Managed Health Care: A Primer

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Summary

Since the early 1970s, market forces have driven profound changes in the financing and organization of health care delivery. Whereas the functions of paying and providing for medical care were once separate, now they are joined together in an increasing number of managed care organizations.

Between 60 to 70 million persons (approximately 20% of the U.S. population) were enrolled in over 600 health maintenance organizations (HMOs) in 1996. In addition, between 80 to 90 million persons were enrolled in more than 1,000 preferred provider organizations (PPOs), which is another type of managed care organization. Altogether, over one-half of the U.S. population and almost three-quarters of insured employees were covered by some form of managed care in 1996.

Individual practice associations (IPAs) are the most common and fastest growing type of HMO; they account for 60% of all HMOs and 44% of HMO enrollment. Together, staff and group model HMOs account for less than 20% of total HMO enrollment. About three-quarters of HMOs now offer a point-of-service (POS) option, which allows enrollees to see out-of-network providers for a higher premium and/or coinsurance payment. The data are mixed on whether medical expenses are higher for POS members than for traditional HMO members.

National managed care firms, also called corporate HMO chains, accounted for 88% of total HMO enrollment and 70% of all HMOs in 1995. By January 1996, almost half of total HMO enrollment was in the seven largest national firms, up from 34% only 6 months earlier. This concentration of membership reflects mergers and acquisitions that have been occurring at a rapid pace in the managed care industry.

For-profit HMOs enroll about 60% of all HMO members and constitute about 70% of all HMOs. Recent analyses indicate that in market areas where there are more for-profit HMOs, net operating margins tend to be lower and annual enrollment growth tends to be higher. However, net operating margins are increasing faster for for-profit HMOs than for non-profit HMOs.

In 1997, the average base salary of HMO chief executive officers (CEO) was $227,133 (the median was $195,787). This is an increase of 56% since 1991. With bonuses and incentives added in, the mean HMO CEO salary was $310,241 (median, $227,500). Ten percent of HMO executives make well over half a million dollars a year.

Almost two-thirds of persons under the age of 65 are covered by employer-sponsored insurance. Of these, in 1996, 73% received health care from a managed care organization. Since 1993, insured workers' enrollment in traditional indemnity plans has dropped from about one half to under a quarter. Managed care enrollment has been particularly rapid in HMOs with a POS option. Cost considerations are closely associated with this change. In 1995, employers paid an average of 15% less for HMO coverage than for traditional indemnity coverage.

Contents

List of Figures

List of Tables

Managed Health Care: A Primer

Introduction

Since the early 1970s, market forces have driven profound changes in the financing and organization of health care delivery. Whereas the functions of paying for and providing medical care once were separate, increasingly they are joined together in the form of managed care organizations (MCOs). By 1996, about 57% of the U.S. population was covered by some type of managed care — including 60 to 70 million persons enrolled in health maintenance organizations (HMOs) and another 80 to 90 million enrolled in preferred provider organizations (PPOs).[1]

As the U.S. health care system continues to evolve, Congress faces an abundance of issues. Legislative options range from encouraging the spread of managed care in parts of the country (e.g., rural areas) and among subgroups of people (e.g., the elderly) which are little affected by it, to protecting consumers from a host of potential managed care excesses which may have deleterious effects on access to quality health care. This CRS report provides basic information to assist congressional committees and staff as they deliberate on a wide range of issues relating to the managed care evolution in the U.S. health care system.

This managed care primer answers the following questions. What is meant by managed care? What are the various types of managed care organizations and how do they differ from one another? How does managed care differ from traditional fee-for-service health care? It briefly reviews the history of managed care in this country, discusses enrollment trends, describes different types of managed care organizations (including HMOs, PPOs, provider-sponsored organizations (PSOs), and point-of-service (POS) options), and examines basic utilization and compensation data. Because far more data are available on HMOs than other forms of managed care organizations, this report reflects this imbalance.

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[1] Health Care Financing Administration. Office of Managed Care. 1996; Standard & Poor's *Industry Surveys, Healthcare: Managed Care*, October 17, 1996. p. 7; Interstudy, *The Interstudy Competitive Edge* (hereafter cited as Interstudy, *The Competitive Edge*), *Part II: Industry Report*, Table 1, p. 20; and American Association of Health Plans, *1995-1996 HMO & PPO Trends Report* (hereafter cited as AAHP, *Trends*).

Additional information — on managed care strategies,[2] on the use of financial incentives in managed care,[3] on state and federal regulation of managed care,[4] and on current legislative issues relating to managed care — will be available in future CRS reports.

What is Managed Care?

No single definition of managed care would satisfy everyone, but certain characteristics stand out, especially in comparison to traditional insurance. Under traditional insurance, the insurer pays a claim when it is filed by the insured or by the insured's provider. The financing function of the payor or insurer is kept entirely separate from the service delivery function of the medical professional. Traditionally, the latter was exposed to few, if any, incentives for efficiency or cost control.

In contrast, an important managed care strategy for controlling costs is to contract with select providers who share financial risk for the cost of care (as is typically done in HMOs) or who accept negotiated discounts in fee-for-service payments (as is typically done in PPOs).[5] Providers' compensation may be tied, at least in part, to their own pattern of clinical decision-making and/or resource utilization. Managed care strategies include various forms of utilization review (e.g., pre-, concurrent, and post-certification; gatekeeping; and practice profiling) and case management.[6] Moreover, managed care organizations employ internal, and often, external quality assurance processes.[7]

In short, managed care organizations integrate the financing and delivery of care, institute cost controls, share financial risk with providers, and manage service utilization. They vary in the degree of control they exercise over costs and medical decision-making. Traditional fee-for-service or indemnity insurance offers the least amount of cost control, although even these programs may adopt some managed care

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[2] U.S. Library of Congress. Congressional Research Service. *Managed Health Care: Strategies for Controlling Cost and Maintaining Quality*. CRS Report, by Jason S. Lee. Forthcoming.

[3] U.S. Library of Congress. Congressional Research Service. *Managed Health Care: The Use of Financial Incentives*. CRS Report 97-482, by Jason Lee and Beth Fuchs.

[4] U.S. Library of Congress. Congressional Research Service. *Managed Health Care: State and Federal Regulations*. CRS Report, by Beth Fuchs. Forthcoming.

[5] In return, these contract providers (also called "staff," "select" or "preferred" providers) are assured enhanced patient volume. Managed care plans use financial incentives (i.e., lower out-of-pocket charges) to encourage enrollees to use "in-network" providers.

[6] For more on this topic see U.S. Library of Congress. Congressional Research Service. *Managed Health Care: Strategies for Controlling Cost and Maintaining Quality*. CRS Report, by Jason S. Lee. Forthcoming

[7] For a discussion of quality of care issues in the Medicare program, see U.S. Library of Congress. Congressional Research Service. *Quality of Care Issues in Medicare Reform*, CRS Report 96-581, by Jason S. Lee.

features, such as pre-certification for hospitalization in all but emergency situations. At the other extreme, staff-model HMOs (discussed below) tend to offer the greatest degree of control.[8]

A Brief History[9]

Managed care, in its essential form, has been around for some time. The first large scale managed care programs date from the turn of the century and the opening of the West to the railroads. Prepaid group health plans were set up as clinics to provide health services for workers isolated in lumber camps, Minnesota iron mines, and railroad construction sites. Other early experiments included the Community Cooperative Hospital of Elk City, Oklahoma, the first capitated[10] physician-hospital organization in the United States (founded in 1929 by Dr. Michael Shadid, who had a major influence on many early organizations); the Ross-Loos Medical Group, which provided health services to Los Angeles County Department of Water and Power employees; and the Kaiser-Permanente Health Care Plan, organized in the 1930s and 1940s to provide health care for workers on dams and roads in the Pacific Northwest and California, and later in the growing Kaiser shipbuilding business in Oakland, California.

During these early years, expansion of managed care was slow. Few Americans had access to a prepaid group health plan. A number of factors accounted for this, including the increased availability of health benefits and services through indemnity (fee-for-service) insurance during the 1940s and 1950s, resistance to prepaid health care arrangements such as HMOs from the traditional fee-for-service medical communities, legal restrictions imposed by state governments, the post-World War II hospital construction boom, and the lack of available financing for start-up and operation costs.

However, beginning in the 1970s, a number of trends coalesced to fuel enrollment in, and numbers of, a specific type of managed care organization known as health maintenance organizations (HMOs). Medical costs had been rising at a rate above the rest of the economy for a number of years, which resulted in ever higher premiums. Many individual and group purchasers came to believe that added health benefits from advancements in medical technology had not kept pace with rising prices. Trust in the medical establishment also began to erode, as practice variations were brought to light, health care fraud and abuse was exposed, and inequalities in access to care were made known. Added to this, the overall economy had slowed, inflation was high, and third party health care purchasers (i.e., employers and the

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[8] See **Appendix A** for a summary comparison of the characteristics of the major types of managed care organizations.

[9] Fran Larkins of the Congressional Reference Division, Congressional Research Service contributed to this section.

[10] Capitation is the *prepayment* of a fixed-fee per person for a range of medical services. A capitated provider accepts a predetermined amount per covered individual per month, regardless of the number and intensity of services provided during the coverage period.

federal government) were alarmed to be paying an increasing share of a total health care expenditure bill that was, in the phrase of the day, skyrocketing.

Traditional fee-for-service payment arrangements — which dominated public and private health care delivery systems — were seen by many as an important root cause of runaway health care costs. Doctors had little incentive to be mindful of controlling costs and hospitals could only maintain or increase revenue under cost-based reimbursement by increasing volume of services or their price. Prepaid plans, such as those exemplified by the Kaiser plans in the West, which rewarded health maintenance, were viewed by some as an antidote.[11] The Nixon administration viewed the "health maintenance strategy"[12] as a way to control health care costs through private sector initiative, rather than through price controls or more sweeping reforms of the health care system.

The Health Maintenance Organization Act of 1973 (P.L. 93-222) and the Health Maintenance Organization Amendments of 1976 (P.L. 94-460) encouraged the development of HMOs by providing federal funds ($190 million from 1974 through 1980) to help qualified HMOs through their start-up period.[13] The new law, which added Title XIII to the Public Health Service Act, preempted some existing state laws that were thought to restrict the development of HMOs. The Act also created a certification process, whereby organizations meeting specified financial and organizational standards could become federally qualified. Federal qualification also allowed organizations to take advantage of the Act's "dual choice" requirement, which under certain circumstances required employers to offer an HMO as a health benefit plan option.[14]

Health Maintenance Organizations

A health maintenance organization (HMO) is a form of health insurer. It may be an independent entity or a line of business within an insurance company. Like other health insurers, an HMO accepts financial risk for a defined set of health care

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[11] See U.S. Library of Congress. Congressional Research Service. *Managed Health Care: The Use of Financial Incentives.* CRS Report 97-482, by Jason S. Lee and Beth C. Fuchs.

[12] The term "health maintenance organization" was coined by Dr. Paul Ellwood, who had concluded that fee-for-service compensation arrangements created "perverse incentives" which rewarded physicians and institutions for treating illness and then withdrew those rewards when health was restored. Ellwood proposed a nationwide system of prepaid group practices, which he believed would help control costs and provide effective care. This became the focus of President Nixon's 1971 Health Message to Congress and led to support for development of HMOs in the 1973 HMO Act. For more on the HMO Act of 1973, see Brown, Lawrence D. *Politics and Health Care Organizations: HMOs as Federal Policy*. Brookings Institution, Washington, 1983.

[13] Federal assistance totaled 43% of the estimated $439 million that helped support new HMO development during this period. See Gruber, L., M. Shadle and C. Polich. From Movement to Industry: The Growth of HMOs. *Health Affairs*, summer 1988. p. 203.

[14] See U.S. Library of Congress. Congressional Research Service. *Managed Health Care: State and Federal Regulations.* CRS Report, by Beth C. Fuchs. Forthcoming.

benefits in return for a fixed monthly per capita premium paid by or on behalf of each enrolled member. But unlike other insurers, HMOs directly provide or arrange for health care services through affiliated physicians, hospitals and other providers. Unlike traditional insurance companies, HMOs do more than finance health care.

HMOs often share financial risk with providers. In contrast to traditional indemnity insurance compensation arrangements, which reimburse providers on a fee-for-service basis, HMOs may partially or fully prepay or capitate[15] providers, just as the purchaser prepays the HMO. Much has been written on different incentives that providers experience under capitation versus fee-for-service arrangements.

HMOs provide access to a limited panel of providers for a comprehensive set of health benefits. Enrollees agree to obtain all services, except emergency and out-of-area care, from or with the authorization of the HMO or its affiliated providers.[16] Specialty care is accessed through referrals from generalists (or "gatekeepers") and as long as members seek care within the HMO, out-of-pocket health care costs are minimized.

Types of Health Maintenance Organizations

There are different types of HMOs. Staff and group model HMOs were the earliest managed care plans. In a **staff model** HMO, physicians are salaried employees who, typically, provide care in HMO-owned offices and hospitals. (Start-up capital requirements for staff model HMOs are high.) Plan enrollees must choose a provider from the HMO's list. The plan does not pay for unapproved, non-emergency care received outside the HMO.[17]

In 1996, two of the nation's 25 largest individual HMO plans — Harvard Community Health Plan and Group Health Cooperative of Puget Sound[18] — were staff model HMOs (see **Table 1**.) Only 3% of all HMOs are staff model HMOs and they account for an even smaller share (1.3%) of total HMO enrollment.[19]

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[15] An essential characteristic of capitation compensation systems is the *prepayment* of a fixed-cost per person for a range of medical services. A capitated provider accepts a predetermined amount per covered individual per month, regardless of the number and intensity of services provided during the coverage period. The capitation payment is, in effect, a budgeted amount of money to be used by the provider, regardless of how little or how much care is required by the patient. *This type of arrangement results in financial risk.*

[16] This agreement is an essential feature of "pure" or "closed" HMOs. Increasingly, HMOs offer a "point-of-service" (POS) option, which allows access to out-of-network providers. This option is discussed in more detail below.

[17] Point-of-service options have liberalized this restriction, but members must pay a substantial share of the out-of-network provider's bill out-of-pocket.

[18] Harvard Community Health Plan has since merged with Pilgrim Health Care, Inc., to become Harvard/Pilgrim Health Care. In 1997, Group Health Cooperative of Puget Sound affiliated, but did not merge, with Kaiser Permanente.

[19] InterStudy. *The InterStudy Competitive Edge. Part II: Industry Report.* Table 11.

A **group model** HMO contracts with one or more multi-specialty medical groups to provide all covered services to HMO participants in exchange for a per capita fee. Each medical group's practice is limited, largely, to the HMO membership and it is managed independently of the HMO. Physicians contract with the medical group, which may compensate them on a risk-sharing, cost, or salary basis.

Although the HMO may have formed the group practice, the medical group is not owned by the HMO. The group practice may, however, own the HMO. In other words, physicians may enter into profit-sharing arrangements with the HMO.

Table 1. The Nation's 25 Largest Individual HMO Plans, 1995

Rank	Plan	Enrollment	Model type
1	Kaiser Permanente MCP/Oakland, CA	2,459,631	Group
2	Kaiser Permanente MCP/Pasadena, CA	2,191,100	Group
3	Health Net/Woodland Hills, CA	1,339,327	Network
4	PacifiCare of California/Cypress, CA	1,214,558	Network
5	California Care/Blue Cross/Woodland, CA	931,700	Network
6	HIP of Greater N.Y./New York, N.Y.	852,555	Group
7	U.S. Healthcare—SE Pa./Blue Bell, PA	823,550	IPA
8	Keystone Health Plan/West/Pittsburgh, PA	765,875	Network
9	Medica Choice/Minneapolis, MN	693,009	IPA
10	U.S. Healthcare—New Jersey/Fairfield, NJ	662,000	IPA
11	HMO Blue/Boston, MA	652,737	IPA
12	Foundation Health—CA/Rancho Cordova, CA	649,342	Group
13	HealthPartners/Minneapolis, MN	632,694	Group
14	Harvard Comm. Health Plan/Dedham, MA	604,043	Staff
15	Keystone Health Plan/East/Philadelphia, PA	575,251	IPA
16	Grp. Health Coop. Of Puget Sound/Seattle, WA	557,852	Staff
17	U.S. Healthcare—New York/Uniondale, NY	554,000	IPA
18	Tufts Associated Health Plans/Waltham, MA	543,714	IPA
19	HMO Illinois/Chicago, IL	541,226	Group
20	Health Options/Jacksonville, FL	529,948	IPA
21	Blue Choice/Rochester, NY	517,525	IPA
22	CIGNA HealthCare of So. CA/Glendale, CA	509,265	Staff
23	FHP/California/Cerritos, CA	507,370	IPA
24	HMO Oregon/Salem, OR	483,537	IPA
25	Community Health Plan/Latham, NY	475,713	Network
	TOTAL	**20,267,522**	

Source: Hoechst Marion Roussel Managed Care Digest Series. HMO-PPO Digest, 1996. p. 10. Data collected by SMG Marketing Group, Inc.

Note: Many "individual" HMO plans also are organized into national HMO chains.

Group model HMOs account for 6.5% of all HMOs and 16% of total HMO enrollment.[20] The northern and southern California Kaiser Permanente plans — the largest of all individual HMO plans — are group model HMOs, as are four more of the nation's 25 largest HMOs (see **Table 1**).

A newer variant is the individual or independent practice association, also known as the **IPA model** HMO. An IPA, which has been described as "an HMO without walls," contracts directly with physicians in independent practice, associations of physicians in independent practices, or multispecialty group practices. Participating physicians retain their private practices, in their own offices, but they see HMO patients as part of that practice. Typically, IPA physicians do not have an exclusive relationship with a single HMO.

The IPA functions much like the medical group in group model HMOs. The HMO capitates the IPA and the IPA, in turn, compensates providers in accordance with contractual arrangements (perhaps paying primary care physicians a fixed-fee per enrollee, and reimbursing specialists on a discounted fee-for-service basis.) The IPA may be responsible for coordinating the activities of member physicians, arranging provider compensation arrangements, and conducting various utilization management strategies. IPAs may withhold money in "risk pools" from which providers can earn "bonuses," but only if care is provided cost efficiently or in accordance with other standards.

IPAs are both the most common and fastest growing type of HMO. Although sources classify and therefore count HMO types somewhat differently, most agree that about 60% of all HMOs were IPAs at the start of 1996. The number of IPAs increased by 35% between 1995 and 1996. Membership increased almost as fast (31.4%), to over 26 million members, or about 44% of the total.[21] Eleven of the 25 largest individual HMOs are IPA model HMOs, including U.S. HealthCare of Pennsylvania and Medica Choice of Minneapolis. (See **Table 1**.)

A **network model** HMO can offer the broadest provider participation of any type of HMO because it contracts with staff, group and IPA models in combination. For this reason, some also call it a mixed model HMO. Network HMOs may contract with primary and specialty care provider groups as well as hospitals — a practice which helps spread financial risk.[22] Network model HMOs offer the least amount of control or management of providers' utilization of services and resources.

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[20] Ibid.

[21] Ibid. InterStudy reported that 58.3% of all HMOs were IPAs as of January 1, 1996. The American Association of Health Plans (AAHP) reported that in 1995 IPAs accounted for about 61-66% of all HMOs, and about 51% of total HMO enrollment. The higher numbers derive from the "predominant model type" counting method rather than the "100% method." For details, see American Association of Health Plans, *1995-1996 Managed Health Care Overview*. p. 13. (Hereafter cited as AAHP, *1995-1996 Managed Health Care Overview.)*

[22] If, for example, an HMO contracts with specialty providers, and pays them a capitated amount, then primary care doctors would not be at financial risk for speciality referrals.

Moreover, providers typically do not have exclusive contracting relationships with network HMOs.

Network HMOs account for between 10-13% of all HMOs, and about 6-15% of total HMO enrollment. Four of the nation's ten largest individual HMOs are network model HMOs (see **Table 1**); namely, Health Net, PacifiCare and California Care/Blue Cross, all of California, and Keystone of Pennsylvania.

National Managed Care Firms

National managed care firms, also called corporate HMO chains, accounted for 88% of total HMO enrollment and 70% of all HMOs in 1995.[23] The fastest growing firms in the year ending January 1, 1996 were: the Blue Cross and Blue Shield System, United HealthCare Corporation, Aetna Health Plans, PacifiCare Health Systems, Inc., and Harvard/Pilgrim Health Care. The seven largest national managed care firms (see **Table 2**) accounted for almost half (49%) of total HMO enrollment, compared to about one-third (34%) only 6 months earlier.[24]

Table 2. National Managed Care Firms Ranked by Total HMO Enrollment, as of January 1996

Rank	National managed care firm	Number of plans	Total enrollment
1	The Blue Cross and Blue Shield	83	10,134,592
2	System	12	6,924,080
3	Kaiser Foundation Health Plans, Inc.	43	3,603,191
4	United HealthCare Corporation	12	2,227,449
5	U.S. Healthcare, Inc.	34	2,073,889
6	Prudential Health Care Plans, Inc.	6	1,904,608
7	PacifiCare Health Systems, Inc.	19	1,875,783
8	Humana, Inc.	8	1,860,926
9	Health Systems International, Inc.	11	1,851,195
10	FHP, Inc.	34	1,734,191
	CIGNA Health Plans, Inc.		

Source: The InterStudy Competitive Edge: *HMO Industry Report 6.2*. Table 28.

Trends in HMO Enrollment and Growth

In 1970, there were approximately 3 million persons enrolled in 37 HMOs in 14 states. By 1975, HMO enrollment had doubled and the number of HMOs had increased fivefold. Enrollment growth slowed somewhat from the mid-1970s to

[23] Hoechst Marion Roussel Managed Care Digest Series. *HMO-PPO Digest 1996*. p. 8-9.

[24] Interstudy, *The Competitive Edge: HMO Industry Report* 6.2, 1996, p. 53-55.

early 1980s, but the mid-1980s witnessed an enrollment boom.[25] Enrollment doubled between 1975 and 1983, an 8 year period, and then doubled again in just 3 years. (See **Figure 1**.)

Some of the factors that may have led to rapid HMO growth in the 1980s are:

- relaxation of state regulations established on behalf of traditional medical interests to stymie competition from prepaid plans;
- passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, which gave states greater flexibility to enroll Medicaid recipients in HMOs;[26]
- implementation in 1985 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized the Medicare risk-contracting program;
- increasing perception among employers and other purchasers of managed care cost savings potential; and
- expanding preference for non-group practice HMOs (i.e., independent practice arrangements [IPAs]), which allowed greater flexibility in composition of provider networks, location of service delivery, and choice of providers.

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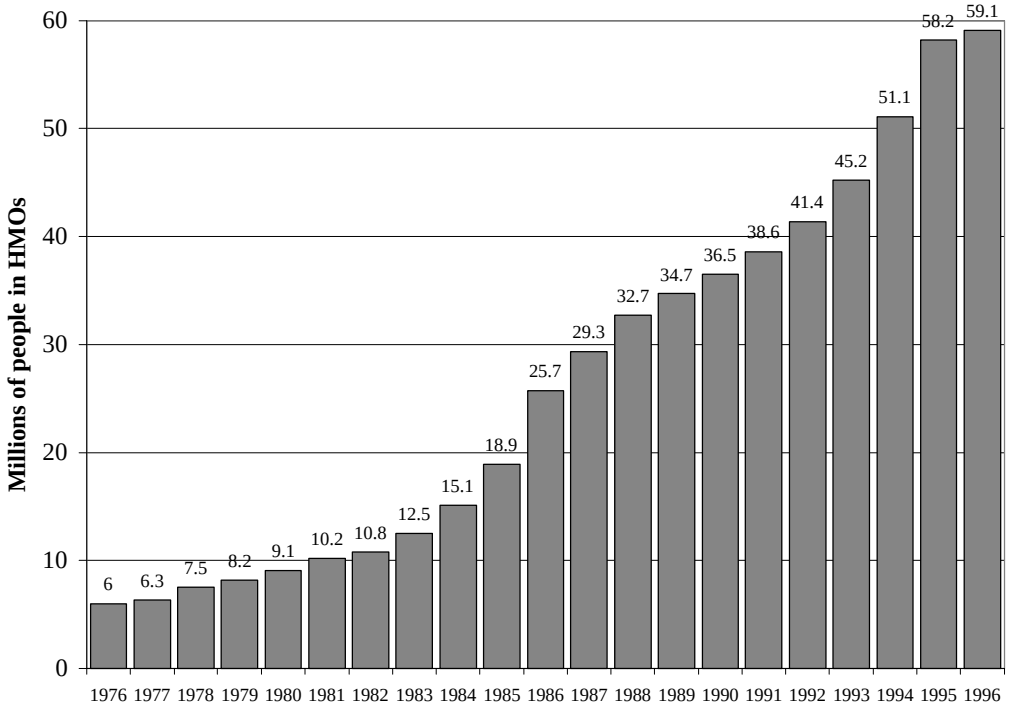
[25] In the early years of HMO development, Kaiser Foundation Health Plans represented a large share of total enrollment (Kaiser had almost half of total enrollment in 1978). But growth in national HMO networks began in the late seventies and by 1986 the number of HMO firms (defined as an organization that owns or operates distinct HMOs in two or more states) had increased from 6 to 42 with 310 affiliated HMOs (or one-half of all HMOs). Although Kaiser enrollment increased during this time (from 3.5 million in 1978 to 4.9 million in 1986), its representation of enrollment in national HMO firms decreased from 94% in 1978 to 31% in 1986.

[26] In

were 500 Medicaid managed care contracting entities. Although only about a quarter million Medicaid clients were enrolled in managed care in 1981, by June 1996, enrollment had increased to 12.8 million (or 39% of the total Medicaid population).

Figure 1. HMO Enrollment, All Ages, 1976-1996

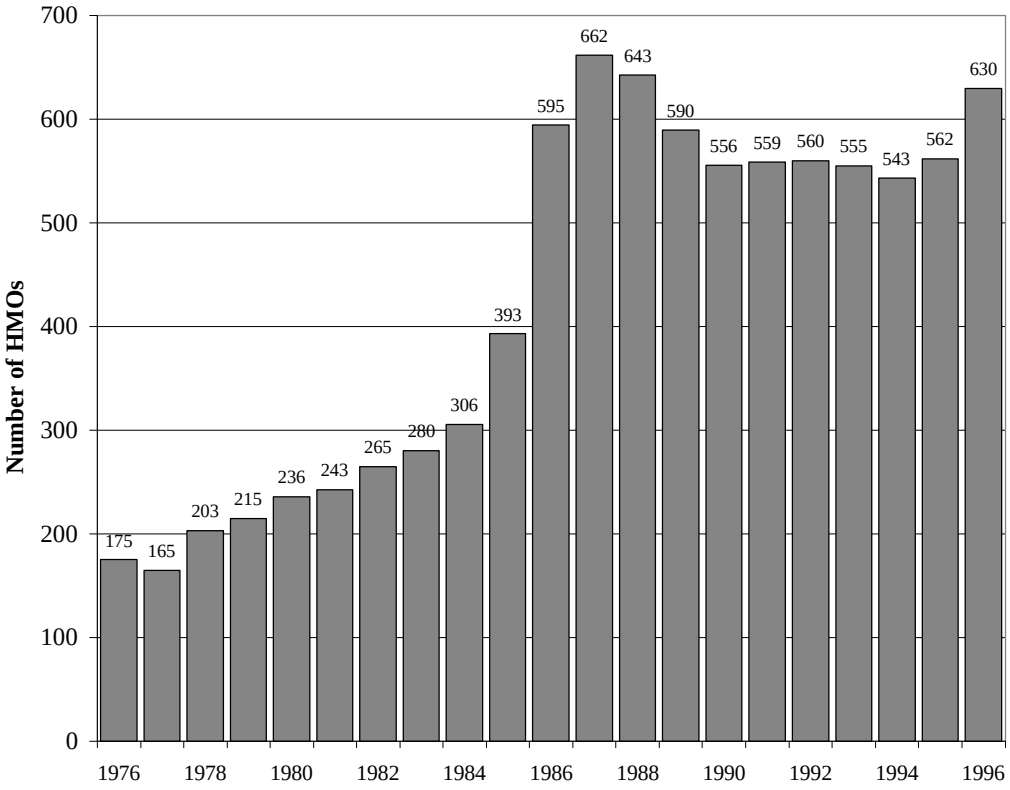


Sources: Gruber, Shadle, and Polich, *The Growth of HMOs* and American Association of Health Plans, *1995 HMO & PPO Trends Report* and Interstudy, 1996, *HMO Industry Report 6.2.*

HMO enrollment slowed somewhat during the late 1980s and early 1990s, but began to grow at a faster pace again in the mid-1990s. Following the failure of the Clinton administration's health care reform initiatives of 1993-1994, and in response to continuing, significant increases in premiums, the private sector embraced managed care cost control strategies with renewed fervor. Increased managed care enrollment in employer-sponsored plans and Medicare drove this trend.

The number of HMOs increased dramatically in the mid-1980s, growing by more than 50% between 1985 and 1986, and then by another 11% to an all time high of 662 in 1987. (See **Figure 2**.) This period of growth was followed by intense competition which drove premiums down — some would say to unrealistic levels — in order to secure market share. Plan closings and mergers resulted. To secure enrollment, HMOs began expanding options, integrating services, developing hybrid organizational forms (discussed below), and enhancing efficiency.

Figure 2. Number of HMOs, 1976-1996



Source: Gruber, Shadle, and Polich, *The Growth of HMOs* , and Interstudy, 1996, *HMO Industry Report 6.2* .

According to one source, by 1996 about 20% of the U.S. population was enrolled in HMOs.[27] At the same time, over one-half (about 57%) of the U.S. population was covered by some form of managed care. This is almost double the share of the population enrolled in managed care plans only 10 years ago. Much of this growth is concentrated in a single type of HMO (the independent practice association or IPA model HMO) and in preferred provider organizations (PPOs). A PPO is a managed care organization, but it is not an HMO (see the section on PPOs in this report).

Service Utilization and Costs in HMOs

HMOs tend to reduce health care costs by managing enrollees' use of services. They may limit hospitalizations, diagnostic tests or specialty referrals through utilization review and by giving participating providers a financial stake in the cost of the services they deliver. Moreover, HMOs try to select cost-effective service providers into their networks.

In a 1996 study of the impact of managed care (defined by the presence of HMOs, provider risk-sharing arrangements, and the involvement of employers in the

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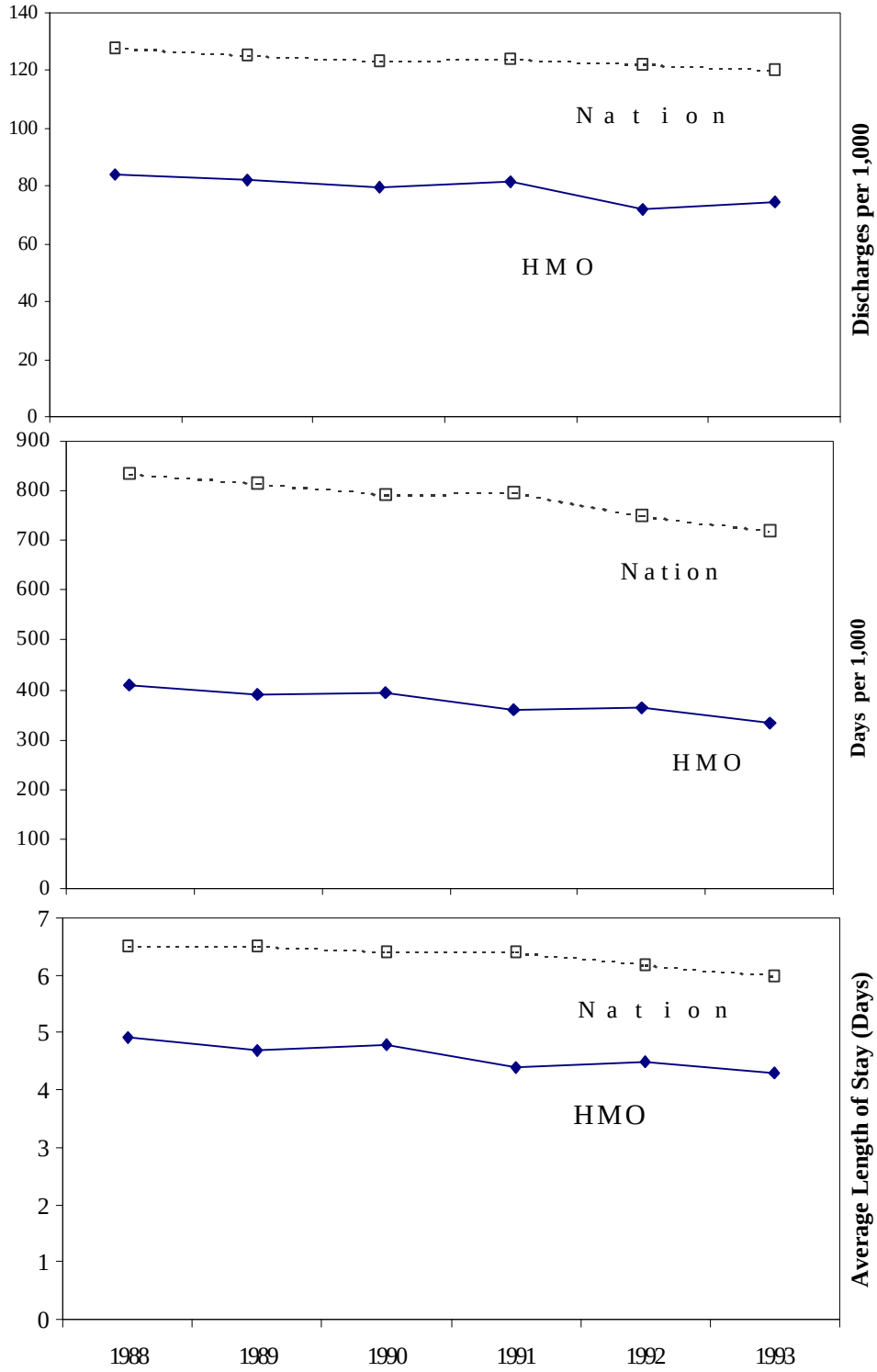
[27] Standard & Poor's, *Industry Surveys. Healthcare: Managed Care*. October 17, 1996. p. 7.

management of care delivered to their employees) in the 50 largest U.S. cities, KPMG Peat Marwick found that markets with high managed care penetration had discretionary acute care (hospital) costs 11% below the national average and 19% below hospital costs in low managed care markets.[28]

Most studies have found that HMOs are able to provide medical care for less than fee-for-service insurance partly by reducing hospital admissions and by providing for shorter lengths of hospital stays. The relative success of HMOs in reducing the utilization of inpatient care (the most costly type of health care event) is shown in **Figure 3**. Total inpatient HMO utilization rates declined between 1988 and 1993. Overall, HMO members were hospitalized about two-thirds as often as the population as a whole in 1993. On average, they spent about half as many days in the hospital. Nationally, total utilization rates have also declined since 1988. Because the national figures include HMO members, the national decline is *partly* explained by increased HMO membership as well as growth in other kinds of managed care, such as preferred provider organizations (PPOs) and the increasing use of utilization review by FFS (indemnity) insurers.

[28] Importantly, KPMG also found that case severity of patients admitted to hospitals in high managed care markets was *higher* than the national average, yet their risk adjusted mortality rates were 5.25% *below* the national average. The cost comparisons were adjusted for differences in severity of patient mix and cost of living. See KPMG Peat Marwick. *The Impact of Managed Care on U.S. Markets, Executive Summary*. 1996.

Figure 3. Utilization Rates: HMO Enrollees and the U.S. Population, 1988-1993



Source: Figure prepared by CRS based on Exhibit 3-3, American Association of Health Plans, 1995-1996 HMO and PPO Industry Profile.

Note: The national rates are inclusive of HMO members. HMO rates include all types of HMOs but not other forms of managed care.

HMO and Fee-for-Service (FFS) Premiums

The difference between HMO and fee-for-service premiums varies from year to year, but it is not unusual to see differences of 10% to 15% reported.[29] Among medium and large employers in 1996, the average difference between FFS and HMO premiums for both single and family coverage was about 20%. PPO and POS premiums were higher than HMO premiums but were lower than FFS premiums. (See **Table 3.**)

Table 3. Average Premiums for All Medium and Large Employers, 1996

	Employee coverage	Family coverage
Fee-for-service	$188.27	$506.30
HMO	$155.77	$424.81
PPO	$173.10	$464.36
POS	$176.35	$482.81

Source: *Hay/Huggins Benefits Report, v. 1*. 1996, Chart 1.2.

Over the last decade, premiums for employer-sponsored health benefits have declined precipitously. **Figure 4** shows that the average annual rate of increase for FFS, HMO, and PPO premiums has changed in tandem since 1987. (However, the rate of increase for HMOs was about 1.5 percentage points less than FFS premiums during this period.)[30]

In 1995 and 1996, the rates of increase in health insurance premiums (overall, 2.1 in 1995 and .05 in 1996) were less than increases in three key indicators:

- overall inflation as measured by the consumer price index (3.2 in 1995, 2.9 in 1996);
- inflation in the health care sector (medical inflation) as measured by the CPI (4.6 in 1995, 3.7 in 1996); and
- growth in workers' earnings. (2.7 in 1995, and 2.9 in 1996).[31]

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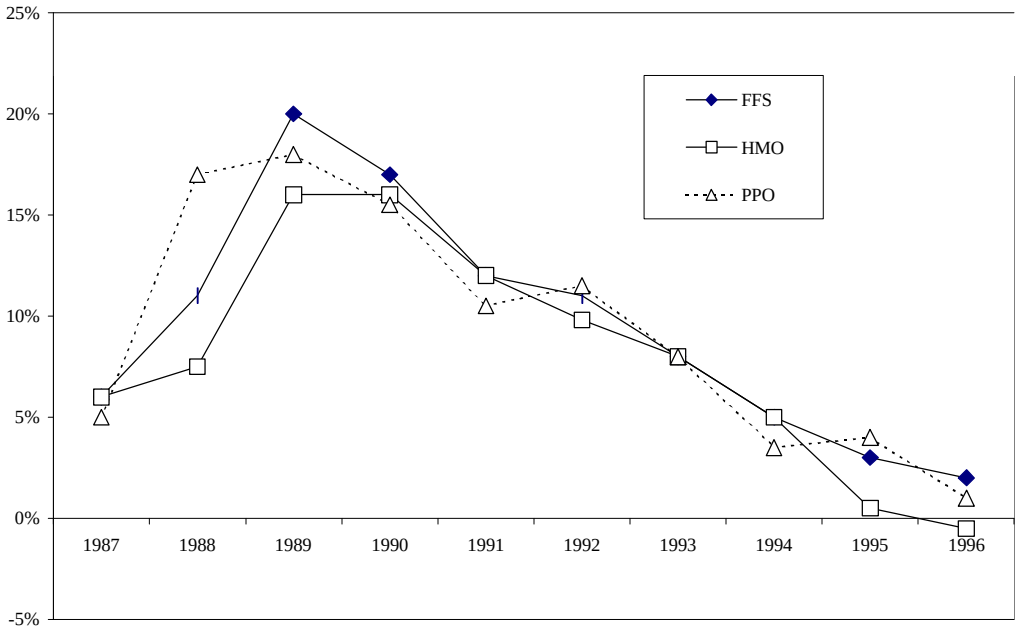
[29] Miller, Robert H., and Harold S. Luft. Managed Care Plan Performance since 1980. A Literature Analysis. *Journal of the American Medical Association*, v. 271, no. 19; and Foster Higgins, *Survey of Employer-Sponsored Health Plans,* 1996.

[30] KPMG Peat Marwick, *Health Benefits in 1996,* p. 12, 13.

[31] Ibid.

Figure 4. Premium Changes in Employer-Sponsored Plans, 1987 to 1996

(firms larger than 200 employees)



Source: KPMG, *Health Benefits in 1996*, p. 13.

Point-of-Service Options

In an effort to make enrollment more attractive to consumers who want to retain some freedom of choice of providers, the majority of HMOs now offer an *open-ended* or *point-of-service* (POS) option. This allows enrollees to go to doctors who are not in the HMO network in exchange for higher premium and/or coinsurance payments. To exercise the POS option, an enrollee forgoes the standard 100% coverage of costs for in-plan services for, most commonly, 70% coverage of out-of-plan services costs. The share of HMOs offering a POS option increased from an estimated 55% in 1992 to 73% in 1995.[32]

The rapid expansion of the POS option suggests that the greater flexibility provided by the POS option attracts people to an HMO who are uncomfortable with "lock in" arrangements. Some believe that, in time, as enrollees become more comfortable with network providers, they will utilize the POS option less. (See **Appendix A** for a comparison of the characteristics of the major types of managed care organizations.)

Because the POS option is relatively new, the extent of added financial risk is uncertain. According to one survey, in half of the 86 responding plans, 10% of

[32] AAHP, *1995-1996 Managed Health Care Overview*, p. 10, 16-17.

enrollees or fewer actually used an out-of-network benefit in 1995 (see **Table 4**.) Utilization of the POS option appears to vary with a number of factors, including plan type. On average, POS utilization in group model HMOs is less than half that in network and IPA models (shown in the table). POS utilization is higher in the Pacific and Mid-Atlantic regions, is lower among the smallest and largest HMOs, is higher among nonprofit and non-federally qualified HMOs, and is higher among the independently owned HMOs (not shown in the table).

According to one source, 42% of surveyed HMOs reported that average medical expenses per enrollee were the same for POS members and traditional HMO members, whereas the same percentage reported that medical expenses were higher for POS members.[33]

Table 4. Percentage of Enrollees Using Any Out-of-Network Benefits in Point-of-Service Products, 1995

	% of Enrollees	
	Mean	**Median**
All plans	17.1%	10.0%
Primary model type		
Staff	13.5	9.5
Group	6.8	5.0
Network	19.4	10.0
IPA	18.8	10.0

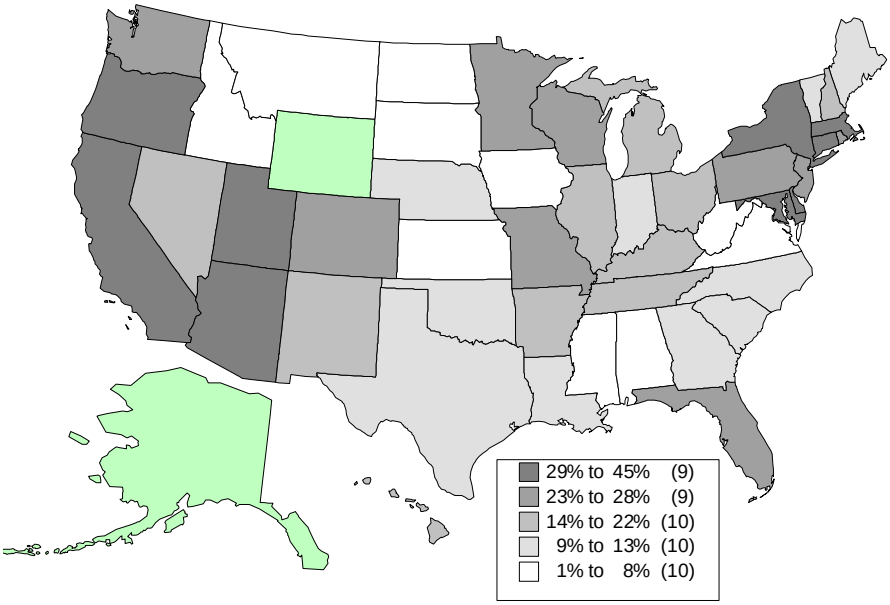
Source: American Association of Health Plans' Annual HMO Industry Survey, see http://www.aahp.org. Findings based on "weighted" data.

State HMO Enrollment

HMO enrollment is distributed unequally across the country. (See **Figure 5**.) HMO penetration, or the percentage of state population enrolled in an HMO, is highest in the Pacific states (38%, on average, in Alaska, California, Hawaii, Oregon and Washington), the Northeast (33%, on average, in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont) and the Mid-Atlantic states (27%, on average, in New Jersey, New York and Pennsylvania). Penetration is lowest in the East South Central states (10.5%, on average, in Alabama, Kentucky, Mississippi and Tennessee) and the West South Central states (12.2%, on average, in Arkansas Louisiana, Oklahoma and Texas).

[33] Group Health Association of American. Annual HMO Industry Survey. Reported in AAHP, *1995-1996 Edition, HMO & PPO Industry Profile*, Table 2-15. p. 117.

Figure 5. Percentage of Population Enrolled in HMOs, by State, as of January 1, 1996



Note: Alaska and Wyoming had no managed care enrollment.
Source : Interstudy, The Interstudy Competitive Edge: *HMO Industry Report 6.2*

Oregon has the highest enrollment rate (44.8%), followed by California (40.3%) and Massachusetts (39%). Alabama, Georgia, Idaho, Iowa, Kansas, Mississippi, Montana, North Dakota, South Dakota, and West Virginia all have HMO penetration rates of well below 10%.[34]

Tax Status and HMO Performance

Some argue that the maximization of profit is the primary orientation of private corporations. For-profit HMOs have an obligation to return revenue in excess of expenditures to investors. In contrast, nonprofit HMOs return excess money to the organization, in the form of capital improvement or expansion of other mission-related activities.

In 1988, 70% of *all* managed care plans were for-profit; this had increased to 82% by 1996.[35] At the start of 1996, over 60% of *HMO enrollment* was in for-profit plans and nearly three-quarters of all HMOs were for-profit organizations (see **Figure 6**).

InterStudy conducted an analysis of HMO financial performance differences across metropolitan markets by various HMO characteristics, including whether the

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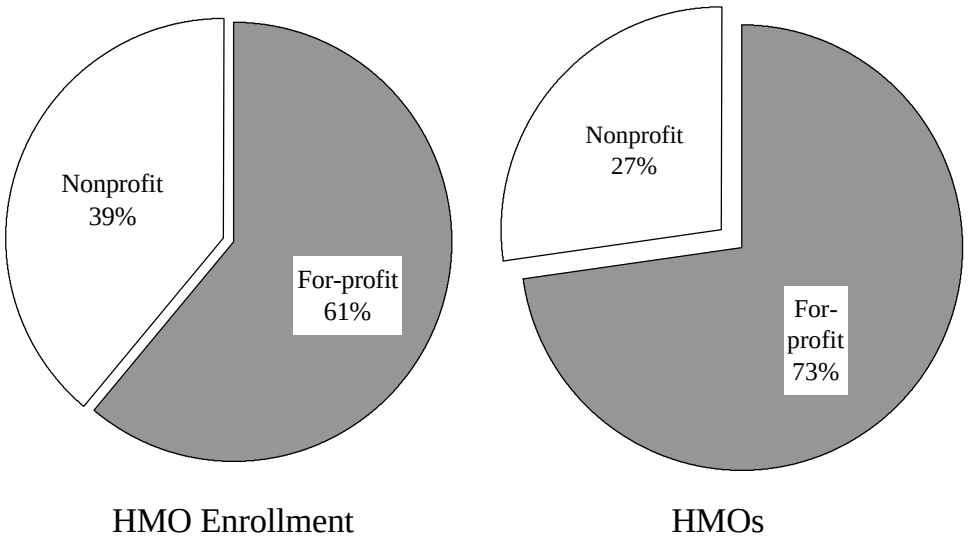
[34] InterStudy. *The InterStudy Competitive Edge: HMO Industry Report 6.2.* p. 29 and Figure 5.

[35] AAHP, *1995-1996 Managed Health Care Overview*.

plans were nonprofit or for-profit. They focused on what they considered "the most important overall measures of an HMO's performance," namely, higher *annual growth rates* and lower *net operating margins*.[36]

Figure 6. HMO Tax Status by Enrollment and Number of HMOs, 1996



Source: Interstudy, *The Competitive Edge, Part II: Industry Report,* 6.2, September, 1996.

Separate analyses — in which for-profit and nonprofit HMOs were compared on these two performance variables — were conducted for large markets (1 million or more enrollees), medium markets (250,000 to 999,999 enrollees) and small markets (less than 250,000 enrollees).

In large markets, metropolitan areas that had annual enrollment growth above the median (an indicator of positive performance) had 20% *more* for-profit HMOs, on average. Furthermore, in both large and medium markets, metropolitan areas with net operating margins above the median (an indicator of negative performance) had 16% and 14% *fewer* for-profit HMOs, on average.[37] All other comparisons resulted in differences that were not statistically significant.

However, InterStudy conducted another analysis of HMOs whose operating margins increased in 1995 compared to HMOs whose operating margins decreased.

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[36] *Annual growth rate* is the net change in enrollment in 1 year divided by the enrollment at the start of the year. *Net operating margin* is defined as medical and administrative expenses divided by premium revenue.

[37] This performance analysis is based on an analysis of variance (ANOVA). Differences are statistically significant at the $p < .05$ level. The Interstudy Competitive Edge, *Part III: Regional Market Analysis, v.* 6, no. 2, December 1996, Tables 34 and 36.

It was learned that a larger percentage of for-profit HMOs than nonprofit HMOs (34.4% versus 20.9%) had increased operating margins between 1994 and 1995.[38] This finding accords with an increasingly competitive managed care environment, typified by lower rates of premium increases, company mergers, and industry consolidation. One source recently reported that 40% of the nation's HMOs lost money in 1995, and that only 35% were profitable in 1996. In contrast 90% of HMOs were profitable in 1993 and 1994.[39]

For-profit HMOs spent more of the premium dollar on administrative expenses than nonprofit HMOs (13.6% compared to 11.9%) in 1995. They also spent, on average, a lower share of total premium revenue delivering medical care than nonprofits (84.3% versus 88.7%).[40]

Compensation of HMO Executives

An HMO's administrative expenses includes the cost of executives' salaries. As managed care plans have increased in number and market penetration, and the media have published the highest salaries, there has been increased public outcry over executive compensation. Much of this attention has focused on the salary of the chief executive officer (CEO), who is the top official responsible to the Board of Directors for the overall administration, growth and performance of the plan.

While it is true that some CEOs of HMOs command annual salaries well over $1 million, averages are rarely reported in the media, and the sums often include stock ownership and other bonuses in addition to salary *per se*. **Figure 7** shows the trend in average CEO base salary, assessed in February of each year, from 1991 to 1997. The number of surveyed plans expanded each year (growing to 270 plans in 1996, and 314 plans in 1997.) At the start of the decade, CEOs' average base salary (not including bonuses), was about $145,000. This increased 56%, to $227,000 in 1997.

The 1997 median CEO base salary ($195,787) is lower than the mean salary ($227,133) due to the fact mentioned above; namely, that some CEOs earn very large salaries indeed. As you can see in **Table 5**, 10% of CEO's received a base salary of over $381,719. Moreover, as alluded to, executive compensation can be substantially higher when bonuses and/or incentives are added to base salary. As the table shows, the median annual salary with bonuses and incentives is just over a quarter million dollars, and 10% of CEOs make well over a half million dollars a year.

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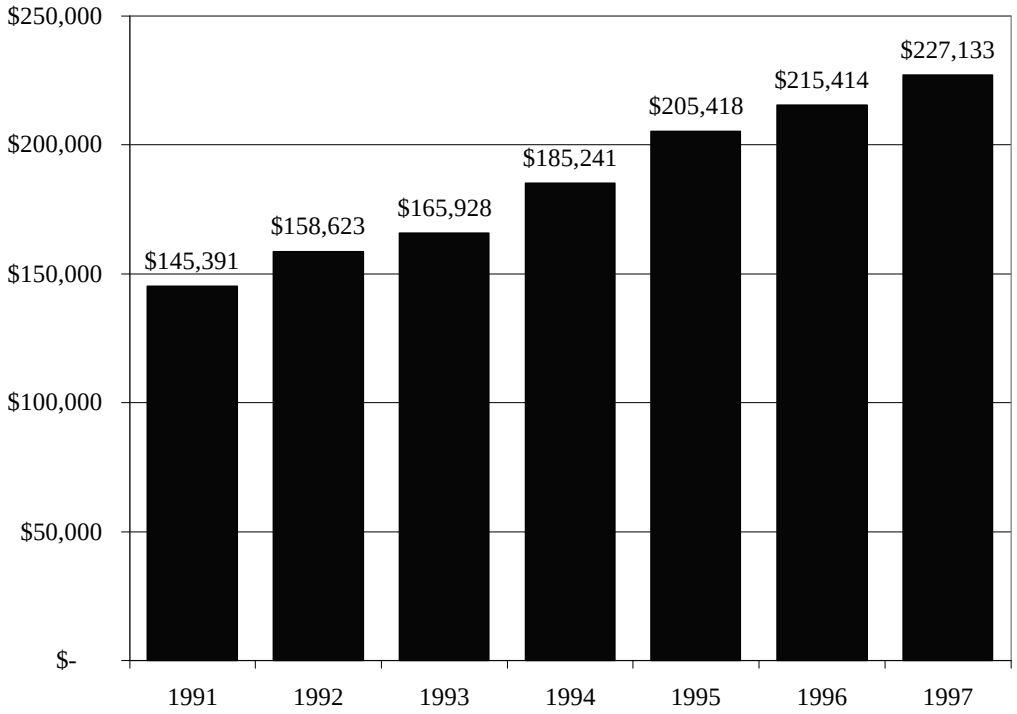
[38] InterStudy. *The InterStudy Competitive Edge, Part II: HMO Industry Report 6.2*, December 1996. Table 32.

[39] Center for Studying Health System Change. Patients, Profits and Health System Change: A Wall Street Perspective. *Issue Brief*, no. 9, May 1997.

[40] Ibid., p. 64. The share of the premium spent on medical care is known as the "medical loss ratio." For example, a ratio of .89 means that $0.89 of every $1.00 is spent on the delivery of medical services. The remaining $0.11 is spent on administrative expenses, including marketing, salaries, and profit.

Figure 7. Average Base Salary of HMO Chief Executive Officers, 1991 to 1997



Source: Warren Surveys, *The Salary Survey*, Spring 1997.

Table 5. Salary of Chief Executive Officers in HMOs, Spring 1997

	No. of plans	10th %ile	Mean	Median	90th %ile
Base salary	314	$126,390	$227,133	$195,787	$381,719
Salary with bonuses/incentives	157	$139,268	$310,241	$227,500	$583,794

Source: Warren Surveys, *The HMO Salary Survey*, Spring, 1997.

Below, **Table 6** shows the distribution of median CEO salaries by HMO model type, by geographic area, by HMO enrollment, and by HMO affiliation. On average, CEOs in staff and mixed models have the highest salaries. CEOs in the northeast and far west have the highest salaries. CEO salary increases as HMO size increases, so that those in the largest plans (over 200,000 enrollees) are paid about twice as much as those in the smallest plans (under 50,000 enrollees). HMOs affiliated with insurance companies are paid far more than those with any other affiliation. This is probably due, at least in part, to greater enrollment in insurer-affiliated HMOs.

Table 6. Chief Executive Officer Salaries by Model, Location, Enrollment and Affiliation, Spring 1997

	Median base salary	Median salary w/ bonus
Model type		
Staff	$217,300	
Group	190,676	not
IPA	180,000	available
Network	190,000	
Mixed	200,996	
Geographic area		
Northeast	$216,000	$275,000
South/Southeast	191,201	220,200
Midwest	180,000	227,500
Mountain	190,000	176,250
Farwest	200,996	247,278
HMO enrollment		
Under 25,000	$167,613	$186,291
25 to 50,000	168,000	186,853
51 to 100,000	195,000	214,221
101 to 200,000	246,000	280,626
Over 200,000	324,000	475,483
Affiliation		
Independent	$200,000	
Physician/Hospital	183,604	not
Insurer	340,200	available
Management Co.	180,003	

Source: Warren Surveys, The HMO Salary Survey, spring 1997.

Preferred Provider Organizations

In the early 1980s, a new type of managed care entity — the preferred provider organization (PPO) — evolved which combines features of traditional indemnity plans and HMOs. Like traditional indemnity plans, these organizations compensate providers on a fee-for-service basis. (This is the major characteristic that distinguishes PPOs from HMOs.) However, like HMOs, they extract discounts from payors. Also, like HMOs, PPOs selectively contract with medical providers on the basis of such factors as cost-efficiency, scope of services, and provider credentials. (See **Appendix A** for a comparison of the characteristics of the major types of managed care organizations.)

The medical providers that contract with PPOs agree to discount their fees. In return, they expect to gain increased patient volume, faster payment of bills, and a reduction in delinquent accounts. PPOs directly administer, or contract for, a wide range of utilization review and case management procedures. They re-credential participating physicians on a regular basis, collect data on providers' practice patterns for use in quality assurance and compensation determinations, conduct or contract for pharmacy benefits management, and engage in physician peer review and quality assurance.

PPO enrollees are given financial incentives to use services within the plan's provider network. This is how PPOs can ensure providers increased access to patients. But PPO enrollees typically receive some payment for covered services even if they decide to obtain care from outside providers. (According to one recent report, less than 25% of PPO plan claim dollars are paid to out-of-network providers.[41]) Visits to specialists usually do not require authorization by a primary care provider, except in the case of gatekeeper model PPOs.

The greater flexibility of PPOs accounts for their popularity and also helps explain POS use by HMOs. By 1995 there were over 1,000 operating PPOs, the vast majority of which were medical/surgical and full-service plans. 1995 PPO enrollment has been estimated at 80 to 90 million, which is at least one-third higher than total HMO enrollment.[42] The ten largest individual PPO plans are listed below in **Table 7.**

Table 7. Ten Largest Individual PPOs, 1994

Rank	PPO	Location	Enrollment
1	The AFFORDABLE Medical	IL	8,903,284
2	Networks	CA	4,491,105
3	Admar Corporation	TX	3,342,945
4	USA Health Network—Texas	CA	2,724,133
5	Prudent Buyer Plan	TX	2,673,911
6	Provider Networks of American, Inc.	CA	2,395,154
7	Beech Street Corporation	PA	2,150,040
8	Intergroup Services Corporation	IL	1,596,000
9	Preferred Plan	CA	1,286,583
10	USA Health Network — California USA Health Network — Florida	FL	1,253,845

Source: American Association of Health Plans, *1995-1996 Managed Health Care Overview*, p. 22.

[41] *1996. Foster Higgins National Survey of Employer-sponsored Health Plans.* Foster Higgins, Survey and Research Services, 125 Broad Street, New York, NY 10004.

[42] AAHP, *1995-1996 Managed Health Care Overview*, p. 18; American Association of Health Plans, *HMO and PPO Industry Profile, 1995-1996 Edition*. p. 67-68.

Exclusive Provider Organizations (EPOs)

Exclusive provider organizations (EPOs) differ from PPOs in one critical respect. As the name suggests, enrollees do not receive any compensation for unapproved care delivered outside the EPO network. According to one source, about one-third of all PPOs offered EPOs in 1996.[43]

Silent Preferred Provider Organizations (PPOs)

Silent PPOs are controversial. They are brokers who purchase negotiated discount information from PPOs and sell it to indemnity insurers, who in turn use the information to access provider discounts. Their entitlement to such discounts is questionable. It is not known how common this practice is.

Consider the following scenario. A patient with indemnity insurance seeks care at a doctor's office or hospital. After the service or treatment is provided, the doctor or hospital bills the insurer for 80% of the full fee; the patient is responsible for the remaining 20%. However, the insurer does not pay 80% of the full fee. Instead, the insurer contacts a broker who: a) identifies PPOs with whom the provider contracts, b) purchases rate discount information from a contracting PPO, and c) sells the information to the indemnity insurer. The indemnity insurer then submits a reduced payment to the provider, claiming that the patient was entitled to the discount through the "silent PPO." Providers typically accept the reduced payment because they do not cross check claims and insurance data.

Critics of silent PPOs charge "foul" because providers receive reduced payments without gaining increased patient volume through the "directive practices" of true PPOs. That is, indemnity patients get the negotiated discounts available to PPO patients, but they are not exposed to financial incentives that encourage them to use preferred providers.[44] Others argue, however, that providers can decline illegitimate claims to discounts, or that they can simply refuse to contract with a PPO that allows the organization to sell negotiated fee information to brokers.[45]

Single-Service or Specialty HMOs and PPOs

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[43] Hoechst Marion Roussel Managed Care Digest Series, *HMO-PPO Digest 1996*, p. 52.

[44] Thus, silent PPOs are also called "non-directed" PPOs.

[45] A bill introduced June 10, 1997 by Representative Burton, entitled *Federal Employees Health Care Protection Act of 1997* (H.R. 1836), would limit the use of silent PPOs by all insurance carriers who contract with the Office of Personnel Management. Section 5(a) requires advance written disclosure if a carrier or its subcontractor, which has entered into a negotiated discount agreement with health care providers, does not use financial incentives or "other forms of steerage" (such as provider directories, 1-800 numbers, or other means) to direct patients to network providers. Section 5(b) prohibits any carrier which fails to disclose such information from accessing negotiated discounts. The bill does not propose an outright prohibition on silent PPOs *per se*.

Experience shows that some areas of health care — such as substance abuse treatment, behavioral or mental health services, dental care, and prescription drugs — can be difficult to control. Because these service areas have been particularly susceptible to rapid cost increases, managed care plans may "carve out" one or more specialty area of care from standard medical/surgical plans. If such an area is carved out and coverage is available, it may be managed through a single service or specialty HMO or PPO. In some cases, enrollees must pay an additional premium for single service or specialty coverage.

Employers and other insurers contract with specialty HMOs and PPOs using capitation or negotiated fee-for-service compensation arrangements. At present, the 100 or so existing specialty HMOs are limited primarily to dental, vision and mental health benefits. One source estimates that over three-quarters of such plans are dental maintenance organizations (DMOs) and that most (87%) are for-profit organizations.[46]

Specialty PPOs number about the same as specialty HMOs, but they cover a wider range of services (including podiatry, chiropractic services and workers' compensation). The majority (60%) of specialty PPOs cover dental, behavioral/mental health and substance abuse services, and pharmacy and prescription drugs. The vast majority (85%) of specialty PPOs are for-profit organizations.

The five largest speciality HMOs and the five largest specialty PPOs are listed in **Table 8**.

Table 8. The Largest Specialty HMOs and PPOs, 1994

[46] AAHP, *1995-1996 Managed Health Care Overview*, 1996, p.24.

Rank	Specialty HMO	Specialty	Location	Enrollment
1	APPS Dental, dba CompDent Corp.	Dental	GA	804,750
2	PMI Dental Health Plan	Dental/ Vision	CA	781,000
3	California Dental Health Plan	Dental	CA	747,035
4	Unified Dental Care of Texas	Dental	TX	651,300
5	Oral Health Services of Florida	Dental	FL	510,588
Rank	**Specialty PPO**	**Specialty**	**Location**	**Enrollment**
1	Medco Behavioral Care Corp.	Mental Health	NJ	14,175,000
2	Vision Service Plan	Vision	CA	8,100,000
3	Value Behavioral Health	Behavioral Health	VA	7,958,007
4	American Chiropractic Network, Inc.	Chiropractic	MN	5,217,391
5	Preferred Chiropractic Care (PCC)	Chiropractic	KS	5,000,000

Source: American Association of Health Plans, *1995-1996 Managed Health Care Overview*, 1996, p. 26, 29.

Provider-Sponsored Organizations[47]

Provider-sponsored organizations (PSOs) have emerged in response to competition in the healthcare marketplace encouraged by managed care. A PSO is a cooperative venture of a hospital and group of physicians — or some other configuration of providers — that is provider-controlled and operated. Some contract with other entities, such as HMOs, to gain access to the HMOs network of providers. Not all PSOs do this though. Like HMOs, PSOs seek to combine the health service and insurance function; but the PSO aims to eliminate the insurer or managed care plan as an intermediary.

The term "provider sponsored organization" is a variant of terms with similar meanings, including "physician hospital organizations (PHOs)" and "provider or physician sponsored networks" (PSNs). "Provider service networks" also is used.

The number of organizations that fit the definition of a PSO is unknown, largely because PSOs are generally not licensed as such, but may be licensed as HMOs or other types of insurers. With the exception of a few states that provide for distinct

[47] Beth Fuchs of the Education and Public Welfare Division, Congressional Research Service contributed to this section.

PSO standards, most states require PSOs to meet the same licensing and solvency standards as HMOs.

The Balanced Budget Act of 1997 (P.L. 195-33) authorizes PSOs that meet certain requirements to contract with Medicare to enroll Medicare beneficiaries under the new Medicare+Choice program (which will offer private managed care and other types of private plans as an alternative to traditional Medicare). In general, organizations that wish to be offered under Medicare+Choice will have to be licensed under state law as a risk-bearing entity eligible to offer health insurance in the state. However, a PSO will be able to seek a time-limited waiver of state law by filing an application with the Secretary. The Secretary will have to approve the waiver if the PSO was denied state licensing because it did not meet solvency standards that were different from the federal standards.[48] (The PSO will still have to meet state laws not dealing with solvency that competing organizations have to meet.) This may enable some PSOs that cannot obtain state licenses because of their inability to meet state solvency requirements to get started. Much will depend, however, on the specifics of the federal solvency requirements, which are to be developed through a process of negotiated rule-making on an expedited basis. Perhaps more likely to stimulate the establishment of PSOs is another BBA provision that allows Medicare+Choice plans to be sponsored by organizations that have no offerings for the under 65 market and that provides for a lower minimum enrollment number for PSOs than for other types of Medicare+Choice plans.

Employer-Sponsored Health Plans and Managed Care[49]

Almost two-thirds of persons under the age of 65 are covered by employment-based health insurance.[50] Recent trends indicate that employers have been sensitive to price differences in their choices of health plans. As shown in **Figure 8**, in 1993 about one-half of all insured workers were enrolled in traditional indemnity plans; but by 1996, the share had dropped to under a quarter (23%). In 1996, almost three-quarters (73%) of all insured working Americans received health care from a managed care organization.

Between 1993 and 1996, growth in closed-panel HMO enrollment has been steady, from 19% to 27%. POS enrollment nearly tripled during this period, growing from 7% to 19%. PPO enrollment increased from 27% to 31%.

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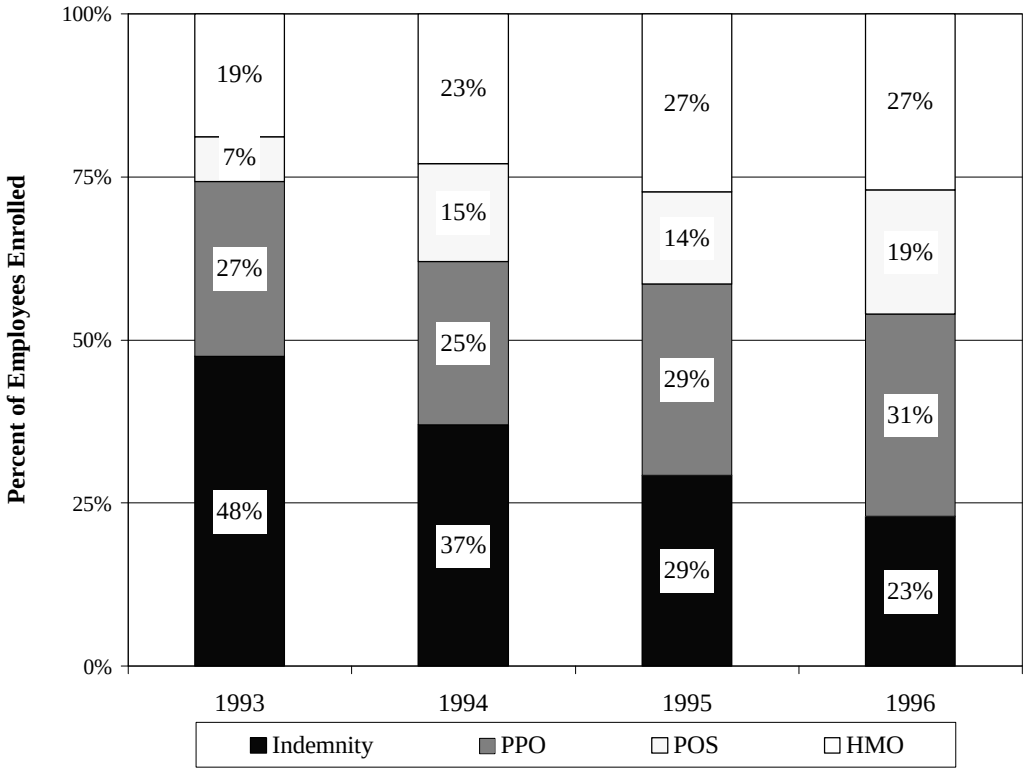
[48] More information on the BBA treatment of PSOs can be found in: U.S. Library of Congress. Congressional Research Service. *Medicare Provisions in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33)*. CRS Report 97-802, by Jennifer O'Sullivan, et al. August 18, 1997.

[49] The data cited in this section were collected by Foster Higgins and KPMG Peat Marwick/Wayne State University. See *Foster Higgins National Survey of Employer-Sponsored Health Plans (A Stratified Random Sample of all U.S. Employers with 10 or More Employees)*, 1997; and Jensen, Gail, M. Morrisey, S. Gaffney, and D. Liston. The New Dominance of Managed Care: Insurance Trends in the 1990s. *Health Affairs*, v. 16, no. 1. p. 125-136.

[50] U.S. Congress. House. Committee on Ways and Means. *1996 Green Book*, Table C-26. p. 1027. CRS analysis of data from the March 1995 Current Population Survey.

Figure 8. National Employee Enrollment, 1993-1996



Source: Foster Higgins *National Survey of Employer-Sponsored Helath Plans*

As shown in **Table 9**, the greater the number of employees in a firm the greater the managed care penetration. However, regardless of firm size, in just 2 years there has been a rapid rise in the share of employees enrolled in each major type of managed care plan (HMOs, PPOs, POS plans).

Since 1993, the cost of providing indemnity insurance increased a total of 29%, whereas the cost of providing PPO coverage increased 8% and the cost of HMO coverage increased 3%. In 1994, the average annual health benefit cost for active employees enrolled in an HMO was 3% less than traditional indemnity coverage ($3,385 and $3,495). By 1995, HMO coverage was 15% cheaper ($3,385 compared to $3,739). Many observers believe that these changes in price have been closely related to the rapid expansion of managed care enrollment in employer-sponsored plans.

Table 9. Percentage of Insured Workers Covered by Different Types of Plans, by Firm Size, 1993 and 1995

	Number of Employees					
1993	**1-24**	**25-49**	**50-199**	**200-999**	**1,000 +**	**All Firms**
Indemnity	78.3%	65.2%	62.4%	44.6%	40.7%	48.9%
HMO	8.2	10.9	17.5	22.4	26.7	22.4
PPO	9.9	11.8	16.4	27.6	20.8	19.6
Point-of-Service	3.6	12.1	3.7	5.4	11.8	9.1
1995						
Indemnity	30.5%	30.2%	25.1%	27.9%	26.3%	27.4%
HMO	19.2	38.9	20.6	26.6	31.0	27.5
PPO	26.8	21.4	30.6	29.2	21.7	25.0
Point-of-Service	23.5	9.5	23.7	16.3	21.0	20.1

Source: KPMG Peat Marwick/Wayne State survey of 1,953 firms in 1993 and 2,037 firms in 1995. Jensen, Gail, M. Morrisey, S. Gaffney, and D. Liston. The New Dominance of Managed Care: Insurance Trends in the 1990s. *Health Affairs*, v. 16, no. 1. p. 127.

Conclusion

Perhaps only change is certain during this time of rapid transformation in the U.S. health care system. However, few observers would characterize managed care as a passing phenomenon. The information presented in this report indicates how far the health care industry has evolved — largely through internal reform rather than legislative mandate — and also reveals the organizational variety and diversity that exists in current models of health care financing and delivery. In the midst of this change and uncertainty, Congress will deliberate on a host of issues surrounding managed health care. This report provides background information that should prove useful to participants in upcoming congressional debates.

Appendix A. Characteristics of Managed Care Organizations

Characteristics	HMOs (health maintenance organization)				PPOs (Preferred provider organization)	POS (point-of-service) (an HMO option)
	Staff	Group	IPA	Network		
Compensation[a]	salary	mixed (risk or cost)	mixed (risk or cost)	mixed (risk, cost, or salary)	discounted cost	cost, discount possible
Network structure[b]	tight	tight	loose	loose	loose	loose
Choice of provider[c]	low	low	medium	low to medium	high	high
Control[d]	high	high	medium	medium to high	low	low

Source: Table prepared by the Congressional Research Service.

Note: This classification system is not an exhaustive list of types of managed care organizations or their characteristics. See the text for more detail. The categorization scheme used here is approximate only. Distinctions among types of MCOs and even between some types of MCOs and managed fee-for-service are becoming increasingly blurred.

[a] "Risk" includes capitation, withhold, and bonus. "Cost" includes fee-for-service.
[b] Plans with mostly exclusive relationships with providers have "tight" network structures. "Loose" networks are composed of providers who also contract with other organizations and/or maintain a fee-for-service line of business.
[c] "Choice of provider" refers both to network size and whether enrollees can see non-network providers.
[d] "Control" refers to the degree of influence the plan has over network providers (through such managed care strategies as network selection, compensation arrangements, benefit plan design, utilization management, quality assurance, and disease management.