senior Plan, a comprehensive service plan for senior citizens over age 65 and eligible for the federal Medicare program.

(a) Key to this special plan, as described by its nurse Director, is its "member driven perspective," based on the concept that "the member's perceived need for services is the driving force". The aim of the program is to keep people in the outpatient/home care milieu, instead of in hospital, as much as is consistent with good care.

(b) Coverage of the Plan, for a low monthly premium, includes all the Medicare covered services plus the Medicare deductibles and most of the copays, and the gaps in Medicare coverage.

(c) Kaiser has a financial risk contract with the federal agency responsible for Medicare.

(d) The Plan has been a popular and financial success due largely to its use of the Team-Case Management approach to care, in which Senior Plan members who have high risk health problems are identified, and for whom a comprehensive plan is developed and followed to assure provision of the most appropriate complex of quality services in both the Kaiser organization and the community, and with an eye toward cost-effectiveness.

(9) The Ambulatory Quality Assurance program in the Hawaii Region as described to the Study Team by the Director of quality assurance for the Hawaii Region, is part of the overall Kaiser Permanente program's efforts to develop and test model outpatient quality assurance systems. The program has adapted hospital inpatient criteria to the outpatient care setting. The director described the program as a cooperative team effort in which "each person in the Clinic has the responsibility for identifying...undesirable outcomes and referring those to" appropriate staff. He said this is "the first truly outcome oriented program that is concurrent rather than retrospective." The Study Team was provided with detailed literature describing the program.

### 3. IPA models.

#### a) Chesapeake Health Plan (CHP) - Baltimore, Md.

(1) The Chesapeake Health Plan is an urban HMO serving a mixed population that includes privately employed groups of employees in the middle income range, low income families supported by the federally funded Community Health Centers (CHC) program, and poverty level families in a federally funded Medicaid program. Current total enrollment of 28,500 includes 14,500 private employees, 8000 in the CHC federal program, and 6,000 in the Medicaid program.

(2) The Chesapeake Health Plan is

essentially an IPA model HMO, although it has significant network model characteristics. The central HMO corporation contracts with a "network" of some 28 IPA corporations, whose physician members, working in their own offices scattered over the city, serve as HMO service access sites. But the HMO health plan corporation also has network type direct contracts with some physician groups (eg, one at Mercy Hospital) and some individual doctors.

(3) The HMO's contracts with different providers are generally standard: contracts with hospitals include per diem, and discounted billed charges; contracts with the IPA corporations are all on a capitation basis, but excluding hospital services; and the IPA's contracts in turn, with their physicians, are either on a capitation basis, or a fee basis with a percentage holdback. Gains or losses on hospital utilization are shared 50/50 with the IPAs (and their individual physicians) on the basis of a risk pool set-aside from the capitation. The average IPA physician signs up a panel of about 1700 patient/members who utilize an average of three visits/person/year. And on the average, about 30% of an IPA physician's total patient load is HMO enrollees.

b) Hawaii Medical Service Assn (HMSA) - Honolulu, Hawaii.

(1) The Hawaii Medical Service Assn is a health services organization providing a number of different programs to about 550,000 members in the state of Hawaii. As of Sept 30, 1988, about 90% of total HMSA membership is enrolled in traditional Blue Shield fee-for-service, indemnity health insurance plans, and 10% is in HMO plans of various types.

(2) The program was started by consumers, about 50 years ago, under the non-profit Blue Shield. In Hawaii, Blue Shield serves the same functions as the combined Blue Cross/Blue Shield does on the mainland of the US. There has also been heavy employer participation in HMSA development, because traditionally HMSA has administered company

financed health plans for sugar plantation employees.

(3) One of these sugar plantation plans was visited by the Study Team. The small town outpatient Clinic used by this plan was built and is owned by the sugar company, is staffed by an independent group of physicians which contracts with HMSA, and the plan is managed by HMSA. The plan premium is fully paid by the company, except for certain employee copays. Program policy is established jointly by HMSA, the sugar company, the Medical Group, and a self-perpetuating Board of Directors.

(4) Through its Blue Shield traditional health insurance plans, which have 90% of HMSA membership, HMSA's major business represents the Hawaiian ffs physicians, in competition with the Kaiser group model HMO. These physicians prefer ffs practice, but for competitive needs asked HMSA to develop IPA model HMO's for them, in addition to the Blue Shield plans.

(5) Thus, while HMSA is categorized in this report as an IPA model HMO because it contracts with several IPA corporations, nevertheless HMSA also contracts directly with some MD groups and individual physicians, and thus has elements of a network model. The total 550,000 members enrolled in HMSA have a market choice between the Blue Shield's ffs traditional health insurance (chosen by 500,000 ), or one of the IPA or group model HMO's (chosen by 50,000 ). HMSA plan managers explain the choice as based on a trade-off between the more comprehensive benefits of one of the HMOs, and the free choice of the MDs in the Blue Shield traditional health insurance plans. The managers report a growing trend toward more frequent choice of the more comprehensive package of HMOs, as greater public understanding of HMOs develops.

(6) In accordance with the provisions of the Hawaii Prepaid Health Care Act, employers pay the legal minimum 50% of the HMSA premiums, with the remaining 50% split between employer and employee in a proportion depending on each company's agreement with its employees.

(7) Financial risk. The nature of the financial risk for providers in HMSA plans, to encourage cost-effective performance, varies widely. For the 90% of its membership covered by the traditional Blue Shield indemnity health insurance, providers have no risk; instead, the incentive to reduce utilization in these plans, including hospital use, lies with the members, who face a copay ranging from 20% to 50%. For the physician providers in the remaining 10% of HMSA plans, that is, the HMSA sponsored HMO's, both the network model medical groups and the IPA corporations mostly receive capitation payments, and therefore are at risk. No individual physicians receive capitation payments, but the individual physicians in the IPA corporations are at some risk because they face the usual 10% fee holdback. Physicians in both IPAs and network groups share in hospital utilization gains and losses via bonus systems based on the overall financial performance of the HMOs.

(8) HMSA managers report the plan faces the usual IPA type problems in controlling the volume of member visits, and in enforcing quality assurance procedures. Historically, however, hospital utilization rates have been lower in Hawaii than in the mainland US, and so the plan has done well so far.

(9) Up to now, Quality Assurance programs have concentrated on inpatient services, but HMSA has begun to develop QA systems for outpatient care in physicians offices as well.

#### 4. Network model.

##### a) Health Net - Los Angeles, California.

(1) The Health Net program, with about 600,000 enrolled members, is the second largest HMO in the Los Angeles area (second to Kaiser). It is a classic example of a network model HMO. It was organized in the late 1970's, and became operational and federally qualified in 1979. The program started with about 25 multi-specialty medical groups which had already been functioning in the community for some years.

Today Health Net has capitation type contracts with 250 independent medical groups, which average 35-50% of their patients enrolled in Health Net, and also has capitated contracts with a number of IPA organizations of individual physicians.

(2) The program was organized specifically to be different from and competitive with the Kaiser Permanente group model HMO. Contrary to Kaiser, the Health Net managers point out, Health Net owns nothing, neither health center Clinics, nor hospitals; instead, it has a "network of contracts" with independent hospitals, with groups of physicians working in their own Clinics, and with IPAs of individual physicians working in their own offices.

(3) The physicians now involved in the Health Net system were interested in getting into an HMO in order to hold their share of the market, which in the urban areas of Southern California has become 35% penetrated by HMO enrollment.

(4) Health Net has remained a non-profit organization, partially, as explained by its managers, because of its historical origin with the non-profit Blue Cross, but mainly because of a philosophical conviction it is better not to pay out surpluses to stockholders.

(5) The program is governed by a self-perpetuating Board of thirteen, of whom three are MDs (two from the contracting Medical Groups), and the balance representing various segments of the community (employers, consumers, and Plan members). The Plan managers emphasize that overall Plan management is based on close cooperation between Plan management and the Medical Groups, just as in the Kaiser program.

(6) As is usual among HMOs, the program offers employers a number of different plans with different benefit packages and different sets of deductibles and copays, from which the employer chooses by what level premium he wants to pay, or has to pay in accordance with a union contract.

(7) However, Health Net does not provide MediCal (Medicaid) or Medicare risk contract programs.

(8) In its marketing efforts, in addition to major dependence on its own staff, Health Net uses insurance brokers who are in business in the community, a practice not common among HMOs. These brokers are paid a 10% commission.

(9) In addition to its standard quality assurance program, Health Net provides two related consumer-oriented programs: (a) a Wellness program with a staff of seven, who provide a strong emphasis on preventive care and health promotion activities; and (b) a Member Relations staff of 33 who concern themselves with member problems. The formal grievance procedure dealt with 15 lawsuits and 12 arbitrations in 1987.

(10) Provider payments, and financial risk sharing.

(a) Health Net has contracts with hospitals mostly on the basis of per diem payments, but some are on discounted billed charges. There are no capitation arrangements with hospitals, and no risk sharing.

(b) Contracts with the medical groups and IPAs are almost entirely on a capitated basis, with risk sharing of gains or losses between Health Net and the groups and IPAs. Risk sharing arrangements for individual physicians is determined by each group or IPA, and is mostly a bonus system based on overall financial performance of the specific group or IPA.

B. Ontario, Canada.

1. The comprehensive, universal health insurance program in Ontario.

a) The Study Team made a very brief, two day visit to Ontario, Canada, to get a quick look at the province's comprehensive, universal health insurance program. Although such programs vary widely in the different Canadian provinces, the Ontario program may be viewed as a middle-of-

the-road example of the general approach in Canada.

b) In contrast to the US, however, which has no comparable comprehensive, universal health insurance program, Ontario has minimal development of HMO/managed care systems, although there is extensive planning for such development.

c) In Canada, health care, which is given a very high priority, is a responsibility of the provincial government, which has the roles of: management of the system in the province; overseeing the delivery of services; payment of a part of the financing, and coordinating all funding mechanisms; planning and development; regulation of professionals; and designing special programs (like Home Care, and the Ontario Health Insurance Program (OHIP) for paying physicians' ffs bills.)

d) The roles of the federal government include: setting standards on a national level; and providing part of the funding - 40% of total health care costs, paid via a negotiated, fixed annual total grant to the province for health and education, so that more spent on one leaves less for the other.

e) Organizing and funding the major segments of the system.

(1) Hospital services.

(a) Hospitals are mostly public, local, non-profit, and community owned.

(b) They are funded 85% from public sources (a combination of provincial taxes and consumer premiums, and federal taxes); and 15% from patient charges, interest, etc.

(c) The hospital levels of institutional care included under the comprehensive coverage are: residential (or custodial), extended care, chronic care, special rehabilitation care, and acute care.

(2) Professional services (90% of this is physicians' ffs bills).

(a) A total amount of money - from

combined provincial and federal government sources - is allocated for MD fee payments; fee levels are fixed in negotiations between the provincial government and the physicians; efforts of MDs to overcome fixed fees by increasing volume, are limited by the ceiling of the total dollars allocated.

(b) The total funds are 85% from combined provincial/federal sources, and 15% from consumer premiums.

(c) Utilization control is provided by a College of Physicians monitoring process in the physicians' offices, comparing individual MDs to norms, and by the ceiling on money available.

(3) Other services.

(a) Home Care Program. This is an extensive program, based on MD referral; over 80% of patients are currently 65 years or older; the program is funded 100% by provincial government funds; demand is increasing rapidly, but there has been no real evidence yet of reduced demand for acute hospital care.

(b) Homemaker Program.

(4) Premiums paid by consumers for hospital and physician services, are not paid by those over 65 years and those on welfare.

f) In summary, total health care expenditures in Ontario are from sources divided as follows:

(1) Federal taxes	25.8%
(2) Provincial taxes	<u>38.7%</u>
(3) <u>Total taxes</u>	64.5%
(4) Federal consumer premiums	4.6%
(5) Provincial consumer premiums	<u>6.8%</u>
(6) <u>Total consumer premiums</u>	11.4%
(7) <u>Private fees, charges etc.</u>	<u>24.1%</u>
(8) <u>Total expenditures</u>	100.0%

2. Planned development of programs based on managed care ideas. Among other plans for future directions in health care, planners in Ontario express a need, within the framework of the current comprehensive,

universal health insurance program, to add - as an alternative to the OHIP traditional ffs health insurance program - improved management of financing and delivery of care, with cost controls and quality assurance. Therefore, a variety of new programs similar to HMOs in the US, are being considered for development.

a) CHOs. These programs - currently in a planning stage, with none yet operational - are to be most similar to US HMOs, in comprehensive coverage and basic operational methods, including risk sharing by physicians. But there are important, basic differences:

(1) All are to be non-profit, regulated by the provincial government, and sponsored and controlled by community Boards.

(2) They are to be financed by a mixture of capitation (paid from provincial tax funds), plus overall program budgets of fixed, negotiated amounts (paid from provincial and/or federal tax funds), plus some payments by enrolled members.

b) HSOs. These programs are similar to CHOs, but have more limited coverage, including mainly outpatient primary care. They are physician sponsored, with physician risk sharing. Currently, 37 such programs are in operation.

c) CHCs. These programs are designed to serve disadvantaged, poor groups, and isolated rural areas. They have a mixture of attributes of both CHOs and HSOs, and many similarities to the US CHC programs, although in Ontario the program is expanding, not contracting as in the US. The Ontario CHCs are sponsored by non-profit community Boards, like CHOs; have coverage limited, like HSOs, to mostly primary care; but funding is 100% by budget from government sources; and physicians are on salary. Currently, 16 CHCs are operational and more have been approved.

d) Needless to say, strong quality assurance is considered indispensable to all of these programs, and a significant amount of research and development efforts are being devoted to this. These efforts were well described, in some detail, for the Study Team.

3. The Ontario experience appears to be of great

interest to the objectives of the Study Team, in terms of both the provincial philosophy of universal coverage, that is, the right of all to health care, and the existing scope of social financing, ie, payment of a significant portion of costs directly by consumers, in the form of premiums, rather than indirectly, via the general tax system.

a) Needless to say, however, international comparisons of health systems and relative costs, need to keep in mind differences in national characteristics: for example, Ontario has a relatively young, healthy population in a relatively prosperous overall economy.

V. Concluding, summary discussion of the Study Team.

A. Introduction. In the closing days of the tour, it was agreed that the final, wrap-up discussion, on the last day of the tour (Nov 4, 1988), would most usefully be spent in outlining the major questions which had arisen during the tour, which were most relevant to the purposes of the tour, and which the Study Team would need to consider in applying what they had seen and learned, in the Indonesian setting. These major questions include the following.

B. Why, in summary, is the development and use of HMO/managed care concepts in the delivery and financing of health care, considered by proponents to be preferable to dependence on the traditional fee-for-service non-system, supported by indemnity health insurance only?

1. In general, the development of HMO/managed care programs introduces necessary new organizational structures and changes in operational incentives, in the delivery and financing of health care, which permit giving conscious direction to the processes of the industry via the use of the organized methods of business management in producing a product. This is in contrast to the non-system of ffs, where historically the reverse incentives - the piecemeal incentives to overutilize, in a framework of lack of concern for cost - have meant that cost has been out of control, maldistribution of resources has been typical, and quality assurance has not been uniformly adequate.

2. Thus, an HMO/managed care system, as an integrated system that takes on responsibility, in a framework of financial risk, for the combined package of delivering and financing care and responsibility for the cost and the quality of that care, is significantly different from and in

contrast to traditional health insurance, which takes responsibility only for indemnifying after the fact, for expenditures made in obtaining care through an essentially unrelated and uncontrolled delivery system.

3. Secondly, such an organized system lends itself better to the development, enabling legislation, and enforcement, necessary to achieve the philosophy that access to health care is a right of all people.

C. Some major questions arising during the Study Team's review of the HMO/managed care industry in the US and Canada.

1. Which model HMO program is best?

a) Is any one, or a given mixture, of the five program models - Staff, Group, IPA, Network, PPO - best in all or most combinations of circumstances?

b) Is the current situation in the US the best milieu: that is, a mixture of all models competing among themselves and with health insurance companies (and employers) using an eclectic but limited set of managed care methods, without HMOs?

2. How crucial is the role of competition in the efficient functioning of all models?

a) Is voluntary enrollment a necessary element: ie, the right of the enrolled member annually to leave one program for another, in the competition for enrollment among many HMOs?

b) What would be the nature of, and the effect, of a mandatory program for a given group of people, on such competition among the providers who might serve the program?

c) Are the advantages of cooperation and the economies of scale which would come with a mandatory program, superior to those of competition?

3. How crucial to the efficient functioning of HMOs, is the role of financial risk and incentives, especially the sharing of risks between the HMO and the providers (both physicians and hospitals), particularly with respect to utilization control and hence costs?

4. How effective is the functioning of quality assurance processes in HMO/managed care systems?

How can the methods of quality assurance be improved?

5. What are the different effects on HMO/managed care functioning, of for-profit vs. non-profit sponsorship?

a) Is the degree of service orientation affected by how surpluses are used - ie, whether plowed back into program needs or distributed to investors?

b) Does the for-profit motive positively affect market incentives and efficiency?

c) Is quality assurance affected?

6. How deal with the problems that limit the extent to which HMO/managed care systems undertake programs that cover the elderly, the poor, the uninsured, and rural areas, including:

a) Programs to fill the gaps left in current programs for the elderly (Medicare)?

b) Overcoming the uncertainties for HMOs, of federal and state capitation payments for the elderly and the poor (Medicaid)?

c) What incentives, and/or legislation, will help overcome HMO reluctance to develop such programs?

d) How finance coverage for the uninsured, including urban unemployed, employees of small employers, self-employed, the rural underserved? For example, the Dana Sehat in Indonesia, where resources and organizational structure are inadequate? What legislation would be feasible and effective?

7. How can greater emphasis be developed, in HMO/managed care programs, on preventive care and health promotion programs - especially life-style matters like smoking, etc. - recognizing that HMOs already generally do much better than traditional insurance in providing coverage for preventive measures such as routine health evaluations and immunizations.

a) What is the effect of preventive care on financial performance? Experience of programs

in the US has produced little statistical evidence, but has gained impressions that in the long run, savings will outweigh the short run costs of the preventive programs.

b) What incentives (financial and other) can be developed with consumers, to promote changes in life style?

8.8. Does the US experience indicate that the widespread use of HMO/managed care programs will in the long run actually result in both control of cost and assurance of quality? The latter appears assured, but the overall national effect on control of cost is not yet assured; US health care costs have continued to rise much more rapidly than general inflation.

9. What is the nature of legislation in Indonesia (additional to the DUKM principles) necessary to promote development of HMO/managed care programs?

10. Is it feasible to project in Indonesia a government/private sector partnership in developing a health care system oriented toward HMO/managed care systems, with the government providing leadership, organizing financing mechanisms, setting standards, and providing regulation - while the delivery of service is chiefly the responsibility of the private sector?

a) Or is a universal national health insurance program, as in Ontario, more feasible in the Indonesian context? Or a mixture of both?

11. Can the principles of HMO/managed care be applied to the current five major programs in Indonesia, with a positive impact on cost control and quality assurance?

a) For example, is the central government system of clinics and hospitals established for the health program of the civil servants (PHB), a potential basis for an HMO with a broadening population base? Should the government employees program and the private employers program, etc., be kept as separate and independent programs? Is a system of competition among themselves for enrollees, feasible among the clinics in the PHB system?

12. Are certain specific areas of administrative and organizational problems experienced in the government-sponsored private employers' program for

the industrial, working population, likely to be generic in application?

a) Organization - overlapping responsibilities of different Ministries; proposal for a committee to coordinate among Ministries, administration of the current, and any new, health programs.

b) Financing - what relative roles are appropriate in financing, among central government, employers, employees and consumers generally, and the local Dana Sehat, in a general system; what mechanisms for assessing and collection of contributions are feasible; is the capitation method feasible?

c) Administrative - how create the needed administrative expertise and experience, and sophisticated management information systems (MIS)?

d) Marketing - how develop the necessary consciousness among the populace, for acceptance of the HMO concepts of sharing costs, and regular periodic payments to buy protection for services in the future; and how develop mechanisms for enrollment?

e) Delivery of care - What are the specific problems and mechanisms in development of a mixed delivery system of government clinics and hospitals, and the private sector?

---x---