Enrollment in alternative delivery systems seems likely to continue to increase as public and private payers attempt to constrain the rate of health care cost inflation.

The Evolution of Alternative Health Care Delivery Systems

Alternative health care delivery systems, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), have expanded rapidly in response to health care payers' demands for less expensive health care. Since alternative providers do not use traditional fee-for-service payment, they have greater incentives to economize on health services delivery. Continual monitoring of alternative delivery systems by management may be necessary to assure that the care provided to plan enrollees is efficiently delivered and of high quality.

Research is currently being conducted to determine whether the theoretical advantages of alternative providers are real. Certain types of HMOs have been shown to reduce hospitalization rates and costs significantly. However, evidence also exists that healthier people tend to enroll in HMOs. This tendency, called "biased selection," may affect HMOs' cost savings. The care provided by HMOs has been shown to be similar in quality to that of the fee-for-service sector, but some potential enrollees object to the manner in which this care is delivered. In particular, they dislike the requirement that enrollees use physicians and hospitals selected by the HMO.

The cost effectiveness and quality of care provided by PPOs has not been evaluated. Unlike HMO enrollees, members of PPOs may choose to obtain care from any provider. It is not known whether PPOs differ from HMOs or the fee-for-service sector in their ability to control costs as a result of this increased freedom of choice.

Enrollment in alternative delivery systems seems likely to continue to increase as public and private payers attempt to constrain the rate of health care cost inflation. Further research to evaluate the cost effectiveness of these systems may be necessary as larger numbers of enrollees increase the potential consequences of enrollment choice.
Why Alternative Delivery Systems?

In 1965, approximately 6 percent of the United States' Gross National Product (GNP) was spent on health care; in 1988, the proportion exceeded 11 percent. The trend toward spending an increasing share of national resources on health care seems unlikely to slow soon. Demographic forces such as the aging of the "baby boom" generation and the growth of the elderly population are both likely to increase future demand for health care (Friedland, 1989).

Numerous strategies have been proposed by private and public payers to constrain the rate of growth in health care costs (Custer, 1989). One of these strategies is to encourage the development of alternative health care delivery systems. These systems include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and organizations that combine characteristics of both. Alternative health plans differ from traditional insurance plans in that they incorporate incentives for providers to pursue cost-effective treatment rather than offer incentives for them to perform all services that may provide a benefit.

Competition for consumers' health care dollars is alleged to create incentives for providers to deliver health care more efficiently while maintaining a high standard of care (Enthoven, 1980).

Many payers, however, are concerned that competition among alternative health care systems may not necessarily decrease costs. Competing alternative health providers may seek to attract members who are less costly to treat. If they seek to distinguish themselves by the amenities they offer in order to attract healthier members, competitive "rivalry" among alternative health plans may promote inflation rather than cost containment (McLaughlin, 1988).

Enrollees who choose alternative providers obtain certain advantages. Most of these providers reduce enrollees' out-of-pocket costs by lowering or eliminating copayments and deductibles, and they may offer broader and deeper coverage of acute care services than is offered by traditional insurance. Furthermore, consumers may feel that choosing from a panel of preselected providers is simpler than seeking an individual physician or hospital. Alternative providers may therefore appeal to a younger, more mobile, healthier population that is less likely to have established relationships with providers.

Because it is difficult to measure the quality of medical care, patients may feel uncertain of their ability to choose among providers. However, alternative health care providers must compete against standards set by traditional providers. The possibility of losing patient revenues helps to prevent alternative providers from providing care that diverges significantly from these standards.

Increased enrollment in alternative health plans may diminish this constraint. Reduced competition with fee-for-service providers may encourage the development of new, more cost-effective styles of care. On the other hand, competition among providers seeking to attract the patients at lowest risk of needing health services may leave higher-risk persons without any plan willing to accept them (Ginzberg, 1987). In particular, lower-income and elderly people may be less able to obtain services within an alternative delivery system.
This Issue Brief explores the growth potential of alternative health care delivery systems, identifies their differences, and reviews research on the quality, accessibility, and cost effectiveness of the care they provide. Public policymakers' interests in regulating and encouraging the market for alternative delivery systems are weighed against the possible consequences of letting them evolve without government intervention. Finally, the possible future evolution of alternative health care delivery systems is examined.

**Defining Alternative Health Care Systems**

When a person covered by traditional health insurance needs medical care, he or she seeks the services of a physician, who attempts to diagnose the illness and choose the appropriate course of treatment. The physician decides whether surgery or drug therapy is needed and whether the illness should be treated in a hospital or in an outpatient setting. The traditional insurance system finances the cost of treatment choices without attempting to influence that choice.

In attempting to remain neutral in the medical decision making process, traditional insurance has inflated health care costs by increasing demand for services (Feldstein, 1973; Pauly, 1986; Manning et al., 1987). Since physicians traditionally are paid a fee for each service they provide and hospitals historically have been reimbursed for the costs they incur, neither type of provider has an incentive to minimize the resources that are used to treat patients. In contrast, alternative delivery systems offer providers incentives to consider the relative costs of treatment.

Alternative provider systems can be considered as one extreme among a number of approaches to health care cost containment that have collectively been called "managed care." Managed care provides oversight, supervision, and feedback to providers related to how their behavior affects the aggregate expenditures of an enrolled group. Managed care implies continual monitoring of the utilization of services to enrolled individuals for the purpose of determining whether patterns of medical practice are appropriate and cost effective.

Managed care systems may be imposed on traditional indemnity insurance. Managed care in this setting, outside of alternative providers, separates the oversight functions from the formal providers of care. Purchasers must establish utilization review systems, or contract for them, to monitor the use of services. Alternative health care systems, on the other hand, integrate care management and utilization review with the provision of health care. The provider becomes responsible to the purchasers for the costs and quality of care delivered to enrollees, but purchasers are separated from the day-to-day management.

Typically, an alternative delivery system comprises acute care providers such as physicians, hospitals, outpatient clinics, and ancillary services such as laboratories and x-rays. Some suggest that new provider sites such as freestanding ambulatory surgery centers and urgent care centers should be considered as alternative care providers (Levey and Hill, 1988). Strictly speaking, these types of providers reflect changes in medical technology that allow medical treatments to be given outside a hospital. They do not, however, have economic incentives to provide care differently.

HMOs, the earliest type of alternative health care delivery system, trace their roots to the 1920s, when they were known as prepaid group practices. Their present name was coined in the early 1970s, when President Richard Nixon made HMOs a centerpiece of his national health policy. He and his advisors hoped that HMOs' incentives to conserve resources would increase the health care system's efficiency while preserving a reasonable standard of quality.

All HMOs receive, on behalf of each enrolled member or family, a premium payment intended to finance most of the participant's care. This per capita payment can be considered to represent the average anticipated expenditure for all necessary covered services on behalf
of HMO enrollees, with a residual in reserve. Although some HMOs may charge their members small copayments for office visits or emergency room services, HMOs do not require any substantial cost sharing. Since an HMO's revenue is fixed to the sum of its members' premiums, it risks losses from services used in excess of the average. Thus it has an incentive to adopt treatment patterns that minimize the average cost of the health care delivered.

Organizational Models

HMOs can be classified according to how they organize their physician providers. Each organizational model differs in its economic efficiency and ability to compete for enrollees.

In recent years, IPAs have been the fastest growing HMO model and have been primarily responsible for the rapid growth in the number of HMOs.

Group, Staff, and IPA Model HMOs—Group model HMOs, such as Kaiser-Permanente, organize physicians into a professional medical group independent of the HMO itself. Staff model HMOs, such as the Group Health Association in Washington, DC, employ and pay physicians directly. In both group and staff models, the physician providers see only patients who are members of the HMO. HMOs provide the clinics where the physicians practice; equip them with what the management considers to be an appropriate set of diagnostic and laboratory tools; hire nurses, assistants, and technicians; and perform the basic administrative functions of a large medical office.

Another HMO model, the independent practice association (IPA), contracts with individual physicians and physician groups already in practice in a community. Each physician provides his or her own office facilities and support staff. Contracting with physicians practicing in their own offices allows the IPA to offer services in a broader geographic area and requires less capital investment than a staff or group model HMO of similar size. The physicians are not as tightly organized as a group practice, and they continue to see patients who do not belong to the IPA. Thus management has less direct control of IPA physicians' behavior.

In recent years, IPAs have been the fastest growing HMO model and have been primarily responsible for the rapid growth in the number of HMOs (chart 1). IPAs tend to be smaller than group and staff models, however, and they continue to hold a minority share of HMO membership. Nevertheless, this share is growing. IPAs' growth both in numbers and membership suggests that offering a wide choice of physician providers, along with the lower out-of-pocket costs of HMO coverage, gives IPAs increasing appeal in the marketplace.

HMO models have different ways of distributing the revenue from premium payments to their providers. Generally, group and staff model HMOs pay their physicians a salary or a salary and a bonus based on the organization's financial performance. IPAs may pay their contracting physicians according to a fee schedule. Often they place a percentage of the contracted fee in a separate fund to cover overuse of services. If the providers exceed expected payment rates, the fund pays the overcharge; if not, the fund is distributed at the end of the year to the physicians. Alternatively, IPAs may make "capitation" payments to individual physicians—those act as gatekeepers and are responsible for paying for all services, including those provided by other physicians. This payment method places the individual physician at risk for services that his or her own patients use in excess of the capitation payment.

PPOs—In contrast to group and staff model HMOs, PPOs do not accept capitation payments and are not at financial risk for costs exceeding premiums. Preferred
providers agree to serve PPO members at a discount from their usual and customary charges and to submit to utilization review by the PPO management. In return, the providers expect a greater volume of patients to be directed to them by the PPO. Patients enrolled in the PPO retain the right to use any practicing provider. Patient cost sharing is reduced, however, when they obtain care from one of the preferred providers. As first conceived, PPOs were a marketing device for hospital and physician providers, and they tried to acquire as many provider contracts as possible to assure broad geographic coverage (Hale and Hunter, 1988). Later, PPOs became more selective and sought to establish criteria to determine which providers offered the most cost-effective care (Boland, 1987).

In general, PPOs retain the fee-for-service reimbursement used by traditional indemnity insurers. A PPO usually negotiates a discounted or prospectively determined payment rate with providers to achieve reductions in the price of health services. PPOs may also require that providers submit to utilization review before authorizing payment of claims, in order to restrict the volume of services delivered. Providers have an incentive to make up losses from unprofitable contracts by increasing the volume of profitable services delivered. The volume of services may be controlled only by the PPO’s utilization management system. However, since PPOs risk losing enrollees if they fail to demonstrate cost reductions to third party payers, they have an incentive to strengthen their utilization management systems. In particular, PPOs will be more successful at controlling costs if they are able to contract with efficiently operated hospitals and physicians who have a cost-effective style of medical practice.

Hybrid Systems—In regard to patients’ choice of providers, alternative health care providers range from restrictive to liberal (Hale and Hunter, 1988). HMOs are the most restrictive of provider choice. Except in emergencies, an HMO will not pay for the services of providers not included in its network of providers. PPOs will cover the cost of care from providers other...
than those with whom it has contracts, but the PPO member must pay more in out-of-pocket cost sharing. Recently, alternative providers that could be considered hybrids of PPOs and HMOs have been created. To satisfy consumer demands for more choice, "open-ended" HMOs have been developed that provide indemnity insurance coverage for services delivered outside their panel of providers. In contrast, concern that PPOs that allow patients to choose non-network providers may not sufficiently restrain health care costs has led to the development of exclusive provider organizations (EPOs). Like PPOs, EPOs pay their panel of providers on a fee-for-service basis, but members of the EPO are required to obtain health care only from the EPO panel of providers. Traditional indemnity insurers are also using more of the utilization review features of PPOs and HMOs—such as requiring second opinions before surgery and prior authorization before a hospital admission—while maintaining free choice of provider and fee-for-service reimbursement.

Any alternative provider or health insurer competing with others for contracts can lower premium costs by attracting a healthier mix of enrollees.

Some companies seeking innovative solutions to health care cost problems have blurred the distinctions between HMOs and PPOs. Allied-Signal Inc., for example, has negotiated a fixed price contract with a single insurer, CIGNA, to cover all health care costs for a three-year period. BellSouth Corporation has created a network of providers in southern states; Pacific Bell has done so in California. Southwestern Bell has entered into a network called Custom Care with the Prudential Insurance Company of America. The Metropolitan Life Insurance Company, Aetna Life & Casualty, and others have also established hybrid networks.

Access to Health Care

Because alternative provider systems limit access to care in order to contain costs, frequent users of health care may opt to continue receiving services in the fee-for-service sector instead. Care can be restricted in a number of ways, including long waiting periods for appointments, nonemergency services, and elective hospital admissions. One criticism of a system in which multiple alternative providers compete to obtain enrollees is that there may be greater rewards for "gaming the system" and attracting lower-cost patients than for efficiently allocating care to those who need it most (Enthoven, 1988).

Any alternative provider or health insurer competing with others for contracts can lower premium costs by attracting a healthier mix of enrollees. This phenomenon is known as selection bias. Some fear that the result of a wholly competitive system would be to attract low-risk people into the competing plans, leaving those at highest risk without basic coverage. Alain Enthoven of Stanford University proposes that risk-adjusted premium payments to HMOs, PPOs, and indemnity insurers would reduce the economic incentive to practice selection bias and make a competitive market viable. However, this practice would require a tradeoff between the costs of obtaining enough information about an individual's risk and the costs of inaccurate risk assessments. Inaccurate adjustment for risks could make it possible for competing medical plans to continue to game the system by attracting people who carry a high payment rate but are in reality low-risk individuals.

Demand for Alternative Health Care Delivery Systems

Both private and public sponsors of health care coverage are paying increasing costs for health services.
Employer-Sponsored Programs

Among private payers, employer-based group health insurance plans are the largest source of health care coverage. Employers' contributions to group health insurance grew from $107 billion in 1986 to $115 billion in 1987, an increase of 7.5 percent. Individual employers' cost increases may vary greatly from this average, however. Some employers have seen double-digit percentage increases in their health care costs, while others have had little or no increase (Gabel et al., 1988).

Despite some continuing questions about whether HMOs and PPOs are ultimately able to retain quality and control costs, their enrollment is growing. In January 1989, enrollment in HMOs was nearly 32 million, with 607 plans operating in every state except Alaska and Mississippi. In addition, there were more than 616,000 members of open-ended HMOs, which offer an indemnity benefit as well as traditional HMO coverage, and 825,000 members of Prudential Plus, a hybrid HMO/PPO insurance product that is not legally constituted as an HMO but has a select panel of providers. HMO enrollment has been growing continuously, although the rate of enrollment growth slowed somewhat in 1988 to 5.4 percent, down from a 13.6 percent growth rate in 1987 (InterStudy, 1989). PPOs have also grown rapidly, from none before 1982 to 674 operating in 43 states in 1987 (American Association of Preferred Provider Organizations, 1988).

Increasing numbers of employers are offering HMOs. Among participants in employer health plans in medium-sized and large establishments1 in 1988, 19 percent were enrolled in HMOs and 7 percent were in PPOs (table 1). The Wyatt Company's 1988 Group Benefits Survey suggests that the proportion of firms offering their salaried employees the opportunity to enroll in alternative delivery systems is probably much larger. Of responding plans, 62 percent offered an HMO option, and 25 percent offered a preferred provider arrangement to salaried employees (table 2).

Hybrid alternative care plans have not penetrated far into the health care market. A Wyatt Company survey

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1Generally, establishments of 100 or more employees.

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Table 1

<table>
<thead>
<tr>
<th>Fee Arrangement and Financial Intermediary</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Participants</td>
<td>100%</td>
</tr>
<tr>
<td>Fee-for-Service Coverage</td>
<td>74</td>
</tr>
<tr>
<td>Self-insured†</td>
<td>31</td>
</tr>
<tr>
<td>Commercial insurance company</td>
<td>25</td>
</tr>
<tr>
<td>Blue Cross-Blue Shield</td>
<td>13</td>
</tr>
<tr>
<td>Independent organization</td>
<td>b</td>
</tr>
<tr>
<td>Other</td>
<td>b</td>
</tr>
<tr>
<td>Combined</td>
<td>5</td>
</tr>
<tr>
<td>Preferred Provider Organization</td>
<td>7</td>
</tr>
<tr>
<td>Self-insured†</td>
<td>3</td>
</tr>
<tr>
<td>Commercial insurance company</td>
<td>3</td>
</tr>
<tr>
<td>Blue Cross-Blue Shield</td>
<td>1</td>
</tr>
<tr>
<td>Independent organization</td>
<td>b</td>
</tr>
<tr>
<td>Other</td>
<td>–</td>
</tr>
<tr>
<td>Combined</td>
<td>b</td>
</tr>
<tr>
<td>Health Maintenance Organization</td>
<td>19</td>
</tr>
<tr>
<td>Self-insured†</td>
<td>–</td>
</tr>
<tr>
<td>Commercial insurance company</td>
<td>3</td>
</tr>
<tr>
<td>Blue Cross-Blue Shield</td>
<td>1</td>
</tr>
<tr>
<td>Independent organization</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>–</td>
</tr>
</tbody>
</table>


†Includes plans that are financed by general revenues of a company on a pay-as-you-go basis, plans financed through contributions to a trust fund established to pay benefits, and plans operating their own facilities if at least partially financed by employer contributions. Includes plans that are administered by a commercial carrier through administrative services only-minimum premium plan (ASO-MPP) contracts and plans in which a commercial carrier provides protection only against extraordinary claims.

‡Less than 0.5 percent.
found that 10 percent of responding salaried employees participated in "dual option" HMOs, in which an indemnity benefit and HMO coverage are underwritten by the same firm. "Triple option" plans, with an HMO, a PPO, and an indemnity option underwritten by the same insurer, were used by 5 percent of salaried employees (The Wyatt Company, 1989).

Public Programs

The high costs of public health insurance programs, principally Medicare and Medicaid, have led the government to seek to increase enrollment in alternative health care systems.

Medicare—In fiscal year 1988, Medicare, the federal health insurance program for the aged and long-term disabled, paid a total of $85.5 billion to hospitals, physicians, and other health care providers. Growth in expenditures under the Hospital Insurance portion of Medicare has slowed to less than 10 percent annually since the imposition of the prospective payment system (PPS) in 1983. Nevertheless, Social Security actuaries predict that increasing expenses will exhaust the Hospital Insurance trust fund by the year 2000. Payments to providers other than hospitals under the

Supplementary Medical Insurance (SMI) portion of Medicare increased by more than 10 percent in 12 of the last 13 years. Because financing for the SMI program comes from federal revenues and beneficiary premiums, expenditure increases exacerbate the federal budget deficit as well as increase the elderly's out-of-pocket costs.

Medicare had little discretion to contract with alternative provider systems before Congress passed the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Before TEFRA, Medicare could contract with HMOs to pay the itemized costs of treating each Medicare patient, instead of making the usual capitation payment. Or Medicare could pay a capitation payment under a "risk contract"; however, the HMO was required to share with the Health Care Financing Administration (HCFA) any savings gained from serving beneficiaries at less than the average cost. The HMO had to absorb the risk of incurring costs that exceeded the average. Few HMOs found these terms attractive.

TEFRA allowed a new type of risk contract in which beneficiaries have the option of joining an HMO instead of using their Medicare benefits to purchase health care services in the fee-for-service market. HCFA pays the HMO a capitation payment of 95 percent of the average cost of treating a Medicare beneficiary in the county that the HMO serves, ad-

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### Table 2

Employer-Sponsored Health Plan Alternative Delivery System Options for Active Employees, by Number of Covered Employees, 1988

<table>
<thead>
<tr>
<th>Delivery System*</th>
<th>Unknown</th>
<th>1-500</th>
<th>501-1,000</th>
<th>1,001-5,000</th>
<th>5,001 or more</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Plans in Survey</td>
<td>117</td>
<td>721</td>
<td>259</td>
<td>404</td>
<td>154</td>
<td>1,655</td>
</tr>
<tr>
<td>Preferred Provider Organization</td>
<td>28%</td>
<td>25%</td>
<td>23%</td>
<td>23%</td>
<td>38%</td>
<td>25%</td>
</tr>
<tr>
<td>Health Maintenance Organization</td>
<td>64</td>
<td>48</td>
<td>64</td>
<td>74</td>
<td>92</td>
<td>62</td>
</tr>
</tbody>
</table>


*Since multiple responses were permitted, columns do not sum vertically.
justed for age, sex, welfare recipiency, and whether the beneficiary resides in an institution. If a beneficiary who joins an HMO does not use health services any differently than the average beneficiary in that county, HCFA should, therefore, spend 5 percent less than it would under a fee-for-service arrangement. This type of contract has proven more attractive to both HMOs and beneficiaries. However, after a period of initial growth, Medicare HMO enrollment has remained steady at approximately 1 million enrollees. As of May 1989, more than 1 million Medicare beneficiaries (3 percent) had enrolled in 133 HMOs under TEFRA risk contracts, and an additional 125,000 were enrolled under cost contracts (U.S. Department of Health and Human Services, 1989).

PPOs can contract with HCFA under a TEFRA provision that allows contracting with competitive medical plans (CMPs) on the same capitation basis as HMOs. CMPs are health plans that are not regulated as HMOs but accept a capitation payment for Medicare-covered services. However, PPOs are not accustomed to receiving capitation payment and absorbing the financial risk of expenditures in excess of the capitation rate. Currently, only two PPOs have contracts as CMPs. HCFA has proposed a three-year demonstration project that would allow Medicare beneficiaries to obtain services from PPO providers in exchange for reduced cost sharing. Five PPOs across the country have been chosen to participate in the pilot project.

Medicaid—This program, which is jointly financed by the states and the federal government to provide health care for the poor, spent $54.8 billion in fiscal year 1988 (U.S. Congress, 1989). Medicaid spending increased at an average annual rate of 14.7 percent between 1968 and 1986, although the rate of growth in spending slowed between 1980 and 1986 to about 9.9 percent annually.

Only about 41 percent of people living below the poverty level had coverage from Medicaid in 1986. However, recent legislation has extended Medicaid eligibility to more of those who would otherwise be uninsured. Most recently, state Medicaid plans have been required to cover pregnant women and their children with incomes up to the poverty level. Yet, despite slower growth, the high cost of Medicaid may constrain states' ability to respond to proposals from Congress and the Bush administration to continue expanding Medicaid to cover more of the uninsured poor.

Medicaid allows states to enter into risk contracts with HMOs to enroll Medicaid beneficiaries, a practice similar to HMO risk contracting under Medicare. In the early 1970s, allegations of abuses in marketing by prepaid health plans in California led Congress to pass legislation regulating state contracting with HMOs. These revised regulations created barriers to significant contracting with prepaid plans, and many HMOs became reluctant to participate. By June 1981, only about 1 percent of Medicaid beneficiaries were enrolled in HMOs (U.S. Congressional Research Service, 1988). The Omnibus Budget Reconciliation Act of 1981 (OBRA '81) relaxed the regulations somewhat, and state programs have taken a number of steps to make Medicaid contracting more attractive to HMOs. By December 1987, the proportion of Medicaid beneficiaries voluntarily enrolled in HMOs had increased to 3 percent (approximately 660,000 beneficiaries), and HMOs in 22 states held Medicaid contracts.

Section 2175 of OBRA '81 allows states to obtain waivers of the Medicaid act provisions requiring that beneficiaries retain the freedom to choose their health care providers. A number of states have used such "freedom of choice waivers" to require enrollment in alternative health care delivery systems. Wisconsin has required 110,000 Medicaid recipients in the Milwaukee and Madison areas to enroll in HMOs—one of the largest groups (Rowland and Lyons, 1987).

In Arizona, under a demonstration waiver approved by HCFA, the entire state Medicaid program contracts with selected prepaid plans (such as HMOs) to deliver services to people eligible for Medicaid. Under other demonstration programs, California, Florida, Minne-
sota, Missouri, New Jersey, and New York have sought to enroll Medicaid beneficiaries in competing prepaid plans (Anderson and Fox, 1987).

There has been little interest in involving PPOs in Medicaid contracting. One reason may be that state Medicaid programs already pay providers a great deal less than their usual charges, and many states have strict utilization review programs in place. PPOs may not offer any particular advantage to Medicaid beneficiaries, who already have little cost sharing and free choice of providers, if they can find one that accepts Medicaid payment.

HMO enrollment may offer an advantage to Medicaid enrollees in terms of access and quality of care. Medicaid HMO enrollees who are treated along with private enrollees may receive better care than Medicaid recipients who depend on the services of so-called “Medicaid mills”—physician practices that specialize in treating Medicaid patients and tend to treat patients quickly, with little attention to their needs. However, the scandals in California involving HMOs established exclusively to serve Medicaid beneficiaries have caused concern among government regulators about the quality of care public beneficiaries receive from HMOs.

Differences in Delivery of Care

There has been concern that alternative health plans’ incentives to contain costs may lead to a reduction in the number of services delivered, thus compromising the quality of care. In most plans, physicians judge what services are necessary to achieve a good outcome for an individual patient. However, a system’s management may develop guidelines and protocols for its physicians to use in evaluating treatment options.

Reduced Services

A reduction in the number of services delivered may not necessarily lead to reduced quality. Wide variations in medical care usage across small geographic areas have often been cited as evidence that differing rates of medical care use are not related to health care outcomes (Caper, 1986). Nonetheless, restricting access to potentially necessary services is a cause of concern. Because alternative health plans and managed care programs in general have the potential to underserve enrollees, the quality of care they provide needs to be evaluated.

Among the major alternative provider systems, group and staff model HMOs have the strongest incentives to reduce services because of their capitation payment system. Early studies of HMO quality found little evidence to suggest that it differed from that of traditional medical care (Luft, 1981). In a study that randomly assigned adults to a group model HMO, health outcomes for those assigned to the HMO were reported to be equal to those who received free fee-for-service care. However, a subgroup of low-income enrollees with preexisting health problems were more likely to experience a worsening of their conditions, compared with similar low-income people who received free fee-for-service care (Ware et al., 1987).

HMOs are known to use hospital services less frequently than the system at large.

Capitation payments might give HMOs an incentive to provide preventive health services, to intervene early in medical problems, and to coordinate care rendered by several providers in order to minimize the average cost of care. However, early empirical studies were unable to confirm that HMOs were more likely than fee-for-service providers to provide preventive services (Luft, 1981), and there are no recent studies.

HMOs are known to use hospital services less frequently than the system at large. Whether they do this by enrolling a healthier population or by practicing...
One study that randomly assigned patients to a group model HMO found that these patients received 40 percent fewer hospital services and had 25 percent lower health care costs overall than a population receiving free service on a fee-for-service basis, with no discernible differences in health care outcomes (Manning et al., 1984). This frequently cited study does not definitively prove the cost effectiveness of HMOs, however, because it examined only a single, well-established HMO using a medical group model. The study has not been repeated for HMOs with different characteristics.

Although HMOs might be less costly than traditional insurance because they use hospital care less frequently, some of the observed difference in premium costs may be attributable to selection bias—enrolling a healthier population. A recent review of the literature concluded that significant evidence of favorable selection among HMOs does exist and is more likely to occur in group or staff model HMOs than in IPA models (Luft and Miller, 1987). Anecdotal evidence also supports this view. Many employers perceive that the HMOs with which they contract do experience favorable selection. A recent survey of employers found that 54 percent agreed with the statement, "HMOs attract the better risks from our employee group" (A. Foster Higgins, 1988).

There are a number of reasons why selection bias may occur in HMOs. HMOs allege that the more comprehensive coverage they offer may attract heavy users of health services. However, their low out-of-pocket costs and comprehensive coverage of basic health services may also be attractive to families headed by younger, healthier individuals. Other characteristics of HMOs tend to discourage heavy users of medical care; for instance, people who are using health services regularly may be less likely to want to change providers, as may be required if their physicians are not on the panel of HMO providers.

Although IPA model HMOs also have reduced hospitalization rates, no controlled study has been done to determine to what extent this reduction is the result of enrolling healthier members or of a less hospital-intensive practice style. IPAs may not be able to control hospitalization rates as well as other HMOs because they do not have as much financial or managerial control over their providers. IPAs may also be more likely to suffer from adverse selection. Privately insured patients of IPA physicians may choose to enroll in the IPA when they anticipate costly health care needs in order to reduce their out-of-pocket costs (Luft, 1981; Luft and Miller, 1988).

Health Care Inflation

Studies have suggested that the rate of cost inflation is the same for HMOs as it is for the fee-for-service sector (Newhouse et al., 1985). Joseph Newhouse and his colleagues hypothesize that the demand for new technologies in both HMO and fee-for-service practices creates similar pressures for cost increases in both sectors. If so, increased enrollment in HMOs may reduce costs in the short term, but an unchanged rate of medical inflation could increase expenditures beyond levels existing before the widespread enrollment occurred.

So-called "shadow pricing" by HMOs may also explain these cost inflation data. Some employers have accused HMOs of setting their premiums just below those of indemnity insurers. Their ability to attract better risks allows them to profit at this rate of payment. Since employers can be required—under certain circumstances—to offer HMO coverage, HMOs can follow the premium increases of other health insurers without losing enrollment.

Reliable empirical studies of PPOs' effectiveness in cost containment are not available. One case study of a California PPO organized by a large employer found that expenditures were less for PPO enrollees than for enrollees remaining in the company’s standard plan, but the study was unable to determine whether this effect was due to differences in enrollment (Hester et al., 1987). Better evaluations of the cost effectiveness
of utilization review systems are needed to determine whether PPOs can effectively control costs.

The quality of care provided by PPOs has been assumed to be similar to that in the fee-for-service sector because they retain the incentives of fee-for-service reimbursement to render all services that can benefit a patient. Because they retain fee-for-service payment, PPOs also retain an incentive to overuse or over-prescribe care (Greaney and Sindelar, 1987). If anything, PPOs have an incentive to provide a larger volume of services because they render services at a discounted charge from their usual fee-for-service practice. Reduced patient cost sharing in HMOs and PPOs also increases patient demand for health services. To control expenditures, the alternative provider must be able to screen out unnecessary care. PPOs presume that their utilization review programs will restrict the number of services, which may reduce quality of care. However, there has been no formal evaluation of quality of care in PPOs.

\[\text{Expansion: Pros and Cons}\]

Expanding the array of alternative providers may have disadvantages as well as advantages. The proliferation of alternative health care systems (and their acronyms) may be confusing to consumers. Plan sponsors' costs of administering health benefits, maintaining enrollment records, calculating premium contributions, and authorizing payment for services may increase. In particular, employers testing their welfare benefit plans to comply with nondiscrimination rules imposed by section 89 of the Internal Revenue Code are finding that having numerous health care options complicates their task. Employers who offer alternative health delivery options frequently offer more than one; a 1988 survey found that employers who offered HMOs provided an average of nine plans across all of the company's operating locations, with an average of two per establishment (A. Foster Higgins, 1989).

Another criticism of alternative health care delivery systems is that by requiring that services be authorized by a central administration, alternative provider systems interpose a bureaucracy between an individual and a health care provider. In obtaining medical care from a bureaucratic organization, those who are most skilled at manipulating a bureaucracy are most likely to obtain services. Conversely, people who are timid, weak, disabled, or ill may have more difficulty in obtaining services if there is disagreement between them and the authorizers of care.

In particular, because beneficiaries of public programs, such as Medicare and Medicaid, are frequently poor, aged, disabled, or any combination of the three, they...
may have difficulty advocating their own case against an alternative provider's management. This concern led to strict regulations in the 1970s that limited the ability of alternative providers to serve public beneficiaries. However, when TEFRA liberalized requirements for Medicare contracting with HMOs, one HMO in Florida generated a scandal when it created difficulties for Medicare enrollees to enroll and disenroll. Managers of that HMO were eventually indicted for conspiracy, obstruction of justice, and receiving kickbacks from their non-Medicare business; HCFA terminated their Medicare contract, and the HMO was driven into receivership (Iglehart, 1987).

Public Policy Issues

The federal government has played a role in regulating alternative health care provider systems since the Health Maintenance Organization Act was enacted in 1973. This legislation established a system of federal qualification in which an HMO adhering to certain standards could obtain benefits such as federal loans for startup costs.

Although the loan program has been phased out, one of the HMO act's most important provisions remains: employers that have more than 25 employees subject to the Fair Labor Standards Act and offer health care benefits must offer employees the option to enroll in either a group or staff model HMO or an IPA, if one operating in their area so requests. Without these requirements, enrollment growth in HMOs might have been constrained. In contrast, PPOs began at the request and sometimes under the auspices of employers, and have not been explicitly encouraged under federal law.

Responding to employer concerns about selection bias and HMO shadow pricing, the amendments to the HMO act enacted in 1988 relaxed some regulations applying to federally qualified HMOs, making it easier for employers to negotiate HMO rates and coverage. The amendments relax the requirement that federally qualified HMOs “community rate,” i.e., charge the same premium to all residents of a community, with adjustments permitted only for individuals' age and sex. The amendments allow employers to negotiate group rates on the basis of an estimate of the likely cost of providing services to an employee group. This type of pricing is similar to the “experience rating” used in fee-for-service insurance plans, except that HMOs are not permitted to adjust premiums retroactively if the estimate proves to be inaccurate. Employers with fewer than 100 employees cannot be charged more than 110 percent of the community rate.

The 1988 amendments also require federally qualified HMOs to disclose to employers how they calculate their premium charges. This has been a point of some contention between HMOs and employer groups. HMOs claimed that providing such data would increase their administrative costs, while employers concerned about shadow pricing felt that HMOs should be willing to reveal how they calculate their premium rates.

The original HMO act also required that employer contributions to HMO coverage be on terms no more favorable to the HMO than to the indemnity insurer. Regulations implementing this provision required employers to contribute on terms no more or less favorable to the HMO. This regulation came to be known as the equal contribution requirement, and has sometimes been interpreted to mean that employers had to pay contributions for HMO coverage equal to what they paid to indemnity insurers. In some cases, because HMO premiums were less expensive, employees who chose the HMO option did not have to contribute anything to their coverage, while those who kept the fee-for-service plan did.

The 1988 legislation amended the HMO act to require only that the employer contribution for HMO coverage not “financially discriminate” against employees electing the HMO option. According to the amendments, a contribution is not discriminatory if the method used to determine the contribution level is “reasonable” and is designed to assure employees a fair
choice among all offered plans. Future federal regulations will further define these guidelines and are likely to allow greater flexibility in determining employer contributions than the equal dollar requirement.

The amendments also rescind, after 1994, the requirement that an employer who has more than 25 employees and who offers health insurance must offer employees the option of enrolling in a federally qualified HMO if one so requests. Opponents of the requirement argued that HMOs no longer need this advantage to compete in the marketplace.

It appears that the players in the health care market have already passed judgment and are expecting increased enrollment in alternative provider systems to relieve some of their cost burdens.

PPOs are regulated by the states under their authority to regulate insurance, and restrictive state regulations may have impeded their early growth. However, only a few states have laws expressly forbidding the selective contracting and channeling of PPOs (American Association of Preferred Providers, 1988). Of more importance to PPO development is the concern that certain types of provider cooperation in forming PPOs may be considered anticompetitive behavior under antitrust laws. Agreements among providers sponsoring PPOs to coordinate pricing and discounting may be perceived as anticompetitive collusion or price fixing (Greaney and Sindelar, 1987).

Conclusion

Alternative health care providers continue to evolve as public and private payers seek alternatives for providing less expensive care without compromising quality. The theoretical appeal of alternative health care delivery systems that change provider incentives remains strong. Definitive evidence of the efficacy of alternative providers in accomplishing these aims still escapes researchers. However, it appears that the players in the health care market have already passed judgment and are expecting increased enrollment in alternative provider systems to relieve some of their cost burdens.

Further evolution of alternative delivery systems may move in either of two directions: toward more control of sources and sites where health care is delivered, as in an HMO, or toward more freedom to choose a provider, as is allowed in a PPO. It seems likely that HMOs can maintain stricter cost control, but it is possible that people's preferences for freedom of provider choice may continue to help PPOs retain a market share.

Managed care programs under indemnity insurance that require prior authorization for use of services also restrict physicians' and patients' treatment choices. Utilization review programs must be able to justify overturning physicians' treatment recommendations to protect themselves from liability as well as to maintain quality. Nevertheless, such decisions may create rancor among physician providers and alienate employees and plan beneficiaries. A health plan sponsor may find it easier to delegate treatment decisions to the alternative health care delivery system. The system's management then becomes responsible for maintaining patient loyalty and the satisfaction of individual physicians as well as for demonstrating the cost effectiveness of their practice patterns.

Freedom of choice among providers or of practice style has its costs. Increasing pressures for cost containment may mean that freedom of provider choice will be restricted for more and more public beneficiaries, as is currently occurring under Medicaid programs. Assuming that quality of care is maintained, policymakers may judge that tradeoff to be worthwhile.
cymakers continue to struggle with the question of how to extend access to health care to those Americans who lack health insurance, and employers strive to fund the promises they have made to their employees and their families, alternative health care providers are likely to continue to evolve as part of the solution.

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