



**THE CAPITOL FORUMS**  
**On Health and Medical Care**

## **Managed Care—Keystone of the Health Care Delivery System in the 1990s?**

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background information for the discussion at the

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## **MANAGED CARE—KEYSTONE OF THE HEALTH CARE DELIVERY SYSTEM IN THE 1990s?**

An issue brief prepared by Joanne T. Fucello, MSW  
for discussion at the February 2, 1994, Capitol Forum.

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### **PROLOGUE**

The topic of this Capitol Forum — “Managed Care - Keystone of Health Care Reform in the 1990s?” — reflects the nation’s and New Jersey’s struggle with analyzing and redesigning the financing and delivery of health care services in a cost-conscious and efficient manner. Managed care involves a multitude of health care industry players - physicians, hospitals, insurance and pharmaceutical companies, governmental agencies and consumers, each trying to “position” themselves and establish a viable role in this new environment. Managed care plans, which create the integration of the previously separate financing and delivery systems of health care, are the shape of things to come in the 1990s in a growing shift away from traditional indemnity insurance plans. The alternative delivery systems of managed care are the fundamental building blocks of the managed competition system, which is currently under great debate on a national level. New Jersey is one of 50 states analyzing its current health care policies, laws and delivery systems, while keeping as the focus of its efforts the acknowledged three substantive objectives of health reform — access, cost control and quality.

The purpose of this brief is to offer what has been called “a snapshot of a moving train” by targeting the “who, what, where, when and how” of managed care, both nationally and in New Jersey, and to identify trends developing in the industry to aid in strategic planning and in some tough decision-making to be done by policy makers. In a recent report on health care costs in all 50 states, a Citizen Action study found that New Jersey ranked seventh in the nation in health care costs per family: in 1993, the average New Jersey family spent \$8,165 in health payments, which was 5.5 percent higher than the national average of \$7,739 per family.

The brief concludes with a list of discussion points for the Forum which are pertinent to New Jersey and its efforts to contain such health care costs, including the issues of how to best re-design the financing and delivery of health and medical care, of monitoring access and quality of care under managed care, and of regulating managed care and the State’s role in it. Appendices include a glossary of terms for managed care and pertinent statistical data on health care spending in general and the current managed care environment.

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## MANAGED CARE

### WHAT IS IT?

What does managed care mean? There is a virtual industry alphabet soup of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Individual Practice Associations (IPAs), Point of Service Plans (POS) and even Triple-option Plans (TOP), which offer the consumer a choice of three health benefit “options” — HMO, PPO or a traditional managed (or non-managed) indemnity plan. A glossary is included for easy reference that “translates” these plan acronyms and abbreviations. Within the industry itself there is no consensus on a definition of managed care. As a model, it is a system that integrates both the financing and delivery of health care. Its underlying principle is cost-efficient, coordinated care, with an emphasis on preventive care, such as annual physicals and well-baby care.

While different models of managed care plans have and continue to evolve, they share the following elements:

- \* Contractual arrangements are made with providers to deliver comprehensive health care services to enrollees;
- \* Standards are put in place for the selection of practitioners;
- \* Strict oversight exists for the monitoring of service utilization and quality assurances;
- \* Financial incentives exist for enrollees to use providers and services under their plan; and
- \* Most managed care plans use the Primary Care Physician (PCP), who is usually a general practitioner, internist or pediatrician, as the case manager (“gatekeeper”) and coordinator of care.

Commonly found cost control features among managed care plans include:

- \* Utilization controls over hospital and specialist physician services;
- \* Explicit criteria for the selection of providers within networks; and
- \* Alternative payment methods and rates that may shift some financial risk to the providers of services. (1993 GAO Report on Managed Care)

### STATUS

How these factors interact and interplay varies depending on the type of managed care model involved, such as Health Maintenance Organizations (HMOs) which may be more restrictive in choice of a physician, or Preferred Provider Organizations (PPOs) which offer more options to use physicians outside of a network. The growth and development of managed care delivery systems in the last 5 to 10 years

is one of the most visible changes in the delivery and financing of American health care. Currently, close to 18 percent of the country's population is enrolled in some form of managed care plan, in a growing shift away from fee-for-service indemnity plans. In New Jersey, enrollment in managed care plans was approximately 12 percent and included 14 Health Maintenance Organizations and some 56 Preferred Provider Organization (PPO) plans (December 1992). Currently, the leading HMO in New Jersey is US Healthcare, with approximately 425,000 enrollees. HIP/Rutgers is the second largest, with 178,000. U.S. Healthcare's entry into the New Jersey marketplace reflects how quickly plans can grow. As recently as 1990, US Healthcare was not included in a listing of HMO plans in New Jersey. Another recent entry into New Jersey's managed care playing field is HMO Blue, offered by Blue Cross and Blue Shield. HMO Blue has an enrollment of 94,000; Blue Cross and Blue Shield's state subscribers number 2.3 million. Blue Cross formed a 56-hospital network as the foundation of its HMO. Premiums for coverage in HMO Blue are currently \$2,264 to \$3,136 for single coverage and \$6,140 to \$8,400 for families. (See Appendix for HMOs in NJ, their enrollment and service locations). But what do these various plans mean for health care financing and delivery and what are their implications for the future of health care reform?

## **HISTORY**

In order to more firmly get a grasp on the concept of managed care, it is important to first define it with specific examples and to provide a brief historical overview of managed care, which has been evolving for decades in the U.S. in one form or another since the 1930s with the establishment of the first prepaid group practices. The architects of managed care saw it as a means to bring together the financing and delivery of health care and to ensure a continuity of preventative and acute, remedial care. The Kaiser-Permanente Health Plan, which is now the largest group model Health Maintenance Organization (HMO) in the country with 6.6 million members and 14 HMOs (1992 data), was started in the 1940s for Kaiser's employees in California and Oregon. Other states, such as Wisconsin and Minnesota, followed suit, establishing managed care systems within their borders. Even though managed care was proving viable in these states, in 1970 there were only 3 million Americans enrolled in HMOs. In 1973, when the Federal government enacted the HMO Act (P.L. 93-222) to authorize Federal funds for HMO development over a five-year period, it became directly involved in looking at managed care as a way to deal with escalating health care costs.

The decade of the 1980s was a period of growth in the managed care industry in the U.S. From just 3 million enrollees in 1970, the number increased to almost 35 million in 1989. Government-sponsored Medicare and Medicaid, which had been operating along traditional health benefit models, also began moving into HMOs during this period, with various demonstration projects being launched to evaluate effectiveness. The managed care industry is undergoing some changes in the 1990s:

enrollments are up, primarily in the "hybrid" plans which are less restrictive and allow for greater choice for consumers to select their own physicians; the number of plans has decreased so that the 25 largest individual HMO plans enrolled 35% of all HMO members in the country. The managed care industry, which includes providers, insurers, consumers and employers, is literally changing daily and is experimenting with the "best" form of financing and delivery of care. In one such major change, currently over 50% of the HMOs offered hybrid open-ended or point-of-service plans to allow the consumer a choice of options at the point when he/she comes in for services, rather than at the time that he/she enrolls. The following are the key managed care model types.

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## STRUCTURE

### MODEL TYPES

At the beginning of the 1980s, almost 90 percent of the population was enrolled in traditional "indemnity" plans, purchased by employers and reimbursed by the insurance company which acted as an "intermediary" with little active participation. Bills were paid by the insurance company to either provider or insured on a retroactive, fee-for-service (FFS) basis. During the 1980s, various types of managed care plans developed with an emphasis on containing cost. By 1991, there were over 2,000 for-profit and not-for-profit distinct health insurance and managed care entities. These managed care plans, or alternate delivery systems, encompass a wide range of forms: some insure, provide and manage care; some only provide and manage care; others only administer plans. Some are offered through employers and coordinate a mix of providers and administrators (physician group plans and hospital providers). Some are offered by businesses, hospitals, or hospital/physician networks. Employers are responsible for making large incursions into managed care systems as increasing numbers take direct control of their health benefits plans.

While there are various names and options in the managed care industry alphabet soup, we will focus on the most active types operating nationally and in New Jersey: HMOs, PPOs, and hybrid plans. The first entry into the managed care environment was the Health Maintenance Organization, or HMO. Four model types developed in the HMO industry:

### HEALTH MAINTENANCE ORGANIZATIONS

- (1) the staff model, which uses salaried, on-site staff physicians and offers a mix of specialists;

- (2) the group model in which the HMO contracts with one or more large multi-specialty group practices;
- (3) the Independent Practice Associations (IPA), which uses independent physicians practicing alone or in small medical groups, and
- (4) the Network model HMO, in which contracts are negotiated with one or more physician groups, who provide facilities and personnel.

In New Jersey, 4 out of the 5 largest HMOs are for-profit, Independent Practice Associations (IPA). The individual physicians in IPAs work in their own private practices and see both fee-for-service patients, as well as their HMO enrollees. For each HMO patient, the physician is paid by capitation, that is, a fixed amount for each patient enrollee. In 1992, IPA-model HMOs continued to dominate the industry nationally as well, representing 65 percent of all operational plans.

### **PREFERRED PROVIDER ORGANIZATIONS**

The Preferred Provider Organization (PPO) model is another one of the fastest growing model types in the industry. PPOs are groups of physicians who contract out with insurance companies, employers, or third-party administrators. PPOs are organizations, not the actual providers. The participating physicians are paid on a fee-for service schedule at discounted fees, usually 10 percent to 20 percent below normal fees. Some HMOs offer PPOs to expand the number of physicians from which a patient may choose.

### **HYBRID PLANS**

A new type of HMO emerged in the early 1990s — the Point-of-Service (POS) or open-ended HMO, which offers the option to choose outside the plan at the time enrollees seek care for a health problem. This point-of-service model combines the best of the features of HMOs (with preventative care and the primary care physician as coordinator), PPOs (with point-of-service choice of physician and fee-for-service discounts for providers) and traditional indemnity plans (free choice of health care provider). These POS plans have strong financial incentives for enrollees not to see physicians outside of the plan, i.e., the patient must pay more out-of-pocket. For our purposes, we will focus on the roles of insurer and provider, plus the financing, risk-sharing and delivery of services.

(see chart 1, next page)

**Chart 1. Summary of Managed Health Care Systems**

	TRADITIONAL INDEMNITY	MANAGED INDEMNITY	PREFERRED PROVIDER ORGANIZATION (PPO)	IPA, NETWORK, GROUP HMOs	STAFF HMOs
<b>CHOICE OF PROVIDER</b>	Consumer Selects Any Provider	→	Selected Providers in PPO Network; Can have Out-of-Network Choices	Pre-Selected Providers	→
<b>CONSUMER CHOICE OF HEALTH CARE DECISIONS</b>	Complete Freedom of Choice	→	Incentivized Choice (Consumer pays more to go out of Network)	No Choice	→
<b>PRACTICE SETTINGS</b>	Community-Based Independent Practice	→	Reduced Co-Payments; Claims Reimbursement	Mixed Practice Settings	Clinic Setting
<b>CONSUMER PAYMENTS FOR SERVICES</b>	Varied Deductibles; Claims Reimbursement	→		Co-Payments	Co-Payments
<b>HOW PROVIDERS ARE PAID</b>	Fee-For-Service	→	Discounted Fee-For-Service	Capitation-Fixed Payment for Each Enrollee	Salary - On Staff
<b>UTILIZATION REVIEW PROCEDURE</b>	None	Precertification of Admissions	MIS Profiling, Concurrent Review		→

*(Adapted from N. Winegar, Clinician's Guide to Managed Health Care)*

### COMPARISON WITH TRADITIONAL INDEMNITY PLANS

Health researchers Weiner and De Lissovoy (1992) looked at the managed care industry in the U.S. by breaking it down along four comparative lines—the traditional, fee-for-service indemnity plan (no managed care review) the managed indemnity plan (which includes a form of case management or utilization review to monitor the appropriateness of medical care provided), the HMO model (IPA, Network and Staff) and the PPO model. Currently, 37 percent of all insured Americans are covered by traditional, fee-for-service indemnity plans; 34 percent are enrolled in some type of managed indemnity plan (with utilization review mechanisms in place, such as second surgical opinions and hospital preadmission certification); 15 percent are enrolled in HMO plan types and 14 percent are enrolled in PPO plan types. These percentages shift based on persons privately insured.

### PAYMENT METHODS

How do these four different model types compare? They differ along the lines of the degree of utilization controls placed on providers; the degree of financial risk assumed by the sponsor (employer; union), the intermediary (or insurer) and physician; the degree of restriction placed on the consumer's selection of a provider, and the extent of enrollee and provider incentives. Within the managed care plans,

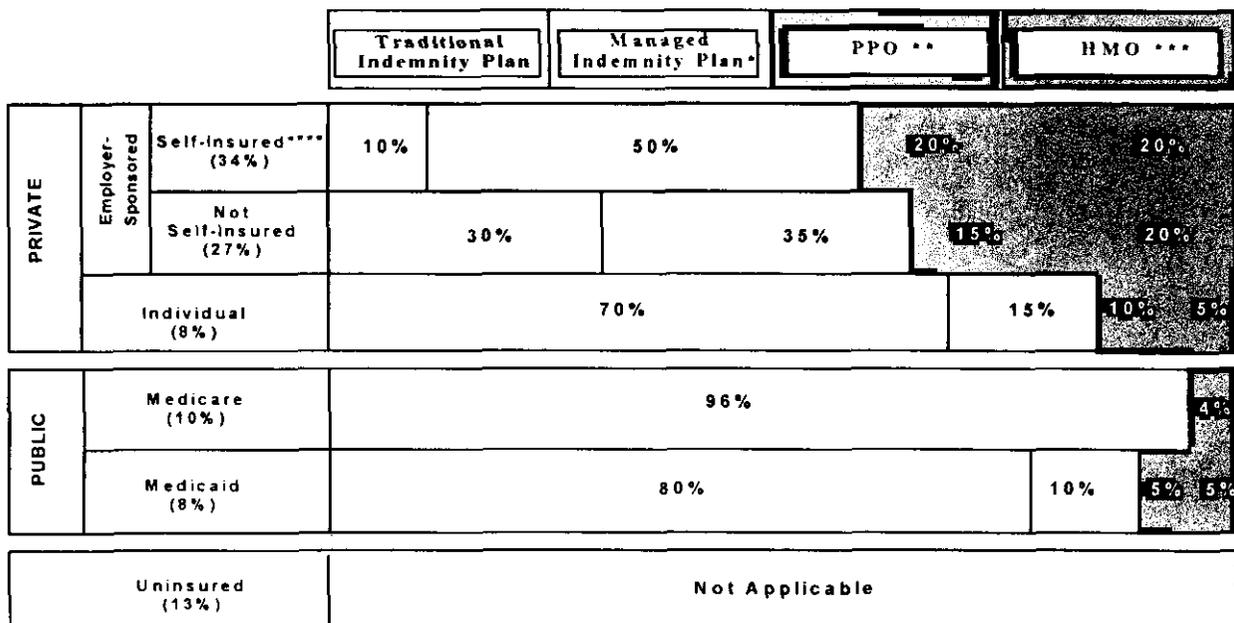
financing systems are varied, and may be either through capitation, discounted fee-for-service, or fee schedules (see Glossary). For example, rather than paying for each individual service, HMOs set up contracts to pay physicians or hospitals a fixed amount for each person enrolled in the plan. This amount is set (it may be either fully or partially capitated), is paid in installments and remains the same no matter how often an enrollee uses services. If the fixed rate is underestimated (or if utilization of services is high), the provider incurs additional expenses and absorbs the loss. If, on the other hand, fewer services are used by patients, the physician experiences a net gain.

### RATE COMPARISONS

Under managed care, premiums are paid for health benefits as they are under traditional plans. On a national level, average premium prices in a "typical" HMO plan range from \$128.76 per month for an individual to \$353.57 for a family (1992). In comparison, in New Jersey the average premium for an individual was \$151.64 and for a family was \$413.65. (The increase can be explained

**Chart 2. Estimated Market Share of Health Insurance Plans by Segment of U.S. Population, 1990**

(bars representing each population segment are not proportionately scaled relative to one another)



- \* Prehospital certification mandated
- \*\* Includes EPOs
- \*\*\* Included open-ended employers that purchase minimum premium policies
- \*\*\*\* Also includes employers that purchase minimum premium policies

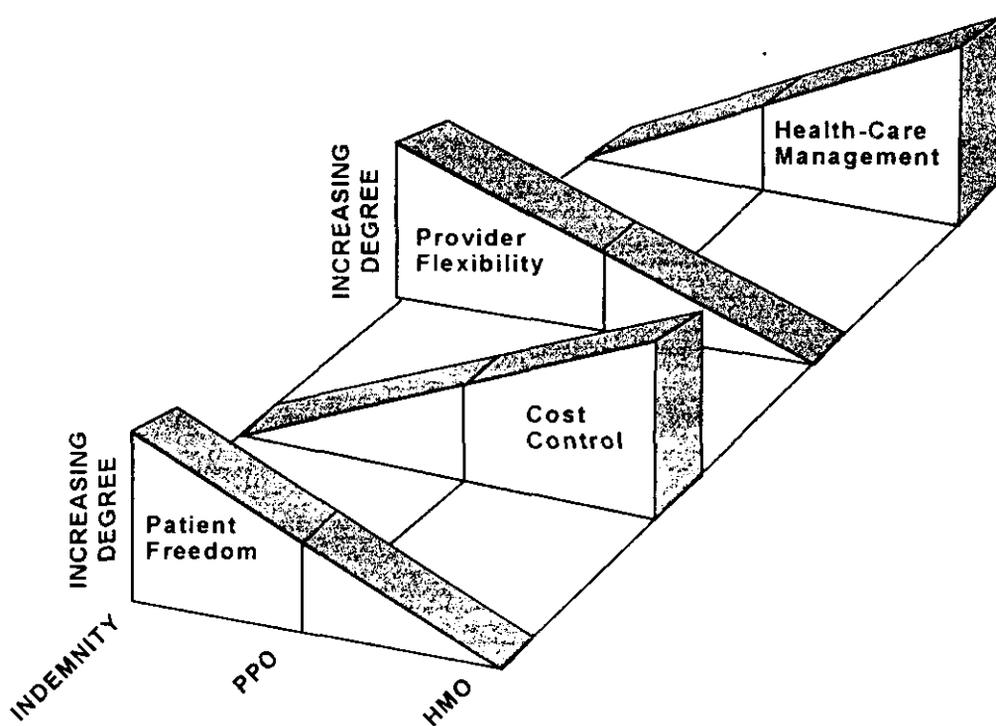
Sources: HIAA 1991, Interstudy 1991, HCFA Office of Research and Demonstrations internal memo, November 1991, Weiner & Lissavoy, Razing a Tower of Babel: A Taxonomy for Managed Care, 1993.

by what the Health Care Financing Administration (HCFA) calls the traditional higher costs for health care in the Mideast region of the country — New Jersey, New York, Pennsylvania and Connecticut.) In a managed care settings, patients pay a small amount each time they see a physician, ranging from \$5.00 to \$10.00. In comparison, under the traditional indemnity plans, patients have a deductible; once it is reached, they must pay a “co-payment” of some percentage of the fee for services rendered. These co-payments range from 20 percent to 50 percent, depending on the plan. Traditional plans also have an out-of-pocket maximum which the consumer pays, which varies based on deductibles and coverage.

How premium rates compare among managed care plans and traditional plans is a point of controversy. A 1993 U.S. General Accounting Office (GAO) report includes one survey of over 2400 employers that indicates that in 1992, HMO plan premiums averaged nearly 11 percent below PPO plans, which were 9 percent lower than indemnity plans. In contrast, two other surveys of equally large numbers of employers showed that managed care premiums were similar to or greater than the premiums for indemnity plans.

Generally, traditional indemnity fee-for-service plans have a high degree of patient freedom and few restrictions on the amount of controls placed upon providers. In comparison, HMOs have a low degree of patient freedom of choice and

**Chart 3. The Amalgam of Managed Care**



Source Johnson & Johnson, *Managed Care Update*, Vol. 1, #7 July, 1992

flexibility for providers. PPOs, which allow for physician selection outside of the provider network, fall somewhere in between the two regarding patient freedom to choose and provider treatment flexibility. When looking at cost control and health-care management, HMOs provide the highest degree of control over these two factors, while traditional plans offer the least. Once again, PPOs fall somewhere in between the two. (See Diagram). It is important to keep in mind that the managed care plans are constantly changing the terms of their financing and utilization controls depending upon the market needs and their financial viability.

## **CHANGING ROLES OF INSURERS AND PROVIDERS**

One of the most dynamic pieces of the managed care industry is the changing roles and responsibilities between insurers and providers, which are no longer as clear-cut as they had been in the traditional model of health care financing and delivery. The factor of risk has always plagued the insurance industry and it continues to do so under managed care. Risk can basically be defined as the responsibility or liability for payment of services (Winegar, 1992)

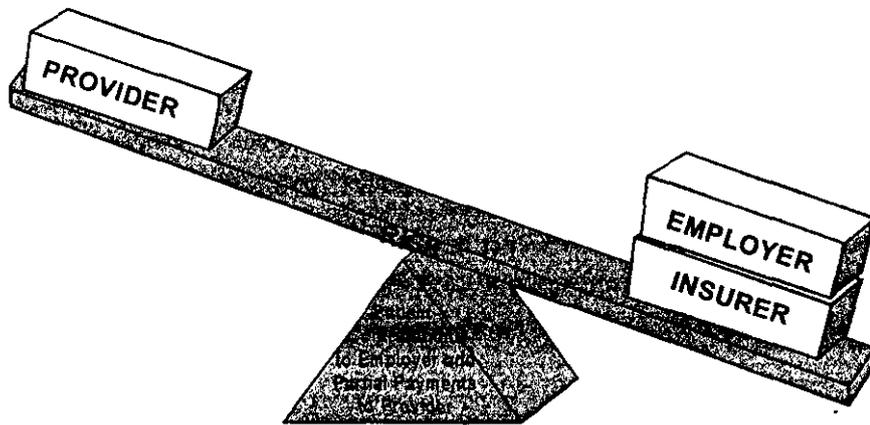
Under traditional, FFS indemnity insurance, insurance carriers acted as passive claims payers, underwriting policies and passing increasing costs on to providers by increasing premiums; employers and insurance carriers shared risk. Managed care spreads out the sharing of risk through the employer (who pays premiums), the managed care entity (intermediary) and the provider, through capitation payments. The balance of how much risk is shared varies depending on the type of managed care plan. For example, through HMO models, risk is shared with providers, either through capitation payments, or via salary (staff-model HMOs). In some IPA and PPO plans, all physician payments are subject to a percentage "withhold" (for example, 15 percent), which represents the degree of economic risk borne by the provider. Periodically, the withhold fund balances are analyzed and any eligible surpluses are distributed to the appropriate providers.

By shifting financial risk to providers, the goal of managed care plans is to discourage extensive use of referrals to specialists and expensive, high-technology services. PPO network physicians are generally not required to assume financial risk for the provision of services. Fees are reimbursed on a fee-for-service basis, but are negotiated to pay discounted fees to both physicians and hospitals. A 1993 General Accounting Office (GAO) study offered a caveat that with discounted fees, incentives exist for providers to offset lowered fees by increasing the frequency and intensity of services. The monitoring for such behaviors is imperative if cost savings are to be effected.

The use of capitated payments, i.e., the use of a fixed payment to providers for each enrollee in the health plan, as with HMOS, has its own set of challenges. For example, how is the appropriate formula for payment to be agreed upon? How can it ensure that costs are adequately predicted, such as in the case of the costs of

catastrophic illness of an enrollee? In such cases, how can the financial viability of the provider entity be ensured? The Medicare program continues to struggle with this problem in finding the "right" formula to set for capitated payments for care. This problem becomes all the more serious in a managed care environment.

**Chart 4. Indemnity Insurance:  
Employer and Insurer Share Risk**



**Managed Care:  
Risk is Shared by Employer, Insurer, and Provider**



## Vignettes

The following are intended to serve as illustrations of how consumers and providers move in a managed care environment.

### CASE #1 - TRADITIONAL INDEMNITY PLAN WITH MANAGED CARE COMPONENT

*Barbara L., a 40-year-old self-employed social worker, has small-group enrollment with a major insurance company under her small group practice. Her 1993 premiums are approximately \$160.00 per month (\$1,920 per year), an increase of 5% from 1992. Her managed care component, which has lowered her premiums by 8%, requires that she get authorization from the medical review team at the insurance company when she needs any surgical or hospital inpatient procedure performed. Under her plan, she has a \$400 out-of-pocket deductible, then she pays 50% of all charges for health care, and the insurer pays the other 50%. She has an out-of-pocket cap of \$1200 for annual medical expenses, over which amount the insurance company pays 100% for services it deems medically necessary. Embedded in Barbara L.'s premium is a charge for preventative care, under the managed care component of her plan. This allows for a waiving of the deductible for one annual physical, one ob-gyn examination and mammogram (if she is over 50). This preventative care package adds 6% onto the baseline premium. If Barbara L. had gone for traditional coverage, without the managed care component and preventative care package, her premium would be \$155.00 per month, or \$1,860 per year.*

### CASE #2 - HMO - STAFF MODEL VS. NETWORK MODEL

*John R. and his family are enrolled in a large staff model HMO. Premiums for a family of four are \$390 per month, an increase of 6% from 1992. The family must pay \$5.00 for each visit to the HMO. Staff model HMOs hire a variety of physicians and specialists as salaried employees to provide services. Providers practice in one or more clinic settings. Enrollees can see only the physicians on staff at the HMO and cannot access physicians in the community who are outside of their HMO. When John R.'s son had an eye infection after chicken pox, he could not see the ophthalmologist at the medical practice in his town who happened to be available on Sunday. He had to see his Primary Care Physician on staff at the HMO, who decided whether or not referral to the on-staff ophthalmologist was appropriate. He also had to wait until Monday morning because the Primary Care Physician had evaluated the problem over the telephone on Sunday and deemed that it was not an emergency (which it was not). He prescribed antibiotic drops, for which the family had to pay \$5.00 for the HMO pharmacy charge. If John R.'s son had seen the non-HMO specialist, he would have paid \$75.00 out-of-pocket for charges, plus \$40.00 for the prescription to be filled at a non-HMO pharmacy.*

*By comparison, if John R. and his family had been enrolled in a network model HMO they would not have been limited to choose only from the salaried staff at the Staff*

*Model HMO. Network model HMOs contract with several groups of physicians or independent practitioners. These panels of providers may include family practice physicians, internal medicine physicians, pediatricians, ob-gyns., etc. The HMO funds the physicians through capitation payments. It may also assist physicians in obtaining discounts from specialists, to whom they have to refer when they cannot provide such services. In this network model, which provides a large number of community-based physicians from which members may select for their primary care, John R. pays \$419.00 per month in premiums in 1993 (an increase of 7% from 1992), or \$5,028.00 annually. He still would pay his co-payment for the visit of \$3.00 to \$5.00 but would have had a wider range of physicians from which to choose, as well as specialists for referral.*

*If John R.'s HMO offers an "open-ended" or Point-Of-Service Plan, he would not be "locked-in" at all to the HMO's providers but would be allowed to go out-of-plan. When John R. goes out of plan he takes on more costs, where he may have to pay a 10% to 20% deductible towards the out-of-plan physician's charges. As discussed in the brief, such Point-of-Service plans are part of a new breed of hybrid plans and would more likely be found offered by non-traditional HMOs, by Preferred Provider Organizations (PPOs) and PPOs offered by HMOs.*

**CASE #3 - PREFERRED PROVIDER ORGANIZATIONS (PPOs)**

*PPOs are organizations, not providers. The providers affiliate with a PPO and may be physicians, dentists, hospitals or nonphysician clinicians, such as social workers. Insurance companies or employer groups purchase services for their subscribers or employees from the PPO. The PPO entity then acts as a "broker" between the purchaser of care and the provider. In a PPO, John R. and his family would have the option of using the "preferred" plan providers, or not using them. The PPO uses an incentive for John R. to use PPO providers; if he chooses a non-PPO provider, the plan may cover only 70% of the charges, as opposed to 90% if he had used a plan provider.*

**CASE #4 - HMO MODEL FROM THE PROVIDER POINT OF VIEW**

*In the HMO model, a new consumer enrollee (let's use John R. again) selects from an available panel of physicians who is to be his primary care physician (PCP) and case manager, usually a general practitioner or internist. The selected physician is paid a fixed monthly amount for that new member. Dr. Smith, the selected physician, must then provide all medical services, preventative and remedial, as specified in the HMO contract. Dr. Smith receives the same capitation payment each month for his patient, regardless of how much or how little John R. comes in to see him. Dr. Smith also has a "referral account" for which he receives an allowance for specialist care. This is in addition to his capitation payment. Dr. Smith, if he makes a referral, pays for a portion of the specialist care through his referral account. At the end of the John R.'s contract year, Dr. Smith, as the PCP, shares in any surplus or deficit in the referral account, which is one of the ways by which he shares risk. For example, if Dr. Smith is paid \$10 per member, per month, over a year he will collect \$120. for John R.'s care. He may receive an extra \$1.00 per month in his surplus referral account, having limited the number of referrals to specialists. He then would receive \$120, plus \$12., or \$132 for year. If John R. visited Dr. Smith three times that year, Dr. Smith would receive \$44 per office visit in that year. In 1992, average PCP office visits by HMO enrollees totaled 3.5 visits per year. (Adapted from Winegar, Clinician's Guide to Managed Health Care, 1992).*

**CASE #5 - PUBLIC PROGRAM - MEDICAID CLIENT**

*(Based on a vignette from National Public Radio illustrating the absence of preventative care for Medicaid clients and the high costs associated with providing inappropriate emergency room care). Maria C.'s three-month-old baby is in the emergency room for an infected ingrown toenail. She tried to use home remedies, which failed, and then could not find a private physician to take her as a Medicaid client. She has been to the emergency room twice for the problem, has waited several hours and is one of several people waiting in the emergency room with non-emergency medical problems because they have no family doctor. Each emergency room visit can run anywhere from \$110 to \$135, compared to \$30 to \$35 for a family doctor. Under managed care, Medicaid clients would be assigned to a primary care physician who would monitor care, including all-important pre-natal and pediatric care for children. A Virginia Medical College study looking at 25 Medicaid HMO programs across the U.S. found that per-member costs were 5 to 15% lower than in conventional Medicaid programs. Savings were primarily based on lower hospitalization rates and lower emergency room usage. Individuals like Maria also cost the health system and Medicaid more money because they come in for help sicker and in need of more acute care, with diabetes out of control and requiring several days of in-hospital care, for example, in the absence of monitoring and preventative care.*

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## **MANAGED CARE - INSURANCE COMPANIES, GOVERNMENT AND HOSPITALS**

### **INSURANCE COMPANIES AND MANAGED CARE**

Insurance companies are active players in the field of managed care, including Blue Cross/Blue Shield Plans and the over 600 commercial carriers. A recent Citizen Action study focused on commercial health insurers and found that those issuing policies in New Jersey are the seventh most efficient group in the country, allocating 28.3 cents to administrative and overhead costs out of every dollar of health benefits they paid to policy holders. Spokespeople from insurance companies believe this ratio will be equalized with the phasing-in of managed care in New Jersey, because while administrative costs increase slightly under managed care, health care costs will drop. Some insurance companies have purchased or established their own discrete delivery systems (such as HMOs), but most private indemnity plans use some type of managed care "controls," such as pre-certification or preventative care premiums. Major insurance giants like Prudential, Cigna, Aetna and Travellers are setting up networks, to organize doctors, hospitals, laboratories, pharmacies and other providers. Costs are contained by negotiating and securing a lower price, sometimes 10 to 30 percent lower, from the provider. Managed care industry trends are indicating an increase in enrollments but a decrease in the number of the plans. Such trends are a concern for the smaller insurance companies, who fear being edged out by the clout of the larger industry firms.

Another interesting trend regards the movement for employers to self-insure in the managed care environment. Health Insurance Industry Association estimates indicate that over 50 percent of all employees are now in plans that are primarily self-insured; i.e, where the employer does not purchase full coverage from an insurer intermediary. In 1992 in New Jersey, 63 percent of HMOs were corporate managed, 25 percent were corporate affiliated, and 13 percent were independent.

### **GOVERNMENT PROGRAMS AND MANAGED CARE**

Regarding government-sponsored programs, most of the care is not reimbursed under a managed care system. 96 percent of Medicare enrollees (the elderly and disabled) are covered by traditional, fee-for service programs, with only 4 percent enrolled in some type of HMO model. The Federal government is now shifting its strategy to actively promote HMO enrollment for Medicare beneficiaries based on a recent 5-year Mathematica Policy Research study that showed that rather than saving money, the Government loses money when enrollees are signed up in HMOs. The Government paid 5.7 percent more for the Medicare patients in HMOs than it would have paid if the patients had been enrolled in the regular Medicare program. The problem lies in payment methodology in that the Government still has not found a satisfactory way of adjusting payments to reflect the health status and medical needs (chronic and disability care) of the individuals enrolled in

particular plans. The study found that the healthier Medicare clients enrolled in HMOs, while those with health problems stayed within the traditional fee-for-service structure.

Medicaid programs, on the other hand, are moving into managed care plans. Nationally, approximately 80% of Medicaid enrollees were in traditional plans, 10% in managed indemnity plans, and 5% in HMOs and PPOs, respectively (1992). It is believed that managed care plans, with their emphasis on preventative care, are a viable alternative for the health care needs of Medicaid clients, in particular in maternity care and pediatrics. Medicaid and managed care in New Jersey will be the topic of the next Capitol Forum in March 1994.

## **HOSPITALS AND MANAGED CARE**

Hospitals continue to play a vital role in the managed care industry as they join with physicians, laboratories and other providers to offer health services. One of the more successful models for hospitals as the center of managed care networks uses the university teaching hospital as its center. Once such system in Detroit, Michigan - the Henry Ford Health System, includes a large teaching hospital, 3 other-owned hospitals, four managed care hospitals, 800 salaried physicians, 26 out-patient centers and several HMOs (the largest of which has 420,000 members). It has recently joined with Blue Cross and Blue Shield of Michigan in a joint point-of-service venture offering broad consumer choice but limiting premium increases for large-group consumers.

New Jersey's environment continues to grow with changes in hospital development of managed care networks. Under health care reform in New Jersey, it continues to be seen what the status of community rating will be for our hospital system. Since January, when legislation ended state control of hospital rates, several hospital and doctors' networks have emerged in the competitive market place. New Jersey's UMDNJ is involved in such a network development. In December 1993, University trustees voted to form the not-for-profit University Healthcare Corp, which will form affiliations with health care facilities throughout the state to provide comprehensive care at reasonable costs. This statewide managed care network will provide medical, psychological and dental care to member patients, through teams of physicians in the communities served and the UMDNJ faculty. Such an alliance allows for cooperation between academics and community physicians, who are traditionally split from each other. It allows for a coordinated access point of care, which research has shown is a success factor in keeping costs down and allowing for a continuum of care. Such networks differ in the financing of care in that they contract with insurers to provide the care, usually at a reduced fee; the network itself does not handle the money. It is also a goal of the network that the University expand its programs in certain areas, especially in the field of family practice medicine.

Another recent development in New Jersey involves First Option, a 42-hospital, 7,000 doctor health network, the first doctor/hospital-owned network. It is the first network of its kind to begin selling health insurance, which is to begin in April 1994. Its plan is to offer premiums at the lowest rate in New Jersey; it already has 55,000 to 60,000 insured hospital employees committed to enrollment. In a recent Newark Star Ledger article (12/16/93), First Option's president John Adessa also states that 50 to 60 percent of the patients at many first option hospitals are poor, elderly and disabled covered under Medicare and Medicaid. First Option, based in Red Bank, has hospitals in its network throughout the state, including Monmouth Medical Center, Community Medical Center in Toms River, Union Hospital and Robert Wood Johnson University Hospital.

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## **PRAGMATIC EVALUATION OF MANAGED CARE**

In all of these plans and models, experts disagree widely on the benefits and problem areas of managed care systems. As New Jersey continues to evolve its managed care identity, the debate continues. Should we look to a state like Maryland, which has a unique "all-payer" system designed with built-in incentives to minimize price increases and eliminate hospital cost-shifting from one payer to another? Or pay closer study to Minnesota, which has pioneered the development of HMOs and other aspects of managed care? New Jersey itself is exploring the "any willing provider" concept, which allows for a managed care plan subscriber to be able to use an alternate hospital or physician, who is outside of the assigned network, if that provider is willing to provide the necessary health services at the same rate and the care does not incur additional costs for the HMO or network.

Whether or not we choose to go more deeply into managed care or experiment with hybrid forms of traditional plans and managed care models, it is important to bear in mind some of the identified issues in the managed care debate.

### **BENEFITS**

- \* Managed care plans do save money when the plans are tightly managed and overseen. In one study a controlled HMO with tight provider oversight and restricted consumer choice had health spending at only 82 percent of a fee-for-service plan with 25% coinsurance. Success, however, depends on the scope and design of program and its flexibility in responding to market changes.
- \* Savings do occur from shifting from fee-for-services to managed care capitation plans; however, studies are showing that these savings are "one-time" savings from lower inpatient use and more appropriate ambulatory care utilization patterns.

- \* A comprehensive emphasis on preventive care and the provision of a continuity of care through the primary care physician case manager. The element of preventive care/well care has long been neglected in traditional health care coverage.
- \* In a 1993 study published in the Journal of the American Medical Association, medical outcomes research found that when asked to compare traditional care with managed care, patients in managed care networks gave primary care physicians in prepaid plans lower ratings for availability, continuity and treatment manner but gave higher ratings for financial access (that is, fees were lower than traditional care) and coordination of care.

## **PROBLEM AREAS**

- \* The operations of managed care require a administrative function for strict oversight and review which may counter-act any cost savings.
- \* In a fragmented insurance system, providers can increase prices for those not in managed care plans and engage in cost shifting from one payer to another.
- \* Physicians complain of micro management of their medical practice and additional layers of bureaucracy; also, specialist practitioners, such as chiropractors, contend that it is inappropriate to have their care managed and coordinated by a general practitioner as gatekeeper; they believe a chiropractor should monitor chiropractic care.
- \* Limited freedom of choice for consumer, who must deal with a Primary Care Physician to manage his/her case.
- \* Inconsistent standards for quality assurance.
- \* Adverse selection in plans whereby "sicker" clients are not accepted in plans and remain in traditional, more-costly plans. New Jersey legislation as of November 1992 remediated this potential problem.
- \* Issues around specific problems associated with rural settings and HMOs. Research has shown that substantial populations in a given market area are necessary for sustaining multiple independent health plans. In rural areas, this becomes difficult if not impossible.
- \* Assessment of quality issue: the problem lies in that many physicians are not in agreement as to which medical treatments yield the best outcomes. Standards need to be developed. Who develops these standards and how should they be developed?

- \* Issues around Medicare beneficiaries, the elderly and disabled, who are high utilizers of health care services, being worked into managed care plans which emphasize preventative care and lower utilization of acute and non-traumatic services. The Federal government has currently backed off actively promoting HMO enrollment for Medicare beneficiaries.

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## ISSUES FOR DISCUSSION

How will New Jersey address the problem of regulating managed care entities? How much/how little? Is it willing to rely on peer review and quality assurance? How much regulation is needed in this era of sensitivity in New Jersey that there is "too much regulation"?

How will we handle groups who are frequent users of health care, such as the elderly, the disabled, the chronically ill, and those with mental illness? Where do high-cost and high-risk individuals go for health care? How will they fare under a managed care system?

Where and how do New Jersey's uninsured fit in with managed care?

Is New Jersey's State Employees Pensions and Health Benefits system a viable candidate to shift to managed care penetration, like California's Public Employee's Retirement System, under which a managed competition system provides health and medical care to almost 1 million public employees, retirees and their dependents in a proven cost-efficient manner?

Where does New Jersey stand in its numbers of primary care and general practice physicians. The distribution nationally is skewed towards specialists, with only 30 percent of the country's physicians in primary care. The success of managed care depends upon the expertise of general practice physicians making referrals to specialists only when necessary. Do we have the physician work force to handle managed care?

## GLOSSARY OF MANAGED CARE TERMS

**Capitation:** A per-member, monthly payment to a provider that covers contracted services, and is paid in advance of its delivery. In essence, a provider agrees to provide specified services to HMO members for this fixed, predetermined payment for a specified length of time (usually a year), regardless of how many times the member uses the service. The rate can be fixed for all members or it can be adjusted for the age and sex of the member, based on actuarial projections of medical utilization.

**Exclusive Provider Organization (EPO):** A defined group of physicians or hospitals that have agreed to perform fee-for-service medicine at a discount, without financial risk. An EPO does not offer employees point-of-service flexibility. Members receive no coverage of medical care outside of the designated panel of providers, hence the term "exclusive." Some benefits experts view an EPO as a hybrid of an HMO and a PPO.

**Fee-for-Service:** Traditional provider reimbursement, in which the physician is paid according to the service performed. This is the reimbursement system used by conventional indemnity insurers.

**Gatekeeper:** Most HMOs rely on the primary-care physician, or "gate-keeper," to screen patients seeking medical care and effectively eliminate costly and sometimes needless referral to specialists for diagnosis and management. The gatekeeper is responsible for the administration of the patient's treatment, and this person must coordinate and authorize all medical services, laboratory studies, specialty referrals, and hospitalizations. In most HMOs, if an enrollee visits a specialist without prior authorization from his or her designated primary-care physician, the medical services delivered by the specialist will have to be paid in full by the patient.

**Health Maintenance Organization (HMO):** A health organization that accepts responsibility and financial risk for providing specified medical services to a defined group of individuals during a defined period of time at a fixed price. Developed as an alternative to indemnity plans, HMOs were the first to offer coverage for preventive health care services. Often the physicians serving HMO patients are paid on a capitation basis.

**Staff-Model:** The staff-model HMO is the purest form of managed care. All of the physicians are in a centralized site, in which all clinical and perhaps inpatient and pharmacy services are offered. The HMO holds the tightest management reins in this setting, because none of the physicians traditionally practice on an independent fee-for-service basis. Physicians are more employees of the HMO in this setting, as they are not in a private or group practice.

***Independent Practice Association-Model (IPA):*** The individual practice association contracts with independent physicians who work in their own private practices and see fee-for-service patients as well as HMO enrollees. They are paid by capitation for the HMO patients and by conventional means for their fee-for-service patients. Physicians belonging to the IPA guarantee that the care needed by each patient for which they are responsible will fall under a certain amount of money. They guarantee this by allowing the HMO to withhold an amount of their payments (i.e., usually about 20 percent per year). If, by the end of the year, the physician's cost for treatment falls under this set amount, then the physician receives his entire "withhold fund." If the opposite is true, the HMO can then withhold any part of this amount, at their discretion, from the fund. Essentially, the physician is put "at risk" for keeping down the treatment cost. This is the key to the HMO's financial viability.

***Group-Model:*** In the group-model HMO, the HMO contracts with a physician group, which is paid a fixed amount per patient to provide specific services. The administration of the group practice then decides how the HMO payments are distributed to each member physician. This type of HMO is usually located in a hospital or clinic setting and may include a pharmacy. These physicians usually do not have any fee-for-service patients.

***Network-Model:*** A network of group practices under the administration of one HMO.

***Point-of-Service Model:*** Sometimes referred to as an "open-ended" HMO, the point-of-service model is one in which the patient can receive care either by physicians contracting with the HMO or by those not contracting. Physicians not contracting with the HMO but who see an HMO patient is paid according to the services performed. The patient is incentivized to utilize contracted providers through the fuller coverage offered for contracted care.

**Preferred Provider Organization (PPO):** A defined group of physicians or hospitals that have agreed to perform fee-for-service medicine at a discount without financial risk. Instead of being regulated by the government, providers are typically required to submit to utilization reviews and to alter practice patterns that reflect excessive use of health services. Audits on financial viability and quality of care must be done independently. From an employee perspective, the most appealing feature of PPOs is the point-of-service option.

**Sources:** Johnson & Johnson, *Managed Care Update*, Vol. 1, No. 7, July 1992. The Conference Board, Publication #968, 1992, *Managed Care Corporations*.

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## APPENDIX

### HMOs Operating in New Jersey (as of December 1992)

	Enrollment	Medicaid	Model Type	PCP Contracts	Specialist Contracts	Tax Status	Other MC Products	NJ Service Area
<b>Aetna Health Plans of NJ</b>	115,802	0	IPA	1,816	1,683	For-Profit	POS,PPO	21 Counties
<b>Cigna Health Plans of Northern NJ</b>	86,238	0	IPA	1,110	1,498	For-Profit	POS, PPO, FFS	12 Counties
<b>Garden State Health Plan</b>	16,000	16,000	IPA	180	n/a	Non-Profit		10 Counties
<b>HIP/ Rutgers Health Plan</b>	177,592	2,413	IPA	120	155	Non-Profit		14 Counties
<b>HMO of NJ/ US HealthCare</b>	424,987	0	IPA	1,147	4,340	For-Profit	Self-Insured	19 Counties
<b>Medigroup Central</b>	46,888	0	Staff, IPA	1,284	4,208	For-Profit		21 Counties
<b>Medigroup Inc.</b>	17,970	0	IPA	1,284	4,208	For-Profit		All Counties
<b>MetLife Northern NJ</b>	22,266	0	IPA	n/a	n/a	For-Profit	PPO, POS, FFS	All Counties
<b>Oxford Health Plans</b>	135,000	3,294	IPA	2,400	2,408	For-Profit	Self-Insured	21 Counties
<b>PruCare of NJ</b>	57,634	0	IPA	1,609	2,006	For-Profit	POS, PPO, FFS, Self-Ins.	All Counties
<b>Sanus Health Plan</b>	80,564	7,131	IPA	917	2,113	For-Profit		7 Counties
<b>Travelers Health Network of NY</b>	20,736	0	IPA	1,856	4,546	For-Profit		15 Counties
<b>Cigna Healthplan of the Delaware Valley</b>	17,137	0	IPA	152	269	For-Profit	POS, PPO, FFS	9 Counties

Source: *Inter Study: The Competitive Edge, 1993.*

Based on data compiled by the InterStudy Center, there were 14 HMOs with enrollment in New Jersey. HMO Blue, operated by New Jersey Blue Cross and Blue Shield, is now operating in New Jersey and reports an enrollment of 94,000 members. The top 5 HMOs in New Jersey are: U.S. Healthcare HMO of New Jersey; HIP/ Rutgers Health Plan; Aetna Health Plans of New Jersey, Inc.; HMO Blue; and Cigna Health Plan of Northern New Jersey. Sanus Health Plan and Travelers Health Network of New York are headquartered in New York and serve New Jersey; Cigna Health Plan of the Delaware Valley is headquartered in Philadelphia and also serves New Jersey.

# HMO penetration reaches 17.3% of U.S. population

HMO market penetration climbed to 17.3% of the U.S. population in 1992, up from 15.9% in 1991. Penetration increased in 34 of the 47 states with active HMOs. Of the 11 states with

decreased penetration, five states, including Arizona, New Jersey, Louisiana, Iowa and Idaho, had a net loss of one or more HMO plans between 1991 and 1992. HMO penetration was

**SUMMARY OF HMO PENETRATION BY STATE\***

STATE	Rank**		State Population*** (000)	Penetration (%)			Enrollment (000)		Total HMOs			Enrollment Change (%)	
	1992	1991		1992	1991	1990	1992	1991	1992	1991	1990	1991-1992	1990-1991
Massachusetts	1	3	5,969	34.5%	30.6%	27.6%	2,056.1	1,832.5	16	21	22	12.2%	10.4%
California	2	1	30,304	34.4	32.5	31.3	10,420.0	9,873.9	48	50	50	5.5	6.0
Minnesota	3	2	4,436	32.5	30.6	28.1	1,441.9	1,354.6	10	11	11	6.4	10.2
Oregon	4	5	2,857	28.6	26.1	25.2	817.3	762.0	10	10	9	7.3	6.4
Maryland	5	6	4,934	27.1	23.1	19.9	1,337.7	1,124.3	15	13	14	19.0	18.3
Colorado	6	8	3,367	26.6	22.5	21.7	894.8	760.5	15	19	19	17.7	6.5
Arizona	7	4	3,858	24.9	30.1	20.6	960.4	1,129.3	11	13	14	-15.0	49.5
Rhode Island	8	7	1,007	24.8	22.9	22.2	249.3	230.3	3	3	4	8.3	3.5
Hawaii	9	10	1,182	22.7	21.5	21.3	268.6	244.4	5	5	5	9.9	3.5
Wisconsin	10	9	4,911	22.7	21.9	20.5	1,114.0	1,083.9	25	25	27	2.8	8.1
Utah	11	11	1,765	21.6	21.4	18.6	381.0	378.0	9	8	8	0.8	18.2
New York	12	13	17,877	21.0	17.0	16.1	3,745.1	3,077.6	36	36	37	21.7	6.1
Connecticut	13	12	3,302	18.7	18.6	17.6	616.1	610.6	10	12	12	0.9	5.4
Michigan	14	14	9,332	17.5	17.0	17.4	1,636.0	1,695.3	19	24	26	2.6	-1.3
Ohio	15	15	10,941	17.3	16.2	15.9	1,894.1	1,771.3	40	39	40	6.9	2.7
Illinois	16	20	11,731	17.1	14.2	15.6	2,010.3	1,642.6	27	25	27	22.4	-7.8
Washington	17	17	4,917	17.1	14.6	14.5	838.9	732.3	10	11	11	14.6	4.0
Florida	18	21	13,586	17.0	14.1	13.8	2,302.5	1,867.2	40	40	49	23.3	5.0
Pennsylvania	19	19	12,068	16.0	14.3	12.3	1,924.5	1,714.8	22	23	25	12.2	17.0
Missouri	20	22	5,269	15.7	13.5	12.4	824.9	695.1	17	17	16	18.7	10.0
Delaware	21	23	705	15.6	12.4	18.2	110.0	84.4	3	3	4	30.3	-30.3
New Mexico	22	16	1,579	15.5	15.5	14.3	244.1	240.1	5	5	5	1.7	11.1
New Hampshire	23	26	1,194	13.7	10.6	9.5	163.7	117.1	2	2	2	39.8	11.3
New Jersey	24	18	7,921	12.0	14.5	13.6	946.4	1,125.6	8	9	11	-15.9	7.0

Data source: SMG Marketing Group Inc. © 1993

\* The total for 1992 HMO enrollment has been rounded, so it is not identical to the total given in other tables. It includes only operating plans. The District of Columbia, with three HMOs enrolling 496,799 members, is not included because its numbers include many residents of Maryland and Virginia who work in Washington, D.C. Alaska, West Virginia and Wyoming had no operating or developing HMOs in 1992.

\*\* Rank based on penetration.

\*\*\* State population data is a projection of the U.S. Department of Commerce Bureau of the Census Current Population Reports/Population Estimates and Projections/Series P-25, No. 1053, Projections of the Population of States by Age, Sex, and Race: 1989 to 2010/ by Signe I. Wetrogan, published January 1990.

one-third or more of the state population in three states: Massachusetts, California and Minnesota. The top 10 states accounted for 45% of total HMO enrollment nationwide. California alone, with 10.4 million

enrollees, accounted for nearly one-fourth of all HMO enrollment in the U.S. The largest percentage increase in HMO penetration between 1991 and 1992 was reported in Maine, to 4.1% from 2.8%.

**SUMMARY OF HMO PENETRATION BY STATE\***

Rank**		State Population*** (000)	Penetration (%)			Enrollment (000)		Total HMOs			Enrollment Change (%)		STATE
1992	1991		1992	1991	1990	1992	1991	1992	1991	1990	1991-1992	1990-1991	
25	27	1,196	11.8%	10.4%	9.0%	141.2	133.0	4	3	3	6.2%	22.7%	Nevada
26	25	17,286	11.5	10.6	9.3	1,988.7	1,839.3	26	28	29	8.1	16.8	Texas
27	29	582	10.0	8.8	7.2	58.0	49.7	1	1	1	16.7	22.7	Vermont
28	30	3,146	9.4	8.3	8.6	295.9	264.1	6	6	8	12.0	-2.8	Oklahoma
29	28	2,538	8.3	8.8	10.0	210.0	219.9	10	10	10	-4.5	-11.3	Kansas
30	31	4,334	7.5	7.9	6.4	325.4	337.2	10	11	11	-3.5	25.1	Louisiana
31	32	3,750	7.5	7.2	5.5	280.5	287.2	6	6	6	5.0	31.7	Kentucky
32	35	6,870	7.4	6.7	6.3	509.7	445.5	9	9	9	14.4	9.8	Georgia
33	36	6,443	7.1	6.4	6.2	457.4	403.6	12	12	12	13.3	5.8	Virginia
34	37	1,599	6.8	6.1	5.9	108.2	97.7	6	7	7	10.7	4.6	Nebraska
35	33	4,218	6.7	6.8	6.0	282.8	277.4	9	9	8	1.9	13.8	Alabama
36	34	5,657	6.6	6.7	6.4	375.5	378.3	13	13	14	-0.7	7.1	Indiana
37	38	6,892	5.6	5.0	4.4	387.3	337.9	10	11	11	14.6	15.4	North Carolina
38	39	5,109	4.8	4.0	4.2	246.1	197.2	10	9	8	24.8	-2.7	Tennessee
39	42	1,261	4.1	2.8	2.5	51.6	35.0	2	3	3	47.4	14.9	Maine
40	24	2,777	4.0	10.9	10.9	110.9	303.3	4	5	7	-63.4	-0.2	Iowa
41	41	718	2.8	3.0	3.1	20.4	21.1	1	1	1	-3.3	-2.7	South Dakota
42	43	3,648	2.8	2.5	1.2	101.1	88.7	4	4	4	14.0	14.0	South Carolina
43	40	2,444	2.5	3.7	2.4	61.0	88.8	4	4	5	-31.3	59.8	Arkansas
44	44	1,018	1.8	2.0	2.5	18.5	20.6	1	2	2	-10.2	-18.5	Idaho
45	45	789	1.3	1.2	0.8	10.2	9.7	1	1	1	5.2	53.4	Montana
46	46	648	0.9	1.0	1.2	6.1	6.3	2	2	2	-3.2	-19.2	North Dakota
47	48	2,678	0.0	0.0	0.0	0.0	0.0	1	0	0	0.0	0.0	Mississippi
		<b>250,607</b>	<b>17.3%</b>	<b>15.9%</b>	<b>14.7%</b>	<b>43,244.3</b>	<b>39,992.2</b>	<b>550</b>	<b>561</b>	<b>610</b>	<b>-5.6%</b>	<b>7.7%</b>	<b>TOTAL U.S.</b>

Data source: SMG Marketing Group Inc. © 1993

\* The total for 1992 HMO enrollment has been rounded, so it is not identical to the total given in other tables. It includes only operating plans. The District of Columbia, with three HMOs enrolling 496,799 members, is not included because its numbers include many residents of Maryland and Virginia who work in Washington, D.C. Alaska, West Virginia and Wyoming had no operating or developing HMOs in 1992.

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### NUMBER OF PPOs SERVICING EACH STATE

