HEALTH MAINTENANCE ORGANIZATION ACT AMENDMENTS OF 1978

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

S. 2534

TO REVISE AND EXTEND THE PROVISIONS OF TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT RELATING TO HEALTH MAINTENANCE ORGANIZATIONS

MARCH 3, 1978

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HEALTH MAINTENANCE ORGANIZATION ACT AMENDMENTS OF 1978

FRIDAY, MARCH 3, 1978

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8:38 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Schweiker.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. We will come to order.

Today the Subcommittee on Health and Scientific Research holds hearings on proposed amendments to Federal statutes supporting the development of health maintenance organizations. Senator Schweiker and I, together with other members of this subcommittee, recently introduced S. 2534, the Health Maintenance Organization Act Amendments of 1978. These amendments would extend and strengthen current authorities supporting HMO's in this country. The administration is proposing similar provisions as well.

These proposed changes in Federal HMO laws come at a time of growing national consensus on the importance of the HMO concept. As the author of the first HMO bill ever to pass the Senate, I find this spreading support for HMO's truly gratifying. Just a few years ago, proponents of health maintenance organizations faced bitter opposition from organized medicine. And just a few years ago, congressional advocates of HMO's faced an administration which was long on HMO rhetoric, but very short on action.

The current revival of the HMO movement should come as no surprise. HMO's have proven themselves again and again to be effective and efficient mechanisms for delivering health care of the highest quality. HMO's cut hospital utilization by an average of 20 to 25 percent compared to the fee-for-service sector. They cut the total cost of health care by anywhere from 10 to 30 percent. And they accomplish these savings without compromising the quality of care they provide their members.

In fact, many medical experts argue that the peer review built into group practice in the HMO setting promotes a quality of care superior to that found in the traditional health care system.

Since the passage of the HMO law, we have made some progress toward making these promising health care organizations more widely available to the American people. In 1970, there were 33 HMO's with a total membership of 3.5 million people. Now, there are 168 prepaid health plans enrolling 6.5 million people.

What is more, federally supported HMO's seem to show all the virtues of the traditional HMO concept. There are currently over 50 qualified HMO's serving over 70,000 Americans. Patients in qualified HMO's, as history would lead us to expect, get good medical care at appreciable savings. Members of federally certified health maintenance organizations use an average of 462 hospital days per thousand patients each year, compared with 1,022 in the fee-for-service sector.

In fact, HMO's have so many virtues, and have had so many demonstrated successes, that it is easy for us to forget the many problems which still confront the HMO movement. I am disturbed to see that HMO's have not developed as rapidly as many of us had hoped they would. One major reason for this is that the Federal Government has never fulfilled its promise to fully support the development of HMO's; of the $210 million authorized for grant support of HMO's since 1974, only $76 million has been spent. The actual number of grants awarded has declined each year since 1975.

We agree with the administration that the time has come to upgrade and revitalize the Federal Government's commitment to the HMO movement. It is our hope and conviction that S. 2534 will make a major contribution to this effort. Among the legislation's major provisions are the following:

One: S. 2534 extends for 5 years at increased authorization levels Federal programs for grant and loan support of HMO's.

Two: S. 2534 ends the demonstration status of the HMO program, and makes it an ongoing program of Federal support.

Three: The legislation exempts HMO's from certain requirements of the planning act which have proven impediments to rapid and widespread HMO development.

Four: S. 2534 provides for Federal loans and loan guarantees to HMO's for the purpose of constructing ambulatory care facilities.

Five: S. 2534 provides specific authorization for a management training program for HMO administrators.

Six: S. 2534 contains disclosure requirements which, together with existing authorities, will go a long way toward guaranteeing the integrity of federally qualified HMO's.

Added to existing law, these provisions provide a firm statutory base for a sound and aggressive Federal program of support for health maintenance organizations. However, no law can substitute for wise and confident administration. Unfortunately, this administrative commitment has been missing in the past. The General Accounting Office has repeatedly criticized the Department for failing to provide adequate personnel with the right talents and skills to administer the HMO program. In addition, Department policies have repeatedly frustrated congressional attempts to get the HMO program moving at an appropriately rapid pace.

Fortunately, the current administration seems genuinely committed to making the HMO program a success. I applaud and welcome this refreshing new attitude. I look forward to working with the new Administrator of the HMO program, Mr. Howard Viet, and I look forward generally to cooperating in pursuit of our common goals.

In our enthusiasm to see HMO's proliferate throughout this country, we should not lose sight of the need to guarantee the quality and integrity of the prepaid plans we create. As the California prepaid health plan scandal demonstrated, it takes only a few mismanaged or fraudulent programs to discredit the entire HMO movement. We cannot allow a repetition of the abuses that occurred in the California situation. On the other hand, we cannot permit excessive regulation of new HMO's to stifle the growth of the HMO movement.

Walking the fine line between promoting HMO growth and regulating the quality of new plans will provide a challenging task for all of us. Working together, I am confident we can do the job. And I can assure you that this subcommittee will do everything it can to make HMO's a viable alternative to the fee-for-service health care system.

[A copy of S. 2534 follows:]

95TH CONGRESS
2D SESSION

S. 2534

IN THE SENATE OF THE UNITED STATES

FEBRUARY 10 (legislative day, FEBRUARY 6), 1978

Mr. SCHWEIKER (for himself, Mr. KENNEDY, Mr. WILLIAMS, Mr. JAVITS, Mr. PELL, and Mr. CHAFEE) introduced the following bill; which was read twice and referred to the Committee on Human Resources

A BILL

To revise and extend the provisions of title XIII of the Public Health Service Act relating to health maintenance organizations.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Health Maintenance Organization Act Amendments of 1978".

(b) Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2. (a) Section 1301 (b) (3) is amended to read as follows:

"(3) The services of physicians which are provided as basic health services shall be provided through physicians who are members of the staff of the health maintenance organization, through a medical group (or groups), through an individual practice association (or associations), through physicians who have contracted with the health maintenance organization for the provision of such services, or through any combination of such staff, medical group (or groups), individual practice association (or associations), or physicians under contract with the organization, except that this paragraph shall not apply in the case of (A) physician services which the organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or (B) any physician service provided a member of the health maintenance organization other than by such a physician because of an emergency which made it medically necessary that the service be provided to the member before he could have it provided by such a physician. A health maintenance organization may also, during the thirty-six-month period beginning with the month following the month in which the organization becomes a qualified health main-

tenance organization (within the meaning of section 1310 (d)), provide physician services through an entity which but for the requirement of section 1302 (4) (C) (i) would be a medical group for the purposes of this title. After the expiration of such period, the organization may provide physician services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity. A health maintenance organization may not, in any of its fiscal years after the end of its fourth fiscal year of its operation, enter into contracts with physicians other than members of medical groups or individual practice associations of the amounts paid under such contracts for physician services exceed 15 per centum of the total amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of physician services, or, if the health maintenance organization principally serves a rural area, 30 per centum of such amount, except that this sentence does not apply to the entering into of contracts for the purchase of physician services through an entity which but for the requirements of section 1302 (4) (C) (i) would be a medical group for the purposes of this title. Contracts between a health maintenance organization and physicians for the provision of physician services shall include such

provisions as the Secretary may require (including provisions requiring appropriate continuing education).".

(b) The second sentence of section 1301(b)(4) is amended to read as follows: "A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing emergency health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization.".

DEVELOPMENT GRANTS AND INITIAL OPERATING LOANS

SEC. 3. (a) Section 1304(f)(2)(A) is amended to read as follows:

"(A) $2,000,000, or".

(b) Section 1305(b)(1) is amended by—

(1) striking "$2,500,000" and substituting "$5,000,000"; and

(2) striking "$1,000,000" and substituting "$2,000,000".

AMBULATORY CARE FACILITIES

SEC. 4. (a)(1) Section 1305(a) is amended by striking "and" after paragraph (2); striking the period at the end of paragraph (3) and substituting a semicolon, and adding at the end thereof the following new paragraph:

"(4) make loans to, and guarantee to non-Federal

lenders payment of principal of and interest on loans made to—

"(A) entities which have submitted and had approved an application for assistance under this subsection in accordance with regulations promulgated by the Secretary, or

"(B) health maintenance organizations which have demonstrated to the Secretary the capability of maintaining continued fiscal soundness in accordance with the requirements of section 1301(c)(1), to assist them in meeting the costs of equipping, constructing, acquiring, or renovating ambulatory care facilities.".

(2) Section 1305(a) is further amended by striking "operating costs" in paragraphs (1), (2), and (3) and substituting in each case "costs of operation".

(b) Section 1305(b) is amended by—

(1) striking "paragraph (2)," and substituting "paragraphs (2) and (3)";

(2) inserting after "under this section" each time it appears "(other than paragraph (4) of subsection (a))"; and

(3) adding at the end thereof the following new paragraph:

"(3) There is authorized to be appropriated for the purpose of the fund for loans made or guaranteed under paragraph (4) of subsection (a) an amount not to exceed $40,000,000. In any fiscal year the amount disbursed to an entity under paragraph (4) of subsection (a) shall not exceed $2,500,000.".

(c) The section heading for section 1305 is amended to read as follows:

"LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION AND AMBULATORY CARE FACILITIES".

(d) Section 1305(d) is amended by striking "1980" and substituting "1985".

(e) (1) Section 1308 is amended by adding at the end thereof the following new subsection:

"(f) (1) There is established in the Treasury a loan and loan guarantee fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loans and loan guarantees issued by him under section 1305(a)(4). There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts re-

ceived by the Secretary in connection with loans and loan guarantees under section 1305(a) (4) and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

"(2) If at any time the sums in the fund are insufficient to enable the Secretary to discharge his responsibilities under section 1305(a) (4) he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of

the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.".

(2) Section 1308(d) is amended by inserting after "under this title" each time it appears "(other than a loan or loan guarantee under section 1305(a)(4)".

BENEFITS REQUIRED

SEC. 5. Section 1301(b) is amended by inserting "and reasonable limitations and exclusions approved by the Secretary," after "under this title" in the language preceding paragraph (1).

EMPLOYEES' DEDUCTIONS FOR HEALTH BENEFIT PLANS

SEC. 6. (a) Section 1310 is amended by adding at the end thereof the following new subsection:

"(i) Each employer with a demonstrated capability to provide payroll deductions, which is required by subsection (a) to offer to his employees the option of membership in a qualified health maintenance organization shall, with the consent of the employee who exercises such option, arrange for the employee contribution for such membership to be deducted from such employee's wages and salaries

and forwarded on his behalf to the qualified health maintenance organization.".

(b) Section 1310(b)(1) is amended to read as follows:

"(1) one or more of such organizations provides physician services through physicians who are members of the staff of the organization or a medical group (or groups), and".

(c) Section 1310(b)(2) is amended to read as follows:

"(2) one or more of such organizations provides physician services through (A) an individual practice association (or associations), (B) a combination of such association (or associations), medical group or groups, staff, or individual nonstaff physicians under contract with the organization,".

CONTINUING DEVELOPMENT

SEC. 7. (a) Section 1304(b)(2) is amended by inserting "improvement of services, or" after "subsection includes".

(b) Section 1304 is further amended by adding at the end thereof the following new subsection:

"(l)(1) A grant made under this section for the improvement of services may be made only to an entity which demonstrates the capability of maintaining continued fiscal

soundness in accordance with the requirements of section 1301 (c) (1).

"(2) Grants made to a single entity under this section for the improvement of services may not in the aggregate exceed an amount equal to the maximum sums which the applicant would have been eligible to receive under section 1303 and this section less any amounts actually received under such sections. The provisions of paragraph (3) of subsection (b) shall not apply to a grant made for the improvement of services.".

AUTHORIZATION OF APPROPRIATIONS

SEC. 8. Section 1309 (a) is amended by—

(1) striking "and" after "1977," the first time it appears, and

(2) striking everything after the semicolon and substituting the following: "$50,000,000 for the fiscal year ending September 30, 1979, $70,000,000 for the fiscal year ending September 30, 1980, $90,000,000 for the fiscal year ending September 30, 1981, $95,000,000 for the fiscal year ending September 30, 1982, and $95,000,000 for the fiscal year ending September 30, 1983; and for the purpose of making payments under grants and contracts under section 1304 (b) for the fiscal year ending September 30, 1984 there is authorized to be appropriated $95,000,000.".

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TRAINING FOR HEALTH MAINTENANCE ORGANIZATION ADMINISTRATORS

SEC. 9. Title XIII is amended by adding at the end thereof the following new section:

"MANAGERIAL TRAINING

"SEC. 1317. (a) The Secretary shall establish a National Health Maintenance Organization Intern Program (hereinafter referred to as the 'Program') for the purpose of training qualified health maintenance organization administrators and other managerial personnel.

"(b) Internships under this section may be awarded by the Secretary either—

"(1) directly to individuals whose application for such position has been approved by the Secretary, or

"(2) directly to a health maintenance organization, or to an entity which has submitted and had approved an application for a grant under this section.

"(c) Payments under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary. Such payments to health maintenance organizations or other entities may be used only for internships, and payments under this section with respect to any internship shall be limited to such amounts as the Secretary finds necessary to cover the

cost incurred by the health maintenance organization under this section.

"(d) Payments to individuals receiving training under this section shall not exceed the sum of $2,000 per month per individual, excluding relocation costs, nor shall the term of such payments exceed twelve months.

"(e) There are authorized to be appropriated for the purposes of this section $2,000,000 for the fiscal year ending September 30, 1979, $2,000,000 for the fiscal year ending September 30, 1980, $3,000,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, and $4,000,000 for the fiscal year ending September 30, 1983.".

FINANCIAL DISCLOSURE

SEC. 10. Title XIII as amended by this Act is further amended by adding at the end thereof the following new section:

"FINANCIAL DISCLOSURE

"SEC. 1318. (a) Each health maintenance organization shall file annually with the Secretary financial information in such form as the Secretary may require (which in the case of an organization which is related to the health maintenance organization by common ownership or control, shall be a consolidated financial statement), which shall include:

"(1) such information as the Secretary may re-

quire demonstrating that the health maintenance organization has a fiscally sound operation;

"(2) a description of transactions, as specified by the Secretary, between the health maintenance organization and a party in interest which transactions may have an adverse effect on the fiscal soundness of and reasonableness of charges to the health maintenance organization. Such transactions shall include—

"(A) any sale or exchange, or leasing of any property between the health maintenance organization and a party in interest; and

"(B) any furnishing of goods, services (including management services), or facilities between the health maintenance organization and a party in interest;

which may have such adverse effect.

"(b) For the purposes of this section the term 'party in interest' means, as to the health maintenance organization, any director, officer, or employee of the health maintenance organization who—

"(1) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity which transacts business with the health maintenance organization; or

"(2) is the owner (in whole or in part) of an in-

terest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity which transacts business with the health maintenance organization, or any of the property or assets thereof; or

"(3) is an officer or director of the entity which transacts business with the health maintenance organization, if such entity is organized as a corporation;

"(4) is a partner in the entity which transacts business with the health maintenance organization, if such entity is organized as a partnership; or

"(5) is an incorporator or a corporate member of a voluntary, not-for-profit health maintenance organization.

"(c) Each health maintenance organization shall make the contents of the annual statement described in subsection (a) available to its enrollees upon reasonable request.

"(d) The Secretary shall, as he deems necessary, conduct an evaluation of transactions reported to the Secretary under subsection (a) (2) for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of charges to the health maintenance organization with respect to which they transpired. The Secretary shall evaluate the reported transactions of not less than five, or if there are more than twenty health maintenance

organizations reporting such transactions, not less than one-fourth of the health maintenance organizations reporting any such transactions under subsection (a) (2).

"(e) The Secretary shall file an annual report with the Congress on the operation of this section. Such report shall include—

"(1) an enumeration of standards and norms utilized by the Department of Health, Education, and Welfare to make the evaluations required under subsection (d);

"(2) an assessment of the degree of conformity or nonconformity of each health maintenance organization evaluated by the Secretary under subsection (d) with such standards and norms;

"(3) what action, if any, the Secretary considers necessary under section 1312 with respect to health maintenance organizations evaluated under subsection (d).

"(f) Nothing in this section shall be construed to confer upon the Department of Health, Education, and Welfare any authority to approve or disapprove the rates charged by any health maintenance organization.

"(g) Any health maintenance organization failing to file with the Secretary the annual financial statement required in subsection (a) shall be ineligible for any Federal

assistance under title XIII of this Act until such time as such statement is received by the Secretary.".

HEALTH PLANNING AMENDMENTS

SEC. 11. Section 1531(5) is amended to read as follows:

"(5) (A) The term 'institutional health services' means (i) the health services provided through health care facilities as defined in regulations of the Secretary including, but not limited to, private and public hospitals and nursing homes; and (ii) diagnostic or therapeutic equipment, acquired through purchase, rental, lease, or gift, valued at the time of acquisition in excess of $150,000, used in the delivery of health care services by any person, institution, or other entity, except such equipment utilized exclusively, except in unusual circumstances, for patients of a health maintenance organization.

"(B) In determining whether diagnostic or therapeutic equipment has a value in excess of $150,000 for purposes of subparagraph (A), the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.".

PROGRAM ADMINISTRATION

SEC. 12. (a) Subsection (h) of section 1310 is repealed.

(b) Subsection (c) of section 1312 is repealed.

Senator KENNEDY. We have the primary sponsor of the legislation here, one member of our committee who has taken such a great interest and leadership, my colleague and ranking Republican member, the Senator from Pennsylvania.

OPENING STATEMENT OF SENATOR SCHWEIKER

Senator SCHWEIKER. Thank you, Mr. Chairman.

As these hearings on health maintenance organizations open today, this subcommittee may be justifiably proud of its accomplishments, as well as sobered by the task ahead.

Five years ago, under the leadership of our distinguished chairman, this subcommittee committed itself to a relatively new idea—a prepaid health delivery reform of enormous potential. And now—at last—we can see the beginnings of real success.

Today our hearings will focus on legislation, introduced by Senator Kennedy and myself with the support of nine cosponsors, which will transform the HMO program from a temporary demonstration project to a permanent health care reform. HMO's have now had time to prove their cost-saving abilities. We know that HMO's can achieve overall cost savings of from 10 to 40 percent.

According to new HMO census, inpatient hospital utilization under health maintenance organizations is only 488 days per 1,000 per year—compared to a national average of over 900 days under the traditional fee-for-service system. Physician visits under HMO's are 3.8 per member per year, compared to 5.1 visits under fee-for-service. The more information we get on HMO performance, the more we know about their cost-saving potential.

Since the enactment of the original act, Federal HMO policy has been confusing and often ineffective. Years of neglect by the executive branch, combined with overly restrictive provisions of the law and regulations, tested our dedication and demanded new energies. The Health Maintenance Organization Act of 1973 was designed to encourage the development of HMO's through Federal grants and loans, and through a number of devices to help HMO's compete with more traditional health systems in the health insurance marketplace. However, it became apparent that the 1973 act contained too many restrictions which kept HMO's from being financially viable. A long implementation process, regulations that made the original law unworkable and years of inattention by the Department of Health, Education, and Welfare, all kept the HMO movement from getting off the ground as it should have. But thanks to the perserverance of all who are dedicated to this innovative prepayment concept, a very difficult beginning has become a constructive educational foundation.

I was pleased to introduce and support the 1976 HMO amendments, which went a long way toward freeing health maintenance organizations from excessive Federal requirements and putting them on an equal footing with the fee-for-service system. They also attacked some troubling instances of HMO fraud and abuse by requiring Federal qualification of any HMO receiving medicare or medicaid money. Now, 1 year after the signing of the 1976 HMO

amendments, we have many reasons to be encouraged. However, it is also clear that HMO's will not be able to achieve their true potential under existing law. Only about 6 million Americans now belong to HMO's. There has only been a 5.2-percent increase in HMO enrollment over the past year.

A number of new steps are necessary to encourage HMO development, assure their financial independence, improve the administration of the program by HEW, and insure that HMO's will not be abused by health care profiteers. Through this new legislation, we will seize the opportunity for the meaningful health care reform offered by HMO's and move further to encourage their development.

I am particularly pleased that the administration has committed itself to HMO development. HEW has taken some essential and encouraging steps to improve the Federal program and respond to real needs. The Schweiker-Kennedy bill, as well as the administration's measure, have, to a great extent, been the product of bipartisan cooperation among HMO proponents, as well as HMO critics, in Congress, in the administration, and in the health care industry itself.

New legislation is vital to correct past mistakes, overcome present difficulties, and create a climate for future HMO growth. Equally important is an administration willing to promote the HMO concept and at the same time conduct adequate monitoring to insure compliance with the Federal law.

I look forward to the constructive comments of our witnesses today. I hope they will address themselves to how both the legislative and the administrative framework of the program can be improved, so that this important program can reach its full potential.

Thank you very much.

Senator KENNEDY. Thank you very much, Senator Schweiker.

Our first witness is Gregory J. Ahart, Director, Human Resources Division, General Accounting Office.

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT V. FARABAUGH, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; THOMAS J. SCHULZ, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; AND IRA A. SPEARS, ATLANTA REGIONAL OFFICE, GENERAL ACCOUNTING OFFICE

Mr. AHART. We are pleased to be here to discuss our current review of the program, and we also have a few comments to make on the HMO amendments which are before this committee embodied in S. 2534.

The HMO Act of 1973 provided for a trial Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMO's.

The original act spells out in considerable detail, the definition of and requirements for an HMO. Among other things, the act speci-

fied basic and supplemental health services to be provided to the HMO members, the basis for fixing the rate of prepayment, the requirement that HMO's have open enrollment periods for individual members without restrictions—such as on preexisting medical conditions—and the organizational structure of an HMO. The original act authorized a 5-year demonstration program designed to promote the development of new HMO's and the expansion of existing HMO's by:

Providing financial assistance through grants, contracts, and loans;

Providing a market for HMO's by requiring certain employers to offer employees the option of joining a qualified HMO—dual choice—and

Removing restrictive State laws and practices which could serve to hinder the development and operation of a qualified HMO.

The Health Maintenance Organization amendments of 1976 (90 Stat. 1945) increased the flexibility of HMO's qualified under the act with regard to basic and supplemental health services, options for staffing and organization, and waivers and delays of imposing open enrollment and community rating requirements. These amendments also increased the funding limits for the grant program and extended the period for use of loan funds to cover operating cost deficits from 36 to 60 months.

The act also places specific evaluation requirements on GAO. Section 1314 of the HMO Act directs GAO to:

Evaluate HMO's in regard to their ability to provide prescribed health services; meet organizational and operational requirements; enroll as members the indigent, the high risk, and the medically underserved; and operate without continued Federal assistance;

Report on the effects of requiring certain employers to offer the option of enrolling in a qualified HMO; and

Evaluate and compare HMO's with other forms of health care delivery.

The act, as amended in 1976, stipulated that we evaluate at least 10 or one-half—whichever is greater—of the HMO's federally qualified by December 31, 1976. At that time 27 HMO's were so qualified by HEW, and we are reviewing the activities of 14 of these HMO's. A report on our review is to be issued to the Congress by June 30, 1978.

PROGRESS IN IMPLEMENTING THE ACT

Through December 31, 1977, HEW had awarded $131.3 million in grant and loan assistance under the act to 172 organizations—$61.7 million in grants and $69.6 million in loans. Two additional organizations have received loan guarantees for $2.2 million. Twenty-four of these organizations also received a total of $7.5 million to develop HMO's under other sections of the Public Health Service Act prior to the passage of the HMO Act. HEW considers 94 of the 174 organizations to be active grantees or active loan recipients. None of the HMO's have defaulted on Federal loans or loan guarantees. There were 80 inactive grantee organizations, which had obtained grants totaling $8.5 million. These latter organizations were either defunct or had obtained non-Federal financial support.

As of December 31, 1977, there were 51 federally qualified HMO's. Thirty-nine received more than $97 million under this act, and two received loan guarantees. We can submit for the record a listing of the allocation of the grant funds for feasibility studies and planning and initial development activities, and loans for operational assistance.

[The following was supplied for the record:]

QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS RECEIVING FEDERAL

GRANTS AND/OR LOANS THROUGH DECEMBER 31, 1977

Region	Organization	Section 304 and 314(e) and RHP 910(c) of the Public Health Service Act	Health Maintenance Organization Act of 1973			Approved loan assistance	Total assistanc (note a)
			Feasibility grant	Planning grant	Initial development grant		
I	Connecticut Family Health Care Bridgeport, Conn.	$ 382,384	$ -	$ 103,492	$ 967,550	$ 2,500,000	$ 3,953,42
I	Community Health Care Center Plan New Haven, Conn.	-	-	-	362,461	2,090,000	2,452,46
I	Rhode Island Group Health Association, Providence, R.I.	-	50,000	-	1,492,255*	2,500,000	4,042,25
II	Central Essex Health Plan East Orange, N.J.	257,828	-	93,145	951,462	2,178,000	3,480,43
II	Group Health Plan of New Jersey Guttenberg, N.J.	-	45,000	125,000	1,063,145*	2,478,000	3,711,14
II	Health Care Plan of New Jersey Hoorestown, N.J.	-	-	124,995	787,784*	1,771,000	2,683,77
II	Rutgers Community Health Plan New Brunswick, N.J.	-	-	125,000	1,000,000	2,000,000	3,125,00
II	Capital Area Community Health Plan Albany, N.Y.	-	-	315,464*	970,409	1,832,000	3,117,87
II	Genesee Valley Group Health Association, Rochester, N.Y.	546,650	-	-	298,500	2,500,000	3,345,15
II	Manhattan Health Plan, Inc. New York, N.Y.	-	49,876	125,000	999,611	2,500,000	3,674,48
II	Westchester Community Health Plan White Plains, N.Y.	-	-	114,902	1,000,000	2,500,000	3,614,90
III	Georgetown University Community Health Plan, Washington, D.C.	296,223	-	-	884,251	1,982,000	3,162,474
III	Group Health Association Washington, D.C.	-	50,000	-	-	-	50,000
III	Penn Group Health Plan, Inc. Pittsburgh, Pa.	524,105	-	-	602,439	1,000,000	2,126,544
III	Health Maintenance Organization of Pennsylvania, Elkins Park, Pa.	-	42,906	108,235	663,965	2,500,000	3,315,106
III	Health Service Plan of Pennsylvania Philadelphia, Pa.	-	-	-	-	2,213,000	2,213,000
IV	Florida Health Care Plan Daytona Beach, Fla.	443,450	-	-	124,456	2,058,000	2,625,906
IV	Health Care of Louisville Louisville, Ky.	b/ 59,700	-	120,566	894,715*	2,500,000	3,574,981
V	North Communities Health Plan Evanston, Ill.	-	-	-	678,618*	1,250,000	1,728,618
V	Anchor Organization for Health Maintenance Organization Chicago, Ill.	-	34,005	-	704,723	-	738,728
V	Metro Health Plan of Indianapolis Indianapolis, Ind.	-	-	-	-	1,264,000	1,264,000
V	Health Central, Inc. Lansing, Mi.	-	50,000	121,084	1,000,000	2,500,000	3,671,084
V	Group Health Plan of S.E. Michigan Detroit, Mi.	-	-	227,129	996,371	2,500,000	3,723,500
V	SHARE Health Plan St. Paul, Minn.	-	50,000	-	525,000*	850,000	1,425,000
V	Marion Health Foundation Marion, Ohio	216,122	-	-	419,115*	681,000	1,316,237
V	Group Health Cooperative of South Central Wisconsin Madison, Wis.	-	-	250,000	1,000,000	2,500,000	3,750,000
VII	Community Group Health Plan (Prime Health) Kansas City, Mo.	-	-	112,381	1,000,000	2,273,000	3,385,381
VIII	Choice Care Health Services Fort Collins, Colo.	298,600	-	-	280,837*	728,000	1,307,437
VIII	Colorado Health Care Services, Inc. Denver, Colo.	-	-	-	548,417*	1,413,000	1,961,417
VIII	Rocky Mountain Health Maintenance Organization, Grand Junction, Colo.	323,286	-	-	192,937	332,000	848,223
VIII	Family Health Program Salt Lake City, Utah	214,580	-	-	211,716	-	426,296
IX	MaxiCare Hawthorne, Calif.	-	-	169,392*	-	-	169,392
IX	Family Health Services Pamona, Calif.	-	-	-	-	2,500,000	2,500,000
IX	Foundation Health Plan Sacramento, Calif.	312,633	-	-	710,213	2,292,000	3,314,846
IX	Health Alliance of Northern California, San Jose, Calif.	328,330	-	120,486	601,738	2,342,000	3,392,57
X	GEM Health Association Boise, Idaho	-	-	124,634	1,000,000	1,747,000	2,871,63
X	Portland Metro Health Plan Portland, Oregon	284,800	-	-	455,188	2,500,000	3,239,98
X	Cooperative Health Plan of Greater Spokane Spokane, Wash.	-	50,000	122,500	999,980	2,500,000	3,672,48
X	Sound Health Association Tacoma, Wash.	417,407	-	-	306,738	2,500,000	3,222,14
	Total	$4,906,118	$471,787	$2,603,405	$24,492,396	$69,774,000	$107,198,11

a/As of December 31, 1977, 51 health maintenance organizations were federally qualified. Of the 51 qualified, 39 received Federal grant and/or loa assistance as shown in the table. Total grant assistance to qualified projects is $31,424,106.

b/Grant awarded to the University of Kentucky Research Foundation, which used portion of funds to help establish Health Care of Louisville.

* NOTE: Includes expansion grants as follows: 7 projects received feasibility expansion grants totalling $396,533; 2 projects received planning expansion grants totalling $1,244,970; and 3 projects received initial development expansion grants totalling $360,061.

STATUS OF ACTIVE AND INACTIVE HEALTH MAINTENANCE ORGANIZATIONS
AWARDED GRANTS AND/OR LOANS THROUGH DECEMBER 31, 1977

Grantee and loan recipients	Total			Active Grantees			Inactive Grantees		
		Amount			Amount			Amount	
	Number	HMO Act	304/314(e) 910(c)(note a)	Number	HMO Act	304/314(e) 910(c)	Number	HMO Act	304/314(e) 910(c)
Grants only:									
Feasibility	64	$ 3,157,456	$ -	3	$ 172,985	$ -	61	$2,984,471	$ -
Feasibility to planning	28	5,916,998	-	22	4,996,436	-	6	920,562	-
Feasibility to planning to initial development	14	11,716,677	112,375	14	11,716,677	112,375	-	-	-
Feasibility to initial development	1	739,611	-	1	739,611	-	-	-	-
Planning	5	816,435	249,600	1	191,435	-	4	625,000	249,600
Planning to initial development	13	9,108,178	512,818	11	7,335,480	512,818	2	1,772,698	-
Initial development	8	2,635,547	1,809,100	1	355,153	245,384	7	2,280,394	1,563,716
Subtotal	133	$ 34,090,902	$2,683,893	53	$ 25,507,777	$ 870,577	[b]/80	$8,583,125	$1,813,316
Grants and/or loans:									
Feasibility to qualified	1	$ 50,000	$ -	1	$ 50,000	$ -	-	$ -	$ -
Feasibility to initial development to qualified	3	6,205,983	-	3	6,205,983	-	-	-	-
Feasibility to planning to initial development to qualified	5	18,044,302	-	5	18,044,302	-	-	-	-
Planning to qualified	1	169,592	-	1	169,592	-	-	-	-
Planning to initial development to qualified	12	39,645,223	1,028,262	12	39,645,223	1,028,262	-	-	-
Initial development to qualified	14	27,199,888	3,877,856	14	27,199,888	3,877,856	-	-	-
Qualified	3	5,977,000	-	3	5,977,000	-	-	-	-
Subtotal	39	$ 97,291,988	$4,906,118	39	$ 97,291,988	$4,906,118	-	$ -	$ -
Total	172	$131,382,890	$7,590,011	92	$122,799,765	$5,776,695	80	$8,583,125	$1,813,316

[a]/Refers to sections 304 and 314(e) and Regional Medical Program 910(c) of the Public Health Service Act, used to fund health maintenance organization projects prior to passage of the Health Maintenance Organization Act of 1973 (Title XIII, Public Law 93-222). Funds were provided to 24 of the 172 organizations.

[b]/According to HEW program officials, 13 inactive grantees are privately pursuing qualification.

Mr. AHART. Preliminary findings based on our review:

In compliance with the act as amended in 1976, we are reviewing the activities of 14 HMO's which had obtained Federal financial assistance under the HMO Act. Our preliminary findings indicate that each is generally providing health services in the manner required by the act and that each generally has been organized and operated in the manner described by the act. However, important exceptions do exist. The 14 HMO's had not expended extensive effort to enroll elderly, indigent, or medically high-risk people. The lack of enrollment of elderly and indigent persons is attributable mainly to problems which HMO's have encountered in obtaining State and Federal contracts to serve medicaid and medicare recipients. The lack of enrollment of high-risk persons stems mainly from the HMO's desire to avoid high utilizers of medical care which could impair the HMOs' financial soundness and their ability to operate eventually without continued Federal assistance.

In our evaluations of the HMO's financial soundness, we focused on their ability to generate enough revenue to cover operating costs—or break even—within their first 5 years of operation as a qualified HMO. Although an HMO may break even, it must be recognized that breaking even does not automatically mean that an HMO can generate enough surplus revenue to repay its Federal loan and finance future growth. If an HMO cannot repay its Federal loan on schedule, and the Government delays repayment or forgives the loan, the Government in effect is continuing to assist the HMO financially.

One of the HMO's reached its break-even point during the quarter ended December 1977. Our preliminary conclusions about other HMO's are that six have a poor chance of breaking even within 5 years and six have a fair to good chance of breaking even. For the remaining HMO, we have not yet reached a preliminary conclusion. Our doubts about the soundness of some HMO's center around the reasonableness of their cost and revenue projections and their managerial capability.

Senator KENNEDY. Would you develop that point to some greater extent?

I would be interested in both the broad sweep and a more precise sweep.

It seems to me that if we were talking about getting new businesses started, you would have a certain amount of failure rate. We are dealing with new but tested concepts, but we are dealing with it in different locations, different circumstances.

What should we except as a failure rate to know whether the program is still successful basically; and, second, what can you tell us more precisely as to the reasons for it?

Is it poor administration and poor planning?

Is it poor oversight?

Can you give us both strokes?

Mr. AHART. On the first part of your question, Senator, I do not know if we have any particular wisdom as to what would be a failure rate that would be acceptable in this program.

Obviously, there are going to be some failures. My judgment would be based on the 14 we looked at. Six have a chance of failure, and we should be able to do better than that.

With respect to what can be done about it, as pointed out, there are managerial problems. The ones that look like they have a poor chance of breaking even are a problem—even for some of them that look like they will reach the break-even point, there is some question as to whether they will ever get healthy enough to repay Federal loan funds that might be there.

With your permission I would ask Ira Spears to give you in more detail what these cost figures look like, what the projection curves look like, and a better understanding of what we are looking at here.

He has some charts.

Senator KENNEDY. I think you understand the question.

For example, are the people they are dealing with sicker?

It may be inefficient administration, the people may be sick, and what I am interested in is how we are able to try and judge these factors?

Mr. AHART. I do not think that is the case.

Senator KENNEDY. That is what I am interested in, what is the case, to the extent that you can tell us?

Mr. AHART. With respect to people being sicker, many have been unsuccessful for one reason or another, reaching the population which is more high risk, elderly, medicare and medicaid programs, which is generally poor people and generally tend to utilize very high—I do not think that is the problem.

They have problems in marketing their plans. Most of them have been using dual choice provisions quite well. They have not been forcing employers to sign up. They have been using the merits of their plan to convince employers, but marketing is a slow process in some cases, it is a difficult process.

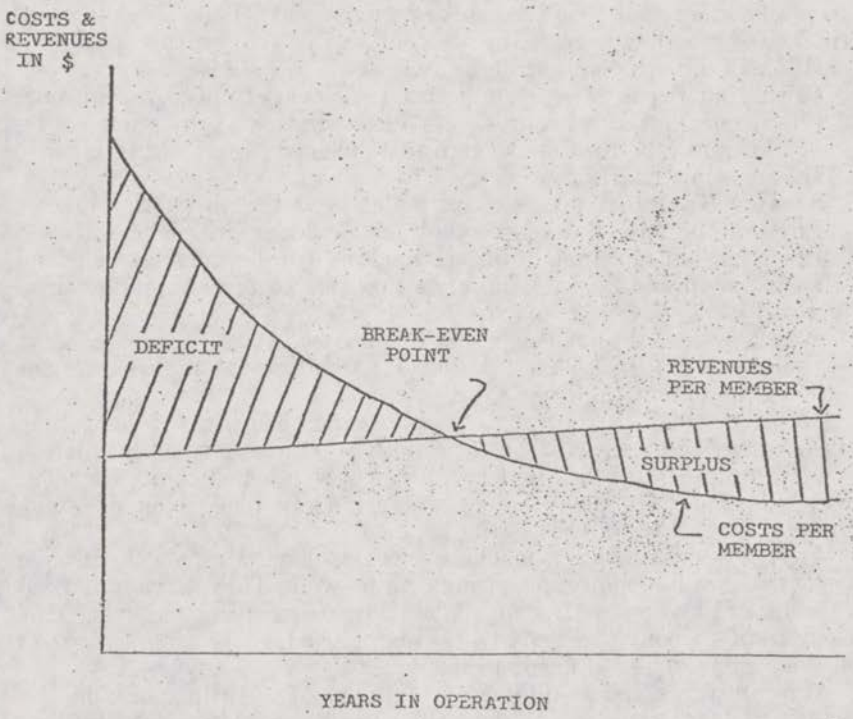
My colleagues here might want to expand a little more on the details of what they found were the specific problems of individual HMO's.

Mr. Spears.

Mr. SPEARS. In talking about broad sweep first, let us talk about the general picture of HMO's that do not seem to have a good chance of breaking even.

[The chart follows:]

PATTERN OF COSTS AND REVENUES PER MEMBER
FOR HMOS WHICH ARE ABLE TO ACHIEVE FINANCIAL INDEPENDENCE



Mr. AHART. The chart here, which is similar to the one in your hands, depicts the general cost and revenue experience of an HMO, which we would expect to see from one that is financially sound.

You can see here that the developing HMO cannot expect its revenues per member to equal its cost per member. If it did this, it would probably be noncompetitive on a cost basis.

But as the HMO expands its operation and moves forward in years of operation and acquires members, its cost per member would gradually decline.

Assuming that the HMO's established an adequate initial price, it could increase its price to offset inflation, and eventually revenue per member would equal cost per member.

That would be the break-even point. Prior to that we have deficit and after that a surplus. After it reaches the break even, the surplus has to be adequate for it to be able to pay the Federal loans, plus it must be able to finance future growth.

As we pointed out, there is one HMO that has reached its break-even point. It reached a break-even point of approximately $30 cost, $30 revenue.

We have noted in our reviews of all the other HMO's that they follow the same general cost curve, their costs are bottoming out at about $30 per member, and for some of them who have been in operation a little bit longer, their cost curves are starting to rise, back up into the thirties and higher.

The HMO which did break even projects that by the end of 1980 its cost curve will be up here close to $40.

Now, the problem that we are finding with other HMO's, that have comparable and greater memberships, and have comparable and greater lengths of time in operation, is that they have a revenue curve which is consistently falling below the cost curve. They have still got a gap between cost and revenue.

Therefore, we believe that they are going to have problems in the future.

Let me give you an example of one, and why we believe it has a poor chance of breaking even.

In 1977 its cost per member per month was $36. It projected that by the end of 1980, 3 years hence, that its cost would have risen to $39 per member, and that would represent an 8-percent cost growth in 3 years.

Now in the 6-month period ending in December of 1977, and that 6-month period alone, its cost had gone up on a permanent basis, 7 percent, or about 14-percent annual rate, and if we project a 5-percent cost increase over the next 3 years, its cost could go from $36 to $42 per member.

If we go to 10 percent, which has been the average increase of national health care costs during the last 4 or 5 years, the cost would go from $36 at the end of 1977 to $48 by the end of 1980. Its actual revenue per member during 1977 was $29. HMO projects that by the end of 1980 its revenues per member will be approximately $42 per member.

That would require a 45-percent increase in the HMO's revenues per member to reach that point.

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If its cost pattern equals this pattern, then it is going to have to go from $29 to $48 by the end of 1980, and that would require a 65-percent increase in the revenues per member per month.

I would like to point out that what this would do would be to get the HMO to its break-even point. It does not address the issues of whether the HMO would be able to repay its Federal loan or to finance future growth.

Senator KENNEDY. It seems to me to be poor management projection on that.

Mr. SPEARS. We did find managerial problems.

We did find problems with financial management and on financial projections.

Senator KENNEDY. I think that argues for one of the aspects of the legislation—management training.

Mr. SCHULZ. We support that.

Mr. AHART. As I mention later in the statement, we are supportive of the provisions of the bill which provide for better management training.

Senator KENNEDY. I think in view of your testimony, and we will continue on through, but first of all we are on this point, and this is an important aspect, as I understand it, from what you are saying, the management and administrative skills in the organization and the administration of this program, and that is an important element of a successful program.

Mr. AHART. That is extremely important.

We think it is also important that HEW have skills in-house to be able to provide technical assistance to these people.

Senator KENNEDY. We will get into that in a little while.

Mr. AHART. Continuing, then, with the statement:

To determine the economic effect of the dual choice requirement we interviewed 247 employers whose business establishments were within the targeted membership area of the 14 HMO's. Most were offering the HMO as a dual choice. The employers contacted reported no significant economic effect from offering the HMO as a health plan option. The employers informed us that the HMO's have not used the dual choice requirement to force them to offer their plans but instead relied on marketing the merits of their plans. We also contacted officials of local labor unions to determine their views toward the HMO Act. The labor union reaction toward HMO's was mixed but mainly favorable.

No commonly accepted standards of techniques exist to evaluate quality of care provided by HMO's. However, it should be noted that HEW has been given the role of assuring the public that a qualified HMO delivers quality health care. HEW has not clearly stated its policy for determining the adequacy of an HMO's quality assurance program. During our study we obtained descriptions of the quality assurance programs of each of the 14 HMO's and noted that the types of quality assurance programs varied. Further, we found that seven had not fully implemented their quality assurance programs.

Senator KENNEDY. Did you draw any conclusion about the adequacy of these quality assurance programs?

Mr. AHART. I do not think we reached any conclusion on our own. Without guidance from HEW as to what should be included and what criteria should be used, we really were not in a very good position to make a judgment on it.

In fulfilling our reporting requirement to the Congress, we also plan to comment on HEW's management of the program, and I will make a few statements regarding this phase of our study.

In our November 1975 testimony before this subcommittee and in our September 1976 report to the Congress, we stated that there were serious concerns about the ability of HEW to effectively implement the HMO Act. We still have some of the same concerns—primarily regarding the ability of the Department to issue regulations and guidelines that are needed to effectively and uniformly implement the act and also the ability of HEW to effectively organize the HMO program and to obtain the numbers and types of personnel needed.

STATUS OF REGULATIONS AND PROGRAM GUIDELINES

Since our prior testimony and our September 1976 report, HEW has made a concerted effort to issue regulations in a timely manner. In June 1977, HEW modified its regulation process by issuing interim regulations. The issuance of interim regulations allows implementation of the HMO Act as amended, prior to resolving all the issues that would have to be covered in final regulations. As of February 1978, the final regulations have not been issued.

HEW's policies and guidance concerning the issues that arise when implementing the act and regulations are to be contained in program guidelines.

Final guidelines concerning the organization and operation of an HMO have not been issued since the passage of the original act. As we reported in September 1976, HEW internally noted the harm to developing HMO's that was caused by the absence of these "rules of the game."

Two examples of issues that need to be addressed in guidelines are open enrollment and community rating. The open enrollment requirement was greatly modified by the 1976 amendments by changing the time period during which the enrollment should occur and when the requirement was applicable.

Secretarial waiver is still permitted. Although HEW informed us that about six HMO's would be required to have open enrollment this year, the Department has not prepared criteria for determining whether to grant an HMO a waiver from this requirement.

The HMO Act also required HMO's to establish premiums based on a community rate rather than on an experience rate. HMO's must establish one community rate to spread equally among all HMO members the costs for comparable coverage. As part of our review of the 14 selected HMO's we obtained descriptions of the different means by which each HMO translates community rating into a rate structure. We were precluded from determining the HMO's compliance with the intent of the act because the Department has not issued its interpretation of how community rating should translate into a rate structure.

Confusion of what exactly constitutes community rating not only applies to those HMO's qualified by HEW, but it also has posed problems for the Civil Service Commission in auditing the rates under the Federal health benefits program. As we noted in a report to the Civil Service Commission on January 23, 1978, we had concerns that the Civil Service Commission had not been able to determine the reasonableness and equity of the premium rates of the community-rated, comprehensive plans which provide services to Federal employees, like the Kaiser plans in California.

ORGANIZATION AND STAFFING

The 1976 amendments legislated a requirement for HEW to centralize all HMO program responsibilities, except for qualification and compliance, under one organizational unit. As stated in the House report on the 1976 amendments the centralization of responsibilities is to include the coordination of the activities of regional office HMO personnel. In December 1977, HEW centralized the headquarters program within the Office of the Assistant Secretary for Health. HEW appointed a director of this centralized program on March 1, 1978. The December 1977 reorganization did not include the regional offices.

HEW does not have the numbers and types of personnel needed to effectively implement the HMO program. As we reported in 1976, few regions employ personnel with needed expertise. Several regional officials told us then that few people with the desired expertise in marketing, actuarial analysis, and financial management and with a broad knowledge of prepaid health plans would work for the Federal Government at the grade levels and salaries offered. This raises questions on the ability of regions, which are the initial contact points for HMO's, to effectively monitor and provide technical assistance. We have been informed that regional staff utilization will be addressed by the new HMO director.

The lack of an adequate number of staff with expertise is also a continuing problem in the headquarters operations of the HMO program. The most publicized result of this problem has been the delays experienced by HMO's in the qualification review process. Not only has this delay had an adverse impact upon the development of HMO's, but also there was an increase in the cost of the Federal program. The investigative staff of the House Appropriations Committee, noted in its recent review of the administration of the HMO program that almost $4 million in additional grant funds were expended by the program for the purpose of sustaining the HMO grant projects until their applications for qualification could be reviewed.

COMMENTS ON S. 2534—INCREASED FINANCIAL ASSISTANCE

I will now address S. 2534. Sections 3, 4 and 7 provide for increased fund authorizations for existing sections of the HMO Act and call for new authority for new types of financial assistance. Under existing law, an HMO can obtain Federal financial assistance totaling $4.65 million, of which $2.5 million is available in the form

of loans or loan guarantees to cover operating deficits. Under S. 2534, the maximum amount of Federal financial assistance would be $10.96 million of which $5 million would be available in the form of loans or loan guarantees to cover operating costs, and $2.5 million would be available in the form of loans or loan guarantees to acquire ambulatory care facilities.

We do not dispute the possibility that the additional financial assistance proposed by S. 2534 could benefit HMO's. However, we have reservations about expanding the loan assistance available to HMO's, because HEW has not demonstrated the ability to effectively administer and monitor the loan program already in effect. As previously mentioned, we believe that some HMO's which have obtained Federal loans under existing authority are not financially sound.

In relation to our concern about HEW's ability to manage the HMO loan program, we found that, as of February 1978, the loan office had no formal uniform loan policy and had only two staff members, a loan officer and a program analyst, to review loan applications and prepare loan award documents. We asked loan officials if they were responsible for monitoring the HMO's financial progress; they said that they relied on the Office of HMO Qualification and Compliance to monitor financial progress.

However, compliance officials told us they do not have enough staff to monitor all qualified HMO's. They characterized the compliance function as a "firefighting" process, allowing little time for advance planning and preparation.

On February 27, 1978, the Senate Appropriations Committee approved a request for 37 new positions during fiscal years 1978–79, raising the present level of authorized positions from 138 to 175. Thirty-six of these new positions were to be allocated to the qualification and compliance functions and none to the loan branch.

Senator SCHWEIKER. How many do you think should go to the loan branch?

Mr. AHART. We cannot give a specific number. With the existing program we do not feel you can run that kind of a program with two people.

With an expanded program authorized by this bill, certainly you would need more than that. I do not know if my colleagues might venture a guess or not.

Mr. SCHULZ. I would not venture a guess.

Senator SCHWEIKER. You think it should be more than none?

Mr. AHART. Certainly more than none.

With respect to financial disclosure, we support section 10 of S. 2534 which deals with financial disclosure because as a result of several reviews by Federal grant programs and the California prepaid health plans we believe there is a need for a clearer picture of the true costs and results of operation—including overall administrative costs and contractual interrelationships—for entities that contract with or receive grants from Federal or Federal/State programs. Further, because of HEW's qualification and continuing regulation responsibilities, such disclosure would also be needed for entities that receive loan and marketing assistance—dual choice—under the act.

During our review, we found several instances of third-party and/or self-dealing relationships which we believe have had or may have an adverse effect on the financial viability of certain HMO's. We are aware that some of these issues have been surfaced for discussion within the Department, but we are not aware of any final policy statement resolving the issues. We believe that this section should clarify the Government's policy toward third-party and self-dealing relationships. Specifically, we believe that the Department should have the authority to impose sanctions, such as dequalification, when it finds that third-party or self-dealing relationships have adversely affected an HMO.

MANAGERIAL TRAINING

Section 9 of S. 2534 provides for an HMO management training program. We believe that there is substantial evidence of the need for managerial training for health maintenance organizations—including training to develop knowledgeable managers in the Federal program.

Mr. Chairman, this concludes our statement. We shall be happy to answer any questions you or other members of the subcommittee may have.

Senator KENNEDY. It is very helpful to this committee as in the past.

We are going to continue to draw on you in the future as well. I think you have developed a lot of expertise in this program.

Let me direct your attention to the provisions which we had in the legislation with regard to community rating and the experience of rating.

I am just wondering, I think the legislation itself as a result of working through the legislative process, has a rather mix in that area.

I do not believe that regulations have been promulgated in those areas or in that area.

I am just wondering whether you drew any conclusions from your review on what the policies were in these various HMO's, any trends that you would notice, and what you might be able to tell us about it?

Mr. AHART. Let me ask Mr. Schulz to respond to that and perhaps Mr. Spears would have some comments as well.

Mr. SCHULZ. What we found was a situation as we conducted our review of the individual 14 HMOs, where we ended up having to describe each system individually. We found very little commonality.

Community rating is one of those things apparently that is hard to describe, but only once you see it, will you know what it means.

In this situation there have been problems trying to interpret how you take the concept of community rating and translate it into a premium that could be competitive, and to what extent there can be differences between how much per month you pay. On community rates, I think most folks think, how much comes out of my paycheck per month, and how much difference is there to the amount you pay on the experience rate. We have not found any departmental guides on that kind of nitty-gritty question.

We have some concerns about how the rate structure is set up, whether it is just individual or family or two-step structure or individual, couple, and this variation.

We have some specific concerns about that.

I could go into that now if you wish, or you can read it in our report.

Senator KENNEDY. Did you draw any conclusions at this time about what is being done in various HMO's to date? I gather from what you say there is no single policy, it is pretty scattered in terms of how their policies are developing on this.

There is no kind of uniform standard. Would it be desirable to have a standard given to different parts of programs; it seems to me it was clear we had established some policy guidelines, legislative guidelines on it.

I am just wondering what you can tell us, what conclusions you draw as to advisability of these provisions, even though they are not being implemented by regulations?

Mr. SCHULZ. I do not think we have to legislate much more. I think it is a situation of the Department needing to have internal guidance as to what the Department should be looking at and have that information available to HMOs when the Department proposes these kinds of things.

Senator KENNEDY. But that is not happening at the present time?

Mr. SCHULZ. The answer is no. What they have had to do is rethink the whole concept of community rating based on revenues rather than costs. Possibly the Department could expand on that some more because it is right in the discussion stage. They have had difficulties implementing community rating and I think they concluded they cannot go any further. They are trying a new tack. You might want to discuss that with them.

Senator KENNEDY. What about the area of open enrollment?

We passed some rather comprehensive provisions on that that were again adjusted down in terms of the conference.

We do have some limited but important provisions for open enrollment to try to balance some of the policy considerations.

What can you tell us about how much open enrollment is taking place and whether those provisions are being implemented? Is it a part of the reasons for the additional financial burden that some of these HMO's are dealing with or what?

Mr. SCHULZ. I think the objection has always been that it is going to create an additional financial burden. Even when it was required under the 1973 amendments, without the kind of liberal waivers you have allowed in the 1976 amendments, the Department just did not do too much of anything. Several HMO's we reviewed asked for waivers of open enrollment, and I guess the silence they received was confirmation. One HMO we reviewed attempted to offer open enrollment and they said it adversely affected them financially.

The 1976 amendments were defined so that HMOs that have been around for awhile, that are stronger in numbers and all of that, will probably be able to withstand any adverse impact of such open enrollment. When we talked to the Department officials a couple of

weeks ago the question was, what are they going to do with the six coming down now?

They have yet to finalize policy as to what they are going to do. Words were said to the effect that it is possible these HMO's can now afford open enrollment. Up to now we have not found any that offer it or have had positive experiences.

Senator KENNEDY. Under the legislation their provisions on it, existence for 5 years, above $50,000, we establish criteria. I do not know how many of those were forwarded in that criteria and should be offered——

Mr. SCHULZ. I think they estimate around six this year.

Senator KENNEDY. None of them are doing it?

Mr. SCHULZ. The question raised is whether or not they should get waivers, I guess the Department should have a position on what it is the Department should have in place to give a waiver—I think the intent was that these were strong enough that they do not need a waiver. They should offer open enrollment.

Senator KENNEDY. Can you tell us what you think of insurance companies starting HMO's?

Should there be guarantees that HMO's are going to be independently managed?

Mr. SCHULZ. Section 10 of this bill has to do with disclosure. It is a question regarding to what extent do you want to have the entity that makes commitment to the public and Government to provide prepaid services, the entity that may borrow money from the Federal Government, the entity that receives grant money from the Federal Government—responsible to the Federal Government.

The question with regard to third party involvement or to what extent does someone who has not any of those commitments to the public or the Federal Government have an opportunity to influence the destiny of this HMO, and create an adverse situation.

We have observed actual situations where there could be adverse effects.

For example, we have situations where insurance or indemnity carriers have their sales representatives go out using dual choice, but not only selling benefits of the plan, but at the same time selling essentially competitive plans.

To some extent that can have adverse effects, and maybe it will not——

Senator KENNEDY. In the kind of example you mention, there are some inherent conflicts.

How can you expect the insurance company on the one hand to have one kind of policy, and then HMO on the other hand, that they are going to have another—well, I would expect there would be inherent conflicts, would there not?

Mr. SCHULZ. I think there would be. We reported in 1975—when we initially looked at the HMO Act—we reported situations where it actually did have a detrimental effect on the HMO. It could be a benefit, too. It could be an entre for an HMO into markets which they could not get before.

It is a kind of thing that possibly, maybe you cannot legislate very tightly, but if you have public disclosure and have notice of

this situation available, maybe they will try and resist the temptation to have this adverse impact.

Senator KENNEDY. What should be our attitude toward the targeted population if these HMO's fail, and say, we in the Federal Government encourage, develop, support, stamp OK—get people in and the thing goes down?

Do we have any responsibility to them?

I suppose that is a broader question. But given your comments about some of the financial problems, I am just wondering.

Mr. AHART. I am not sure what our responsibility would be, Mr. Chairman, in case of a defunct HMO. There are competing organizations out there that could pick up some of the slack. If it is the medicaid population, certainly there are other mechanisms to meet their needs. I do not think we have really given too much thought to that particular issue.

Senator KENNEDY. As you understand, if they get into those HMO's, they give up their group plans, they get it at more favorable rates, and if this goes down, they may have a hell of a tough time getting back into their group and scrambling around.

I do not think you have to ask what other kinds of responsibilities which would be toward those vulnerable groups.

Mr. SCHULZ. The point clearly is that there is an aspect of managing the HMO program, not only just to promote them and develop them, but to be responsible to the kinds of public assurances we are making. So, a little more care about getting them into the pipeline, technical assistance, managerial capacity, monitoring capacity is needed.

Senator KENNEDY. Concerning the self-dealing relationships in terms of the HMO concept, how evident did you find these, your own kind of review?

What are these relationships specifically and how extensive?

Mr. SCHULZ. We did find some.

Mr. Spears here was actually on location directing one of the reviews where we found a primary example of the circumstance.

I think I will have him give you an eye witness account.

Mr. SPEARS. We had one example which from the time the HMO opened its doors, it has been leasing an outpatient health care facility with a capacity which far exceeds resonable expectations of its membership growth during the foreseeable future. In our opinion, this has occurred mainly because of inadequate planning by persons who had no prior experience in HMO management and partially because of self-dealing relationships involving officers of the HMO.

Three persons on the HMO's board of directors are members of a partnership, which is separate from, but exists because of, the HMO. One partner is the HMO's president and medical director. Another partner is the HMO's executive vice president and medical center administrator, and the third partner serves as secretary and treasurer of the HMO and represents it as its general counsel.

In 1973, the partnership leased a tract of land from the partner who is the president of the HMO, and the partnership borrowed about $1.1 million to build a health center large enough to serve about 40,000 members. However, the HMO estimates that its membership at the end of 1981 will be only 20,400.

In mid–1974, the HMO leased the building from the partnership and agreed to pay all costs associated with maintaining the building, including taxes, insurance, maintenance, and principal and interest on the building mortgage. The HMO estimates that these costs will amount to over $200,000 for calendar year 1978.

As of June 30, 1976, the HMO's balance sheet showed that it had furniture and office equipment which had been purchased with Federal grant funds at a cost of about $13,000. All medical equipment and some office equipment used by the HMO had been leased from the partnership; however, neither the HMO nor the partnership could provide to us an equipment inventory listing which segregated equipment purchased with grant funds from the partnership's equipment.

Example 2:

The HMO's organization chart indicates that it is an independent entity which obtains certain services through a contract with Blue Cross-Blue Shield; however the HMO interrelates with BC-BS in several ways.

Board of Directors:

BC and BS elect the HMO's Board of Directors. In addition, 5 of the 25 members on the HMO's 1976 Board were also on either the BC or the BS boards of directors.

Executive Director:

For a period of about 3 weeks in February 1977, BC's president also served as the HMO's executive director. He told GAO that the HMO's board of directors felt that a full-time executive director was no longer needed. Therefore, the board's executive committee recommended his appointment as the HMO's executive director contingent upon a legal determination that there would be no conflict of interest between these two positions.

At its February 1977 meeting, the executive committee apparently recognized that there would be a conflict and promoted the associate executive director of the HMO to executive director. Before coming to the HMO in 1972, he had about 17 years of experience with another Blue Cross organization.

Mr. SCHULZ. These are qualified HMOs that have these relationships, but I think you can see they are not fully in control of their own destinies.

Senator KENNEDY. Well, those can be made a part of the record.

[The following was supplied for the record:]

SELF-DEALING AND/OR THIRD PARTY RELATIONSHIPS

Section 10 of the HMO Act Amendments of 1978 (S. 2534) proposes that HMOs be required to publicly disclose self-dealing relationships which have the potential of adversely affecting HMOs' financial soundness or reasonableness of payments to related organizations. We support this amendment. Six of the HMOs we evaluated have self-dealing and/or third party relationships. Five of the HMOs were tied to insurance companies and one to a partnership composed of HMO officers. Their relationships involved such areas as interlocking directorates, financial assistance, management and marketing services, and facilities and equipment leases. We found no evidence of fraud; however, some of the relationships present the possibility of adverse effects. Several examples of the relationships follow.

Example 1

The HMO's organization chart indicates that the HMO is an independent entity which obtains certain services through a contract with Blue Cross - Blue Shield (BC - BS). The official BC - BS organization chart, however, indicates that the HMO is a co-equal component of the combined HMO/BC - BS organization. We found that the HMO interrelates with BC - BS in several ways.

Board of directors

BC and BS elect the HMO's board of directors. In addition, 5 of the 25 members on the HMO's 1976 board were also on either the BC or the BS boards of directors.

Executive director

For a period of about 3 weeks in February 1977, BC's president, also served as the HMO's executive director. He told GAO that the HMO's board of directors felt that a full-time executive director was no longer needed. Therefore, the board's executive committee recommended his appointment as executive director, contingent upon a legal determination that there would be no conflict of interest between these two positions.

At its February 1977 meeting, the executive committee apparently recognized there would be a conflict and decided to promote the HMO's associate director of the HMO to executive director. Before coming to the HMO in 1972, he had about 17 years experience with another Blue Cross organization.

Services agreement

Most of the HMO's administrative services other than health center administration are provided under a contract with BC - BS. These services include personnel, purchasing, accounts payable, general accounting, data processing, and services related to administering subscriber contracts.

The HMO pays for these services based on an allocation of BC - BS's actual administrative expenses. Although the HMO has the contractual right to audit BC - BS's records, the present and past executive directors told us that it has never exercised this right. The previous executive director told us that he had expressed dissatisfaction with the services provided and the costs allocated to the HMO under this contract.

Marketing

The HMO's executive director told us that, currently BC - BS performs marketing services for the HMO. The HMO's marketing manager coordinates the HMO's sales effort with BC - BS, and he reports to the HMO's executive director. However, he has no authority over the HMO's two full-time marketing representatives, who report to the BC - BS vice-president for marketing. According to the executive director, the marketing representatives market the HMO to new employer groups, while the regular BC - BS marketing staff markets both the HMO and BC - BS to currently enrolled groups. The HMO's former executive director advocated an independent HMO marketing staff because he felt the HMO did not have the element of advocacy and competition was limited.

Example 2

In 1973, the HMO signed a five-year management services agreement with Prudential Insurance Company of America. Prudential manages the HMO on a day-to-day basis and also provides consultant assistance. The HMO's executive director and controller are Prudential employees. For these management services, the HMO pays Prudential 150 percent of the salaries of the Prudential employees and a monthly fee of $1,000. The Prudential has made various consultant services available to the HMO including actuarial, accounting, legal, marketing and loan services. Prudential has loaned the HMO a total of $1.5 million.

Example 3

Three persons on the HMO's board of directors are members of a partnership, which is separate from, but exists because of, the HMO. In addition to being on the board of directors, one partner is the HMO's

president and medical director. Another partner is the HMO's executive vice president and medical center administrator, and the third partner serves as secretary and treasurer of the HMO and represents it as its general counsel.

In 1973 the partnership leased a tract of land from the partner who is the president of the HMO and borrowed about $1.1 million to build a health center large enough to serve about 40,000 members. In mid-1974, the HMO leased the building from the partnership and agreed to pay all costs associated with maintaining the building, including principal and interest on the building mortgage, taxes, insurance, and maintenance. The HMO estimates that these costs will amount to about $225,000 for calendar year 1978.

The HMO applied for Federal qualification 6 months after it leased the health center. In the application, the HMO estimated that it could achieve solency by mid-1978 with a membership of 10,000--about 30,000 members less than the capacity of the health center. The HMO now estimates that by December 1981 it will have about 20,400 members, or almost 20,000 members less than the capacity of the health center. This means that the HMO has been paying for excess capacity since it opened its doors and likely will continue to pay for excess capacity for many years into the future.

As of June 1976, the HMO's balance sheet showed that it had furniture and office equipment which had been purchased with Federal grant funds at a cost of about $12,600. All medical equipment and some office equipment used by the HMO had been leased from the partnership; however, neither the HMO nor the partnership could provide to us an equipment inventory listing which segregated equipment purchased with grant funds from the partnership's equipment.

As a result of this poor control over equipment, about $2,300 of grant-purchased equipment had been mistakenly included in the equipent lease agreement between the HMO and the partnership. The HMO, therefore, had been paying rent on its grant-purchased equipment. To correct the error, the partnership agreed to lease an additional $20,000 of equipment to the HMO at no charge for about 1 year.

Senator KENNEDY. How many HMO's have lost their certification and qualification?

Mr. SCHULZ. None.

They have considered kind of suspension type of activity, but none have been dequalified. I guess that is the jargon as of now.

Senator KENNEDY. Would it not present problems?

I would imagine it would.

But what is your conclusion about dequalifying unless you have some guidelines, or unless you have some specific requirements, I suppose there will be court challenges and the rest, but they are not there.

Can we agree that it would be a lot easier to dequalify if you have criteria and have standards that have failed to be met?

Mr. SCHULZ. That is correct.

They have had problems in even denying qualification. That process has been appealed in several instances, at least two, where the Department has had difficulty in maintaining its case because of the lack of consistency in its handling of it.

It might ask HMO to do ABC to qualify and deny them for E, F, and G, and so there have been some problems with that.

Senator KENNEDY. As one who is very strongly committed to the program and who has been after the administration for years getting the program moving, finally we have an administration that has gone ahead and qualified half of the total HMO's that have ever been qualified in the past year.

Do you have any impression whether the new group is going to run into some of the problems we had in the old? Have you drawn any conclusions about the types of personnel running those programs?

I want to know at least from my own point of view how much heat, pressure, influence we can have in getting more qualified?

Yet we do not want to see the program on shaky grounds because they are moving too fast. What can you tell us in terms of any impressions that you have?

Mr. AHART. Mr. Schulz may have some general impressions.

The 14 we looked at were drawn from those qualified prior to December 31, 1976. I do not know if Mr. Schulz would have any impressions on the quality of those that have been qualified since that time or not.

Tom, would you?

Mr. SCHULZ. Not specifically on HMOs.

I think as in your opening statement, both yours and Senator Schweiker's opening statement, there is much more obvious or vocal commitment to the program and as for the Department—there has been a lot of activity studying the problem, and I think our testimony indicates though there are still a lot of things that need to be done, some of the basic issues raised in 1973 still have yet to be resolved.

But what we are detecting though are real sincere attempts to get at those. There are a lot of promises now. I guess, the same time next year we will see how well they do.

Senator KENNEDY. Senator Schweiker.

Senator SCHWEIKER. Thank you, Mr. Chairman.

In your statement you say that one of the HMO's reached break even point in December of 1977. Six have a poor chance of breaking even within 5 years, and six have a fair to good chance of breaking even.

You cite facts centered around cost and revenue projections and managerial capability.

My question is: Were there any other distinguishing characteristics beyond those items that might be a guide to us in the legislation or administration of the act? Are there any other characteristics that we ought to be looking at or HEW ought to be looking at to use as guidelines in the future?

Mr. AHART. I do not think any directly related to legislation, Senator Schweiker.

The managerial problems at the local level, at the HMO level, are severe in some cases, and if you would like we can discuss those, to give you a feel of what kind of problems we have.

I will ask Mr. Spears who has met with these people and been at local level quite a bit to try to inform you about that.

Senator SCHWEIKER. How can we translate that information into a better compliance program?

That is something that HEW should be sensitive to. How do you translate your information into administering the law in a way that we know what is happening in time to do something about it, rather than wake up some day and find out it's too late.

Mr. SCHULZ. I think I heard most of the question, but basically the activity should start before compliance.

The Departmental program should be involved, when it is providing technical assistance and grant assistance, and reviewing them before qualification.

There should be a situation where those that are assisted by the program, which are the only ones we have looked at—should be solving some of the problems we have noted before becoming qualified.

The other point I think we have stressed continuously is that the kind of people the Department has regarding compliance and some of the other programs, should have the knowledge and capacity to deal with these rather knotty issues that come up. It is not a situation where we want a lot of numbers.

We want the kind of people who really know what is going on in the program. It is not something, I guess, you can legislate.

It is something like the chairman said, that you can ask and push for getting the proper kind of skills in the Department.

Senator SCHWEIKER. In your testimony you also say that the employers contacted reported no significant economic effect from offering HMO's as health plan option.

What do you mean by that?

Mr. AHART. Basically that means they are not paying anymore for their employee health-benefits by using the HMO option.

Senator SCHWEIKER. Are they paying anything else?

Mr. AHART. In their own contracts with the union or the employees, generally they pay up to a certain amount——

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Senator SCHWEIKER. Do you have any rough figures in areas where there is real choice, an effective alternative to fee-for-service, as to what ratio they are taking or not taking the HMO option?

Mr. SCHULZ. No.

The Department has figures indicating comparisons of utilization—hospital utilization rates—to fee for service.

But we have not found any major penetrations in employer groups by the HMO's.

Back to your earlier question, as I heard it, none of the employers I talked to have detected any major significant increase in healthy people, no great reduction in sick leave, most of them say it is too soon to call.

They are not achieving any savings in the costs of, as I see it, sick leave, things like that.

Senator SCHWEIKER. What effect, in your opinion, have the 1976 HMO amendments had in cleaning up PHP abuses in California?

Mr. SCHULZ. I think it is primarily the State of California's activities rather than any Departmental role.

California itself made a significant effort to do that.

There were 43 PHP's at one time, during the period of the scandals. I think it is down to around 13 or 14 right now of which 3 or 4 are now qualified.

I think it was scandals from California which adversely affected the Federal program.

It was a State responsibility. It was the State of California with the authority in the 1976 amendments trying to clean up some of their own problems.

I guess the concern is that the Federal Government does not replicate the problems encountered by the State. I think the 1976 amendments and these ones before you, are attempting especially through that financial disclosure aspect to help the Federal Government from not repeating the problem that California had.

Senator SCHWEIKER. You do touch in your statement on the provisions of section 10 of my bill concerning fraud and abuse protections.

Do I gather from your comments that you think section 10 is adequate to deal with fraud and abuse in the future?

Are there any other suggestions you would make for our bill to deal with fraud and abuse?

Mr. AHART. It certainly is not a total cure to the problem. I do not think you can totally cure the problem through legislation.

Section 10 is a good provision. It should go a long way to make sure we know what is going on, what the financial relationships are, who has financial interests.

For the purpose it is intended to serve, we think that is adequate.

Senator SCHWEIKER. Based on the experience that GAO has had in investigating and appraising a number of health maintenance organizations, do you feel that the Federal HMO program has sufficient promise to warrant continued Federal funding provided that adequate fraud and abuse procedures are put into effect?

Mr. AHART. That is a concept which should be furthered in this country. I think we do need some basic changes in health care delivery systems. I think we need to be concerned a little bit with how

fast we push it and how far we push it and how much of a Federal commitment we want to make to it. If it is a good concept, eventually it should be able to stand on its own feet.

I do not know how long we want to pour Federal money into it. This bill that is before us, would make additional funds available to HMOs.

Until we are very good on the administrative side in evaluating financial feasibility of the HMO's at the front end and knowing we are going to be able to make it or have a good chance of making it—well, I think we might have a danger of difficulties down the road, and I think the administration must get people aboard in HEW who can take a good look at the chances at the front end before we put additional money in. This is going to be extremely important.

Senator SCHWEIKER. Going back to the 14 HMO's that you analyzed, the 6 that were not going to break even in 5 years, what was your conclusion about when they would break even, or was that hard to determine?

Mr. AHART. We looked at the 5-year period. Mr. Spears, do we have any of them that would be very close at that point?

Mr. SPEARS. In looking at the 5 years, we did not do that. We were looking at it in terms of what the law presently allowed. We confined our examinations to that. It is possible that several of them would be approaching a break even point before 5 years, but that is not a certain conclusion.

Senator SCHWEIKER. We thank you all very much for participating.

We will go on with our next witness.

Mr. AHART. Thank you.

Senator SCHWEIKER. Our next witness is the Honorable Hale Champion, Under Secretary, Department of Health, Education, and Welfare.

Senator KENNEDY. I understand Dr. Richmond wants to join Mr. Champion.

I understand you both have time constraints.

STATEMENT OF HON. HALE CHAMPION, UNDER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. JULIUS B. RICHMOND, ASSISTANT SECRETARY FOR HEALTH, DHEW

Mr. CHAMPION. Dr. Richmond has another hearing in 5 minutes.

Dr. RICHMOND. Mr. Chairman, I would like to emphasize in concert with the Under Secretary, Mr. Champion, the deep commitment of this administration to the extension and improvement of the HMO program.

It is rather interesting that the Under Secretary and I have had a long-standing personal interest in this problem going back to looking at one of the first, probably the first, the Elk City, Okla., program that was developed back in the 1930's, and in looking at the Kaiser Permanente development and Health Insurance Plan of Greater New York and major developments.

I think we are both convinced of the importance of health maintenance organizations as alternatives to fee for service health care.

We feel that although these programs historically had a great deal of difficulty acquiring funding and facilities—indeed, encountered a good deal of hostility for many years by health providers, that time should be behind us. Congress is acting, but unfortunately many aspects of the program, as you have already heard this morning, remain to be fully implemented and fully effective.

In just a very few moments available to me, I will concentrate on what I know best, that is the medical side of these programs, the professional organization within the health maintenance organizations, and indicate to you that we intend to take a very critical look at the quality of services developed.

We are appreciative of the fact that you know that the state of the art is not highly developed in this area, and, indeed, I think you have anticipated some of the solutions to the problem by your pressures on us to look at the issues of health technology transfer and assessment.

Certainly, we need to identify better technologies for looking at the assessment quality in these programs.

I anticipate that some of the work that has been done in the past on quality assessment and some of the work that is ongoing, offers great promise in providing a more creative way of looking at quality than we have yet had. I am particularly interested in the work that my colleague at Harvard Medical School, Dr. Rustin, has been doing.

We will continue to pursue the efforts to improve the state of the art as well as to apply what we know about the assurance of quality so that we can have some notion that the people who enroll in these plans will be assured of the highest quality of health care.

I regret, Mr. Chairman, that I do have to go to another hearing and present some testimony.

I will be glad to supply for the record any answers to questions which you feel I may be in a position to answer.

Senator KENNEDY. We know of your strong personal interest as well as the administration's interest, both by the times you have appeared before the committee and from your own history.

As I understand it, you have had six hearings in 5 days.

Senator SCHWEIKER. I would like to ask one quick question.

When you testified before the Labor-HEW Appropriations Subcommittee regarding the 37 positions we discussed here, you did give us a general break-down of those positions, and I am sure you heard this morning the testimony of GAO stating the need for some of these assignments in the loan division.

In view of GAO's testimony that six HMO's may not make it, I wonder whether we ought to look a little more closely at how those 37 positions are assigned, in particular to see whether some should not be placed in that area.

Dr. RICHMOND. I think the Under Secretary and I will be conferring on that. We are very pleased that the new director of the program, Mr. Howard Viet, as of 2 days ago, came aboard, and I think when you and I talked about this at a previous hearing, I indicated that we would await his approval before we made final allocations.

We certainly will take those suggestions.

Senator KENNEDY. Thank you very much, Doctor.

Mr. CHAMPION. Mr. Chairman, Senator Schweiker, I appreciate this opportunity to testify today in perhaps a special way, as Dr. Richmond indicated.

Like his, my relationship to and interest in health maintenance organizations is not new.

As a matter of fact, I wrote a series of articles on the merits of the Kaiser plan in California for the old Progressive Magazine about 25 years ago.

Most of the things that a journalist says 25 years ago are at risk. I do not think they have been in the Kaiser plan. There are a lot of articles I recall with less pride.

For several years I was director of the Harvard Community Health Plan and helped start an internal prepaid health plan with the University itself. Like you, I know they are not some new-fangled, experimental idea. They have served millions well. They should be serving tens of millions.

I am a satisfied customer and undeniable partisan, and regard the long history of opposition to and harassment of health maintenance organizations by much of organized medicine as either a failure of vision or an unwillingness to let the American people make the kind of choice organized medicine has always claimed it wanted for everyone.

Members of this subcommittee have led the way in Congress in trying to give HMO's the equal opportunity they have so long been denied, and I am pleased more than I can say to be permitted to join with you in that effort today.

I am equally pleased to be able to report that the Department of Health, Education, and Welfare, which in recent years has often offered HMO's more problems than solutions, is not only in general agreement with your legislative efforts, but has launched a vigorous administrative campaign of its own to improve the management of the Federal program and to foster an effective HMO movement in the Nation.

Secretary Califano has called a conference of business and labor leaders which will meet here next week to discuss their participation in the movement, and the response has been unprecedented. More than 300 of the Nation's largest firms will be represented by top executives and there has been a comparable response from union leadership.

There is a growing consensus that HMO's offer great promise. The advantages of HMO's were cited recently by the prestigious Labor-Management Group which is chaired by George Meany and Reginald Jones and coordinated by former Labor Secretary John Dunlop. The Washington Business Group on Health urges employers to get involved with HMO's. Even the National Commission on the Cost of Medical Care, sponsored by the American Medical Association, has recommended equal treatment for HMO's. Working with your guidance and assistance, this administration can take advantage of this growing consensus. The 6.5 million now served is only 3 percent of the population. It is only the beginning.

After years of delay and frustration, I think HMO's are on their way to playing a major role in this country, and the pioneering work of this subcommittee has been essential to making that possible.

As we take the next steps, the fact that our proposed HMO legislative amendments are so close to those of your bill, S. 2534, gives us real satisfaction. Clearly, with so much in common, we should have good HMO legislation this year.

I want to pledge to make an equal effort on the part of HEW to provide good administration. We are conscious of the concerns expressed by the General Accounting Office, especially in the area of compliance activity. We have moved to improve our capacity for monitoring and quality assurance. As you have noted, the Congress has just consented to reprograming of $2 million in grant funds, some of which will underwrite 37 new positions for the program.

Almost all of them will be used for either qualification or compliance work, and I might note that, whether it is in the loan office or in the field, those two things ought to work together.

To demonstrate the impact over all, however, our compliance staff is likely to increase from 4 to 24. I have not yet had an opportunity to review in detail the General Accounting Office's assessment of the soundness and prospect of the 14 HMO's that they looked at, but I would like to offer three general observations.

First: I think the cost trends they displayed should be looked at with closer reference to what is happening in the competitive organizations in terms of what capacity they have to raise prices as compared to what is going on in comparable insurance benefit plans.

My experience would indicate those curves are much more devastating in those other plans than they are at least in the kind of stable growing HMO that the Harvard Community Health Plan was, and that the gap in cost between the two was still widening.

Both have sharp upward cost curves, but revenue requirements of the HMO's have been rising less rapidly.

Second: I would like to note that early experiences of most HMO's have never been very encouraging. Their review is difficult for accountants, for people who are looking at the early stages of what has to be in part an entrepreneurial effort.

Again, the one I know best from history is the Harvard Community Health Plan.

It took a lot more risks and a lot more money, about $7 million, as I recall, before it became one of the most successful in the country.

I know of times and can show the books, when GAO standards would have required them to express deep doubt about its survival.

Finally, the fact is, we should expect occasional failure. We should do everything we reasonably can to avoid it, but a program of this kind has to be designed to take some financial risks in the interest not only of great gains in the quality of health care, but in containing the Nation's health costs.

I think it is remarkable we do not have any HMO failures to date despite the nature of the conversation this morning. If we do not have a single failure in the next couple of years, we probably will not be doing the job that Congress has given us to make HMO's a major deliverer of health care in the Nation.

We will have had our real failure if we do not make good quality HMO's available to millions more Americans in the next few years.

We should not stand by and watch a fee for service system have this cost skyrocket out of control at the rate of billions of dollars a year when Federal venture capital of $18 million a year can bring some competition in proven elements of cost control into the health marketplace.

We should try to avoid a $2 million loss in an HMO, no question, but we should try a lot harder to avoid having the old fee for service system waste $2 billion in needless hospitalization costs, that HMO's could have avoided.

Something is wrong with our ability to do more than add or subtract if we do not do that.

Fortunately, this subcommittee has always seen it.

The whole Federal investment in HMO's to date would not begin to cover what we project as a loss of $250 million each month that we do not have hospital cost containment.

I think the total HMO investment of the Federal Government is somewhere between $100 and $150 million in what is now the third largest industry in this Nation.

Senator KENNEDY. Before we leave that point, I agree with everything that you have said. I quite frankly would be remiss if I remained silent, in not suggesting that the administration be a little more aggressive in requesting additional moneys to reflect the rhetoric on this. I am convinced of your own commitment, and I am delighted you are having the conference next year on it.

I think many of us remember the former administration's big conference that they had on HMO's, too, they have done a lot of statements and all of that, and the job was not really done.

I know that you have been fighting for the increase, but when we talk about all of this and the savings that can be done, and if you are also familiar with it in terms of the Harvard Community Health Plan, what we have been able to do with medicaid, particularly, and other savings, increasing this $6.5 million is not being overly generous in terms of getting the program going.

I just think we have to establish some benchmarks, quite frankly, and we will measure it. As pointed out earlier, you have approved as many as have been approved, over the whole length of the program.

We are encouraged by this. That dollar figure is still there. We cannot escape it, not that that in and of itself is the answer.

I just mention that in passing.

Mr. CHAMPION. This was in the GAO testimony. We have had an administrative mess in this program and we need to shape capacity to do more things with more dollars.

I think there will be substantial overtime, if things proceed as they should, that there will be the kind of request that you have in mind.

Senator KENNEDY. I thought I would raise that before Senator Schweiker raised that.

Mr. CHAMPION. I want to add at this point that I do not want to indicate any lack of concern that we make every effort to see that every dollar that we spend in this program is well spent. It should be, and we will try to do that job.

Before I turn to some of the provisions, I want to touch very briefly on some of the things we have already done administratively, some of which I am sure you know about.

We did inherit a program that had been systematically undercut, was poorly organized, and under and inappropriately staffed, and I think inappropriately should be stressed, and chronically slow in issuing regulations and processing qualification applications.

There is no doubt that this incompetence did dampen significant enthusiasm for HMO concept.

Secretary Califano and I hope we have succeeded in the rekindling of enthusiasm and although our reform efforts are not as far along as we would like, I think we have made a solid start.

Perhaps our progress in promoting HMO's outside the Federal program has been our greatest area of success today. We have changed the Department's philosophy and started progressively to promote the concept.

In the program, through the reprograming which Congress assented to, we have significantly increased our capacity to do promotion and to offer technical assistance to those who are not coming into the Federal program.

Our major activity to date, of course, is the conference of which you spoke.

There will be about a thousand labor and business leaders on hand to learn more about HMO's. One of the things about that conference, I think, is that there are going to be people there with successful models of what they have been able to do, something that I think will prove influential among the listeners.

We are honored, Mr. Chairman, and Senator Schweiker, that both of you have agreed to address that group.

We have just brought in new and aggressive leadership. Howard Viet has managed an HMO and most recently was assistant commissioner of Public Health in Massichusetts. He will be given all the support the Secretary and I can provide to make the program a success.

While we are awaiting his arrival, we put a special task force to work to make some preliminary efforts to restore administrative vigor.

Here are some of the specifics.

We reorganized and brought both parts of the operation into one office for his leadership. We reached preliminary decisions on a number of policy issues, some of which were being discussed earlier this morning, and some of which have indeed remained unanswered for more than 4 years.

Several sets of long-delayed regulations will now begin to move as a result, including those on dual choice, what an HMO entity should be, and compliance.

Yesterday we approved a proposed regulation which should improve immeasurably HMO's troubled relationship with the certificate-of-need process.

Our proposal is that HMO application for certificate of need should be based principally on the basis of need of present and anticipated membership of HMO.

Applications to expand service areas are being addressed for the first time. Three have been approved, and we will reach decisions on six more by the end of March.

Expansion of existing capacity, we think, is a very important area.

Senator SCHWEIKER. When you reach a decision on six more, will that pretty well clear up the backlog?

Mr. CHAMPION. Yes, there were nine; we have done three, and we have six more.

We also took steps, as I indicated, to build an effective qualification and compliance program. We have 37 new positions which are targeted in this area.

We have in the meantime detailed 11 HMO professionals from other parts of HEW to the program. The result was that February was our most productive month, ever.

While we have been averaging two determinations per month, in February we qualified four plans, denied one, and issued two notices of intent to deny.

The backlog, while it is still high, has shrunk from a high last summer from 31 to 29 at present. Our goal is to reach a decision on all those pending by May.

I pledge to you we will continue to give this program the highest administrative priority. As we continue to improve HEW's use of existing law, we welcome the chance to work with you to refine the legislation further.

We want to commend you as authors of the sound aggressive policies reflected in Senate bill 2534. We believe that a variety of its provisions help to promote a more favorable environment for HMO expansion.

In our view the key feature of this legislation is the enhanced flexibility it provides. Unnecessary constraints on HMO development are removed through increases in limits on initial development and operating loans, creation of a fund for loans, loan guarantees, construction, acquisition, and renovation of ambulatory facilities, and changes in several other provisions.

Dual choice is strengthened by requiring employers with demonstrated capability to make payroll deductions for HMO benefits.

We are also in substantial agreement regarding financial disclosure to determine ill effects of self-dealing relationships and with provisions which prevent discrimination against HMO's in the certificate-of-need process.

We intend to issue some regulations with respect to making sure that these entities do, in fact, control their own destinies.

Major points of difference in our approaches to achieving these goals are outlined in my statement for the record before you, but the goals are in clear agreement.

We appreciate your introduction of the administration's proposal, Mr. Chairman and Senator Schweiker.

We would ask the subcommittee to consider the merits of additional provisions contained in this bill which would complement the provisions in S. 2534.

Our ability to target funds effectively and increase health care capacity in underserved areas would be helped immeasurably by deletion of the provisions in the current law.

We seek to repeal prohibition against the use of other public health service funds to promote prepaid health services to enrolled populations, and we want to delete the mandatory allocation of a percentage of HMO funds in certain areas.

In combination these provisions would help us put together funding from several different sources, to develop prepaid plans appropriate to local conditions, and to avoid investment in certain free standing HMO's which might be less likely to succeed.

An example of how this enhanced flexibility would be helpful is that in rural underserved areas we would work with local institutions, using community health center funds, National Health Service Corps personnel and other PHS funds in combination with HMO development moneys. Such combinations would offer the best hope of increasing health care capacity in underserved areas.

In addition, Mr. Chairman, I would like to review briefly amendments to the Social Security Act that are included in our HMO proposal.

We hope that you will urge favorable consideration of these proposals.

Most important are provisions that would amend the methods of medicare and medicaid reimbursement for services provided by HMO's in order to promote enrollment of these beneficiaries through a prepaid capitation plan that is consistent with the HMO concept.

In addition, we are proposing a requirement that States offer HMO enrollment to medicaid beneficiaries in areas served by federally qualified HMO's. This dual-choice requirement will complement our other efforts to improve the environment for HMO development.

Finally, our proposal contains an amendment to the titles XVIII and XIX requirements that the enrollment of qualified HMO's seeking medicare or medicaid reimbursement must include at least 50 percent non-Federal beneficiaries. We are asking that the 50-percent requirement be retained, but that an exemption be granted to HMO's sponsored by general-purpose governments, such as county hospitals, or supported by community health center grants. This exemption and general authority to waive the 50-percent requirement, where appropriate, will remove an impediment to HMO development in service areas with particularly large populations of medicare and medicaid beneficiaries. Our strengthened quality control efforts will be more than adequate to insure that the deficiencies in the "medicaid mills" of the past will not recur.

In conclusion, Mr. Chairman, I would like to thank you and Senator Schweiker and other members of the subcommittee. We want to work closely with you in this area, and I think support of this concept deserves all of our best efforts.

You will have ours.

[The prepared statement of Mr. Champion follows:]

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

STATEMENT

BY

HALE CHAMPION

UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

COMMITTEE OF HUMAN RESOURCES

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

UNTED STATES SENATE

FRIDAY, MARCH 3, 1978

Thank you, Mr. Chairman, members of the Subcommittee.

I appreciate this opportunity to testify today perhaps more than you know.

As in your case, my relationship to and interest in health maintenance organizations is not new.

I wrote a series of articles on the merits of the Kaiser plan in California for the old Progressive magazine about 25 years ago. I was for several years a director of the Harvard Community Health Plan and I helped start an internal prepaid health plan with the University itself. Like you, I know they are not some new-fangled, experimental idea. They have served millions well. They should be serving tens of millions.

I am a satisfied customer and undeniable partisan, and I regard the long history of opposition to and harrassment of health maintenance organizations by much of organized medicine as either a failure of vision or an unwillingness to let the American people make the kind of choice organized medicine has always claimed it wanted for everyone.

Members of this Subcommittee have led the way in Congress in trying to give HMOs the equal opportunity they have so long been denied, and I am pleased more than I can say to be permitted to join with you in that effort today.

I am equally pleased to be able to report that the Department of Health, Education, and Welfare, which in recent years has often offered HMOs more problems than solutions,

is not only in general agreement with your legislative efforts, but has launched a vigorous administrative campaign of its own to improve the management of the Federal program and to foster an effective HMO movement in the nation.

Secretary Califano has called a conference of business and labor leaders which will meet here next week to discuss their participation in the movement, and the response has been unprecedented. More than 300 of the nation's largest firms will be represented by top executives and there has been a comparable response from union leadership.

There is a growing consensus that HMOs offer great promise. The advantages of HMOs were cited recently by the prestigious Labor-Management Group which is chaired by George Meany and Reginald Jones and coordinated by former Labor Secretary John Dunlop. The Washington Business Group on Health urges employers to get involved with HMOs. Even the National Commission on the Cost of Medical Care, sponsored by the American Medical Association, has recommended equal treatment for HMOs. Working with your guidance and assistance, this Administration can take advantage of this growing consensus. The 6.5 million now served is only 3% of the population. It is only the beginning.

After years of delay and frustration, I think HMOs are on their way to playing a major role in this country, and the pioneering work of this subcommittee has been essential to making that possible.

As we take the next steps, the fact that our proposed HMO legislative amendments are so close to those of your bill, S. 2535, gives us real satisfaction. Clearly, with so much in common, we should have good HMO legislation this year.

Let me begin this discussion with an explanation of why we feel that HMOs are so important. Then I will describe for you what we have done and plan to do to improve the administration of the Federal HMO program. Finally, in light of these objectives and administrative improvements, I will turn to the specific issues in the legislation.

THE ROLE OF HMOs IN OUR HEALTH STRATEGY

Mr. Chairman, as I travelled around this country as Chairman of HEW's Advisory Committee on National Health Insurance Issues, I watched almost all the members of that committee become firm believers in HMOs. In my opinion, any national health program which this Administration proposes will encourage the development of HMOs and other organized systems of care. And, Secretary Califano and I look forward to working with you, Mr. Chairman, and the members of your Subcommittee, in the very near future on the design and enactment of such a national health plan.

But, we must not stand still while we develop and debate a national health plan. We must do all we can in the interim. The ruinous 14 percent annual increase in health costs, a rate

almost two and a half times that of the rest of the economy, plus the significant proportion of Americans who lack access to high quality, comprehensive health services are problems too serious to await development of an optimal solution.

For this reason, we appreciate the efforts of your Committee in approving our Hospital Cost Containment legislation. We also believe that aggressive promotion of the HMO concept represents yet another critical step in our efforts to design an affordable, high quality health care system. HMOs offer advantages over fee-for-service care because of the economic incentives at work, and the organized arrangement of the delivery system. And the quality of care provided does not suffer. Let me amplify.

HMOs save money. Much of the excessive cost in the American health care system stems from over-utilization of hospitals. Hospital costs comprise 40 percent of total expenditures. HMOs, as demonstrated by the prototypes such as Harvard Community Health Plan, HIP of New York, Kaiser Foundation Health Plan, and others, are capable of meeting this problem. Prepaid group practices based on these models have been shown to reduce hospitalization from 30 to 60 percent. With hospital expenditures of over $45 billion last year, the economic impact of expanded HMO coverage is not difficult to assess. It has been estimated that even a

10 percent reduction in hospitalization last year would have produced an immediate $2 billion savings for American taxpayers and consumers.

The cost containment potential of HMOs has been shown by studies of HMOs serving Medicaid eligibles. For example:

> During 1973, the State of Washington Department of Social and Health Services compared the costs for Medicaid eligibles enrolled in Group Health Cooperative of Puget Sound with those receiving services on a fee-for-service basis. This study showed that enrollment of an average of 4,438 persons per month in GHC saved the State $22,975 per month--a savings of 29.8 percent compared to comparable coverage under fee-for-service.

Another study of Medicaid eligibles enrolled in the Group Health Association in Washington, D. C. showed that:

-- Ambulatory physician encounter rates decreased 15 percent, drug utilization dropped 18 percent, hospital admissions decreased 30 percent, and hospital days declined 32 percent.

-- For the same benefit package annual prepaid per capita costs for 1,000 Medicaid enrollees for 1972, 1973, and 1976 were $282, $232, and $282, respectively, compared to Medicaid fee-for-service

per capita costs of $373, $435, and $465 over the same period.

Similar costs savings have been demonstrated by HMOs serving Medicare beneficiaries:

A study by the Office of Research Statistics of the Social Security Administration compared the experience of persons enrolled in seven group practice, prepayment plans (HMO prototypes) with control groups in the same geographic area, standardized for age and sex differences. This analysis, as reported in Table I, showed that in 5 of the 7 comparisons HMOs saved up to 34 percent over fee-for-service care provided to the control groups.

An impressive 17-year record of cost containment has also been recorded by HMOs serving Federal employees. As reflected in Table II, HMO charges over those 17 years increased at a much lower rate than the Service Benefit or the Indemnity Plan.

Cost savings produced by early prototypes are being replicated in newer, federally qualified HMOs. Utilization data continue to show reductions in the rate of inpatient care which approach the 50 percent level. The average yearly inpatient hospitalization rate for all federally certified HMOs (as of September 30, 1977) was 529 days per 1,000 members (Table III). This compares with a national yearly average of 1,022 days per 1,000 persons.

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HMOs also effect cost savings by introducing competition into the marketplace. A recently published staff report of the Federal Trade Commission shows that where HMOs are present, competing plans increase benefits and the community's hospital utilization decreases.

Many have observed that without health cost inflation, the government would be content to permit business-as-usual in the health market place. Cost containment is clearly a central goal to both public and private sector leaders. However, it would be shortsighted, indeed, if cost control were the only goal of our efforts to redesign the health industry. Moreover, merely focusing on the economic benefits of HMOs fails to recognize the other important contributions they can make to meeting our health objectives.

HMOs provide an invaluable alternative to the pattern of acute, episodic care produced by our fragmented fee-for-service delivery system. Because prepaid practice offers an organized setting with comprehensive services available and appropriate incentives at work, several strengths emerge.

HMOs provide easier access to the appropriate level of care. When the average consumer approaches the current health care system, that person is faced with a bewildering array of providers and a complex set of decisions regarding treatment. That person needs assistance. In the fee-for-service sector, the

consumer turns himself over to his family doctor or else he walks into a clinic, or physician's office, or hospital outpatient department without any real guidance. Sometimes he gets a good result, sometimes he gets what can most charitably be called inappropriate care.

HMOs provide an attractive alternative for dealing with this shortcoming of the present health care system. The HMO enrollee knows precisely where to go to receive the kind of care he needs. Moreover, the HMO provider has few financial incentives to promote unnecessary treatment. Entry into the system is not confusing, and the services are provided with an eye to appropriate utilization.

HMOs also can be helpful as we try to place greater emphasis in this country on preventive medicine. One of the most shocking situations this Administration inherited was the low level of immunization. Nineteen million children under 14 years of age--36 percent-- were inadequately immunized against polio and other childhood diseases. Yet, I fear that these low levels are indicative of a much greater problem, the lack of adequate health services for our children.

HMOs certainly have the organizational capacity to insure that this problem does not exist among their membership. With an enrolled population, HMOs can aggressively pursue an active campaign to provide adequate immunization and health services

coverage for children. Their defined membership base also puts HMOs in a unique position to educate their enrollees about the relationship of lifestyle and health, to detect problem patients at an early stage, to observe emotional problems, and to provide counseling and treatment programs.

In addition to appropriate access and strong preventive services, I believe that HMOs have the organizational capability to provide high quality care. I subscribe to the belief that physicians who practice medicine in the company of other physicians generally do a better job. Interaction among peers is a fundamental strength of HMOs. Thus, physicians can keep abreast of the latest medical procedures and frequently consult with one another on difficult cases.

It is no surprise to me then, that with the single exception of the abortive cut-rate California prepaid health plans (sometimes called PHPs), HMOs have been consistently observed to deliver a standard of care as good or superior to the fee-for-service sectors. The American Medical Association, never a vocal proponent of prepaid group practice, noted in its 1959 Report of the Commission on Medical Cre Plans that its study committee had "uniformly observed care of good quality" in the plans surveyed. Federal HMO qualification now requires the use of quality control mechanisms. Yet, even in advance of this stimulus, a survey published by a Johns Hopkins study

team in 1976 found widespread use of utilization review and medical audits by HMOs and important experiments underway on the development of outcome measures, and quality of care and audit systems for ambulatory care. The collegial support, administrative organization, and economic incentives of the HMO setting have made HMOs a leader in the movement toward increased quality control measures.

Despite this overall evidence that prepaid health plans can and do provide quality care, I think it is clear that the scandal in California with certain prepaid health plans which enrolled only Medicaid patients on a cut-rate basis offers clear evidence of what we need to be alert to avoid. The GAO deserves credit for its reports on these California plans which documented deficiencies in quality controls, rate structures, and procedures for enrollment. disenrollment and grievances; GAO also highlighted abuses in corporate relationships between the prepaid plans and their for-profit affiliates.

It should be remembered, however, that this is a single unhappy episode in the history of HMOs. There have been many more unhappier and even more disreputable episodes in the history of fee-for-service.

All HMO proponents must help insure however that the PHP abuses do not recur. I think that the initial steps in this direction have been taken. Because of strong action by the

Congress and the State of California, the number of such plans serving California's Medicaid eligibles has decreased from 43 to 13. Furthermore, it should be noted that intensive GAO surveillance of Federally qualified HMOs has been helpful in calling attention to HMOs requiring assistance, but no case of financial abuse or underservice comparable to the previous California situation has been discovered. While this evidence that the problem is under control is certainly good news for the HMO movement, the Federal government must be vigilant in its efforts to make sure that quality care is being delivered.

HEW's past performance in this area and in most other aspects of its management of the HMO program has left something to be desired. Let me describe for you the steps which Secretary Califano and I have taken to improve this situation.

ADMINISTRATIVE ACTIONS

As we surveyed opportunities and problems in the early months of this Administration, Secretary Califano and I identified the HMO program as ranking near the top on both scales. No other program held such promise or was in such disarray. We clearly were hurting HMOs as much as we were helping them. Despite the promise of President Nixon in the early 1970's that by 1976 there would be 1,800 prepaid health plans with 40 million enrollees, when we arrived, there were only 6.5 million people in 165 HMOs. We found a program that

had been systematically undercut by previous HEW leadership, was poorly organized, under and inappropriately staffed, and chronically slow in issuing regulations and processing qualification applications. This incompetence had dampened significantly enthusiasm for the HMO concept.

Secretary Califano and I have been successful, we hope, in rekindling that enthusiasm. Through our statements, and an extensive series of consultations, the Department's commitment was communicated. In this period, we also learned more about HEW's problems and decided on the directions in which we should be moving.

At the same time, we launched an extensive search for a knowledgeable and aggressive leader to head our program. We grew impatient with the time we lost in this careful process, but clearly we found the right person in Howard Veit. He has been a manager in an HMO, he has consulted widely and knows the Federal program, and he is an experienced public administrator, having been most recently the Assistant Commissioner of Public Health for the State of Massachusetts. Mr. Veit, I can assure you, will be given all the support he needs to make this program a success.

But, of course, new leadership is only the first step. Much more needs to be done. In advance of Mr. Veit's arrival, we convened a special task force to begin to address some of the worst problems. We have begun to move and move vigorously to bring this program to life.

REORGANIZATION

Perhaps the most obvious problem which we inherited was the organizational split between the Grant and Loan division and the Qualification and Compliance group. This split had helped fragment HEW's HMO program, and had led to internal conflict, confusion, inconsistencies, burdensome paperwork, and excessive delays.

As a first step toward a more coherent and efficient organization, we created the Office of Health Maintenance Organizations in the Office of the Assistant Secretary for Health. This restructuring brings to one locus all the HMO functions. But creating this office is only the beginning. We have already begun to think about other organizational changes, changes which will insure that developing and operational HMOs are measured by the same standards, face similar reporting requirements, and are insured speedy decision making.

RESOLVING UNANSWERED POLICY QUESTIONS

Another demonstration of HEW's fumbling has been its inability to resolve several policy issues critical to creation of a better investment climate. Some of these questions stood unanswered for over four years. As we began to get this program moving, virtually all these unresolved issues have been addressed. Several sets of long delayed regulations will now be written as a result. In a few cases, some additional legislative authority may be necessary to carry out these policies. As you will see, some are already

reflected in your bill and the Administration's proposal. Other extensions of authority may also be requested. We are analyzing those needs right now and we will report to the Committee shortly on the necessity for technical changes in our authorities. Let me discuss the preliminary decisions which we have made.

Implementation of the powerful dual choice provision has suffered from the lack of adequate HEW guidance. A revised regulation will soon be proposed that will lead to more equal treatment of HMOs. The regulation would require that employers have payroll deductions for the HMO where they have the capability, and that employers unbundle benefit packages so that HMOs can compete on an equal footing and not be offered unfairly as an alternative to a full array of health, life, and other employee benefits.

The Federal government has never made a clear statement of policy on the responsibilities of the employer under ERISA (Employee Retirement Income Security Act) in relation to an HMO. This lack of clarity has led some employers to refuse to offer HMOs. We are on the verge of an accord with the Department of Labor on this matter. Our agreement will reduce employers' reporting burdens, and will eliminate unfounded employer fears concerning potential fiduciary responsibilities arising out of the offering of a federally qualified HMO.

Yesterday we approved a proposed regulation which should improve immeasurably HMOs' troubled relationships with the certificate of need process. Our proposal is that an HMO's application for a certificate of need should be judged principally in terms of the needs of the present and anticipated membership of the HMO. Given the frequent difficulties of HMOs in receiving a certificate of need, and the resultant slowing of growth, we feel that this kind of protection is warranted, and long overdue. While we are attempting to accomplish this through regulation, we are including a special criteria provision in our proposed legislation which will strengthen the Secretary's ability to provide special consideration to HMOs. Our proposal also sets forth a set of fair conditions under which an HMO will be expected to use existing facilities, rather than building its own.

Yet another example of HEW's previous inability to be flexible and timely involves nine applications for federally qualified HMOs to expand the areas which they can serve under the dual choice provision. Because there were no guidelines on which to base a decision, no decisions were made. PRUCARE, the Prudential's HMO in Houston, Texas, opened a satellite health center and yet could not get its boundaries redrawn. Some of the applications sat for about a year. This inaction was a direct contradiction of our policy to encourage HMO expansion and growth. But recently, with our special task force in operation, preliminary guidelines were developed and action taken on all nine expansion requests. Three were approved,

and six are providing us more specific information. Our goal is to decide all of them by the end of March. Applications for service area expansions will never experience such delays again.

One of the more damaging HEW failures has been its inability to define the conditions which an HMO must meet to become federally qualified. We believe the resultant uncertainty has been a major impediment to HMO growth. Commercial insurers, the Blues, employers, and other potential HMO sponsors have never been sure whether HEW really welcomed their sponsorship. We want to make it clear at this time that we do welcome their participation and that we consider such participation essential for HMO growth. We intend to remove the uncertainty and to establish and clarify policies which we think will encourage investment in HMOs. While we are interested in increasing private investment in HMOs, I want to assure the Subcommittee that the Administration does intend to construct safeguards necessary to prevent fraud and abuse. We are now establishing HMO policies which we think will strike a proper balance between growth on the one hand and preventing fraud and abuse on the other. We have made a number of preliminary decisions and will soon be proposing regulations to reflect these decisions.

Privately financed HMOs seeking Federal qualification will be required to be organized and operated in a manner that will allow us to determine their financial solvency and to avoid fraud and abuse. For example, we plan to require public

disclosure by HMO board members of their financial interests in the HMO and all the HMO's affiliates. Where there are affiliated organizations contracting with HMOs, we will have the authority to require consolidated financial statements. Both HEW and GAO will have the right to audit HMOs. And, we will work closely with the Anti-Trust Division of the Justice Department and the Federal Trade Commission in instances where anti-competitive behavior is affecting an HMO's ability to market in an area.

Where HMOs receive Federal grants and loans, we plan to take additional steps to assure the Federal investment is adequately protected. We are considering limiting to less than a majority the number of board members with a financial interest in an affiliate, such as an insurance company, which is contracting with the HMO. We also plan to require that business transactions between HMOs and affiliated organizations reflect the fair market value of the goods and services which are exchanged.

We think that these policies on third party relationships and self-dealing will provide the safeguards that we need to manage the HMO program responsibly. At the same time, we think that once they are clearly understood, potential HMO sponsors will find them reasonable and will participate in an accelerated national HMO development program. Our decisions will be reflected in proposed revisions to the Subpart A regulations, which we expect to issue next month.

QUALIFICATION AND COMPLIANCE

HMOs applying for qualification for the dual choice provision have found themselves the victims of inconsistent standards, enormous paperwork requirements, and unconscionable delays. Then, in a complete turnabout, those plans which do clear this indefensible process have been subject to virtually no measurement of their continuing compliance with the law.

We have recently begun to build a vigilant, effective and yet reasonable qualification and compliance program. As we have started this process, our assumption has been that we can protect the Federal interest and the HMO enrollee without constructing requirements that would burden HMOs and hinder growth. Let me discuss the steps that we have recently taken.

We have just been granted permission by the Congress to reprogram $2 million in grant funds. A portion of this money will underwrite 37 new positions for the HMO program. Virtually all of these people will work in the qualification and compliance area, and special preparations are being made to hire the right people quickly.

In the meantime, we have not waited to attack the backlog of qualification applications. Several HMO experts have been brought in from the regions to help, and five people have been detailed from the grant and loan program. The result of these changes has been that February was our most productive month ever, as we qualified four HMOs, denied one, and issued two notices of

intent to deny. Over the past year, an average of two determinations were made per month. From a high of 51 pending applications last summer, the backlog--which is fed by an average of four new applicants a month--has been reduced to 29. Our goal is to deal with each of these plans by the end of May, either qualifying, denying or reaching a mutual decision to delay the decision pending the development of further information.

Our goal is to put an end to these delays, and to build a record of prompt decision-making. We want to reduce the average waiting period from 180 to 90 days, and stop forever the phenomenon of several plans awaiting a decision for more than a year. Our success is predicated on a lowering of the average processing time of a qualification application by at least 25 percent. We also plan to rely not on extensive application requirements, but rather on the measurement of several key variables, and a more productive use of site visits.

We feel strongly that this type of concentrated approach, operating in concert with an effective compliance effort, is the right strategy. We are making progress in measuring the key variables that contribute to an HMO's success or failure. Now in use is a preliminary set of standards, and a study is in process to refine further our ability to evaluate HMOs. The results of this study are due next Fall. In addition, we have begun to use more physicians and site visits in our processes

and this has enhanced our ability to make judgments about the quality of care to be provided.

The underlying philosophy of our compliance effort will be the same as in the qualification process. We will be vigilant and effective in our enforcement of quality standards without creating unnecessary burdens for the HMOs. The crux of our effort will be concentration on key variables, site visits to HMOs with potential problems, and enforcement of the dual choice provision. With the reprogramming approved, 24 people will soon be at work in this area, where there now are only four.

STIMULATING GROWTH OF HMOs

The area where Secretary Califano and I have made the most progress to date is in the revival of interest in HMOs. We have moved HEW from a passive posture of waiting for applicants for grants and loans, to agressive promotion of the HMO concept. Clearly, increasing HMO capacity is the heart of our program.

The grant and loan program is our starting point. We see this money as a catalyst, as venture capital to be used in areas without HMOs, or for groups unable to generate other sources of financing. Thus far, the success rate of HEW projects has been good, and we will strive to maintain that record. However, it is important for all of us to realize that venture capital is risk capital, and that not every HEW financed and qualified

HMO is going to be successful. The success percentage should be very high, but we have to expect some failures. If the Federal government is not going to accept some risk in this HMO development business, then there was no logic to a federal grant and loan program in the first place.

Under any circumstances, however, federal money will comprise but a fraction of what's needed to promote significant HMO growth. Even more important than this financing role is the Federal government's capacity to offer technical assistance and aggressively promote the HMO concept. We have started to act accordingly.

The recently approved re-programming request gave us $900,000 for promotion and $850,000 for technical assistance. This money provides us the capacity to offer technical assistance on more than an episodic basis as we do presently. We want to be as helpful as possible to developing plans and HMOs in trouble.

The money for promotional activities will help us to move aggressively to stimulate delivery system reform. We know that the environment is ripe for this kind of effort. The response to Secretary Califano's HMO Conference, which I mentioned earlier, is instructive. This conference is being held to acquaint business and labor leaders with the potential and the problems of HMOs, to let them hear the ideas of leading Administration and Congressional officials, and to give HEW officials the opportunity to learn what these leaders think needs to be done. We are pleased that you, Mr. Chairman, and Senator Schweiker have agreed to

participate. We have been deluged with requests to attend. George Meany and Charles Pilliod, Chairman of the Goodyear Tire Company, are keynoting the meeting; and more than 300 of the largest corporations in the country will be represented. We expect in excess of 1,000 people to attend. This conference is indicative of the kind of program we have begun to build.

In all, we have begun to turn the corner in the administration of the Federal HMO program. We have a long way to go. But we will fulfill the mandate which Congress has given us.

THE LEGISLATIVE AGENDA

Mr. Chairman, I have taken the time to summarize these administrative initiatives in order to make it clear to the Subcommittee that we are committed to doing our part--to assuring more prompt and aggressive implementation of our current authorities. With this growing record of accomplishment, we now look forward to working with the Congress to improve and extend these authorities in order to create a more favorable environment for HMO development and to insure greater fiscal and quality control. We believe that the reauthorization of the program presents a wonderful opportunity to lay to rest any notions that we are in a "demonstration" phase of the HMO program. The worth of the concept is unquestionable--it has only lacked the strong, long-term commitment that can lead to achievement of this promise.

It is in that spirit that we commend you, Mr. Chairman, and Senators Schweiker, Williams, Pell, Chafee, and Javits for the

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introduction of S. 2534. Almost without exception, the Department supports the policies reflected in this bill. We strongly endorse provisions which promote a flexible and favorable environment for HMO development, including:

-- Section 2, which provides valuable flexibility in the amount of time new HMOs are allowed to meet the 15 percent limitation on direct contracting;

-- Section 3, which provides for necessary increases in the limits on initial development grants and initial operating loans which take account of the inflation that has occurred since the limits were set in 1973;

-- Section 4, which authorizes loans and loan guarantees for construction which can contribute to HMOs' cost-saving potential;

-- Section 5, which eases strict benefit requirements for disaster coverage that have unnecessarily delayed HMO development;

-- Section 6, which requires employers, with a demonstrated capability, to make payroll deductions for HMO health benefits;

-- Section 7, which amends current law to provide important flexibility to the grant program so that federally qualified and operational HMOs can receive development grants for improvement of services; and

-- Section 12, which deletes the requirement that qualification and continuing regulation be administered by the Office of the Assistant Secretary for Health, thus permitting uniform administration of our HMO activities.

Today, Mr. Chairman, you and Senator Schweiker and Senator Ribicoff are introduing the Administration's proposal. We appreciate this introduction and would urge your consideration of three provisions of this bill that differ slightly from those contained in S. 2534, as well as additional provisions which we believe make other needed changes in HMO authorities.

APPROPRIATION AUTHORIZATION

Like S. 2534, the Administration's proposal extends the appropriation authorization for feasibility, planning, and initial development grants. However, our bill calls for an appropriation of $23,910,000 for the fiscal year ending September 30, 1979, and the authorization of such sums as may be necessary for fiscal years ending in 1980 and 1981.

CERTIFICATE OF NEED

Both the Administration's bill and S. 2534 include provisions that amend the certificate of need program in order to promote fair treatment of HMOs. However, there are subtle, but important differences in some of the specifics. Both proposals exempt

HMOs from the certificate of need process as a condition for establishment. This provision puts HMOs on the same footing as fee-for-service clinics, which are not required to have a certificate of need as a condition of operation.

Both Senate and Administration health planning proposals require a certificate of need for the purchase of major medical equipment valued at $150,000 or more. The Senate bill, however, provides HMOs an exemption from this expensive equipment provision. The Administration bill, on the other hand, does not exempt HMOs from this new provision by law. Rather, we add statutorily to the criteria section of the planning law a requirement that planning agencies may consider only those criteria specified by the Secretary in their review of HMO facilities, equipment, and services. Under this authority, the Secretary would, by regulation, provide an exemption for HMOs from the expensive equipment certificate of need review.

We believe this approach provides the flexibility to establish varying criteria, particularly for HMOs that have a major fee-for-service component. In addition, authority would be available to require review should a pattern of unnecessary equipment purchases develop. Finally, this special criteria provision will allow us to firmly establish criteria which will assist in the development of HMO-affiliated hospitals.

FINANCIAL DISCLOSURE

We are in substantial agreement with the provisions of Section 10 regarding financial disclosure of transactions between HMOs and related organizations. Relationships between such organizations are often essential for delivery of comprehensive health services under tight management, but these corporate arrangements can provide opportunities for abuse. We share your view that the best way to reduce undesirable self-dealing without discouraging appropriate corporate relationships is to require open disclosure of all such transactions and to monitor them for abuse. We would prefer, however, to delete from your bill the specific definitions and additional details regarding the annual report to Congress so that the Department will have sufficient flexibility to administer the program in the most effective way.

ADDITIONAL PROVISIONS

Now, Mr. Chairman, I would like to turn to provisions contained in the Administration's bill that are not included in S. 2534. These provisions, like the majority of legislative changes in which we concur, seek to provide additional flexibility in our ability to promote HMO development.

Our bill deletes provisions in the Act which mandate priority investment in HMOs that will take the longest to succeed and will have the highest failure rate. The Act now requires that a specified proportion of funds be directed to rural and medically

underserved areas. To date, 38 or 22.6 percent of the organizations receiving HMO development funds were intended to serve non-metropolitan populations. Three of these have become qualified and 13 projects are still active. Forty-two (25%) of the 168 organizations funded were intended to serve medically underserved populations. Two of these have become qualified and 16 are still active.

While we will continue to encourage HMO development in non-metropolitan areas and the inclusion of medically underserved populations, we believe other programs, such as the National Health Service Corps, Rural Clinics, and the Community Health Center programs are often better suited to these needs or can provide an initial capacity-building in advance of HMO activity. Capacity development in these areas is a major Departmental priority. The Congress may be assured of our commitment to focus HMO efforts on these areas where and when there is a strong basis for successful development and continued operation.

Our ability to target funds effectively and to increase health care capacity in underserved areas would be helped immeasurably by our provision to repeal a prohibition in the Act against the use of other Public Health Service funds to promote prepaid health services to an enrolled population. This provision would permit other federal funds to support the development of HMOs or other prepaid capitation plans where conditions and local preferences warrant.

Finally, Mr. Chairman, I would like to review for you amendments to the Social Security Act that are included in our HMO proposal. We hope that you will urge favorable consideration of these proposals.

Most important are provisions that would amend the methods of Medicare and Medicaid reimbursement for services provided by HMOs in order to promote enrollment of these beneficiaries through a prepaid capitation plan that is consistent with the HMO concept.

In addition, we are proposing a requirement that States offer HMO enrollment to Medicaid beneficiaries in areas served by federally qualified HMOs. This dual choice requirement will complement our other efforts to improve the environment for HMO development.

Finally, our proposal contains an amendment to the Titles XVIII and XIX requirements that the enrollment of qualified HMOs seeking Medicare or Medicaid reimbursement must include at least 50 percent non-federal beneficiaries. We are asking that the 50 percent requirement be retained, but that an exemption be granted to HMOs sponsored by general purpose governments, such as county hospitals, or supported by Community Health Center grants. This exemption and general authority to waive the 50 percent requirement where appropriate will remove an impediment to HMO development in service areas with particularly large populations of Medicare and Medicaid beneficiaries. Our strengthened quality control efforts will be more than adequate

to insure that the deficiencies in the "Medicaid Mills" of the past will not recur.

CONCLUSION

In conclusion, Mr. Chairman, I would like to thank you and the members of your Subcommittee for the opportunity to review our progress in building a program that is capable of meeting the Congressional desire to introduce cost-effective, quality-enhancing reform to our health care delivery system. The importance of HMO development is reflected in the unanimity of purpose that is expressed in both Senate and Administrative legislative proposals. It is clear we concur that the HMO concept has come of age--that its contribution to rationalizing the delivery of services in an economical manner merits the long-term commitment of the Federal government.

We in the Administration look forward to working with the Congress to perfect these new authorities, and pledge to administer this program aggressively but also responsibly and in so doing, stimulate HMOs to reach their full potential.

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TABLE I

Average Reimbursement Per Medicare Enrollee:

	1969	1970
Plan 1	$444.92	$507.26
Control group	426.69	489.20
Plan 2	$422.83	$431.05
Control group	391.32	423.20
Plan 3	$355.67	$388.11
Control group	395.39	414.49
Plan 4	$309.72	$331.10
Control group	357.19	405.72
Plan 5	$265.28	$311.61
Control group	394.17	398.18
Plan 6	$214.11	$225.88
Control group	298.08	330.65
Plan 7	$211.30	$196.33
Control group	312.60	295.52

Senator KENNEDY. Thank you very much, Mr. Champion, for a first-rate statement, one with a strong commitment toward HMO's concept.

I think what we would like to be able to try and establish is some benchmarks and some criteria so we know when you are back in another year or two, whether the goals are being achieved or surpassed.

I think this is important. I do not think we have needed them so much in the past, I think we have reached the general conclusion, as you point out, that the program was not administered effectively and did not get the kind of support, so I am hopeful that both your testimony this morning and response to some of these questions—that we can establish some baselines in which we can measure the progress in the program over the future years.

Let me perhaps start off with new personnel.

This was a feature of GAO's comments.

I would like to have some idea as to the nature of the capabilities of these new people that you are bringing on, the extent that they have had experience in financial management, administration, accounting, marketing.

Who are these people? Are they just being transferred from one department to another? Are they bringing to this particular program the kind of special skills which are necessary to address the kinds of problems that have been outlined in the GAO report?

Mr. CHAMPION. On an interim basis we are using consultants with those kinds of skills in order to get at some of the problems immediately.

We also intend to determine which are the best kinds of people, how they should be trained, and what is most significant in terms of technical-assistance capacity.

The President's proposal for civil service reform has our heartfelt agreement, and there are some limitations, but we are trying to design specifications that will bring in those people, not to transfer people in with inappropriate skills and inappropriate backgorund for this kind of work.

As in all kinds of relatively new industries, there is a problem, that HMO's have and we will have it, in developing people and training them. Training provisions are clearly very importnat.

Senator KENNEDY. Can you give us some kind of flow chart in terms of who these new people are; you have indicated you are doing it by contract now for skills that are necessary. I think it would generally be valuable to know who these new people are, their skills, and how they relate to the particular problems you are facing in terms of overviewing the HMO program.

Mr. CHAMPION. Senator, I will provide that.

At the moment I can give you only some anecdotal kinds of things. We have consultants from business schools, and from existing HMO's, who give us 1 day a week. They have the right kind of background and experience.

Those are the people we are trying to use.

Senator KENNEDY. If you can provide who the people are, the skills that they bring to this program, I think that would be helpful to us.

Let me ask, some of the points that have been brought out here this morning have dealt with the quality of the HMO's that have already been approved.

As one who has urged more attention and more rapid consideration of various applications in noting what has been an impressive record in the approval of these HMO's over the period of these last 12 months, are you satisfied that you can screen these applications for basic kinds of integrity and quality at the rate that you have been doing it over any immediate period in the future?

Mr. CHAMPION. Yes, we can.

We are relying heavily on site visits with selected consultant experts to review the data.

We think the previous method of compiling enormous amounts of printed material, which was basically the delay problem, is not the important part of that process.

It is evaluation by real experts on site, and that is what we have been deploying. We have been turning down people instead of leaving them hanging for 1 year or 15 months, when we did not think we had the situation in hand.

Senator KENNEDY. Mr. Champion, we have Congressman Pepper here. He is going to be with us for about 10 minutes.

I know you have got a time problem.

Could we hear him and then we will come back and take maybe 20 minutes with you afterwards?

Mr. CHAMPION. Fine.

Senator KENNEDY. We welcome Congressman Pepper.

I remember our visit with you down in Dade County not long ago with some of your friends and elderly people of this country.

We know what a tireless champion you have been for them and also for good health.

We know you have only 8 or 10 minutes to be with us, and we are glad to hear from you.

Senator SCHWEIKER. We are very glad to have you here. We remember your years of service on this committee.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, SELECT COMMITTEE ON AGING AND SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, U.S. HOUSE OF REPRESENTATIVES

Mr. PEPPER. Thank you very much, Senator, for your kind words.

I was just over at Miami Beach the other day and some people were remembering the vivid testimony that you had from some of the people who were so very poor and the problems they had in meeting the drug costs they had. That was a great hearing.

It is a great honor and privilege to be here with this distinguished committee, because no one in the Congress has provided greater leadership than the members of this committee in the whole field of health.

As Senator Schweiker was kind enough to recall, I was on this committee for 14 years when I was in the Senate and when I first went on the committee, then Senator Hugo Black was the chairman

of it. He went to the Court along about April or May of that year, but beginning in January 1937, he was chairman of the committee and I was a member of the committee.

I was Chairman of the Subcommittee on Wartime Health and Education of this committee from 1943 to 1946. We were the first committee of the Congress to recommend national health security—we called it national health insurance—along about the same time that President Truman recommended it.

Senator KENNEDY. We are building on those strong shoulders that were raised many years ago.

Mr. PEPPER. I was delighted to find out there in the other room Mrs. Whittaker, who is still a member of this staff, and was a member of the staff when I was a member of the committee.

Senator KENNEDY. She is an excellent one, too.

Mr. PEPPER. Mr. Chairman, I thank you and the members of this distinguished committee very much for the privilege of being here with you today.

Those were trying days back there when all of us were trying to do what we are still trying to do in this country—provide adequate and proper medical care for the people of this country.

We have made great strides since those early days, but we all know so much remains to be done.

That is why I am pleased to be here to discuss with you a matter of great mutual interest.

I believe, as you do, that we must make available to all our people a high quality of health care that is economically efficient. And I believe we can achieve this goal, in part, through responsible development of health maintenance organizations.

I commend the distinguished chairman and ranking minority member of this subcommittee and other members of the Human Resources Committee for your farsightedness in proposing S. 2534, the Health Maintenance Organization Act amendments of 1978.

It is a sound bill, and it should receive favorable consideration at the earliest possible time.

On October 27 of last year, I introduced in the House H.R. 9788, legislation to promote the systematic development of HMO's and to enable them to better serve the poor and the elderly people of this country.

I was especially pleased to note that you saw fit to include in your bill a provision similar to my own for establishment of a loan program to help support the construction of ambulatory care facilities. My own bill would also establish a grant program to cover part of the construction costs for facilities for ambulatory services for HMO enrollees who live in medically underserved areas.

I applaud many other provisions of your bill. By extending the authorization periods for feasibility, planning and development grants, and increasing the authorized amounts for grants and loans under the program, we will create a financial climate which makes it possible for developing HMOs to gain sound footing in the medical marketplace.

The provisions you have included in order to avoid any potential for fraud or abuse are commendable. I support these reporting and

disclosure requirements and believe that they will complement our ongoing efforts to discourage any who would take unfair advantage of Federal programs designed to expedite HMO growth.

Strengthened administration of the HMO program within the Department of Health, Education, and Welfare, can only enhance our ability to promote responsible expansion of health maintenance organizations while, at the same time, making it possible for necessary regulatory actions to be carried out in an efficient manner.

Exempting HMOs from the certificate of need process under the Health Planning Act as you propose will further reduce the bureaucratic impediments which hinder development. It is my hope, however, and my belief, that this aspect of the program will be monitored closely to prevent any unintended consequences, and I know the members of this committee are in full agreement that we must take all steps possible to avoid the proliferation and duplication of health resources.

Finally, I was most pleased to note the inclusion in your bill of authorization for a 5-year program to train management personnel who will be involved in HMO administration. Efficient management of prepaid health plans is not an uncomplicated proposition. I strongly endorse this provision, but I urge that the subcommittee make this program available not only to traditional administrative personnel, but also to young physicians who are likely to become involved in HMO management.

I have been pleased to note the similarities between my own bill and S. 2534. It is my understanding that the bill which has been submitted by the administration is very similar to the legislation we have proposed, and I believe the Congress will be receptive to these initiatives.

In addition to the proposals included in your bill, I have proposed two additional steps which I believe would further streamline and enhance HMO qualification and operation. My bill includes a provision for granting non-profit HMO's tax-exempt status to make them eligible for tax-exempt donations and to enable them to attract physicians through the deferred compensation arrangements which are permitted under the Code.

Moreover, I have sought to expand the concept embodied in the current HMO law by providing that Federal law supersede State laws, with the exception af applicable criminal laws, general laws of incorporation, and building codes. I hope that the subcommittee will consider including these provisions in the bill you report.

Finally, Mr. Chairman, I know you share my concern that HMO enrollment be widely available to all Americans. The most tragic victims of our health care crisis are those who have no health insurance or only very little coverage. As is so often the case, this means the poor and the elderly. HMOs offer comprehensive and cost-effective medical benefits. We can and must assure the elderly and the poor of unfettered access to them.

Provisions included in my bill, H.R. 9788, would address this issue. First, current law requires that at least one-half of HMO membership be nonmedicare or medicaid. This denies HMO membership to many medicare eligibles and may well impede HMO

growth in areas which are heavily populated by the poor or the elderly. My bill would permit the Secretary of HEW to waive this requirement where an HMO proposes to serve an area where there is a high concentration of elderly or poor citizens and where the HMO could not adequately serve the population of that area under the current requirements.

I would commend that point to your consideration.

Senator KENNEDY. Maybe if you could elaborate on that point very briefly.

I think you have had a lot of experience in this area. It is a very important one. It is one we are going to have to address.

If there is inclusion of elderly people in these programs, the amount that can be retained within the HMO has been very limited by regulation or by legislation and therefore there is little appeal for HMOs to really pursue the elderly because of the range of regulations and paperwork which on the one hand is evident, and then the incentive for them to save on the other hand.

Is that substantially the situation?

Mr. PEPPER. That is basically correct.

Senator KENNEDY. So you want to address that issue.

Of course, the balance is how are we going to use Federal funds as an incentive on this as an alternative delivery system, and how much of an incentive are you going to provide and what we know to date is that we have not provided enough to bring meaningful alternative delivery systems to the elderly. Your recommendation and the one the administration has addresses that particular issue.

Mr. PEPPER. That is right.

Senator, in developing the comprehensive medical care plan for the people of this country, we may approach the matter by steps.

I share the opinion that you have eloquently presented for a long time, of having a comprehensive bill to provide adequate medical care to the people of this country, like national health insurance.

If the administration's timidity about going the whole distance at one time appears with obstacles in the enactment of that kind of legislation, then we have to take more or less of a piecemeal approach, in which it seems to me we can effectively use HMOs. It would seem to me possible that we might allow the Federal Government to pay a reasonable prepaid amount to the HMO—in other words, instead of paying the cost of medical services actually rendered to the elderly and the poor, why, we might simply pay the few dollars a month into the HMO and let them take the responsibility of rendering the service. I think that may possibly develop as a usable part of some sort of comprehensive plan.

Senator KENNEDY. The obvious intention would be the savings you would have as a result of this would be increased benefits to elderly people.

Mr. PEPPER. Right.

Senator KENNEDY. It makes so much sense. But, you know, that is not a good criteria around here. We will ask your continued help on that.

Mr. PEPPER. Second, right to participation in HMOs should be guaranteed for medicaid recipients. At this time, only 13 States con-

tract with HMOs. My legislation would remedy this unfair exclusion of medicaid eligibles by requiring States to offer the option of membership in qualified HMOs with a negotiated prepaid risk contract.

Finally, Mr. Chairman, my bill seeks to bring medicare reimbursement of HMOs into line with prevailing practices by allowing the Secretary to negotiate a prospective per capita reimbursement rate for medicare beneficiaries.

Under my proposal, an HMO would be paid on a prospective basis 95 percent of the cost of rendering the part A and B services in the community. In addition to the obvious 5 percent saving to the Government, the HMO would be required to use its savings to reduce premium rates charged to medicare enrollees or to provide additional benefits, such as expanded home health care, day care, and other services which can help to prevent the institutionalization of older citizens.

This proposal would reward HMOs for their efficiency and, at the same time, allow them to provide a wider range of services to medicare enrollees. It can reduce, to a great extent, the out-of-pocket costs to the medicare member and encourage the enrollment of more medicare beneficiaries.

Both my subcommittee and the full Select Committee on Aging have as the highest priority the expansion of noninstitutional services for care of the elderly.

I do not know about the limits of jurisdiction of this committee, but I know that this committee with its keen and long-proven interest in health care for the elderly is interested in what we are focusing on now in our Aging Committee—that is, home care for the elderly as an alternative to institutionalization. We certainly want to work with this committee as we have been privileged to do in the past in addressing that very critical subject.

Our current medical programs, medicare and medicaid, promote an institutional bias which is both callous and costly. The care a patient receives under medicare is determined less on the basis of need than on the basis of what will be reimbursed. And those services which are reimbursed deny the most pressing need of the vast majority of older citizens—care for chronic illness and health maintenance.

The current medicare program denies coverage for preventive health care. It is in the area of prevention and maintenance that HMOs can provide such enormous assistance to the elderly.

We are all aware of the advantages of HMO enrollment. Through an emphasis on outpatient services, they are able to significantly reduce hospital utilization and channel the savings into broader services. The poor and the elderly of this Nation should be invited to participate fully in the development of an alternative health care delivery system which can reap such great benefits for all our citizens. I hope this subcommittee will strongly urge that they are guaranteed a place in HMO growth and development.

Thank you, again, Mr. Chairman, for allowing me to participate in this hearing. I stand ready to assist you in any way possible in meeting the goals we share.

Senator KENNEDY. I have no further questions, Congressman. I think you have really addressed that issue with regard to our senior citizens.

I know you can talk about a variety of others, but having your judgment on that particular issue and your experience on it I think really helps our record.

I want to thank you very much for taking the time to come.

Mr. PEPPER. Hurry back to Florida.

Senator KENNEDY. Thank you very much.

Mr. PEPPER. Thank you.

Senator KENNEDY. Mr. Champion, if you would return to the witness table, I have just a few questions, and then I would like to submit other questions to you.

Can you tell us what is the attitude of the administration on this for profit HMO?

Do you plan to encourage the creation of such HMOs?

If you do, what are your concerns?

Mr. CHAMPION. Yes, Mr. Chairman.

We think there is a real role here. My conversations with various people in the private sector confirm a real opportunity here. We obviously do not think we should do the same things for profit making plans to the extent that we do them for those plans which are nonprofit.

However, the basic problem is establishing reasonable margins or return as against other investments and giving investors some sense of security coming into this area.

Therefore we believe that they should have loan guarantees, and in some cases where it is necessary, where it clearly is important to get the investment. A similar situation exists with respect to the building of ambulatory facilities. Loans would be provided again where they are necessary.

We are very concerned about not having for profit plans come in with a conflict.

One of the regulations that we will be proposing will make it clear that if anybody we deal with in terms of qualification, has any competitive relationships, they must not be in a controlling position on the board or in the management of the HMO enterprise.

From my own experience, while it was in a nonprofit institution such as Harvard, the opportunities to use staff plans and to perform real services both for employees and for other people in the community even though they are not members—or employees, is substantial.

We think there are a whole mix of profit and nonprofit ways to go about this. We want to encourage it. We certainly want to do as much as possible to have them go forward on their own funds, but we do think on occasion loan guarantees, or some help on a matching basis with free standing ambulatory facilities, would be wise.

Senator KENNEDY. I am just wondering, are we going to be in a situation where there would be loan guarantees for, say, either Prudential to get HMO started or General Motors, Exxon? I think there are some situations in which they should do it.

Mr. CHAMPION. Depending on the population they would propose to serve, and what obligations they make to the community, and to us in terms of serving more than their own interests.

The fact is, an insurance company going with an HMO proposal to the board of directors which is used to looking at projected terms on initial risky investment of 15 percent, looking at a 5 to 7-year development history, probably could stand some assurance in some cases that the Federal guarantee is available to them.

But we never proposed to let them make that kind of money.

Senator KENNEDY. You are going to make some recommendations?

Mr. CHAMPION. Yes.

Senator KENNEDY. Just when?

When can we expect those?

Mr. CHAMPION. I think that follows logically on the development of regulations on third party and self-dealing, those kinds of controls, so that it is clear what we are prohibiting in this area before we have transactions with the for profits.

Senator KENNEDY. You recommend deletion of priorities and set asides in underserved and rural areas.

I suppose the real question is how are we going to get HMO's started if the Federal Government does not place priority on them?

You indicated an elimination of the restrictions in terms of other health services or health resource money. We have seen in the past where that can be extremely dangerous in terms of moneys which are allocated to the neediest and poorest groups being really kind of siphoned off into resources which had been available to other interest groups. That has been true in education, it has been true in the Indian education bill, and others, but nonetheless you do have the deletion of the set asides.

I think, given the issue of the importance of HMO's and the quality of health care, we see from the kind of cross-fertilization idea, communication with an HMO setting, and the savings, the cost savings advantages which HMO have with the expansion of the range of services to the people, given the need for the poorest people, I am just wondering whether we ought to be denying these kinds of opportunities to people who live in inner cities or rural communities?

Mr. CHAMPION. Mr. Chairman, we do not think we should.

I do think what we are trying to say in these proposals is that we want to do that wherever we can, wherever it is feasible, and that we think by relaxing the limitations on the use of other PHS funds, we can develop the kinds of capacities in that area.

Senator KENNEDY. When are these poor going to have to choose between lead paint poisoning, immunization, and HMO? Funds, as you well know, and even under this last budget request, are not ample or generous to the neediest or poorest people in the country, and they are making tough decisions in any event.

I am just wondering whether we are robbing Peter to pay Paul in terms of the switching around of various funds in these areas?

Mr. CHAMPION. Senator, I want to assure you, and this is something I hope the subcommittee will observe very carefully, there is no attempt at diversion at all.

The question is being able to make funds work together in a useful way, that there are times when combining National Health Service Corps people, combining community health centers with HMO development, can bring about an overall better system.

I would be opposed to diverting any money in any health funds now, in the sense of diverting it. Adding them, putting them in a package which provides more services through the use of HMO devices and bringing prepaid groups into the same setting is what we are talking about—not diversion.

I quite agree with you.

Senator KENNEDY. In recommendations that you have for the lifting of those kinds of restrictions, that I think would have to be very, very carefully spelled out, and I think you understand the concerns and I think the real potential danger in this area, at least in some initial reluctance in resistance, maybe it can be worked out in a way to have a centeristic type of effect.

Given the basic kinds of track record on program after program, when you have either a geographical area or populated area that is eligible for certain programs, you permit them to be melted into broader kinds of political subdivisions—I do not find many instances where the poorest or the lowest income people have had salutary effects that you outlined, that would be purpose of your program.

Maybe we can do something different in terms of this.

Mr. CHAMPION. Mr. Chairman, we would like to work with your staff.

I have in mind the Contra Costa situation where they have a county delivery system and where by combining several kinds of funds we can create a very good system.

Senator SCHWEIKER. Mr. Under-Secretary, I must say that I am a little disturbed by some things that were said in the last line of questioning.

In the HEW bill earmarking for rural areas would be required. The National Health Service Corps would emphasize health centers primarily in urban and urban areas which I would have no quarrel with.

What about rural areas in Pennsylvania, a State that has the largest rural population of any State in the country, as well as large urban areas?

I am concerned about the Department policy in this regard and its probable impact on those undeserved areas.

Mr. CHAMPION. Senator, there is not any intention to do anything less than what we can in rural areas. We do have a feeling at this point that more money can effectively be used in capacity building in those areas, rural health centers, things this new clinic bill provides, and other programs of this kind. At that point HMO development becomes much more possible, and tends to be much more successful.

There is the intent, however, to spend more than 20 percent in the rural areas if we can see the opportunity to do so.

The removal of set asides is simply to provide flexibility of judgment, not to in any way decrease the emphasis on the need to improve rural health, which is our greatest problem.

Senator SCHWEIKER. I do not question the Departments motivation. I have heard that argument used often in connection with set-asiding and I appreciate your response.

Mr. Under-Secretary, Senator Kennedy earlier asked some questions about the Department's commitment to the HMO program.

In the past of course, I have very severely criticized Administrations of my own party for the way they were running a number of programs, particularly health programs.

To some extent, Senator Kennedy anticipated my own concern with respect to the HMO program, but not too much because I do expect that you have done very well in these areas.

I think the fact that you have moved to improve the programs' organizational structure, the fact that you are moving ahead on policy questions, the fact that you are committing yourselves to deadlines on the issuance of regulations, and Mr. Viet's appointment, shows good faith motivation on your part.

I commend you for that.

Initially, of course, we had a similar good faith motivation in the Nixon Administration's original HMO proposal; and suddenly it reversed course, evaporated, and died. That is why we may be a little skeptical here this morning.

My point is, first, that we do appreciate the commitment, motivation, and high priority that HEW has given the HMO program.

But we have two concerns: One is that the HEW commitment retains its strength and vitality. The second is that, the signals from GAO as to what can go wrong with this program be responded to through manpower commitments in the areas of compliance, quality assurance, and fraud, and abuse. From what you said, I gather this is one of your concerns, as well.

Mr. CHAMPION. Yes, that is right.

Senator SCHWEIKER. I have one or two additional questions. First, do you anticipate that HEW's new compliance program will be adequate to prevent the kind of abuses, self-dealing, diversion of funds from non-profit HMOs to their for-profit suppliers, marketing abuses, and poor quality of care?

I know your intent is that it will hurt. I would like your practical assessment of the implementation problems.

I just am questioning the practical way of implementing that.

Mr. CHAMPION. Yes, Senator.

I think you are right. It does take more than just hiring more personnel. As a matter of fact, I think I would put somewhat more reliance on the kinds of regulations and the kinds of qualification and monitoring process that we are going to put in place to deal with those problems.

We should not put them into this business in a situation where self-dealing is easily accomplished. It is a process that I would hope from the beginning to avoid that problem.

But more people are required. We do need stronger and more explicit standards and we will provide them.

Senator SCHWEIKER. Under your proposed reorganization, will screening for HMO qualification be loosened as compliance oversight is tightened?

Mr. CHAMPION. Senator, I do not know whether the word loosened is correct. We certainly want to look, give entrepreneurs a chance to do things in their own way. We do not want to impose a simple framework that is the only way you can do anything, or to require only one model.

If the question means, do we intend to look at these in a flexible way, we do, but I do not regard that as loosening. We will have standards in place and will enforce them.

Senator SCHWEIKER. I meant "loosening in" terms of quicker decisionmaking rather than going strictly by the book.

Mr. CHAMPION. Our present goal, Senator, remains to reduce in half the average time for consideration. I see no reason why we cannot achieve that.

We will depend more on site visits and personal investigation and less on tons of paper.

Senator SCHWEIKER. The only other question I had is, in the Administration's HMO bill, which Senator Kennedy and I introduced, by request, you would authorize not specific amounts for the program, but such sums as may be necessary.

Why would you not specify authorization amounts?

Why can we not be more specific on our objectives, goals, and project costs so that we can deal a little more realistically, legislatively, and administratively, with where we are going?

Mr. CHAMPION. We will be glad to discuss that with you. The present Office of Management and Budget policy is for "such sums" but subject to working with committees where they wish to discuss specific authorization levels.

Senator SCHWEIKER. That is interesting.

Our new Congressional budget process takes the opposite approach. We do not allow bills to come to the floor anymore that authorize such sums as may be necessary. That used to be our cop out around here. Now, the new Office of Management and Budget is using it.

I just wanted to raise the point. I appreciate your response.

Thank you very much.

We particularly appreciate the courtesy to Congressman Pepper.

Mr. CHAMPION. Thank you very much, Senator Schweiker.

Senator SCHWEIKER. We now call a panel consisting of Jeffrey Cohelan, executive director, Group Health Association of America, Washington, D.C.; James A. Lane, counsel, Kaiser Foundation Health Plans, Oakland, Calif.; Roger Graham, assistant vice president for health care services, Blue Cross/Blue Shield Association, Chicago, Ill.; Steven Epstein, counsel, American Association of Foundations of Medical Care; Larry Hoffheimer, counsel, American Group Practice Association; and James Anderson, counsel, Connecticut General Life Insurance Company.

Senator KENNEDY. Before Mr. Champion leaves the room, will you give us a report on the reorganization of the HMO office in a year; will you give us exactly, whatever studies exist or plans for documenting the effectiveness of federally funded HMOs in a year?

Mr. CHAMPION. Yes.

Senator KENNEDY. Thank you very much.

STATEMENTS OF JEFFERY COHELAN, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA, WASHINGTON, D.C.; JAMES A. LANE, COUNSEL, KAISER FOUNDATION HEALTH PLANS, OAKLAND, CALIF.; ROGER GRAHAM, ASSISTANT VICE PRESIDENT FOR HEALTH CARE SERVICES, BLUE CROSS/BLUE SHIELD ASSOCIATION, CHICAGO, ILL.; STEVEN EPSTEIN, COUNSEL, AMERICAN ASSOCIATION OF FOUNDATIONS OF MEDICAL CARE; LARRY HOFFHEIMER, COUNSEL, AMERICAN GROUP PRACTICE ASSOCIATION; AND CALVIN JOHNSON, COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA, A PANEL

Mr. COHELAN. I am Jeffery Cohelan.

I am currently executive director of the Group Health Association of America. I am grateful for the opportunity to appear before the committee this morning.

My statement will be short because the specific provisions of the legislation will be covered in detail by the other witnesses here this morning.

We in GHAA enthusiastically support the amendments to the Health Maintenance Organization Act as contained in S. 2534. We do have some specific comments as to the amendments of the National Health Planning and Resources Development Act contained in S. 2534, and these will be covered in the statement by Mr. Lane from the Kaiser Foundation Health Plan.

In December 1976, the HMO amendments of 1976 were signed into law. Those amendments were the result of a long and sometimes arduous deliberation before this committee and were primarily designed to make the 1973 act workable. It had become clear to all of us, early on, that the original law was simply too restrictive to enable HMO's to operate effectively in the marketplace. We are pleased that over 50 HMO's have now been qualified and we are confident of their success.

This confidence is a direct result of the 1976 amendments and, with the administration's renewed HMO effort, we can look forward to a heightened interest in HMO's in the coming months.

But there are growth and development problems which S. 2534 is designed to alleviate by removing many of the obstacles to a rapid and orderly HMO growth. Most of us are familiar with the unfortunate course of the program from its inception. Lack of Federal support, inadequate funding, unrealistic regulation, and general confusion had a dampening effect on what should have been an exiting new endeavor in health care delivery. Thankfully, the administration is moving toward a strong, well-administered program.

According to a 1977 national HMO census survey, a little over 6 million people receive health care from HMO's. However, if the mature prepaid group practice programs which only in the last year converted to qualified status are excluded, then we can safely say that less than 2 percent of the American population receives health care from HMO's. Yet in those areas where HMO's have formed, they are successfully enrolling members and are on target with their

marketing objectives. With continued Federal support, HMO's will be able to expand their memberships, which is essential if HMO's are to achieve a significant impact nationally on health care cost inflation.

S. 2534 is designed to insure growth. It increases funding levels for development. It assures a source of financing for facilities and equipment which will permit sensible planning for future growth. It relieves the problems caused by the shortage of trained personnel through the internship program. It also extends the authorizations for HMO organization and development—putting to rest the concept of a demonstration program—and makes Federal financing available in future years as HMO interest grows.

We are also pleased that the legislation contains provisions which will help insure against fraudulent practices on the part of officials of any HMO that receives Federal funds.

We are grateful to you and Senator Schweiker for initiating this legislation which will give the administration the necessary tools to realize the high hopes we all have for a solid HMO base in this country.

I will be happy to respond to any questions you might have.

Otherwise, we can proceed with Mr. Lane's testimony.

Mr. LANE. My name is Jim Lane.

I am vice president and counsel of Kaiser Foundation Health Plans.

I want to speak on the planning act as it affects HMO development in this country which we think is a very critical issue.

Basically, there is a conflict between two Federal policies, one having to do with HMO promotion and development, and the second having to do with the restriction of capital development in this country in conventional fee-for-service systems.

To this date that conflict has resulted in what we consider serious discrimination toward HMO's. That discrimination takes two phases.

The first is that HMO's are covered under the planning act for their startup and their ambulatory facilities. No fee-for-service provider is so covered for ambulatory or startup.

The second is that as new entrants into the health care arena, there is a definite bias against HMO's as far as their hospital bill is concerned.

Any certificate of need program establishes a right for status quo. It is incumbent upon new entrants to overcome that right regardless of quality of hospitals or facilities.

It is often extremely difficult to overcome. In this regard, both this bill and S. 2410, the bill on planning, make a good start in the direction of overcoming this bias, and we think they do not go far enough.

First, they remove HMO's from the definition of new institutional health service which we think is appropriate.

Second, your bill, S. 2410, requires planners to have HMO's in this plan. In addition, we would like to propose three additional changes.

These are outlined in my formal presentation and amendments you propose. The first is the planning act should be amended to re-

quire State programs and certificate of need laws required under them to cover HMO's to the extent and only to the extent required by Federal law.

What has happened since 1974 is because of Federal requirements over 30 States have enacted certificate of need laws covering HMO's. In your proposal you will remove that requirement, but there will be no requirements for States to remove that coverage.

We feel that in many States where HMO's are relatively weak politically, they will have an extremely difficult time convincing their legislature to remove that requirement.

Should you decide not to do so, and still remove the Federal requirement, then we think you should establish criteria for States to use when they review HMO's, if they continue to do so, because otherwise it will be a free ballgame and States will be able to use any criteria they want.

To date, we have not seen very good or satisfactory review of ambulatory care or startup of new HMO's.

Second, it relates to HMO hospital, and it is our view as a hospital-based program, this is the most effective way to provide HMO services.

There are not many such programs in this country. There are only a few such as the Harvard plan and group health here in Washington that look like they might be able to support hospitals in the near future.

We think they should be able to do so when they get to the size that it is economically feasible.

There are two ways of solving this problem. One, of course, is to exclude HMO hospitals from the provision of the planning act, and the second is to provide specific criteria to review HMO hospital requests.

We have provided examples for that criteria which is on page 7 of my statement.

The third major area of change which is necessary is to bring section 1122 of the Social Security Act, which covers medicare and medicaid payments, and review for capital expenditures into conformity with whatever you do in the planning act.

At the present time, 1122 covers HMO's and recommends it be changed so it not do so.

I will be happy to respond to your questions.

[The prepared statement of Mr. Lane and additional material follows:]

Statement Before the Subcommittee on Health and Scientific Research
of the Committee on Human Resources
United States Senate

Submitted by Kaiser Foundation Health Plan, Inc.

March 3, 1978

Summary of Presentation

This presentation emphasizes the following points:

1) HMOs should be excluded from required certificate of need programs and states should not be permitted to include them under such programs.

2) HMOs should not be subject to greater certificate of need requirements than non-HMO providers.

3) If hospitals providing 75 percent or more of their services to HMO members are covered under the certificate of need program, the construction of such hospitals should be allowed unless it is determined that hospital services are available to HMO members in a cost-effective manner consistent with the HMO's basic method of operation.

4) Any HMO projects that are subject to certificate of need requirements should be judged on the needs of existing and reasonably anticipated new members of the HMO.

5) Health systems agencies should be limited to reviewing and commenting on grants, loans and loan guarantees under the HMO Act.

Statement Before the Subcommittee on Health and Scientific Research
of the Committee on Human Resources
United States Senate

Submitted by Kaiser Foundation Health Plan, Inc.

March 3, 1978

Mr. Chairman and Members of the Committee, I am James A. Lane, Vice President and Counsel of Kaiser Foundation Health Plan.

The Kaiser-Permanente Medical Care Program

The Kaiser-Permanente Medical Care Program is comprised of Kaiser Foundation Health Plan, a nonprofit corporation, Kaiser Foundation Hospitals, a charitable and nonprofit corporation, and six independent Permanente Medical Groups. It is an economically self-sustaining health care system that provides prepaid health care services to more than 3.3 million members in California, Oregon, Washington, Hawaii, Ohio and Colorado. It is a systematically planned and organized approach to the provision of health care that arranges direct health care services for its members in 26 acute general hospitals and 72 outpatient facilities. The Program employees more than 28,000 non-physician personnel. Professional services are provided by more than 3,300 physicians associated with the independent Permanente Medical Groups.

The Kaiser-Permanente Program is the largest group practice prepayment program in the United States. It has succeeded and grown in the face of healthy competition from commercial health insurance, Blue Cross, Blue Shield, self-insured programs, and other HMOs,

despite the opposition of some segments of organized medicine. The Program has pioneered many features, such as comprehensive prepaid services, including prevention and early detection of disease, quality assurance based on peer review, and effective cost control, particularly with regard to expensive hospital services, that Congress has sought to encourage and expand.

Congress intended to encourage development and expansion of group practice prepayment programs when it enacted the Health Maintenance Act of 1973 and the HMO Amendments of 1976. This occurred because such organized health care systems have demonstrated their ability to provide a comprehensive range of prepaid health services to their members at a reasonable cost. They are at the forefront of innovation in health care delivery and have led in providing preventive health services and using health care resources efficiently. Furthermore, the success of group practice prepayment programs has resulted in innovative responses from traditional health care providers, such as the development of Foundations for Medical Care and expansion of the prepaid benefits offered by competing health benefits carriers.

HMOs and P. L. 93-641

Therefore, it is ironic that as far as health maintenance organizations are concerned, P. L. 93-641 could be called the Anti-HMO Act of 1974. This is because the Act's required certificate of need program discriminates against and creates serious problems for HMOs in two ways.

First, HMOs are required to obtain certificates of need for their ambulatory and administrative facilities and equipment while fee-for-service providers are not.

Second, HMO hospitals (hospitals that provide 75 percent or more of their services to HMO members) are covered in the same manner as fee-for-service hospitals. Although this may appear to be a neutral posture toward HMOs, it is, in fact, discriminatory. Certificate of need laws perpetuate the status quo. They protect existing facilities from competition without regard to the need for such facilities, their quality or their cost effectiveness. Discrimination also occurs due to the bias against HMOs of some providers who serve on Health Systems Agency (HSA) boards.

Congress was concerned about this bias and the Act requires State Agencies and HSAs to consider the special needs and circumstances of HMOs for which assistance may be provided under title XIII of the Public Health Service Act (§1532(c)(8)). However, the Department of Health, Education and Welfare has failed to adopt adequate regulations to implement this provision despite clear instructions to do so in the Conference Report on the HMO Amendments of 1976 (pp. 36-37).

Therefore, we have concluded that the most appropriate action to insure that certificate of need programs do not impede development and expansion of HMOs is to exclude HMOs and their facilities, including their hospitals, from required certificate of need programs.

The exclusion also should provide that a state health facilities

planning program may not be approved by HEW if it requires certificates of need for HMOs or their facilities. This is necessary because some states have already included HMOs in their certificate of need programs pursuant to the requirements of P. L. 93-641, and it may be difficult to exclude HMOs from certificate of need laws in some states due to the opposition of those special interests which want to control or stop HMO development.

HMOs and their facilities should be excluded because:

1) There is no reason to impose external constraints upon the development of HMO resources. Unlike the fee-for-service system which certificate of need programs are designed to regulate, HMOs have inherent incentives which result in appropriate development of resources to meet the needs of existing members and reasonably anticipated new members. HMOs have no incentives to have unnecessary facilities or to provide unnecessary services.

2) Mature HMOs have demonstrated their capability to plan appropriately and new HMOs have shown that this capability can be replicated.

3) Hospital-based HMOs have grown at a rapid rate and should be encouraged to continue that growth without changing their essential method of operation. They should not be required to attempt to use unacceptable, inefficient or otherwise undesirable excess resources in the area. Although conceptually attractive, the use of such resources can fragment and distort an HMO's delivery system and can impair

the quality and availability of services to the members of HMOs. HMOs have not been responsible for developing excess resources. They should not be required to use inappropriate facilities and increase the costs for their members.

4) The certificate of need process can cause unreasonable delays and exhaust valuable managerial resources. Even though a certificate of need is granted, it may be after a substantial struggle and considerable delay. This is especially true where there is strong anti-HMO bias.

5) Hospital-based HMOs combine appropriate hospital utilization with increased physician efficiency and thus have lower total costs than non-hospital based HMOs. Being hospital based enables an HMO to develop needed resources in more appropriate ways. This model should be encouraged, not artifically constrained by certificate of need laws.

6) If an HMO is required to use excess resources in an area, there is no guarantee that they will be available to HMO members as long as they need them. A major concern is that hospital based HMOs will be denied permission to build based upon a short-term bed surplus which will disappear because of population growth or an aging population. The resulting shortage of beds will mean that the bed needs of the HMO's members can no longer be met and it will have no alternative resources available and will not be able to construct necessary beds within a time frame that will meet the needs of its members.

7) If a hospital-based HMO is allowed to develop its own hospital in an area where there are excess hospital beds, the cost to the total community will be lower in the long run than if the HMO is not allowed to expand. (See Exhibit I.)

We strongly support the exclusion of HMO hospitals from certificate of need requirements, but the Committee may feel differently; if so, we suggest the following guidelines in making decisions concerning HMOs and certificate of need programs:

1) HMO facilities and equipment should not be covered unless fee-for-service facilities and equipment are covered. To do otherwise is discriminatory.

2) States should not be permitted to include any HMO facilities and equipment which are excluded from Federal certificate of need requirements. Otherwise, because many states have already included HMOs, elimination of the federal requirement may have no effect.

3) The public interest in fostering development of effective organized health care delivery systems requires that projects for HMO facilities and equipment should be judged on the needs of existing and reasonably anticipated new members of the HMO, not on the needs of the community in general. This is especially important for the modernization and replacement of existing HMO hospitals and other facilities. An HMO should not be denied approval to maintain or modernize its hospitals and other facilities simply because there are excess hospital facilities in the area. To do so, would result in disruption of existing

services to HMO members and fragmentation of effective health delivery systems.

4) If HMO hospitals are covered, an HMO should be allowed to build its own hospital unless the State Agency determines that hospital services are available to HMO members in a cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the State Agency should be required to find that:

(a) The services are available in one hospital;

(b) The services are available on a long-term contractual basis commensurate with other long-term committments of the HMO or five years, whichever is longer;

(c) Qualified physicians associated with the HMO will be granted full staff privileges at the hospital; and

(d) The services are available in a manner which is economically and clinically feasible for the HMO.

Anything less than this in the Act will leave HMOs at the mercy of regulation writers and the interpretations and biases of HSAs and State Agencies and will continue the discriminatory aspects of P. L. 93-641.

We support the provision of S. 2410 (in §141) which eliminates HMOs from the definition of institutional health services and the provisions (in §§117 and 118) which require HSAs and State Agencies to prepare specific plans for HMO development and expansion. Each

health system plan and state health plan should contain an HMO element which describes existing HMOs, their membership, facilities and services and their plans for expansion. It should be the goal and high priority of each HSA and State Agency to develop enough HMO capacity so that all persons in the area will have the option to voluntarily join an HMO. Otherwise the objectives of the HMO Act of 1973 can be subverted.

We recommend four additional changes. First, §1513(e) should be amended so that HSAs are limited to review and comment authority over grants, contracts, loans and loan guarantees under the HMO Act, rather than review and approval authority. The implementation of the HMO Act has a high national priority. HSAs should not be permitted to thwart this priority by disapproving HMO development or expansion projects which HEW determines are in the national interest.

Second, the amendment to §1523(a)(4)(B) in §118(b) would require that a project be consistent with the State health plan before it may be approved. However, the State health plan may not cover the subject of the application for a certificate of need. We have experienced this situation a number of times. Therefore, this provision should be changed so that projects may be approved if they are not inconsistent with the plan.

Third, the present Act does not provide for an appeal to the Secretary of HEW by an HMO as does §1122 of the Social Security Act. We believe such an appeal provision should be included in the Planning Act. It is an excellent means of assuring that state

certificate of need laws do not frustrate the national policy to develop and expand health maintenance organizations.

Fourth, §1122 of the Social Security Act should be amended so it is consistent with the certificate of need requirements of the Planning Act.

Attached are amendments to S. 2410 which make the changes we have recommended. They include alternative approaches for HMO hospitals. Alternative A would exclude HMO hospitals from the certificate of need program. Alternative B would include such hospitals and would provide criteria to be used when they are reviewed.

These changes to P. L. 93-641 are essential to the development of new HMOs and rapid expansion of existing HMOs. This is a stated goal of Congress and the Administration. It should not be frustrated by a planning act which is designed to impose rationality upon the fee-for-service delivery system. HMOs already plan rationally because they have internal incentives to do so.

Sound public policy requires that regulatory systems be carefully designed to address specific problems. They should not be applied to organizations which are not creating the problem or in a manner which inhibits organizations which have great potential to assist in solving the problem. Therefore, we conclude that the soundest approach is to exclude HMOs and their facilities and equipment from certificate of need programs and not permit states to cover them.

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Exhibit I

SELECTED USE OF COMPETITION BY HEALTH SYSTEMS AGENCIES

FINAL REPORT

Submitted to:
Bureau of Health Planning and Resources Development
of Health Resources Administration, DHEW
Contract No. HEW-HRA-230-75-0071

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This is especially the case where competition from HMOs and other health plans ensures that individual HMOs maintain close control over their expenditures. The possible exceptions would be where HMO competition does not exist or where external subsidies offset the effect of such expenditures on premiums. However, in general, there is little evidence that there is anything to be saved by implementing controls over HMO outpatient facility construction and equipment purchases, especially in light of the cost of implementing these controls and the risk of limiting the long-term useful effects of HMO competiton.

c. HMO Hospital Construction. We found that several large HMOs have sought to build or purchase their own hospitals when their enrollments reached high levels. Hospital ownership appears to produce significant savings over the continued use of non-HMO facilities and allows HMOs to improve the quality of inpatient care to their members. In addition, hospital ownership ensures that beds are available when needed, that HMO physicians can obtain staff privileges and that HMOs do not indirectly subsidize other health plans. In order to evaluate the desirability of HMO construction of hospitals, we estimate the impact of HMO hospital construction on community costs. We assumed that an HMO's acquisition of its own hospital produced net savings from all sources of 10 percent in average HMO costs. Although there is little evidence on the actual savings available from HMO hospital ownership alone, HMO administrators indicate that a ten percent savings seems attainable. This savings is consistent with the HMO cost comparisons cited in Chapter III. Using this assumption and our HMO cost model, we examined the annual community costs (savings) per

member under two cases: the first, where community beds are not needed; the second, where they are needed. In addition, we examined the impact of alternative HMO enrollments over the likely range of values where hospital construction might be effective. Table II-9 summarizes these results.

Table II-9

Annual Community Costs (Savings) Per Member (In Dollars) Under Alternative Enrollments (In Thousands)

Alternative Bed Requirements	60	80	100	120
No Community Beds Needed				
Group Practice HMO (Base Case)	($21.17)	($24.25)	($26.10)	($27.33)
Group Practice with New Hospital	($ .17)	($ 3.25)	($ 5.10)	($ 6.33)
Community Beds Needed				
Group Practice HMO (Base Case)	($53.27)	($56.35)	($58.20)	($59.43)
Group Practice with New Hospital	($59.77)	($62.85)	($64.70)	($65.93)

We found that where community beds are needed, HMO development and HMO hospital construction both produce substantial savings. HMO hospital ownership clearly enhances the savings made possible by encouraging HMO development. Where beds are not needed, HMO hospital ownership still produces community savings, but is less attractive than the continued use of existing hospitals. The best alternative in this situation is the purchase of an existing hospital by the HMO. Specifically, our analysis suggests that:

- where additional community beds are needed, community costs can be reduced the most by permitting an HMO to purchase or build its own hospital facilities; HMOs can reduce community costs as long as hospital ownership permits HMOs to reduce their hospitalization costs;

- where additional community beds are not needed, community costs can be reduced the most by requiring an HMO to acquire an existing community hospital in lieu of building a new one, if an appropriate existing hospital is available at a reasonable price;

- when existing community hospitals are not suited to HMO needs or unwilling to sell at a reasonable price, community costs are reduced the most by delaying all new construction until additional beds are needed in the area and by giving the HMO first priority on construction when need appears. However, if the HMO, as a result of such delay, is likely to lose enrollment or otherwise not expand its enrollment, then community costs are reduced the most by permitting the HMO to build. In addition, reducing the need for fee-for-service beds by appropriate amounts enhances the savings still further; and,

- where new beds are needed within the next 3-5 years (the lead time for construction of a new hospital), where the HMO has an enrollment in excess of 80 thousand members, and where the HMO has demonstrated an inability to purchase an existing facility under reasonable terms, community costs are reduced the most in the long run by permitting the HMO to build new beds. Community savings in the short run are sufficient to justify the construction of the hospital prior to an explicit need for more community beds.

We did not examine these factors for networks and IPAs because their enrollments typically have not been high enough to justify hospital construction. However, this characteristic may change in the future and may warrant closer examination.

d. Recommendations. Based upon our findings above, we developed recommendations affecting health planners' major activities, including health plan development, project review and health plan implementation. Our findings strongly indicate that HMO development is consistent with the long run health planning priority of cost control even though there may be

a slight increase in costs in the short run. In addition, we could find no basis for concluding that HMOs achieve these reduction at the expense of quality. HSAs concerned about the possibility of lower quality can better address this concern by ensuring that consumers are informed about publicly available measures of quality rather than preventing HMO development. Generally, we recommend that health systems agencies:

- promote HMO development by allowing unrestricted entry of HMOs, encouraging potential sponsors, and eliminating local conditions that inhibit HMO entry; financially viable HMOs will generally reduce long run community costs, and past experience shows that HMOs that are not viable close without adverse impact upon HMO enrollees. Active competition among HMOs appears also to decrease community costs. Hence, HSAs should give a high priority to competitive HMO development in areas where significant community cost savings can be achieved. Such areas can be identified by using local cost and utilization characteristics and expected HMO enrollment projections with the community cost-estimating methodology presented here. The most important point here is for HSAs to understand that HMOs, unlike hospitals, can reduce community costs in the long run even though there is some duplication of investment in the short run.

- address the potential problem of poor quality or accessibility which could result from unrestricted entry by emphasizing the public disclosure of information on HMO utilization rates, accessibility, and patient satisfaction; establishing and enforcing quality standards for HMOs is the primary responsibility of state licensing authorities, PSROs, state Medicaid agencies, and DHEW, in the case of federally assisted or qualified HMOs. More importantly, HMOs competing in the private group market are continually subject to scrutiny by prospective consumers. Hence, HSAs should adopt a quality assurance role that supplements rather than duplicates the activities of these bodies. HSAs can do so by cooperating with these organizations and consumer groups to make information that is collected on HMOs more readily avaialble to the public in an understandable form. Because HMO quality is difficult to predict prior to operation and difficult to observe and interpret subsequent to operation, this communications role for HSAs effectively complements existing quality controls.

II-31

In developing local area health plans, HSAs should include explicit provisions regarding HMO growth and development. Specifically, HSAs should:

- establish an explicit need for HMOs in all areas where HMOs are likely to reduce community health care costs, using the methodology developed here. Even where community costs may not fall, a need for HMO development should be established where less than 80 percent of the local population has an option to join an HMO. This definition ensures that, in areas where HMO development can reduce community costs, HSAs establish a clear need for HMOs even if over 80 percent of the population already has the option to join them. This approach encourages competitive HMO entries so that community savings are generated beyond the savings a single HMO could produce. In addition, in areas where community costs might not fall, the importance of making the choice of greater accessibility to primary care available is the primary concern. Although HMO operations may not be feasible in these areas, this definition ensures that sponsor interest or federal support is not discouraged or precluded on the grounds that community costs are not likely to fall.

- establish an explicit need for both community and HMO beds which reflect expected HMO growth and development. HSAs should establish explicit measures of community and HMO bed need so that bed need projections reflect the impact of lower hospital utilization rates of HMO members, and so that future requirements for hospital facilities by large HMOs are anticipated. By forecasting bed need in this way, HSAs can avoid the construction of too many community hospital beds and ensure that HMOs growing toward 80-100 thousand members can anticipate HSA reactions when they want to acquire their own hospital. This in turn enhances the community cost impact of HMO development by reducing the costs of supporting underutilized hospitals.

In project reviews of HMO requests for approval of new institutional health services (NIHS) and certificates-of-need, HSA criteria should reflect our findings about the ability of HMOs to reduce community cost. Specifically, HSAs should:

- permit all HMOs to enter the local market or add new services, because financially viable HMOs will generally reduce community costs in the long run. HMOs unable to control costs or enroll enough members to break-even will typically not reduce community costs. However, they are likely to go out of business and consequently pose little risk of raising long run costs due to a duplication of resources. Even if HSAs wish to restrict HMO entry, they should approve HMOs that are likely to reduce com-

munity health care costs in areas where the local health plan identifies a need for HMOs. HSA should also permit new HMOs to enter and compete with existing HMOs because active competition among HMOs generally increases community cost savings.

- approve all construction of outpatient facilities or purchase of new equipment by existing HMOs; HMOs, unlike hospitals, have no incentive to invest in facilities or equipment unless these purchases reduce long run costs of operation, or maintain or increase enrollment by improving the quality or accessibility of care. In some cases, outpatient or equipment expenditures might diminish the overall community cost savings available from HMO operation. However, in such cases, the community cost impact of these expenditures is relatively small. Finally, HSAs may be able to strengthen incentives for reducing community costs in the long run by giving HMO investments in outpatient facilities and equipment higher priority than traditional provider investments. Traditional providers facing such review criteria might consider HMO development opportunities more carefully under these incentives.

- approve all HMO requests to purchase, lease or otherwise acquire existing community hospitals regardless of the number of beds available or needed by the community; in all cases, HMO use of existing hospital facilities produces the greatest community cost savings. HSAs and SHPDAs can give large HMOs an added incentive to pursue this alternative by adopting policies to approve all such acquisitions. Some caution should be exercised where HMOs with fewer than 80-100 thousand members seek to acquire hospitals; however, HMO administrators advise us that this is most improbable.

- approve all HMO requests to construct hospitals where there is or will be shortly (3-5 years) a need for additional or modernized hospital beds; our analysis shows that community costs are reduced the most where HMOs can operate their own hospitals. Although HMO purchase or lease of existing hospitals is always desirable, it is possible that existing community hospitals are not well-suited to HMO operations because they are not located near HMO members, would require excessively expensive modernization, or are not available at a reasonable price. Thus, although HMOs have an incentive to purchase or lease rather than build if it is less expensive, they may not be successful in securing reasonable terms. In such circumstances, community costs are reduced the most where HMOs are permitted to build hospitals. In fact, HMO construction of needed beds reduces community costs more significantly than traditional provider construction of new beds.

- approve HMO requests to build a hospital in areas without any need for additional beds, when:

  -- an HMO's ability to reduce community costs is severely hampered by use of existing community hospitals; and,

  -- the HMO can show that existing hospitals are not suitable or not available at reasonable terms for sale or lease.

  Our analysis of the community cost impact of hospital construction by an HMO showed that community cost savings are still obtained, even if an HMO builds its own hospital in an area with too many community hospital beds. Hence, HSAs should permit HMOs to build their own hospitals where the continued use of existing community hospitals threatens the HMO's financial viability or the maintenance of its current enrollment. This produces more significant community savings than letting the HMO fail, especially over the expected life of the hospital.

These recommendations are based upon a careful analysis of the community cost effects of HMO growth and development. Because the results vary from region to region and because BHPRD may want to extend the use of the methodology developed here, we recommend that BHPRD review and refine the models developed here to confirm their soundness and suitability. Particular attention should focus on:

- the verification and refinement of the community cost-estimating methodology presented here;
- the differential effect of federally qualified HMOs on community costs;
- the effects of HMO competition on premiums, community costs, and quality; and,
- the problems that face members of HMOs that close due to financial failure.

A careful review of these factors could greatly expand the applicability of the basic analysis presented here.

Exhibit II

March 1, 1978

Amendments To
S. 2410

1. Amend §118(b) to read as follows:

(b) The second sentence of section 1523(a)(4)(B) is amended by inserting "and that are not inconsistent with the State health plan required by section 1524(c)" after "found to be needed".

2. Amend §119(b) by redesignating it as §119(c) and add §119(b) to read as follows:

(b) Section 1513(b)(3) is amended by inserting before the period at the end of the second sentence the following: ", and to the development and expansion of health maintenance organizations, and their facilities and equipment".

3. Amend §141 to read as follows:

SEC. 141. Section 1531(5) is amended to read as follows:

"(5)(A) The term 'institutional health services' means (i) the health services provided through health care facilities as defined in regulations of the Secretary including, but not limited to, private and public hospitals and nursing homes; and (ii) diagnostic or therapeutic equipment, acquired through purchase, rental, lease or gift, valued at the time of acquisition in excess of $150,000, used in the delivery of health care services by any person, institution or other

entity, except such equipment utilized to provide substantial services to members of health maintenance organizations.

"(B) In determining whether diagnostic or therapeutic equipment has a value in excess of $150,000 for purposes of subparagraph (A), the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included."

4. Add §152 to read as follows:

SEC. 152. Section 1532 is amended by adding at the end the following:

"(d) If a project for facilities or equipment to be used to provide substantial services to members of health maintenance organizations is denied a certificate of need by a State Agency, a health maintenance organization may immediately appeal the decision directly to the Secretary, or may appeal the decision to the Secretary after all State legal remedies have been exhausted. The appeal must be made within 60 days of the State Agency decision or the date upon which all State legal remedies are exhausted. The Secretary must decide the appeal within 60 days and shall reverse the decision if it is determined that it would discourage the operation or expansion of a health maintenance organization which has

demonstrated to the Secretary's satisfaction proof of its capability to provide comprehensive health care services (including institutional services) efficiently, effectively and economically, or it is inconsistent with the State Plan or appropriate HSP or federal law or regulations."

Alternative A

A-5. Add §153 to read as follows:

SEC. 153. (a) Section 1513(e)(1)(A)(i) is amended by inserting "except for title XIII" after "this Act".

(b) The second sentence of Section 1523(a)(4) is amended to read as follows:

"Such program shall provide for review and determination of need prior to the time such services are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide that only those services found to be needed shall be offered or developed in the State, but shall not provide for review of or determination of need for health maintenance organizations or entities which provide substantial services to members of health maintenance organizations."

(c) Section 1531 is amended by adding at the end thereof the following paragraphs:

"(6) The term 'health care facility' does not include a health care facility used to provide substantial services to

members of a health maintenance organizations.

"(7) The term 'provide substantial services to members of health maintenance organizations' means to provide at least seventy-five percent of all services to persons who are members of health maintenance organizations.".

A-6. Add §154 to read as follows:

SEC. 154. (a) Section 1122(a) of the Social Security Act is amended by striking "or health maintenance organizations".

(b) Section 1122(b)(1) of the Social Security Act is amended by striking "or health maintenance organization".

(c) Section 1122(b)(2) of the Social Security Act is amended by striking "or health maintenance organizations".

(d) Section 1122(d)(1)(B)(ii)(L) of the Social Security Act is amended by striking "or health maintenance organization".

(e) Section 1122(d)(2) of the Social Security Act is amended to read as follows:

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility would discourage the operation or expansion

of such facility or a health maintenance organization which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVIII, or XIX, he shall not include such expenses pursuant to paragraph (1).

(f) Section 1122(h) of the Social Security Act is amended by inserting before the period the following: "or to health care facilities which provide at least seventy-five percent of their services to members of health maintenance organizations"

Alternative B

B-5. Add §153 to read as follows:

SEC. 153. (a) Section 1513(e)(1)(A)(i) is amended by inserting "except for title XIII" after "this Act".

(b) The second sentence of Section 1523(a)(4) is amended to read as follows:

"Such program shall provide for review and determination of need prior to the time such services are offered or developed or substantial expenditures are undertaken in preparation for such offering or development, and provide

that only those services found to be needed shall be offered or developed in the State, but shall not provide for review of or determination of need for health maintenance organizations or entitles used to provide substantial services to members of health maintenance organizations, except health care facilities.

(c) Section 1531 is amended by adding at the end thereof the following paragraph:

"(6) The term 'provide substantial services to members of health maintenance organizations' means to provide at least seventy-five percent of all services to persons who are members of health maintenance organizations.".

(d) Section 1532(c)(8) is amended by adding at the end thereof the following:

"Health care facilities projects which will be used to provide substantial services to members of health maintenance organizations shall be approved if they involve remodeling, modernization or replacement of existing facilities or services to meet the needs of such members; or if they involve new facilities or services, unless the appropriate health systems agency and the State Agency determine that the services to be provided by such a project are available from an existing health

care facility on a long-term contractual basis under circumstances in which an adequate number of physicians in appropriate specialties who are associated with the health maintenance organization have full and equal staff privileges and in a manner which is economically and clinically feasible for the health maintenance organization.".

B-6. Add §154 to read as follows:

SEC. 154. (a) Section 1122(a) of the Social Security Act is amended by striking "or health maintenance organizations".

(b) Section 1122(b)(1) of the Social Security Act is amended by striking "or health maintenance organization".

(c) Section 1122(b)(2) of the Social Security Act is amended by striking "or health maintenance organizations".

(d) Section 1122(d)(1)(B)(ii)(I) of the Social Security Act is amended by striking "or health maintenance organization".

(e) Section 1122(d)(2) of the Social Security Act is amended to read as follows:

"(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of

expenses related to any capital expenditure of any health care facility would discourage the operation or expansion of such facility or a health maintenance organization which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVII, or XIX, he shall not include such expenses pursuant to paragraph (1)."

27-273 O - 78 - 9

Exhibit III

KAISER CENTER · OAKLAND, CALIFORNIA 94666, PHONE 415/271-2211

EXECUTIVE OFFICES, ORDWAY BUILDING

March 1, 1978

The Honorable Edward M. Kennedy, Chairman
Subcommittee on Health and Scientific Research
Committee on Human Resources
431 RSOB
Washington, D. C. 20510

Dear Senator Kennedy:

Following are the comments of Kaiser Foundation Health Plan on the amendments to Public Law 93-641 proposed by DHEW. They are limited to the proposed amendments which will have an impact upon health maintenance organizations (HMOs).

The proposed amendments represent an attempt to deal more equitably with the problems which P. L. 93-641 creates for developing and established HMOs. However, we believe that the amendments we have submitted to you achieve this objective in a more appropriate manner. Specifically:

1) §213 would eliminate HMOs from the definition of new institutional health services and would include major medical equipment under the certificate of need requirement. However, the provision ignores the fact that a substantial number of states cover HMOs under their existing certificate of need laws as a direct result of the requirement that is contained in P. L. 93-641. These states should conform their certificate of need laws to the federal requirements as proposed in our amendments A-1 and B-1. In addition, we believe major medical equipment used substantially by HMO members should be exempt from the certificate of need requirement as in S. 2410 as modified by our amendment 3.

2) §214 would require that projects must be consistent with the State health plan and the State medical facilities plans under title XVI before they can be approved. However, the plans may not cover the subject of the application for a certificate of need. We have experienced this situation a number of times. Therefore, this provision should be changed so that projects may be approved if they are not inconsistent with the plans as proposed in our amendment 1.

3) §219 would repeal the requirement that HSAs and State Agencies consider the special needs and circumstances of HMOs and replace it with a requirement that they apply criteria to HMOs which will be developed by the Secretary. This approach has merit, but we prefer our proposed amendment B-5. However, if the Administration's approach is used, we believe the criteria should be set forth in the Act. We propose the following substitute for §219(d) if HMO health facilities and equipment are covered by the certificate of need requirement:

> "(d) Projects which will provide substantial services to members of health maintenance organizations shall be approved if they involve remodeling, modernization or replacement of existing facilities, equipment or services to meet the needs of such members; or if they involve new facilities, equipment or services, unless the appropriate health systems agency and the State Agency determine that the services to be provided by such a project are available from an existing health care facility on a long-term contractual basis under circumstances in which an adequate number of physicians in appropriate specialties who are associated with the health maintenance organization have full and equal staff privileges and in a manner which is economically and clinically feasible for the health maintenance organization."

This provision is consistent with the comments in the Conference Report on the HMO Amendments of 1976 (Attachment A).

4) The proposed amendments do not require the HSP and the State health plan to contain HMO elements. Such requirements are provided for in §§117 and 118 of S. 2410 and our amendment 2.

5) The proposed amendments do not provide that an HMO can appeal an adverse decision to the Secretary as set forth in our amendment 4.

6) The proposed amendments do not limit HSAs to review and comment with regard to grants, loans and loan guarantees under the HMO Act as do our amendments A-5 and B-5.

7) The proposed amendments do not conform §1122 of the Social Security Act to the proposed amendments to P. L. 93-641. Our amendments A-6 and B-6 do so.

We appreciate the opportunity to comment on the proposed amendments.

Sincerely yours,

KAISER FOUNDATION HEALTH PLAN, INC.

By: James A. Lane
James A. Lane
Vice President and Counsel

JAL/rsb
Attachments

cc: Hale Champion
Henry Foley, Ph.D.
Frank Newman, M.D.
James Doherty

ATTACHMENT A

94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 94-1513

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976

SEPTEMBER 13, 1976.—Ordered to be printed

Mr. STAGGERS, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 9019]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 9019) to amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Maintenance Organization Amendments of 1976".

(b) Whenever in title I an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—AMENDMENTS TO TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

SUPPLEMENTAL HEALTH SERVICES

SEC. 101. (a) Section 1301(b)(1) is amended by adding at the end the following: "A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence.".

(b) The first sentence of section 1301(b)(2) is amended by striking out "the organization shall provide" and all that follows in that sentence and substituting "the organization may provide to each of its

* * * * * * *

RELATIONSHIP BETWEEN HMO'S AND HEALTH PLANNING PROGRAMS

Applicability of Certificate of Need

Existing Law: Specifically includes HMOs in the definition of "institutional health services" in section 1531(5) of the PHS Act. This subjects HMOs by law to the certificate of need process required by title XV in every State.

House Bill: No change.

Senate Amendment: Deletes reference to HMOs from the definition of institutional health services. This has the effect of subjecting those specific services of HMOs which are institutional health services as defined in regulations of the Secretary to certificate of need but not the specific services of HMOs which are not institutional health services nor the establishment of the HMO itself. Section 16(a) of S. 1926.

Conference Substitute: Conforms to the House bill. The Conferees noted that the entire subject of certificate of need for outpatient and ambulatory services in both prepaid and fee-for-service settings will be considered next year when P.L. 93-641 is reviewed for extension. Thus it was felt that it would be more appropriate to deal with inclusion of HMOs under the requirements of the planning act at that time.

Consistency in Procedures and Criteria

Existing Law: Section 1306(c) of the PHS Act requires the Secretary to establish standards and procedures for areawide and State health planning agencies to follow in reviewing HMO applications for assistance under title XIII. Section 1532 requires areawide and State health planning agencies to follow procedures and criteria, developed and published in accordance with regulations, which criteria are to include criteria respecting the special needs and circumstances of HMOs for which assistance is available under title XIII.

House Bill: No change.

Senate Amendment: Requires the criteria established by areawide and State health planning agencies under section 1532(c) to be consistent with standards and procedures established by the Secretary under section 1306(c). Section 16(b) of S. 1926.

Conference Substitute: Conforms to the Senate amendment, because although the procedures and criteria required of health planning programs by P.L. 93-641 were required to include special consideration of the needs and circumstances of HMOs, this provision was not enlarged

upon or specified in any way in regulations published by HEW. The Senate amendment would assist in correcting this situation because the standards and procedures established by the Secretary under section 1306(c) would be the responsibility of the HMO program rather than the health planning program.

Specification of criteria for HMOs is of critical importance because projects for the development and expansion of HMOs and their services should be judged on the basis of the need for HMOs and the need for their services for their enrolled members and reasonably anticipated new members and not on the need for the services in general if proposed by non-HMO providers.

Thus, in considering requests for new HMOs or the expansion of existing ones, the State agency and the health system agency should consider:

1. The number of HMOs of the same type in the area,
2. The number of persons in the area enrolled in qualified HMOs of the same type, and
3. The percentage of major employers and all employers of over 25 employees in the area which offer or will offer qualified HMOs as benefits for their employees.

In considering requests by HMOs to provide or arrange for new institutional health services, the agencies should consider whether the proposed service is available from non-HMO providers in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO. In making such a determination, the agencies should consider:

1. Whether the alternative service would be more costly to the members of the HMO.
2. Whether the alternative service would be available to the members of the HMO on a long-term basis, and
3. Whether the alternative service would be available and conveniently accessible through physicians and other health professionals associated with the HMO. (For example, whether physicians associated with the HMO are granted full staff privileges at the hospital which is proposed to provide the alternative services.)

Proposals to provide new institutional health services, after feasibility of an HMO has been demonstrated, should not be subject to redetermination, subsequent reviews, public hearings, etc., at later stages of activity, if the proposals are consistent with the basic objectives, schedule and plan of the earlier application approved by the HSA. Similarly, certificate of need determinations should be made during the planning stage of the HMOs development. This is to prevent up to $1 million of initial development funds being awarded only to have a certificate of need denied, or the need for an HMO questioned by antagonistic groups late in the HMO's developmental sequence.

* * * * * *

Group Health Association, Inc.
2121 Pennsylvania Avenue, N. W.
Washington, D. C. 20037
Louis Segadelli
Executive Director

Group Health Association, Inc. (GHA) is a federally-qualified prepaid group practice HMO which provides health care services to 103,500 enrollees in the Washington metropolitan area. The enrollee population is distributed as follows: approximately 50,000 enrollees live in the District of Columbia; approximately 37,000 reside in Maryland equal numbers located in Prince Georges and Montgomery Counties; and the remainder, 16,500 enrollees, live in northern Virginia (most of them in Fairfax County). Hospital care is provided in a number of metropolitan area hospitals.

In recent years, GHA has had two major problems with local planning agencies. The first problem concerned their application to the District of Columbia Planning Agency for a certificate of need to build a hospital and primary secondary care center for the use of its enrollees. Because the success of this application would eliminate GHA's existing D. C. ambulatory facility and because of the growing number of GHA enrollees living in Prince Georges County, GHA also submitted a proposal to establish an ambulatory medical facility in the county. This latter proposal will be discussed here.

Proposal to establish an ambulatory medical facility

In January, 1977, GHAA submitted an application to the Southern Maryland Health Systems Agency (SMHSA) in order to obtain a Section 1122 certification review. The application proposed the development of a satellite clinic in Prince Georges County because GHA had determined that improved access to a GHA facility was necessary for GHA enrollees living in the county.

On February 2, 1977, a staff officer submitted a report to the SMHSA Project Review Committee recommending approval of a one year Section 1122 certification. This report made, among others, the following observations:

> The particular clientell served by the proposed center is not served by nearby facilities but must travel into the District of Columbia or Hyattsville for services. If the GHA plans for closing their D. C. facility entirely and moving tertiary functions into a hospital is realized, subscribers will have no ready access to medical services.
>
> The Southern Maryland HSA is believed to be a physician-deficient area leading to gaps in the medical services delivery system. GHA makes use of physician (pick up on page 2)

extenders . . . to reduce costs and expand service offerings. In this regard it functions as a model for providing ambulatory care. By nature of its organization, it provides competition to other providers of health services in Southern Maryland but because of the shortages of providers the impact of this organization on the other providers would be negligible.

At the February 9th meeting of the SMHSA, the Project Review Committee advanced the approval recommendation to the full board. There was considerable public comment in opposition to the proposed project, all such opposition coming from providers located in Prince Georges County.

The negative comments included the following: the president of the Southern Maryland Hospital Center did not understand the "sudden desire" for adding health services in predominately rural area, citing an inadequate population based for additional medical services; it was stated that the GHA facility would be a "dramatic encroachment" into the market of the Southern Maryland Hospital Center Ambulatory Facility; and it was stated that there were 80 physicians in the County who would rather establish their own IPA-type HMO "and offer choice of physicians and continue the free-enterprise system." After lengthy discussion, the board voted to resubmit the application to the Committee.

The Project Review Committee scheduled a special meeting on February 23, 1977. This meeting was attended, by, in addition to the Committee members, approximately 100 persons. However, the minutes of the meeting note that the providers who voiced opposition at the SMHSA meeting on February 9th were "noticeably absent". The Committee, after hearing several speakers testifying in favor of the project, voted 7-2 to recommend approval of the GHA application.

The governing body of the SMHSA met again on March 9, 1977. The Project Review Committee moved the approval of a one year federal Section 1122 certification. After discussion, the motion was amended to read: "the recommendation that Group Health Association be issued a one year Federal Section 1122 Certificate and that a detailed list of services proposed to be offered at the site be appended." So amended, the motion was carried by a narrow margin with 13 members affirming, 10 opposing, and 2 members abstaining.

Rutgers Community Health Plan
57 U. S. Highway #1
New Brunswick, New Jersey 08901
Roger W. Birnbaum
Executive Director

The Rutgers Community Health Plan (RCHP) is an independent, non-profit organization with a Board of Trustees composed of representatives from area industry, organized labor, community organizations, the medical community, and consumers enrolled in the Plan.

RCHP is a State Certified Health Maintenance Organization. This means that the Plan was subject to a review process by, and continues to be monitored by, the State Departments of Health and Insurance. Under the provisions of N. J. HMO Law (P. L. 1973, Chapter 337, C. 26:2J-1), these Departments must receive assurances regarding the availability and accessibility of required resources; quality assurance programs; accounting, reporting and auditing systems; financial soundness; protection of members in the event of cessation of operations; enrollees' participation in policy determination; and the maintenance of a complaint procedure.

RCHP is a Federally Qualified Health Maintenance Organization. This means that the Plan was subject to an extensive series of requirements including and going beyond those of the State of New Jersey noted above. RCHP initially planned its program under Certificate of Need #00443-12-13, awarded November 15, 1972. Certificate of Need #01580-12-11 was awarded August 15, 1975, for the construction of the initial 10,000 square feet of the proposed 35,000 square foot ambulatory facility.

In providing capacity for its ultimate membership objective of 35,000 enrollees over a three-year period, RCHP developed a two-stage facility plan to minimize fixed costs during early months of relatively low membership. Construction on the second state was to commence when membership reached a level of about 8,000 and become available at a membership level of about 14,000. This facility program has been consistently outlined in all Certificate of Need Applications and Federal HMO development grant applications approved to date.

The experience of the Rutgers Community Health Plan in making its way through the various stages of the review process raises a number of questions relative to whether the process as currently operating serves the intended objectives of the legislation.

In the interests of providing feedback that might be useful as the health planning process further evolves, the step-by-step process experienced by RCHP's attempt to secure Certificate of Need approval is briefly summarized below:

1. Somerset County Advisory Committee - In mid-November 1976, the Somerset CAC met to review the RCHP Certificate of Need Application. The applicant was not notified of or invited to attend the meeting. The Somerset CAC recommended deferral of the Certificate in part because "it is premature, the need for expansion has not been demonstrated" and, "according to figures supplied enrollment has not met projection." Since RCHP had in fact met and far exceeded projection, and has demonstrated a significant volume of potential membership it does not have the capacity to serve, the County Committee's action is puzzling. RCHP has no information regarding the data made available by HSA staff, the composition of the Committee in attendance on the day of the meeting or what the nature of the discussion and vote was; specifically, was there a majority of consumers board members in attendance, were providers invited and permitted to speak, etc.

2. Middlesex County Advisory Committee - On November 30, 1976, the Middlesex CAC reviewed the RCHP Certificate of Need Application. The applicant was invited to appear and did attend. Area providers were all sent notices by the Chairperson encouraging them to appear because of their vital interests involved. They attended in force. Only eleven Board members were present, a substantial majority of them providers, raising questions regarding whether requirements of both quorum and consumer representation were satisfied. The ad hoc format announced by the chairperson provided for the applicant to present its case in ten minutes with "opponents" having ten minutes to respond. There was no opportunity for the applicant to rebut the charges made by its opponents. The adversary format, together with the opportunity given to provider opponents to make various uniformed, unfounded, and ofter irresponsible comments, served to put the applicant on the defensive with its credibility under question, rather than to elicit information for the Committee's consideration. It very much appeared to be a forum where community providers were telling Committee providers what they wanted to hear. The Middlesex CAC recommended denial of the Certificate.

3. Regional Review Committee of the Central Jersey Health Planning Council - On December 1, the evening following the Middlesex CAC meeting, the Regional Review Committee of the Central Jersey Health Planning Council reviewed the RCHP Certificate of Need Application. The applicant and several area provider interests attended. Once again, the applicant and opposing interests presented their arguments, but with more of an opportunity for additional discussion between committee members, applicant and opponents. Consumer members were considerably more evident than at the prior evening's meeting. The Regional Review Committee recommended endorsement of the Certificate (the vote was 8-3 with 1 abstention due to conflict of interest), citing the following as need factors:

> Present enrollment and projected growth demonstrate need for additional square footage. As of January 1, 1977, the enrollment will be 8,700 individuals; by July 1977 the projected enrollment will be nearly 13,000 and by July 1979, the projection is for 35,000 individuals.

4. Central Jersey Health Planning Council - On December 8, the Central Jersey Health Planning Council reviewed the RCHP Certificate of Need Application. The meeting attracted a wide audience of provider interests and some consumers. In order to keep the discussion within a reasonable time frame, the Council adopted a format it utilized at the prior month's hearing of a controversial abortion clinic: five minutes for the applicant to present, and 15 minutes each for "opponents" and "proponents", with alternating 2-2½ minute presentations by each side. "Opposing" views were presented by representatives of the County Medical Society, the Osteopathic Association, local physicians, and two area hospitals which are not currently RCHP participating hospitals. Several consumers and a representative of the State Health Department, as well as the applicant, spoke as "proponents". There are a number of problems with this format: Once again, the adversary nature of the proceedings is counterproductive to the need to elicit information. In fact, the requirement for speakers to declare themselves as either "proponents" or "opponents" provides no appropriate platform for objective, factual materials to be made available (e.g., by the State Health Department). The applicant is provided an inadequate

amount of time to present his case and is then put on the continual defensive in an inappropriate debating arena. To respond to inaccurate, unfounded, and often irrelevant and irresponsible charges made by "opponents" serves to legitimatize such charges; on the other hand, not to respond to them is to leave seeds of doubt in the minds of Council members, presenting the applicant with significant credibility problems. At no time were issues irrelevant to the demonstration of need ruled out of order. Specific criteria to be used as guidelines by HSAs in reviewing HMO Certificates, although presented by the HSA's executive director, were totally ignored.

The objective of eliciting information would be far better served through a question and answer format where the chairperson gives the applicant (and/or Council staff) an opportunity to respond to responsible, relevant questions. Permitting unsupportable charges presented by "opponents" inconflict of interest with the applicant to stand on the record represents a total subversion of the intent of the certificate of need process.

The Council failed to endorse the recommendation of its Regional Review Committee and recommended deferral. The vote for deferral was 12-10 with one abstention and two members not voting because of possible conflict of interest. Other area providers on the Council did not see fit to disqualify themselves because of possible conflict of interest. Some consumer members of the Council, concerned with the outcome, specifically asked that the endorsement of the Regional Review Committee be included as a minority report.

5. Mercer County Advisory Committee - On January 4, 1977, the Mercer CAC reviewed the RCHP Certificate of Need Application. The Committee recommended endorsement by a vote of 6-4 (with 1 abstention), specifying a number of qualifications.

6. State Review Committee - On January 18, 1977, the State Review Committee unanimously supported RCHP's Certificate of Need request.

7. State Health Coordinating Council - Late in January, the SHCC recommended that a Certificate of Need be granted to RCHP to expand its facilities.

Community Health Care, Inc.
615 Anderson Building
12th and O Streets
Lincoln, Nebraska 68508
Stephen R. Tiwald
Executive Director

In August, 1975, Community Health Care, Inc. (CHCI) sent its HMO Planning Grant Application to DHEW and to the Southeast Nebraska Health Planning Council (SeNHPC). Following its usual procedures, SeNHPC established a multi-disciplinary Project Review Task Force to conduct a detailed examination of the proposal. Task Force members were: J.H. Hopkins, Bankers Life Nebraska; Harold Norby, Tabitha Home; John I. Wise, Dorsey Laboratories; Richard Marshall, D.D.S.; Don Penney, actuary from Stennes and Associates; Leonard Jennings, Lincoln Community Services; and Sue Scott, homemaker. Over a period of several weeks, the Task Force met five times and conducted a public hearing. It concluded its review by voting six to one to recommend approval of the application; the lone dissenter was Dr. Marshall. The SeNHPC staff recommendation was also positive.

In September, 1975, the SeNHPC Board of Directors deliberated and voted against accepting its Project Review Task Force's positive recommendation. Voting in favor were three consumer members; voting against were the seven providers and four of the consumer members; abstaining were four consumers, three of whom were CHCI Board members who did not vote because of the conflict of interest principle, and the acting chairman; twenty-three members were absent. Shortly thereafter, the CHCI Board of Directors decided to reconsider and therefore it withdrew its proposal at least temporarily from consideration by DHEW.

Over the winter and spring of 1976, CHCI did further study. During this time, results became available from a Lancaster County community attitude survey conducted by the University of Nebraska-Lincoln Bureau of Sociological Research which showed considerable dissatisfaction with the present health care system and significant support for the development of a health maintenance organization.

The CHCI Board felt that the survey findings were an additional reason to continue its effort to establish an HMO in Lincoln. After updating and improving the proposal, CHCI again submitted an HMO Planning Grant Application to DHEW and to SeNHPC in May, 1976. Again, the SeNHPC established a Project Review Task Force, this time composed of J. H. Hopkins, Bankers Life Nebraska; Harold Norby, Tabitha Home; Richard Marshall, D.D.S.; Dale Karnopp, Administrator, York General Hospital; George Rejda, Professor of Economics, UN-L; Carolyn Massey, homemaker;

and Marge Bush, homemaker. This Task Force met four times and conducted a public hearing. It concluded its review by voting five to one to recommend approval of the application; Dale Karnopp voted negatively. Once again, the SeNHPC staff recommendation was positive.

In late June of 1976, the SeNHPC Board of Directors voted eleven to ten against accepting its Project Review Task Force's positive recommendation. Voting in favor of the positive recommendation were four providers and six consumers; voting against were eight providers and three consumers; there were two abstentions; nineteen SeNHPC members were absent.

This was the last meeting of SeNHPC. Its successor organization, the Southeast Nebraska Health Systems Agency (SeNHSA), which was composed of many of the same individuals, held its first meeting immediately following the SeNHPC meeting. The SeNHSA decided to also vote on the project, although its action would not be the official local health planning agency comment. By a vote of ten to seven the SeNHSA voted to not accept the Project Review Task Force's positive recommendation. Voting in favor of the positive recommendation were three providers and four consumers; voting against the positive recommendation were seven providers and three consumers; there were two abstentions.

The CHCI Board of Directors felt that the SeNHPC and SeNHSA votes were so close that their results were not conclusive statements of local opinion on the topic of HMO development in Lincoln. Knowing that the local health planning agencies' comments did not constitute approval or disapproval, the CHCI Board of Directors decided to not withdraw the HMO Planning Grant Application from consideration by DHEW. After its review, DHEW decided in August, 1976, to make the grant award.

In late November, 1976, the SeNHSA voted to request an explanation from DHEW of why it had proceeded to award the grant. In a three-page letter from Dr. Holman R. Wherrett, Regional Health Administrator, DHEW responded with its reasons which included the following:

1) The SeNHPC staff report and the Task Force report recommending favorable review and comment used the established criteria for review. Positive comments indicated by the record were also received by representatives of Blue Cross, Bankers Life, employers, consumers, labor and elected officials of Lancaster and Lancaster County. An absence of these criteria was apparent in the final review and comment of the SeNHPC Board.

2. Twenty-three members attended the Board meeting. The acceptance of the majority Task Force report failed on a vote of 10 to 11; with proponents of the report abstaining due to conflict of interest. There was voting by members who could be considered as being in competition. In addition, letters of support from absent board members were later received.

3. The official review of two other Nebraska agencies was positive (The State of Nebraska Office of Comprehensive Health Planning and the Office of Planning and Programming).

4. The provisions of the HMO Act of 1973 and the concern of Congress for review and comment and the possibility of local provider interests thwarting the development of alternative delivery systems.

5. A misunderstanding by local provider representatives that the HMO Act was intended to provide for the medically underserved; and the statement by these representatives that if the HMO did not use federal support there would be no objections.

6. An acceptable application from a consumer based, non-profit corporation with endorsement from labor, employers, third party payors, and city and county elected officials, and with acceptable physician input was convincing that the objectives of a planning grant could be reached.

7. SeNHSA's review activity did not include approval/disapproval authority, but only review and comment authority.

CHCI's Initial Development Grant Application was received by the SeNHSA on July 25, 1977. On September 21, 1977, the Project Review Task Force recommended disapproval of the application. The Board of Directors accepted the majority report of the Project Review Task Force by a 16-8 vote on September 28, 1977. CHCI's Initial Development Grant Application had been accepted by DHEW on August 23, 1977. However,

On October 27, 1977, the State of Nebraska's Designated Planning Agency (DPA) sent a letter to SeNHSA in response to the latter's recommendation of disapproval. This letter refuted the major objections presented by the SeNHSA's Project Review Task Force and upon which it based its negative recommendation. The Task Force had a total of 10 objections to the CHCI application. The following discussion outlines

seven of those and includes the Task Force's comments and the DPA's responses:

1. The Task Force alleged that the project was inconsistent with the priorities established in Public Law 93-641, concerning the development of multi-institutional systems which promote the coordination and consolidation of institutional health services and the sharing of support services necessary to all health institutions. DPA advised the Task Force that, while the HMO might be inconsistent with those stated objectives, it was consistent with others including the priority to develop medical group practices and HMO's.

2. The Task Force believed that the HMO would not serve those with the greatest health care needs in the community. DPA noted that through open enrollment, some individuals with the greatest health needs would be enrolled in the HMO.

3. The Task Force stated that the HMO would duplicate existing health resources. DPA disagreed, however, stating that unnecessary duplication would not result.

4. The Task Force claimed that the application failed to identify physicians who would serve the HMO as primary care physicians and those willing to offer specialty services. In addition, it questioned the applicant's ability to attract new resources into the area. DPA responded that the HMO had submitted a list to DHEW of physicians willing to offer specialty services. (The application contained three signed letters from physicians for the primary care staff, meeting the requirements of HMO Planning Phase regulations). Since the HMO stated its intention to recruit physicians on a nation-wide basis, new resources would, in fact, be attracted to the area.

5. The Task Force was concerned with the HMO's potential to attract physicians away from non-metropolitan areas. The DPA pointed out, however, that HMO's could not be held solely responsible for the maldistribution of physicians. It noted that HMO's were not the only potential competitors with non-metropolitan areas -- hospitals also share that characteristic.

6. The Task Force felt that the HMO had not demonstrated that it would achieve cost containment goals. DPA replied that the inflationary trend of medical costs was a motivating factor in the promotion of HMO's. Substantiation of the HMO's ability to contain costs was based on operating data of HMO's nationwide.

7. The Task Force cited the lack of major consumer community support as another reason to disapprove the application. The DPA staff concluded, however, that adequate support was demonstrated in the application by the inclusion of 26 letters from employers, labor leaders, and government officials expressing approval and interest in CHCI. These groups represented 68,000 employees and their dependents.

Consistent opposition from the local medical society to HMO development is evidenced by the attached letters to the HMO Project Review Task Force.

LANCASTER COUNTY MEDICAL SOCIETY
2966 "O" STREET
LINCOLN, NEBRASKA 68510
TELEPHONE 474-2401

June 16, 1976

TO: HMO Planning Grant Review Task Force

FROM: Board of Trustees, Lancaster County Medical Society

On September 18, 1975 the Southeast Nebraska Health Planning Council voted to not approve a federally financed planning grant for an HMO in Lincoln, Nebraska. The main reason for this rejection was the fact that the federal monies earmarked for HMO's and HMO planning was to be funneled to the high priority of medically underserved populations. Evidence then and evidence now indicates that it is indeed questionable whether Lincoln, Nebraska and Lancaster County Nebraska is medically underserved. We would like for you to consider the following:

Medical facilities, medical care and medical planning in Lincoln are excellent.

Evolution of medical care in Lincoln is steadily progressive and responsive to community needs indicated by the fact that since May of 1975 eighteen new physicians have started practicing medicine in Lincoln, Nebraska.

The use of tax money to support ventures into competition with groups which have been exposed to the risks of the market place is questionable. We must realize that government money can not do all things for all people. The cost of running local, state and federal governments has increased from $63.3 billion in 1950 to $579.5 billion in 1975 - an increase of over 900%. Ironically, with the 200th birthday of our country close at hand it is evident that government has overly involved itself in the lives of its citizens.

Proponents of an HMO organization indicate that an HMO can stabilize and/or reduce the cost of health care. Between fiscal year 1950 and 1974 the cost of personal health care went from $10.4 billion to $90.3 billion-of this increase

----about 46% or $36.8 billion can be attributed to inflation.
----another 15% or $12.3 billion is the result of population growth.
----the remaining 39% or $30.8 billion is due to the publics increased use of medical services and to a wide variety of lifesaving, but often costly medical techniques.

How an HMO, or any other health delivery agency for that matter, would be immune from these cost increases is difficult to understand.

Therefore, in view of the above information, the Board of Trustees of the Lancaster County Medical Society would like to respectfully ask that the HMO Planning Grant Project Review Task Force recommend to the Board of Directors of the Southeast Nebraska Health Planning Council and the Southeast Nebraska Health System Agency that the request by the Community Health Care Association for a $125,000.00 HMO Planning Grant Application be denied. The need for and the utilization of an HMO in Lincoln, Nebraska has not been established and it is extremely doubtful that such can be established in the future.

Thank you for your time and consideration.

LANCASTER COUNTY MEDICAL SOCIETY
2966 "O" STREET
LINCOLN, NEBRASKA 68510
TELEPHONE 474-1423

August 11, 1977

Dear Community Health Care, Inc.
HMO Development Grant
Project Review Task Force:

The Board of Trustees of the Lancaster County Medical Society would like to respectfully comment on the application of Community Health Care, Inc. (CHCI) for a one million dollar development grant from the federal government.

The position of the Lancaster County Medical Society is a matter of record. We continue to support community efforts directed towards unnecessary and costly duplication of facilities and services while protecting the freedom of choice for every patient. The CHCI proposal would defeat these objectives.

The current CHCI proposal contains the same flaws previously identified by the local health planning agency. For example, the proposal contends that its "two-tier rate structure (is) comparable to premiums paid for conventional employee benefit insurance plans." Even if we acknowledge this debatable point, the rate structure will still be underwritten by an expense of $1 million in a federal grant and over $2 million in loans. It seems appropriate to ask where the savings are and what revenue will be available when the loan funds are exhausted? Also, what is the proposed source of the loan funds?

On June 23, 1976 the Southeast Nebraska Health Planning Council Board of Directors and the Southeast Nebraska Health Systems Agency Board of Directors wisely and appropriately voted to not approve a CHCA HMO Planning Grant for $125,000.00 from the federal government. It is indeed unfortunate that these actions are rendered moot by a federal law (P.L. 93-641) which allows federal officials to overrule decisions of local and state agencies. This law is presently being challenged legally by the states of Nebraska and North Carolina and the American Medical Association in Raleigh, North Carolina.

Respectfully,

R. F. Mueller, M. D., President
Lancaster County Medical Society

Health Maintenance Organization of Baton Rouge, Inc.
5790 Florida Boulevard, Suite 206
P. O. Box 64967
Baton Rouge, Louisiana 70806
Director: Joseph H. Carabello

Health Maintenance Organization of Baton Rouge, Inc. (HMOBR) initially submitted a planning grant application for review by the local 314(b) agency under the HMO Act of 1973. On July 9, 1975, HMOBR forwarded a second application for a planning grant to the local health planning council for its review. In both instances, the local agency recommended disapproval. HEW overrode both recommendations, however, finding that an HMO was feasible and that the planning should continue.

Thereafter, HMOBR submitted an application for its Initial Development Phase to the newly formed HSA. Prior to the reorganization, the application had been reviewed by the former 314(b) agency, which had forwarded its recommendation for approval to the board of the HSA, as well as to the State Health Planning Council. On the 58th day of the review cycle, HMOBR received a certificate of need from the State Health Planning Council. On the 62nd day of the review cycle, the HSA board voted to recommend disapproval. The action was essentially initiated, however, by the lapse of the allowable review period and by the issuance of a certificate of need.

The process of evaluation reflects the many inadequacies demonstrated by HSA's in dealing with HMOs. Emphasis on criteria outside of the agency's scope of review and the general refusal to approve the project based on a dislike of the HMO philosophy are evident in the minutes of the HSA's meetings. Examples of this are documented below.

(I) Requirements of consumer representation were not adhered to during the review process. The Comprehensive Planning Act, 87-749, and the Health Planning and Resources Development Act, 93-641, require local health planning bodies to be consumer dominated and to function with consumer representation at all levels. Disregarding these requirements, the Health Services Committee reviewed the project with two members present -- both physicians. The meeting, which lasted for two hours, consisted of questions directed to the director and president of the HMOBR. Although the two projects were approved, the committee felt that they could not vote on HMOBR since there were not enough members present.

(II) Reactions of the members of the HSA to the HMO concept can be gleaned from the grounds stated by the Planning Council for recommending disapproval of the HMOBR application:

(1) The study did not adequately justify the need for an HMO;

(2) The application was poorly prepared with inadequate information in some aspects and misinformation in other portions of the grant;

(3) The proposed HMO represented probable duplication of services since another HMO was being developed by Blue Cross and Stanocola.

To substantiate HMOBR's failure to demonstrate a need for an HMO, the HSA argued that HMOBR was merely proposing an alternative service delivery system which assumed the inadequacy of the present system. However, it was not felt that this inadequacy was demonstrated in the application. The situation was constrained with the Kaiser-Permanente Plan in California, which was developed because medical services were unavailable. Since this was not the case in Baton Rouge, the need for an HMO was doubted.

The second criticism faulted the application for data deficiencies. However, the HSA was uncooperative in providing health related demographic data. The Council was subsequently furnished with additional answers relating to the areas in question, some of which had been included in the document before the Council. The alleged inadequacies included the absence of a definition of primary care physicians, information on how the HMO would serve medically indigent population, how the HMO would relieve the shortage of primary care physicians, the absence of a list of community needs and how the HMO would address them, and a demonstration of the inadequacy of the existing system.

The third basis of disapproval concerned the duplication of services posed by the HMOBR and Stanocola-Blue Cross HMP. The assessment ignored the significant differences between the plans, the most important distinction being that HMOBR is seeking federal qualification. In addition.

noting the mere existence of a similar system did not address the question of whether the community could support the two operations. HEW, in approving the application, stated its opinion that HMOBR was feasible, and refuted the assumption that more than one HMO in a community implies duplication of services.

Group Health of El Paso, Inc.
Eastwood Medical Center
10301 Gateway West
El Paso, Texas 79925
(915) 592-0201
Barry C. Strittmatter, President

Group Health of El Paso (GHEP) submitted an Initial Development Application to the local HSA. The application had already received approval by the Regional Office of HEW. On July 13, 1976, the application was presented to the Project Review Committee. This Committee submitted 'Negative Comments' to the HSA on July 15, 1976, at which point the HSA voted to table the project for 30 days in order to study the problem. On August 18, 1976, the HSA took an informal poll which showed nine (9) members against, one (1) for, and twelve (12) abstentions. When this information was made available to the West Texas Council of Governments, the Council directed the HSA to submit a definite decision. The HSA then voted "no comment". The Council subsequently voted unanimously to approve the project.

The factors which contributed to the indecisiveness and negative comments on the part of the HSA can be categorized as follows·

(a) Complexity of HMOs preclude an effective evaluation by planning agencies without definite guidelines.

All facets of HMOs are not understood by HSA members. Often comments are based on factors which do not account for

HMO legal requirements, and opinions are formulated in reaction to HMO philosophy rather than the specific needs of the project under evaluation.

This experience is exemplified by the Review Committee's recommendation of 'Negative Comments', which were based on the following reasons:

1. The program was too restrictive because it did not include all physicians and hospitals in El Paso.
2. The plan had asked for too much money in the budget. [The Committee had not reviewed the budget, but felt that $528,000 was too much money, just to develop an HMO]
3. Since they had already been funded for two years and had not become qualified, it should not be continued for an additional year.

The President of GHEP attempted to overcome the apparent lack of basic knowledge of HMO statutory requirements, structure, and funding provisions by explaining those aspects of HMO law to the HSA members. As evidence by the HSA's continuing indecisiveness, an ad hoc education of HSA members does not meet the problem. Firm criteria must be supplied if HMO's are to be adequately evaluated by planning agencies.

(b) Conflict of Interest -- Provider hostility of HMOs.

The Chairman of the Project Review Committee and the HSA is a member of the Trans-Pecos Medical Foundation; a separate entity which has applied for a feasibility grant under P. L. 93-222. Five members of the Board share a common office complex area, as medical doctors on the board are represented outside of the Trans-Pecos Foundation for Medical Care.

Although the members with direct conflict of interest ultimately abstained from voting, the influence sustained throughout the discussion was unquestionably substantial. The problem is particularly acute in this case in that the chairman of the HSA and the Project Review Committee, while conceding to a conflict of interest, proceeded to lead the discussion at all times.

Family Health Plan, Inc.
5413 S. 76th Street
Greendale, Wisconsin 53129

BACKGROUND: Family Health Plan is preoperational, proceding under the HMO grant program. The HMO is entering the initial development phase, requiring review by the Southeastern Wisconsin Health Systems Agency. The review process was complicated by recent passage of certificate-of-need legislation in the State of Wisconsin.

REVIEW PROCESS: Due to the certificate-of-need legislation, FHP was subjected to two separate reviews - one for the program and one for the facility. SEWHSA staff decided that the review process would be simplified by using the same review committee to do both reviews.

Program review resulted in few problems. The necessary application was submitted in July to the HSA. A minor problem developed in ascertaining whether the new legislation applied to this project. SEWHSA was neither sure of the law's applicability nor were they sure of the appropriate forms that had to be submitted. It is our opinion that this is not their fault since the state passage of the law was occurring concurrently and final regulations were somewhat ambiguous.

The program review took place on July 28, 1977, with only a few minor objections by committee members. The staff recommendation was very favorable. Approval of the program specifically did not include the facility which was left open until a subsequent review would take place. The executive board confirmed the program approval on August 4, 1977.

Facility review under 1122 posed the most serious problems. SEWHSA staff review and recommendation on the application again was very favorable. The review took place September 22. During the discussion, a number of negative points were brought up and refuted by FHP staff present at the review. The review committee finally recommended approval by a margin of one vote, that being cast by the committee chairman.

The executive committee of the SEWHSA subsequently turned down the application on October 6, citing 5 reasons for the rejection. FHP staff felt the rationale was unjustified. Two options remained, - either seek an appeal or attempt to get the state to reverse the committee's decision. The FHP Board took the former route. FHP staff submitted documentation to refute each of the five reasons for disapproval, and at a subsequent review on November 3, obtained approval for the facility.

MAJOR DIFFICULTIES: From the standpoint of an HMO, a number of difficulties with the review process were perceived. These are:

1. Inability of review committee members to reasonably evaluate a program like an HMO. It is the contention of FHP staff members present that the committee members do not really understand what an HMO is. Several committee members continued to perceive the HMO as a subsidized plan which is to serve the low-income population. Location of facility was a major issue. Committee members wished the HMO to locate very close to the low-income population to increase their access to care. However, this would have had a significantly negative effect in attempting to reach the primary market the HMO intends serving. Committee members would evaluate "need" for the project only on the basis of providing care to an under-served population.

2. Protection of personal interests by review committee members. Since the review committee has ample representation from providers of health care, it appears that some view HMO's as a potential threat. Because of this fact, and HMO will certainly face a hard core of committee members who will be trying to protect the "status quo". The most outspoken plan critics were providers of health care, especially physicians, some of whom were not even close to the proposed service area. It goes without saying that new programs such as this will always have to struggle against established participants in the health care field, due to the committee structure.

3. Refusal of committee members to deal with relevant issues. Much of this can be attributed to the prior two points. FHP staff successfully refuted the five major objections to approval. In the subsequent re-review, almost no mention was made of the issues; instead, other issues, mainly those of personal opinion, were brought out. Since the reviewee is unable to speak at an executive board review, many issues that could have been refuted went unanswered and swerved other committee members.

4. Lack of clear, concise standards by which an HMO can be evaluated. No clear criteria exist to guide HSA committee members in their decision. For example, it is difficult to evaluate need for a project, when no standards of need have yet been developed for an HMO review. Since there are no applicable guides, committee members use their own criteria.

SUMMARY: The whole review process was a strenous undertaking for FHP staff. The process took nearly five months from beginning to end and involved substantial time and effort. The process created a great deal of uncertainty and set the HMO's timetable back 60 days. While we could appreciate the cooperation of SEWHSA staff, the review process leaves a lot to be desired. After all, the primary objective of an HMO is cost-control, which is, after all, one of the major goals of the HSA.

Valley Health Plan
P. O. Box 227
441 West Street
Amherst, Massachusetts 01002
F. Q. Rice
Executive Director

Valley Health Plan (VHP) is a HMO program grantee. In January 1976, VHP submitted its application for an initial development grant to the Western Massachusetts Health Planning Council (WMHPC) for review. An adversary relationship quickly developed between VHP and WMHPC. From this experience VHP's Executive Director drew the following conclusions:

"1. Neither the staff nor the sub-area advisory council understood anything in any depth about HMOs. What they thought they knew was erroneous or severely biased for the most part.

2. Many of the consumer members of the council, reflecting the motivations that led them to volunteer in the first place, had strong social action agenda of their own. They could not accept any intrinsic value in an organization that valued fiscal solvency or saw its role as different from serving the poor as its top priority.

3. Allied to this was the lack of pragmatism on the part of much of the council. Few were willing to acknowledge the necessity of the politics of compromise in the difficult task of HMO-building. I simply couldn't get through why the physician groups interested in joining VHP did not feel they could donate their time, or why they would not leap from virtually no formal quality assurance program to external view.

4. Finally, I am afraid that the HSAs continue to be greatly influenced by the health care establishment, who fear the change HMOs threaten. This is both by their direct representation on the councils, but also by their studied courting of staff members. Underpaid, young planners can all too easily be turned just enough in their perspectives to distrust things that they don't really understand, such as HMOs. This happened in our situation."

Health Care Plan, Inc.
664 Ellicott Square Building
Buffalo, New York 14203
Arthur Goshin, M. D.
Project Director

The Western New York area is fortunate in having a health systems agency which is well-organized and progressive in its concern for the efficiency and effectiveness of the health delivery system as well as for innovative program development. The agency has had little previous experience with HMO-type organizations, inasmuch as the Health Care Plan and the Western New York Health Planning Corporation, both developing HMO's, are the first in the region. Because the HSA staff and members had a minimal exposure to HMO issues, the agency sponsored a one-day educational session in which federal and state officials as well as HMO executives from other parts of the State were invited to discuss relevant matters. Such sessions are valuable and should be encouraged.

The Health Care Plan has observed certain difficulties with the planning and review process, however. In a recent series of events concerning the HSA review and comment on the initial development applications of the two developing HMO's, important deficiencies in the structure and process of such reviews were encountered.

The Health Care Plan and the Western New York Health Planning Corporation applied for federal initial development funds at the same time and will serve partially overlapping geographical areas. By the usual federal planning parameters, the total area (Erie County and parts of Niagara County) is capable of supporting more than one HMO. At one time in their respective development, the two organizations considered the potential for merger but through a course of discussions concluded that an organizational merger was not feasible. The HSA reviewed two independent applications.

The staff of the HSA is open to admit that, given time constraints and staff expertise, the only feasible review of such applications is a very superficial one. Both applications are approximately 1,400 pages in length and contain financial and statistical data which could not be adequately reviewed in detail. Moreover, it was not possible for the staff to discern the subtle, underlying differences and objectives. Although the HSA staff was involved in the previous merger discussions, the impracticality of such a move was not fully appreciated. At the same time, the HSA's and state regulatory offices are operating under a criteria of reducing or avoiding non-duplication of service.. Hence, the two applications which proposed to

impact on the same geographical area were interpreted as duplication of service. Although previous HSA reviews have demonstrated a lack of primary care resources and even though no other HMO organizations currently exist or are under development in the area, the criteria usually applied to hospitals and nursing homes were applied to HMO development. The recommendation which the HSA staff initially made was that the two organizations merge and that the one organization be funded.

The process of subarea and executive committee review yielded a different interpretation in which the objective of maximizing financial resources to the area became more important. The executive committee recommended that both independent organizations be funded.

At the conclusion of the DHEW review, the regional office notified both organizations that it intended to fund only one organization. This action on the part of DHEW was apparently taken without notifying or consulting the HSA. The HSA executive committee met again and agreed to maintain its initial recommendation for the funding of both organizations.

The process which Health Care Plan has undergone demonstrates clearly that many HSA's do not have appropriate staff expertise to deal with the unique issues of HMO development. The criteria outlined in the federal regulations are too general and can, in some cases, be misleading. There is a definite need for more specific criteria and for criteria which are relevant to the major issues being addressed by HMO development.

The following organizations encountered serious planning difficulties with the local HSA during the grant funding process and have not become operational:

1. North Central Connecticut HMO
   275 Broad Street
   Windsor, Connecticut 06095

2. The Gulf Coast Family Health
   Foundation, Inc.
   912 Convent Avenue
   Pascogoula, Mississippi 39567

3. Southwest Medical Plan
   Suite 1111
   7430 Louis Pasteur Drive
   San Antonio, Texas 78229

4. Southeastern Montana Health Plan
   2101 Clark Street
   Miles City, Montana 59301

Documentation of the problems encountered by these organizations is on file with HEW's Division of HMO Development, 5600 Fishers Lane, Rockville, Maryland.

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TABLE II

Federal Employees Health Benefits Program Increase in Premium 1961-1978

Self and Family - High Option Coverage

	Biweekly Premium by Contract Year		Percent Increase
Government-Wide Plans	1961	1978	1961 - 1978
Service Benefit Plan	$ 8.94	$51.55	476.6%
Indemnity Benefit Plan	8.06	40.41	401.3%
Group Practice Plans			
Group Health Association, D.C.	13.09	56.38	330.7%
Group Health, Puget Sound	10.77	44.64	314.5%
Group Health, St. Paul	10.52	45.93	336.6%
HIP of Greater New York	12.89	37.33	189.6%
Kaiser, Hawaii	9.51	39.86	319.1%
Kaiser, Northern California	9.55	39.76	316.3%
Kaiser, Oregon	8.47	41.08	385.0%
Kaiser, Southern California	9.21	46.63	406.3%
Metro Health Plan, Detroit	11.45	61.15	434.0%
Ross-Loos Medical Group	8.72	49.97	473.0%
Individual Practice Plans			
Group Health Inc., New York	11.78	42.35	259.5%
Hawaii Medical Service	10.48	44.63	325.8%
Washington Physicians Services	10.71	51.13	377.4%

Source: U.S. Civil Service Commission, Bureau of Retirement, Insurance, and Occupational Health, Washington, D.C.

Senator KENNEDY. We will go to Mr. Graham now.

Mr. GRAHAM. Mr. Chairman and Senator Schweiker, I am Roger Graham, assistant vice president of health care services of the Blue Shield Association.

Today, I am also representing the Blue Cross Association. The Blue Cross and Blue Shield Association are the national coordinating agencies respectively of the 70-member Blue Cross plans in the United States and Puerto Rico and the 70-member Blue Shield plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts generally on amendments to the HMO Act, and on S. 2534 more specifically.

The views I shall present reflect the knowledge and experience gained by the Blue Cross organization, and the Blue Shield organization through the administration of both governmental and private underwritten health care financing programs, and through involvement in the HMO movement at the local, State, and national levels.

Today, Blue Cross and Blue Shield plans serve over 90 million subscribers under private programs and an additional 26 million people under Government programs.

Over the past 20 years, the Blue Cross and Blue Shield organizations have invested increasing amounts of financial resources and expertise in HMO's, in order to provide additional choice for our subscribers with respect to community financing and delivery of health care services. Blue Cross and Blue Shield plan associated HMO's now number 65, operating in 26 States and the District of Columbia and serving over 1.5 million people.

Generally, we support the majority of amendments proposed in S. 2534 as a means of fine tuning certain existing provisions of title XIII of the Public Health Service Act and furthering the development of HMO's into the next decade. Accordingly, for the sake of brevity, our statement will focus primarily on those proposed amendments which cause us some concern.

SPECIFIC COMMENTS ON S. 2534

First, we fully support as reasonable and needed changes sections 2, 3, 5, 6(a), 8, and 12, of S. 2534, which would respectively:

Clarify that only physician services offered by an HMO must be provided through the medical staff, group, or IPA; clarify that out-of-area services must be emergency services to be compensible, and permit waiver on contracting limits for outside services in the HMO's first 4 years of operation;

Increase the maximum overall and annual levels of financial support for individual HMO's, which we believe reasonably reflects inflationary trends since the act's inception;

Provide for reasonable limitations and exclusions on benefits as the Secretary may approve, as a contingency—we presume—against such major catastrophies as nuclear disaster, war, et cetera;

Require employers maintaining deduction systems to provide payroll deductions for employees electing HMO's; and

Extend the act through September 30, 1984, and increase the appropriations on a sliding scale from $50 million in fiscal year 1978 to $95 million in fiscal year 1983; restore to the Secretary's discretion the assignment of HMO administrative responsibilities.

Second, we generally support section 9, which establishes a national HMO intern program for HMO management personnel. We believe that such a program would significantly enhance the quality of HMO administration. We have two recommendations for improving this section. First, we recommend that a national advisory committee, consisting of representatives of appropriate health management disciplines, be established to guide the Secretary with respect to the overall implementation of this program, particularly the curriculum content. Also, we recommend that section 9 provide for the development by the Secretary of standards for intern applicants and the HMO's or other entities which may apply for grants under this section.

We oppose section 11, which would exempt HMO's from Federal requirements for State certificate of need programs. We believe, as the Blue Cross Association recently stated in testimony on the Health Planning Amendments of 1978, that HMO's should be subject to no more, and no fewer, controls than are imposed on capital expenditures of providers in the traditional health care delivery system or other alternative systems.

We recognize that problems may arise where an HMO's intent to use existing facilities on a contract basis is thwarted for one reason or another. Such as HMO may be forced to propose a capital expenditure to provide such services. To address this problem, we recommend that the act's provision for "special consideration" review criteria with respect to HMO applications be maintained. This provision assures an opportunity to examine the merits of the individual circumstances of such entities.

We wholeheartedly support the intent of section 10, to insure that HMO's are fiscally sound and do not engage in inappropriate business transactions. However, we have serious concerns with the specific requirements of section 10. The requirement to report transactions which "may have an adverse effect on the fiscal soundness and reasonableness of charges to the HMO" is vague. Overzealous administration of such a broad provision could place excessive administrative burdens and costs upon HMO's. To guard against that potential, we recommend either (1) that reasonable dollar or percentage of the budget parameters be specified in the act for transaction reporting; or, even more preferably, (2) that existing health insurance industry reporting practices be adopted. These require a detailed financial statement, a listing of parties at interest, and a report of the precise nature and extent of any relationships with other organizations, including common ownership and control. Authority should be given the Secretary to require further information on a case-by-case basis for investigative purposes.

Finally, we have a basic concern with sections 4 and 7 which would provide Federal financial support under the act to HMO's which "demonstrate capability for continued fiscal soundness" for the costs of equipping, constructing, acquiring, or renovating ambu-

latory care facilities and for the "improvement of services." We recognize the need to assist those HMO's which, although they are fiscally sound, are unable to obtain funds in the private market either because of the significant amount of debt they incurred to begin initial operations or because their short term in operation places them at a disadvantage against borrowers with more established credit records.

However, we argue against the provision of Federal funds to established HMO's whose fiscal soundness makes them capable of service improvement or facilities expansion through their own debt structure.

We would hope that the committee's report reflects the intent to provide Federal assistance only to those fiscally sound organizations unable to obtain financing in the private marketplace. Grant moneys to well-established HMO's might well merit support when those HMO's provide care to medically underserved areas.

Thank you again, Mr. Chairman and Senator Schweiker, for the opportunity to present our views today.

Thank you.

Senator KENNEDY. Let me just ask you if I could on these, Mr. Graham, as I understand what you are saying, you favor the requirements that exist under SEC in terms of disclosure?

Mr. GRAHAM. Essentially; yes.

We have talked about it in those terms.

Senator KENNEDY. Is it comparable comparison between HMO and insurance companies?

It seems to me that once providing services to a more complex, more complicated, more involved set of interests, their potential for conflict may very well be——

Mr. GRAHAM. I agree with you that they are different.

But the insurance industry has been through a number of comparable things.

I am thinking back to the days of management contracts which is abuse of a self-dealing type that we are now concerned about in HMO's, and I really think there are some things that could be crossed over effectively.

Senator KENNEDY. Mr. Lane, do you support financial disclosure?

Mr. LANE. Yes.

Mr. COHELAN. Yes, Senator.

Senator KENNEDY. The staff informs me that we have been over a number of times in terms of those particular provisions, and we are open to suggestions, and we are fully convinced that you are sincere in trying to deal with this issue as well, and will ask the staff to sit down with you and review them and find out again and see what suggestions you have.

Mr. GRAHAM. We would appreciate that opportunity.

Senator KENNEDY. Mr. Graham, in cases where Blue Cross/Blue Shield create an HMO, and that HMO is in competition with the existing Blue Cross or Blue Shield plan, do you see any danger of conflict of interest which may arise?

Mr. GRAHAM. I think there can be. I do not think there has to be, and I think we have built into this program perhaps inad-

vertently some things which tilt the balance toward the creation of a conflict-of-interest situation, the separate entity requirements and the concern over self-dealing, which we got burned pretty badly in California, and the concern is justifiable, but we should not let it make us paranoid.

Let us use your friendly Buick dealer as an example. He has got everything from an Opel to a Limited on the floor. And what he wants to do is sell you a car as an alternative to your buying it from the Chrysler dealer.

He will tell you what kind of car you want. The Blue Shield plan I was with has converted a third of their membership from conventional coverage to HMO coverage, using again the model you are familiar with because it was cited in the conference report of 1973.

In that kind of situation there is no conflict of interest. In fact, the plan is pushing the HMO expansion. If we create situations where there must be virtually adversary relationships between the two entities, then to try and bring the strengths of the private sector to bear on HMO problems does create some kind of conflict of interest.

I think the problem reaches back beyond conflict of interest, though.

Senator KENNEDY. Is it not different from the local car distributor in that the fact that the insurance company has heavy influence in terms of doctors themselves that would be involved in these programs?

Mr. GRAHAM. Well, we are sometimes given credit for having more influence than we do. I do think that the Blue Shield plans particularly can influence doctors' attitudes toward such things as HMO's, and we have got a flock of them to demonstrate that.

Senator KENNEDY. Mr. Lane, how many maintenance organizations are on hospitals or have exclusive use of hospitals?

Mr. LANE. There are five Kaiser Regions—we have six Regions—five of them own and operate their own hospitals.

Senator KENNEDY. How many HMO's would take advantage of the provision excluding certificate of need for hospitals?

Mr. LANE. It is a little difficult to say.

We think at the present time our organization would because we are planning either to buy or build new hospitals depending upon the economics of the situation.

Group Health Association here in Washington probably would. They have a serious problem. They have had difficulty in certificate of need. It does not appear that Group Health would in the near future.

The major development would be in southern California where we are growing rapidly and closed at the present time because we cannot get facilities on line. Also, in Hawaii.

Senator KENNEDY. This is what I was interested in, what you could tell us about the numbers that had been turned down by certificate-of-need panels for hospital construction.

Mr. LANE. My basic knowledge in that area is Group Health Association here in Washington, our own experience, and to date we have not been turned down.

We have come very close in about three cases within one vote, one of them lasting over a year, and the vote had to be reversed; we had to do some work.

It is a political process. It was not based on the merits of the case.

We have had to date no adverse experience in our own program.

I would like to give you a couple more illustrations of the kinds of things we are facing.

In Orange County, which you are probably familiar with, we have at the present time over 100,000 members, and we do not have a hospital. We need to get one there.

The HSA there has indicated very strongly that they would oppose our construction of the hospital.

We have had a site there——

Senator KENNEDY. What is the occupancy rate of the hospital?

Mr. LANE. Very low. About 50 percent.

There are a lot of little proprietary hospitals in that area, many of them inadequate, so the proposal by HSA is for us to purchase a hospital instead of building our own, and you would be surprised what that does to the price of hospitals.

We have had a number of proposals to sell hospitals to us at prices above any conceivable worth—one of them in bankruptcy two or three times.

Senator KENNEDY. Well, isn't there another side of that coin, too, that if you exclude the HMO's, they come in and increase the beds? We've seen in the past very unimaginative way of dealing with unused beds. Maybe you could do it better and cheaper in the one sense, and we are going to find unused beds in the other that we can't do anything with, in effect ending up in the totality paying a good deal more.

Now, how do we deal with that?

Mr. LANE. Well, there are two questions. The first is whether the total community really ends up paying more, and we have a study here by ICF, Inc., for HEW—we did not do, but we have looked at it—which indicates that even where an HMO develops its hospital, where there are excess beds, there is a total savings to the community. Now, that is based on some studies and premises which may be questioned—and what we have proposed in our amendments is an alternative for your consideration, because we realize that's an important question.

And that alternative basically says that if an HMO in an area where there are excess beds can't make use of those beds in a manner that makes sense—and we have outlined what we think that is: cost effective, get the positions on the staff—then in that case it should be allowed to build, because if you don't do that, what you are doing is placing in the hands of the existing hospitals and their reluctance to deal with the HMO the ability to stop it. It's essentially what you are doing.

So what we are proposing is to say if that occurs, then free the HMO and let it go ahead.

Senator KENNEDY. Well, what do we do—look at it from our point of view—if we give you an exclusion, what about other groups that are going to come in and ask for an exclusion?

Mr. LANE. Well, we will help you resist them. I think you have to look at each on their merit. That's why we have presented an alternative. If you would ask us what we like, we would like an exclusion.

But we are also proposing an alternative, and we think that alternative is defensible. It is in the California law now. We are using it in California and testing it. For example, we have a CT scanner application before the California State agency, in that we have estimated that it's costing us over $350,000 more a year to buy scans on the outside than to have our own scanner. We have 1.4 million people in northern California without a scanner.

Senator KENNEDY. Hoy many scanners do you have for your whole population? Relatively few, isn't it?

Mr. LANE. We have one.

Senator KENNEDY. As I remember, there are 75 in Los Angeles County.

Mr. LANE. There's a large number. I don't know that anybody knows exactly how many there are, because many of them don't have to go through the planning process.

Senator KENNEDY. I think it is interesting that you have been able to provide a high degree of quality care and have still, in the particular area of technology, been able to keep the care from——

Mr. LANE. Well, we do use outside resources.

Senator KENNEDY. Yes.

Mr. LANE. We used Dr. Shumway for open heart in California. The thing that we are concerned about, Senator, is basically we have a fairly sophisticated organization, and we have been fairly successful. That is not true of practically any other HMO in the country.

And unless the Federal Government really lays down guidelines and has proper criteria, those HMO's are going to be in real trouble when it comes to getting approval. And it is just as simple as that.

And they just don't have the ability to put on the political capability, the lawyers and everything else, on top of the manager capability. It's a tremendous drain on the managers in an HMO to have to go through a process like this. It has to get approval to build an ambulatory clinic, to go to night meetings, and the whole business. So we think very strongly on the ambulatory side your bill moves in the right direction. It just needs to go further and require States to do the same.

On the inpatient side we have offered two alternatives.

Mr. COHELAN. Senator, adding to the eloquent testimony of Mr. Lane, there will be a panel following this one where some of these developing programs will be testifying.

Senator KENNEDY. Senator Schweiker.

Senator SCHWEIKER. Thank you, Mr. Chairman. First, I would like to commend this panel. I know they have worked very hard with other members of the "consensus group" on HMOs to try to define their differences and reach some common agreements on where the program should go. And I know that isn't easy in a group that has such diversity as yours. I think that you have made great efforts for the benefit of the HMO concept, and I think you should be commended for that.

I would like to ask you, Mr. Anderson, following up on our earlier discussion, what your views are concerning the need for some sort of fraud and abuse provision, in addition to the present law, in order to prevent recurrences of the type of abuses and occurred in California?

Mr. ANDERSON. I do have a prepared statement.

Senator KENNEDY. That's right, I don't think we have given you a chance to deliver that. I am sorry, I apologize.

Senator SCHWEIKER. Please go ahead.

Mr. ANDERSON. Mr. Chairman and Senator Schweiker, my name is James Anderson, I am counsel of Connecticut General Life Insurance Co., and appear today on behalf of the Health Insurance Association of America.

The companies I represent, who provide health insurance protection for over 100 million Americans, have long been concerned with the health delivery system, and in that connection have lent active support to HMOs. Our companies have invested approximately $80 million in HMO development.

Fifty-five insurance companies are involved in 79 development projects nationwide. Twenty-two such companies are involved in fifty operational HMOs located in 25 States. Twelve of these HMOs have received HEW qualification.

Connecticut General has been involved in the development of closed-panel group practices for some 10 years. Our first plan was established in conjunction with Johns Hopkins Medical School in Columbia, Md., in 1969, and our second plan, the Arizona Health Plan, was established in Phoenix, Ariz., in 1972. We currently have enrolled over 60,000 prepaid members.

Mr. Chairman, I think it obvious from what I have said that commercial insurers support the development of HMOs. Accordingly I want to express our approval of your and Senator Schweiker's efforts to stimulate the development of HMOs and express our support with qualifications that I will mention of S. 2534, the Health Maintenance Organization Act amendments of 1978. This legislation will assist HMOs to develop in the market place and give the Department of HEW the wherewithal to implement a program that will constructively assist HMOs to develop.

Today I would like to comment specifically on section 10 of S. 2534, which adds a new section, section 1318, to title 13, to impose certain financial reporting requirements on HMOs. Subsection 1318 (a)(2) is intended to address financial abuses which have arisen with certain prepaid health plans by requiring that so-called party-in-interest transactions be reported to HEW. Such reports would serve to advise HEW of situations which they may wish to investigate relative to possible noncompliance with the act, would enable HEW to report to Congress concerning the consequences of these transactions, and, through public disclosure, would hopefully deter transactions which are grossly unfair to the HMO. We agree that some abuses have taken place and that the approach of addressing this situation through appropriate disclosure is sound.

The problem is to adequately define those transactions which would be reported for this purpose. Obviously an overbroad or

vague definition may impose an unnecessary and complex reporting burden on the HMO, but it may also frustrate the purpose of the reporting requirement. The report should serve the practical purpose of being a red flag as to transactions which bear looking into by HEW.

Accordingly, section 1318(a)(2) reporting requirements should not be overly broad.

HEW is much less likely to identify and follow up on a particular suspicious transaction if it is buried in a report containing many other unexceptionable transactions. The general concept I have described—what we might call the "red flag" approach—seems to be intended in the existing bill, since only transactions which "may have an adverse effect on the fiscal soundness of and reasonableness of charges to the Health Maintenance Organization" need be reported.

I would suggest, however, that this language be made more specific. Our particular concern is that the present language may result in filing requirements which have more to do with the happenstance of the organizational structure of the particlar HMO than with the existence of transactions which constitute a red flag in any meaningful sense. This point may best be made through a specific example.

Assume, in case A, a staff model HMO which is owned by the fulltime staff physicians who provided the equity capital. Their provision of medical and other services to the HMO would not create any reportable transactions since there is only one entity involved. In case B, assume that these physicians own the HMO and devote their energies to it full time, but that they chose to operate under a medical group model. These two cases may be equivalent for all practical purposes, and yet in case B the reporting of various transactions between the medical group and the HMO may be required simply because an additional entity exists.

How would such transactions be defined? Suppose, for example, that the HMO pays the medical group for its services monthly. Is each monthly payment a reportable transaction? If so, how detailed need the report be as to the medical and other services for which compensation is being paid?

The solution to this problem is to somehow distinguish between transactions involving ordinary activities of the HMO and transactions which are exceptional in nature. For example, if the HMO were to buy a piece of land on which to build a facility or contract with a construction company or engage a management consulting firm to perform a particular consulting contract, these would all be extraordinary transactions which would be subject to the reporting requirement irrespective of the organizational form of the HMO.

What it really comes down to is that there are certain basic functions which must be accounted for in order for any HMO to operate. Under the act, the risk-bearing function must basically be assumed by the HMO entity itself. Apart from this constraint, so long as the operational criteria mandated in section 1301 are effectively met, it is the policy of the act to allow flexibility as to how the HMO is organized. It is unnecessary and inadvisable to allow section 1318 (a)(2) to conflict with this basic policy.

If such a conflict is to be avoided, it should be made clear that the transactions which are subject to reporting under section 1318 (a) (2) are somehow extraordinary, that is, that they are not the kind of services, et cetera, which the principal parties involved in any HMO would normally be expected to provide, whatever the organizational format.

We would be more than happy to work with the committee and its staff in attempting to draft appropriate language such that the definition of reportable transactions accomplishes its purpose of constituting a red flag in a meaningful sense.

We have one additional suggestion, namely, that there be a specific minimum size criterion as to transactions which would be reportable. Since the purpose is to identify transactions which might have a significant adverse effect on the HMO, some sort of sliding scale would seem appropriate. We would recommend that this minimum be expressed as a percentage of annual operating revenues of the plan. Five percent, for example, might be a reasonable minimum reporting amount.

In 1967 the National Advisory Committee on Health Manpower in its attempt to assess the primary causes of what they conceived as a crisis in the American medical care system concluded that a structural change in the delivery of medical care was needed, stating:

> Unless we improve the system through which health care is provided, care will continue to become less satisfactory, even though there are massive increases in cost and in numbers of health personnel.

The 1973 Health Maintenance Organization Act, the 1976 amendments, and these proposed amendments are large steps towards effectuating that 1967 recommendation.

That's the end of my prepared statement, and now perhaps I should answer your question.

Senator SCHWEIKER. Well, I think you did through your statement.

Mr. Lane, what does the available data show about the effect of health care costs in a community where an HMO hospital is introduced?

Mr. LANE. There isn't a lot of very good information on the subject, but the best we have been able to find is the study by ICF, Inc., for HEW, and I have included an excerpt from that statement. And essentially they have determined that over a reasonable period of time, when an HMO gets to be about 60,000 members, if it builds its own hospital, even though there are surplus beds in the community, there is a general savings to the total community and that results essentially in lower utilization by the HMO membership.

They obviously determined also that if the HMO can have satisfactory relationships with the hospitals in the area that there is an even greater savings to the community. And that is one of the reasons why we proposed the alternative.

But there has not been a lot of work in this area. There are only about 38 HMO hospitals in the country and nobody is really very interested in studying them very much that I can determine.

Senator SCHWEIKER. All right. Are there any other panelists who would like to make a statement?

Mr. Hoffheimer?

Mr. HOFFHEIMER. Thank you, Senator. Mr. Chairman, my name is Larry Hoffheimer, I am counsel to the American Group Practice Association.

The AGPA represents medical group practices across the country. Our membership includes groups practicing totally on a fee-for-service basis, some totally on a prepaid basis, and some which operate in a mixed form, both prepaid and fee for service.

The American Group Practice Association supported the original enactment of the HMO Act in 1973, most of the 1976 amendments to that law, and we are in substantial agreement today with the proposed amendments being testified on here.

However, we are concerned, as we have been in the past, with the law's treatment of fee-for-service medical groups which desire to convert a portion of their practices to federally qualified prepayment or HMO plans. Because we feel that our country's group medical practices offer one of the most fertile grounds for HMO development, and because of our support of HMO development, we would like to address this issue in more detail with staff and by a written submission.

We appreciate the opportunity to be here today. Thank you.

Senator SCHWEIKER. Thank you. Are they other comments?

Mr. EPSTEIN. Senator Schweiker, I have a short statement which I will just give to the record in the interest of time.

Senator SCHWEIKER. Fine. I thank you all very much for your participation. I am sure that on some of these issues we will probably need to continue discussions to see if we can't resolve some of the issues you have raised. We appreciate your assistance and interest in this legislation.

Thank you very much.

STATEMENT OF ROGER W. BIRNBAUM, EXECUTIVE DIRECTOR, RUTGERS COMMUNITY HEALTH PLAN, NEW BRUNSWICK, N.J., ACCOMPANIED BY ELI EGERT, PRESIDENT, PENN GROUP HEALTH PLAN, PITTSBURGH, PA.; ROBERT RASMUSSEN, EXECUTIVE DIRECTOR, PRIME HEALTH, KANSAS CITY, MO.; AND FREDERICK RICE, EXECUTIVE DIRECTOR, VALLEY HEALTH PLAN, AMHERST, MASS., A PANEL

Senator SCHWEIKER. Now we will call a panel consisting of Roger Birnbaum, executive director of the Rutgers Community Health Plan, New Brunswick, N.J.; Eli Egert, Penn Group Health Plan, Pittsburgh, Pa.; Robert Rasmussen, executive director, Prime Health, Kansas City, Mo.; Frederick Rice, executive director, Valley Health Plan, Amherst, Mass.

In view of our time constraints, I wonder if you limit your oral presentation to five minutes, so that we have a little more time for questions. We, of course, will insert your complete statement in the record.

Mr. Birnbaum?

Mr. BIRNBAUM. Thank you, Senator. Mr. Chairman and members of the committee, I am Roger W. Birnbaum, executive director of the Rutgers Community Health Plan located in New Brunswick,

N.J. With me today are Eli Egert, Robert Rasmussen, and Richard Rice, executive directors respectively of the Penn Group Health Plan in Pittsburgh, Prime Health in Kansas City, Mo., and Valley Health Plan in Amherst, Mass.

The four nonprofit HMO's we represent, serving varied population groups in different parts of the country, are perhaps typical of the many and new developing plans whose existence is the direct result of the support provided under the federal HMO Act of 1973 and the HMO amendments of 1976.

The Rutgers Community Health Plan's development was an outgrowth of interest on the part of Rutgers University faculty, staff and administration in making available to the university community alternative health benefit and service arrangements. With a broadened involvement of area management, labor and community interests, the plan incorporated as an independent nonprofit entity in 1975. RCHP opened its doors for service as a federally qualified HMO on July 1, 1976, currently serves 21,000 members in a centrally located health center and expects to reach a break-even enrollment of 32,000 in about 1 year. With a total service area population of 1.3 million, the potential for growth beyond the 35,000-member capacity of the plan's current facilities is significant.

The Penn Group Health Plan's development represents an alliance of Pittsburgh area labor and corporate interests. The plan started service in June 1975 and became federally qualified in November of that year. Penn Group currently serves 18,000 members in two leased facilities, and expects to reach a break-even enrollment level of 23,000 to 25,000 this summer. Serving a two-county area with a combined population of 1.6 million, Penn Group also has significant potential for future growth.

HMO field development activities conducted by GHAA in the early 1970's, combined with Federal financial support in 1974 and 1975, led to the initiation of Prime Health under joint labor-management sponsorship in November of 1976. Prime Health currently serves 12,000 members in a centralized health center, and expects to reach a break-even level of 20,000 members in January of 1979. The plan serves the southern part of Kansas City, Mo., with a population of 850,000, but future expansion could enable it to reach a total metropolitan area population of 1.3 million.

The Valley Health Plan has brought together consumer interests, the University of Massachusetts Health Service and a private physician group in a unified HMO that started serving enrolled members in October of 1976. AHP's 7,500 members are treated in either the university's or the medical group's facilities. The area served by the plan has a population of 125,000, and future expansion would enlarge the service area by an additional 60,000 residents.

I would like to briefly comment on prospects for and what we see to be obstacles to future growth.

All four HMO's have a short but successful track record in fulfilling the congressional intent embodied in the Federal HMO Act and its amendments.

Like the more mature HMO prototypes they have demonstrated their ability to offer accessible quality health care to their enrolled

members with greater reliance on diagnostic and treatment services in ambulatory health centers, fewer days of haspitalization, and lower overall health care costs than traditional fee-for-service arrangements.

All four plans, and others like them around the country, have the potential to offer these advantages to substantially larger numbers of enrollees than their current resources permit, but still face formidable obstacles in doing so. Clearly, it is in the national interest to assist in the further expansion of young successful HMO's to assure a maximum return on the investment already made in their development.

The HMO amendments of 1978 embodied in S. 2534 represent a logical extension of earlier Federal initiatives to reduce obstacles and provide encouragement to further HMO expansion. I would like to briefly address the four issues that we regard as most significant in the legislation.

First, development grants and initial operating loans. By increasing the maximum amount authorized for development grants from $1 million to $2 million per HMO, and by permitting HMO's to continue to receive grant money after they become operational for purposes of continued development, the proposed 1978 amendments properly recognize both the impact of inflation since the original limits were authorized in 1973, but, more significantly, the needs for expanded development activity as demonstrated by the four relatively young HMO's represented here today.

As in the case of grants for continuing development, the larger operating loan sums should be considered as providing the potential to support the further development of successful plans.

Second, I would like to comment on the ambulatory care facility issue. Ownership and control of ambulatory facilities are important to an HMO's ability to maximize its cost containment potential. However, even the more successful of the new and developing plans lack the equity base and the track record of many years' standing to successfully generate capital in the private financial community. The program of loan and loan guarantees provided in S. 2534 are necessary to meet the clear needs of HMO's for facility capitalization.

On the subject of health planning amendments, HMO's are currecently required under Public Law 93–641 to submit to local, regional, and State health planning reviews in order to secure certificates of need for development and for facility construction. Despite the nominal majority of consumer representatives on HSA Boards, HMO's are confronted by vocal and influential providers who are antagonistic and unsympathetic to the increased competition in the health care marketplace that HMO's present. The result is too often a subversion of the intent of the legislation under which the health planning process was established. And, in addition, it is clearly inequitable to require of HMO's what is not required of competing fee-for-service providers.

The demonstrated achievements of HMO's, after all, are primarily a product of that system's internalized planning mechanism that utilizes financial incentives in balancing resources to needs. If

HMO's are to be encouraged to develop, they clearly require the kind of exemption from the certificate-of-need process contemplated in S. 2534. The amendments must provide an affirmative statement of exemption from all State CN laws as well, however, to avoid continued entanglement with various State statutes that will be very difficult to modify on a State-by-State basis.

Finally, with regard to managerial training. Management is second only to facility capital as the critical resource limitation to further HMO development, and it may even be first. There is a paucity of experienced HMO management in the country, and the health care sector generally has not been considered an attractive career setting for well-trained and experienced managers. Resources are desperately required to support the same programs of management development that can produce individuals with the management skills and knowledge necessary to assure the most effective use of limited HMO resources.

We thank you for your consideration of these issues that are so vital to the future development of this promising pattern of health care delivery in our country.

A more complete statement, Senator, has been made available to committee staff. Any or all of us would be pleased to respond to your questions.

[The prepared statement of Mr. Birnbaum and additional material for the record follows:]

STATEMENT BEFORE THE

SUBCOMMITTEE ON HEALTH
AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

SUBMITTED BY

RUTGERS COMMUNITY HEALTH PLAN, INC.
PENN GROUP HEALTH PLAN
PRIME HEALTH
VALLEY HEALTH PLAN

MARCH 3, 1978

Mr. Chairman and Members of the Committee, I am Roger W. Birnbaum, Executive Director of the Rutgers Community Health Plan (RCHP) in New Brunswick, New Jersey. With me today are Eli Egert, Robert Rasmussen and Richard Rice, Executive Directors respectively of the Penn Group Health Plan in Pittsburg, Prime Health in Kansas City, Missouri, and Valley Health Plan (VHP) in Amherst, Massachusetts.

New and Developing Plans

The four HMOs we represent serving varied population groups in different parts of the country, are perhaps typical of the many new and developing plans whose existence is a direct result of the support provided under the Federal HMO Act of 1973 and the HMO Amendments of 1976.

The Rutgers Community Health Plan's development was an outgrowth of interest on the part of Rutgers University faculty, staff and administration in making available to the University community alternative health benefit and service arrangements. With a broadened involvement of area management labor and community interests, the Plan incorporated as an independent non-profit entity in 1975. RCHP opened its doors for service as a Federally-Qualified HMO on July 1, 1976, currently serves 21,000 members in a centrally located health center and expects to reach a breakeven enrollment of 32,000 in about one year. With a total service area population of 1.3 million in a mixed urban and suburban area with a strong and growing academic and industrial base, the potential for growth beyond the 35,000 member capacity of the Plan's current facilities is significant.

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The Penn Group Health Plan's development represented an alliance of Pittsburgh area labor and corporate interests. The Plan started service in June 1975 and became Federally Qualified in November of that year. Penn Group currently serves 18,000 members in two leased facilities, and expects to reach a breakeven enrollment level of 23-25,000 this summer. Serving a two-county area with a combined population of 1.6 million, Penn Group also has significant potential for future growth.

HMO field development activities conducted by the Group Health Association of America in the early 1970's, combined with Federal financial support in 1974 and 1975, led to the initiation of Prime Health under joint management-labor sponsorship in November of 1976. Prime Health currently serves 12,000 members in a centralized health center, and expects to reach a breakeven level of 20,000 members in January of 1979. The Plan serves the southern part of Kansas City, Missouri with a population of 850,000, but future expansion could enable it to reach a total metropolitan area population of 1.3 million.

The Amherst Health Plan has brought together consumer interests, the University of Massachusetts Health Service and two private physician groups in a unified HMO that started serving enrolled members in October of 1976. AHP's 7,500 members are treated in either the University Health Services' or the Amherst Medical Associates' facilities. The Amherst/ Northhampton, Massachusetts area served by the Plan has a population of 125,000, and future expansion would enlarge the service area by the additional 60,000 residents of Greenfield.

Prospects for, and Obstacles to, Future Growth

All four HMOs have a short but successful track record in fulling the Congressional intent embodied in the Federal HMO Act and its Amendments. Like the more mature HMO prototypes they have demonstrated their ability to offer accessible, quality health care to their enrolled members, with greater reliance on diagnostic and treatment services in ambulatory health centers, fewer days of hospitalization, and lower overall health care costs than traditional fee-for-service arrangements.

All four plans, and others like them around the country, have the potential to offer these advantages to substantially larger numbers of enrollees than their current resources permit, but still face formidable obstacles in doing so. Clearly it is in the national interest to assist in the further expansion of young successful HMOs to assure a maximum return on the investment already made in their development.

Congressional activity in encouraging HMO growth has been steadily responsive to the barriers confronted in attempts at their development or expansion. The Federal HMO Act of 1973 provided financial assistance, access to market and supersession of certain restrictive state laws and regulations; but at the same time it imposed coverage and open enrollment provisions so far in excess of those offered by traditional plans that the ability of HMOs to survive in a competitive marketplace was jeopardized. The HMO Amendments of 1976 corrected the shortcomings of the 1973 Act and made possible a substantial increase in the number of enrollees in Federally Qualified HMOs. Barriers remain, however, to accelerating the development and

growth of HMOs and, therefore, to realizing the cost containment potential of such health care delivery systems. The HMO Amendments of 1978 embodied in S. 2534 represents a logical extension of earlier Federal initiatives to reduce obstacles and provide encouragement to further HMO expansion. I would like to briefly comment on four issues addressed in this legislation: development grants and initial operating loans; ambulatory care facilities; health planning amendments; and managerial training.

1. Development Grants and Initial Operating Loans.

By increasing the maximum amount authorized for development grants from $1 million to $2 million per HMO and by permitting HMOs to continue to receive grant money after they become operational for purposes of continued development, the proposed 1978 Amendments properly recognize both the impact of inflation since the original limits were authorized in 1973 and the needs for expanded development activity as demonstrated by the four relatively young HMOs represented here today.

S. 2534 wisely requires that grants made for initial and continuing development not in the aggregate exceed the maximum sums authorized per HMO, providing an incentive for each plan to expend its initial development grant carefully thus retaining as much as possible for continuing development at a later date. The amendment providing that continuing development grants may be made only to an entity which demonstrates the capability of maintaining continued fiscal soundness, requiring that HEW apply tight fiscal standards, should serve to safeguard these incremental authorizations and assure their

effective utilization. Recognizing the risks inherent in any new project, development funds invested in further developing a successful HMO have greater prospects for successful return than those invested in additional new HMOs, although both are clearly needed.

Similarly, increasing the maximum initial operating loan available per HMO from $2.5 million to $5 million would assist HMOs in coping with the effects of inflation, as well as the need to support the second-stage operating losses incurred as a result of the expansion of initial facilities. As in the case of grants for continuing development, the larger operating loan sums should be considered as providing the potential to support the further development of successful plans, not the bailout of weaker ones, necessitating monitoring for continued fiscal soundness.

2. Ambulatory Care Facilities.

Group Practice HMOs require ambulatory health centers to coordinate a range of diagnostic and treatment resources and to serve as primary delivery sites. When the original Senate and House HMO bills were reconciled in conference, the resulting Act of 1973 failed to recognize the necessity for construction capital. The four plans represented here today managed through various approaches to overcome that obstacle in their initial development, although in some instances to their economic detriment; all four plans, however, in spite of their ability to demonstrate financially successful programs lack the equity base and the track record of many years standing, to successfully generate capital in the private financial community.

The Rutgers Community Health Plan has perhaps been unique among the newer plans in assembling a consortium of local banks to finance the expansion of its initial health center. Given its negative net-worth position, however, it will lack the borrowing capacity to finance the future facility growth it will require in about 15 months if it is to continue to meet the demand for membership in its service area.

Ownership and control of ambulatory facilities are important to an HMO's ability to maximize its cost containment potential. The program of loan and loan guarantees provided in S. 2534 are necessary to meet the clear needs of HMOs for facility capitalization.

3. Health Planning Amendments.

HMOs are currently required under P. L. 93-641 to submit to local, regional and state health planning reviews in order to secure certificates of need for development and facility construction. Despite the nominal majority of consumer representatives on Health System Agency Boards, HMOs are confronted by vocal and influential providers who are antagonistic and unsympathetic to the increased competition in the health care marketplace that HMOs present. The result is too often a subversion of the intent of the legislation under which the health planning process was established. In addition, it is clearly inequitable to require of HMOs what is not required of competing fee-for-service providers.

The Rutgers Community Health Plan faced considerable opposition in its efforts to secure approvals for its facility expansion from the provider

interests on county and regional planning bodies, gaining approval from the state body only after long and costly delays. We, and most of the other plans here today, expect to encounter similar resistance in the future as provider groups threatened by our attempts at future expansion exert pressure on local and regional planning bodies.

The demonstrated achievements of HMOs, after all, are primarily a product of that system's internalized planning mechanism that utilizes financial incentives in balancing resources to needs. If HMOs are to be encouraged to develop they clearly require the kind of exemption from the certificate-of-need process contemplated in S. 2534. The Amendments must provide an affirmative statement of exemption from all state CN laws as well, however, to avoid continued entanglement with varied state statutes that will be very difficult to modify on a state-by-state basis.

4. Managerial Training.

Management is second only to facility capital as the critical resource limitation to further HMO development, and it may even be first. There is a paucity of experienced HMO management in the country, and the health care sector generally has not been considered an attractive career setting for well-trained and experienced managers.

While expertise is available from the established base of successful operating plans, premium charges to enrolled members cannot be expected to support the cost of transmitting that expertise to others. Resources are required to support sustained programs of management development to produce individuals with the management skills and knowledge necessary

to assure the most effective use of limited HMO resources. A segment of this training can be secured through specialized academic programs; the major share can best be provided by the programatic field internships of the type provided for in S. 2534.

We thank you for your consideration of these issues that are so vital to the future development of this promising pattern of health care delivery in our country. Any or all of us would be pleased to respond to your questions.

VALLEY HEALTH PLAN

AMHERST, MASSACHUSETTS

Valley Health Plan was proposed in the late '60's by the Faculty Senate of the University of Massachusetts. It was planned and developed in the '70's by a coalition of consumers and providers in the Amherst area, most notably the University Health Services of UMass and Amherst Medical Associates, a private group practice. VHP was incorporated in 1975 as a non-profit corporation, governed by a board of providers (6) and consumers (9).

VHP was planned and developed by federal grants under P. L. 93-222 totaling $648,000. It began serving members in October, 1976. As of March, 1978, VHP has approximately 7,500 enrollees, of whom 60% are employees or their dependents at UMass.

VHP is a medical group HMO. The two VHP groups are the University Health Services and Amherst Medical Associates. VHP applied for federal qualification in May, 1977; that application is pending with DHEW. VHP holds license No. 3 as an HMO under Massachusetts law enacted in 1976.

VHP has operated at breakeven since it began operations in 1976. It has no current indebtedness, although the future likelihood of capital needs for expansion will probably change this situation.

PRIME HEALTH
Community Group Health Plan

The optimum in coordinated medical services: individualized concern and specialized care.

PRIME HEALTH: A Brief Description

PRIME HEALTH, a not-for-profit, community-sponsored health maintenance organization, can trace its beginnings to the early 1970's, when a group of interested citizens, with the support of Group Health Association of America, Inc., combined to demonstrate the feasibility of a prepaid group practice in Kansas City. Grants in 1974 and 1975 from the Department of Health, Education and Welfare allowed the planning and development of PRIME HEALTH to be completed.

In November, 1976, PRIME HEALTH received notice from the Department of Health, Education and Welfare of its Qualification under the HMO Act of 1973 and opened its doors to members. Acceptance by the community has been good for this new concept. Sixteen months after opening, PRIME HEALTH enjoys a membership of over 11,300 through the participation of some 75 different employers. The Plan continues to grow ahead of schedule, with current projections indicating that a membership of 24,000 members can be anticipated by July 1, 1979.

The PRIME HEALTH medical staff, numbering over 25 full and part-time physicians, provides services in a modern 32,000 sq. ft. medical center. The center is designed to provide care for over 24,000 members and includes services such as laboratory, X-ray, pharmacy, eye care and mental health, in addition to pediatrics, internal medicine and obstetrics.

PRIME HEALTH is located in the southern portion of Kansas City, Missouri, close to I-435, a major highway encircling the urban area of Kansas City. Indications are that expansion will soon be required to provide services to other regions of the Kansas City area.

PRIME HEALTH enjoys a broad base of consumer and provider support. It is no longer supported by grant funds and has made good use of the federal monies invested in the program. The Board of Directors, composed of management, labor, health professionals, and Plan members, is dedicated to assuring that high quality health care is provided to citizens of Kansas City in a cost-effective manner.

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Senator SCHWEIKER. Thank you. Are there other statements?

Mr. RASMUSSEN. I think we can respond to questions.

Mr. BIRNBAUM. This is a joint statement, Senator, by the four plans, and we are all available to respond to questions.

Senator SCHWEIKER. Very well. In your statement, you say, "In addition, it is clearly inequitable to require of HMO's what is not required of competing fee-for-service providers."

I wonder if you could just elaborate on that.

Mr. BIRNBAUM. Yes, Senator. Fee-for-service providers could develop facilities, resources, with equipment identifical in scope to those proposed by HMO's, but would not be subject to certificate-of-need requirements as HMO's are. That is, they are considered to be in the private sector; they are not institutional health services; they are subject to no controls whatsoever.

To that exent, subjecting HMO's to these requirements represents an inequity.

Senator SCHWEIKER. I would like to ask you, Mr. Birnbaum, what is your estimation of the need for fraud and abuse provisions such as section 10 in our bill?

Mr. BIRNBAUM. Well, I think I speak for all of the developing plans sitting here in supporting the fraud-and-abuse provisions. We all represent nonprofit HMO's. We have an interest in seeing that the HMO's that develop, whose experience will certainly contribute to or detract from our reputation, not be troubled by the few but troublesome fraud-and-abuse problems that have come to the public attention.

So we would support those provisions.

Senator SCHWEIKER. Do you have any observations on the difficulties HMO's have had in getting money for ambulatory care facilities? Why you would find this provision of our bill necessary?

Mr. BIRNBAUM. Well, I think it's primarily necessary because we are dealing with a group of nonprofit HMO's. By definition these are programs that do not have an equity base. They cannot go into the financial community; they cannot demonstrate positive net worth; they do not represent bankable propositions, at least not during their second and third stages of continuing growth.

I think until they have an opportunity to demonstrate that they have long-term potential, they are not going to be attractive in the financial community.

Now, in our particular setting, we were successful in getting a consortium of banks to advance funds to expand our initial health center, but as we look 18 months down the road to the need for additional expansion, we have no more borrowing capacity to draw upon.

So the need in our particular case—and I think we are typical of a number of successful plans that want to capitalize on our early success, make this program to the larger number of potential members who would take advantage of it—we really would have no place to turn.

The combination of our long-term Federal loan, and what private capital facility we have been able to generate, leaves us no further borrowing capacity to draw upon in the private sector.

Senator SCHWEIKER. Now, you mentioned your concern about the planning process, and discrimination against HMO's. I wonder if you could give us a specific example illustrating your concern with certificate of need review with respect to HMO's.

Mr. BIRNBAUM. Senator, I have left with committee staff a document that describes the problems encountered by some six or seven HMO's in securing certificates of need. But in general response to your question, I think the problems are twofold.

No. 1 is the problem of delays, inevitable delays in handling the bureaucratic process of securing an HMO——

[The information referred to follows:]

Question. Can we give examples of third party and self-dealing relationships?

Answer. We found that six HMO's had third party and/or self-dealing relationships.

EXAMPLE 1

From the time the HMO opened its doors, it has been leasing an outpatient health care facility with a capacity which far exceeds reasonable expectations of its membership growth during the forseeable future. In our opinion, this has occurred mainly because of inadequate planning by persons who had no prior experience in HMO management and partially because of self-dealing relationships involving officers of the HMO.

Three persons on the HMO's board of directors are members of a partnership, which is separate from, but exists because of, the HMO. One partner is the HMO's president and medical director. Another partner is the HMO's executive vice president and medical center administrator, and the third partner serves as secretary and treasurer of the HMO and represents it as its general counsel.

In 1973 the partnership leased a tract of land from the partner who is the president of the HMO, and the partnership borrowed about $1.1 million to build a health center large enough to serve about 40,000 members. However, the HMO estimates that its membership at the end of 1981 will be only 20,400.

In mid-1974, the HMO leased the building from the partnership and agreed to pay all costs associated with maintaining the building, including taxes, insurance, maintenance, and principal and interest on the building mortgage. The HMO estimates that these costs will amount to over $200,000 for calendar year 1978.

As of June 30, 1976, the HMO's balance sheet showed that it had furniture and office equipment which had been purchased with Federal grant funds at a cost of about $13,000. All medical equipment and some office equipment used by the HMO had been leased from the partnership; however, neither the HMO nor the partnership could provide to us an equipment inventory listing which segregated equipment purchased with grant funds from the partnership's equipment.

EXAMPLE 2

The HMO's organization chart indicates that it is an independent entity which obtains certain services through a contract with Blue Cross-Blue Shield (BC-BS); however the HMO interrelates with BC–BS in several ways.

BOARD OF DIRECTORS

BC and BS elect the HMO's Board of Directors. In addition, 5 of the 25 members on the HMO's 1976 Board were also on either the BC or the BS Board of Directors.

EXECUTIVE DIRECTOR

For a period of about 3 weeks in February 1977, BC's President also served as the HMO's Executive Director. He told GAO that the HMO's Board of Directors felt that a full-time Executive Director was no longer needed. Therefore, the Board's Executive Committee recommended his appointment as the HMO's Executive Director contingent upon a legal determination that there would be no conflict of interest between these two positions.

At its February 1977 meeting, the Executive Committee apparently recognized that there would be a conflict and promoted the Associate Executive Director of the HMO to Executive Director. Before coming to the HMO in 1972, he had about 17 years experience with another Blue Cross organization.

Senator SCHWEIKER. You feel it is deliberately directed at HMO's or just "normal" bureaucratic delays?

Mr. BIRNBAUM. I think it's a combination of the two, but I think the provider elements on the HSA Boards can deliberately compound the bureaucratic process and use the bureaucratic process in a way that makes it more difficult for the HMO.

The HMO is the new boy in town. To the extent that providers on HSA Boards cooperate with one another in working out what they mutually hope to achieve through the process, the HMO represents an outsider trying to come into the process. So the provider indirectly can make the bureaucratic process a more formidable obstacle, but the examples indicated in the materials left with the committee staff provide very specific illustrations of overt hostility on the part of providers who just don't want to welcome competition in the health care sector. And even though they may not in all cases represent a majority on the board, their persistence, their vested interest in the planning process as such—that they tend to by and large represent the prevailing viewpoint of the health planning agencies.

Senator SCHWEIKER. I would be glad to have any other responses to my questions from any of the other panelists.

Mr. RICE. Thank you. Senator, I am Frederick Rice—I didn't get a nameplate. I think one of the other things that you ought to keep in mind is the consumers on most HSA's are relatively new to what is a relatively new process. And that most of the ones that I have been involved with are pretty conscientious about their responsibilities, but they are focusing on a mandate which really doesn't apply to HMO's. They are trying to deal with an allocation of resources in a market which doesn't allocate its own resources. And their perspective on what their job should be is very difficult for them to give up when they come to something like an HMO, which is basically dealing with internal allocation of resources.

I think if you see some of the plans that have been produced by the HSA's over the recent past, and you see their—what they are intending to do in terms of providing service to under-served areas in terms of regulating resources in an area, you will see that there isn't much place for HMO's in that process. There is not much consideration of HMO's except as an afterthought.

So our experience has been not necessarily that the providers are antagonistic, but that the consumers really don't understand.

Senator SCHWEIKER. Mr. Egert?

Mr. EGERT. Yes; I would like to respond to your question concerning the ability to attract capital.

Firstly, ambulatory care facilities for an HMO are generally a single-purpose building which has potential, great potential risk to a venture-capital developer putting it up and leasing it to an organization which does not have a balance sheet that is bankable. That's one thing.

The second area that I would like to suggest consideration upon in relation to the loan program for ambulatory facilities is some consideration of considering in the bill the effects of inflation on the $2.5 million ceiling. Two and a half million might be very adequate presently, but if the legislation is going to continue for a long period of time, perhaps you want to build in a similar escalation as you have in the health planning act on the minimal levels of requirement for consideration by agencies.

Mr. RASMUSSEN. Senator Schweiker, I would like also to address this need for capital.

I think we stand on the opportunity to really rapidly expand our capacities, all four of these plans here, if we have the resources. Now, if we don't have the entry into the capital market, this process will take place, but it will take place over a much longer time. And our impact on the health care system will be delayed. And I think that the point that we are trying to make, this additional capital, we will be able to take advantage of the market, which we see the market swinging more and more to recognizing HMO's among the general population we serve.

Senator SCHWEIKER. Well, thank you all very much. I certainly appreciate your participation and your comments this morning, and, because you people are the ones on the firing line, your comments will weigh very heavily in our deliberations.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The material referred to follows:]

AMERICAN NURSES' ASSOCIATION

Statement On

S. 2534

Health Maintenance Organization Amendments of 1978

March 21, 1978

Submitted To

Subcommittee on Health and Scientific Research

Human Resources Committee

U.S. Senate

The American Nurses' Association is pleased to have the opportunity to submit comments on S. 2534, the Health Maintenance Organization Amendments of 1978.

Since 1971 the American Nurses' Association has been on record in support of health maintenance organizations as means to help make comprehensive health care accessible and acceptable to all people [1] by offering preventive, health maintenance, diagnostic, treatment, restorative and protective services through an integrated delivery system.

It is from this perspective that the following comments are made regarding S.2534, intended to revise and extend the provision of Title XIII of the Public Health Service Act relating to health care organizations.

HMO Fiscal Arrangements

ANA supports the proposed changes in fiscal arrangements for HMO's including: Section 3 which doubles the amounts available for development grants and initial operating loans; Section 4 which provides for federal loan guarantees for funds borrowed for facility equipment, construction, acquisition or renovation; Section 7 which permits grants for improvement of services; and Section 8 which authorized appropriations for grants and loan guarantees. These measures broaden and extend support for an alternative mode of health care delivery which is no longer experimental but the mode of choice for 6.5 million Americans.[2] Section 6 will allow subscribers to

prepaid health care a convenience, hitherto unprotected by law, of electing to have their employers deduct premiums from their paychecks.

Training of Administrators

ANA has consistently advocated advanced preparation for nurses in managerial positions. Hopefully nurses can avail themselves of the type of training addressed in this bill.

Certificate of Need

ANA has concern about the exemption of HMO's from certificate of need provisions in the Health Planning Act. We recommend that integrated systems for delivery of comprehensive health care be developed through and subject to local health planning mechanisms in which consumers are involved, and which include certificate of need requirements.

The responsibilities of health planning agencies, which include increasing the accessibility, acceptability, continuity, and quality of health services and preventing unnecessary duplication of health resources,[3] cannot be fully met when a growing segment of the health care delivery system does not fall within their purview. The need for this country to contain its health care costs and utilize its finite health care resources effectively supersedes the need for health maintenance organizations to be exempt from health planning control.

Nurses in HMO's

We also have some concern about Section 2 of S 2534. It appears to attempt to give HMO's greater flexibility in hiring professionals; however,

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we believe the section should be clarified to protect the consumer who may be prevented from accessibility to nursing services, because an HMO determined to hire only or primarily physicians.

Nursing is an integral part of the HMO, and in order for the HMO to provide comprehensive health care services, nurses must participate in the planning, operation and evaluation of the health care program.

Nurses' involvement is crucial in providing the following essential components of an organized health maintenance system:

1. Health education programs to develop the health capability of individuals, families and populations and encourage their knowledgeable participation in the management of their own health problems.
2. Identification, mobilization and coordination of appropriate medical, community and self help resources for dealing with health threats and health problems.
3. Analysis of socio-cultural and economic barriers to the use of health resources and assistance aimed at the development of desirable health practices.
4. Promotion of consumer representation at the decision-making level.
5. Evaluation of the quality of nursing care and total health care services offered to the members of the HMO.
6. Development and more effective utilization of manpower.
7. Provision for continuity of care through long range planning.

Nursing care in the HMO is directed toward helping patients and their families to identify health needs and to assist them in planning preventive, supportive, therapeutic and rehabilitative services.[4]

For these reasons, we believe it is vital that Health Maintenance Organizations strengthen the accessibility and availability of nursing services for the health care consumer.

In summary, the American Nurses' Association supports changes in fiscal arrangements that will enhance the viability of health maintenance organizations and strongly urges that HMO services be subject to the Health Planning Act as are other community health care agencies. We also believe that any changes must safeguard the consumer's access to nursing services.

We ask that this statement be made part of the hearing record.

REFERENCES

1. ANA Statement on S. 1182 - Health Maintenance Organizations presented to the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, November 2, 1971.

2. Statement by Hale Champion, Under Secretary of Health, Education and Welfare before the Committee of Human Resources, Subcommittee on Health and Scientific Research, United States Senate, March 3, 1978.

3. Public Law 93-641 Part B, Section 1513 National Health Planning and Resources Development Act of 1974.

4. ANA's Division on Community Health Nursing Practice Statement on Nursing in Health Maintenance Organizations.

STATE OF CALIFORNIA EDMUND G. BROWN JR., Governor

HEALTH and WELFARE AGENCY
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Mario G. Obledo
SECRETARY
James W. Connor
DEPUTY SECRETARY

April 3, 1978

Honorable Edward M. Kennedy, Chairman
Health and Scientific Research
Subcommittee
Senate Committee on Human Resources
New Senate Office Building
Washington, D.C. 20515

Dear Senator Kennedy:

The State of California respectfully requests that the enclosed comments be included in the record of the Subcommittee's March 6, 1978 hearings on Health Maintenance Organizations. We appreciate the opportunity to present our comments and are hopeful that the Subcommittee's deliberations will result in new directions in health care in the nation.

Sincerely,

Mario G. Obledo

MARIO G. OBLEDO
Secretary

Enclosures

My name is Mario Obledo. I am the Secretary of California's Health and Welfare Agency and have overall responsibility for our State's Title XIX Medical Assistance Program, which we call Medi-Cal. Currently, the Medi-Cal program makes services available to approximately 2.9 million eligibles per month. Annual expenditures are in the neighborhood of $3.1 billion, inclusive of government's administrative overhead (State/County administration, and claims processing costs). Approximately 4.6 percent (124,000) of our eligibles are provided services through Health Maintenance Organizations (HMO) type operations known as prepaid health plans (PHPs) at an annual cost of $55 million.

PHPs have been a part of the Medi-Cal program since 1971, providing services to an indigent population on an at-risk prepayment contract basis. PHP members receive the same services as they would through straight fee-for-service Medi-Cal. The past seven years have gained us considerable experience in the HMO/PHP field as a puchaser and overseer of health care services, and it is with this perspective that my comments are offered. While California has had its full share of problems, we are tenacious in our belief that the HMO delivery model can and does represent a system truly capable of providing good quality health care at a reasonable price. I am convinced that the time has come to move cautiously forward in encouraging the nationwide growth of HMOs.

Since our experience with HMOs has been strictly limited to Medicaid services (and all of the responsibilities and requirements attached thereto), the reader should understand that most of the following commentary uses governmentally funded health programs as its base. Discretion should be used when applying these comments to the private sector HMO market.

Perhaps the best place to begin is with a brief exploration of our perception of the advantages of HMOs in Title XIX programs. The overriding consideration historically has been cost. In California, we are statutorily obliged to keep PHP per capita costs at or below the equivalent fee-for-service (read "regular non-PHP Medi-Cal") per capita cost. Our experience to date shows that PHPs save from 10 to 17 percent when compared to Medi-Cal fee-for-service. It should be noted that in California, with the exception of hospital costs, all levels are controlled by the State. Medi-Cal fee-for-service noninpatient payments and PHP payment levels are not truly reflective of an open market place. While the impact of a 17 percent savings pales in the light of a cost controlled system, it is our belief that HMO prepayment rates can, and do, represent a better deal than conventional pay-as-you-go medicine.

The other component of the cost issue is administrative expense. By contracting with HMOs on a per capita, at-risk basis, California escapes nearly all of the administrative expense associated with the claims processing and utilization control necessary in the fee-for-service system. These responsibilities are transferred to the PHP contractor and become part of the administrative costs for which he is also at risk.

In addition to fiscal considerations, there are other major advantages to prepaid at-risk contracts insofar as the State of California is concerned:

- PHPs are mandated to provide a comprehensive medical care system which not only provides the full scope of services but also urges continuity of care through specialty referral mechanisms, follow-up care where appropriate, and comprehensive medical records which include documentation of all care provided to the member.

- Contractors are required to institute a program of preventive health care services including patient education.

- All services are organizationally tied, so that members may receive any covered service through the PHP, without having to seek out a provider who will treat them.

- Contractors are required to operate and maintain systems for peer review, grievance resolution, and consumer representation, all overseen by the Department, which serves to ensure protection of the member.

- Contractors are subjected to constant scrutiny by the State in the areas of organizational capability, financial integrity, marketing practices, and service availability. This scrutiny is accomplished in much greater depth and frequency than in the fee-for-service program.

Having stated what we believe are the major advantages to the State, as a party to an HMO/Title XIX contract, I would like to broach some of the problems which we encounter in the current HMO/Title XIX field.

A. Membership Diversity

Current law requires that an HMO's membership be comprised of not more than 50 percent Medicare/Medicaid members. This requirement has as its goal the inclusion of Title XVIII and XIX patients in a mainstream, community medical care setting, while embargoing HMOs set up to deal exclusively with "welfare medicine". While the goals are admirable, we have found that, as a practical matter, such a requirement can be extremely difficult for us to enforce and for contractors to comply with. Many PHPs and HMOs operate within a service area which is either uniformly low in socioeconomic status, or is reflective of some other demographic quirk. In these cases it is unreasonable to expect the operator to successfully market his services to private pay members or to commercial groups which may, in fact, not exist. For example, one of our older PHPs in the Watts area of Los Angeles has a service area population 98 percent of which is at or below the poverty level. It would be impossible for this contractor to meet the 50 percent rule, even if all of the population in the service area were to be enrolled. This plan is an established, highly respected health care service plan providing crucial services to an exceptionally needy community. It would be an unconscionable error for government to eliminate this service on the basis of the 50 percent rule.

Another example of difficulties brought about by the 50 percent rule is the situation of the county PHP. Currently, we have one PHP run by county government. Its facilities are all those hospitals and health centers existing within the county's medical services system. By requiring that this PHP maintain a 50 percent mix, several negative consequences accrue.

1. We put county government into direct competition with local health plans for commerical memberships.

2. We disenfranchise those eligibles who wish to enroll in the PHP but cannot because the 50 percent balance would be undone.

3. We limit the full exploitation of any HMO advantages.

4. We force the county to maintain the duality of fee-for-service medicine and HMO medicine.

5. We encourage the escalation of administrative costs by mandating nonfruitful marketing efforts.

Strict compliance with the 50 percent rule can have the effect of denying HMO access to Medicare/Medicaid eligibles who wish to join, since aggressive marketing to these individuals cannot proceed apace without a head-for-head match in the private sector. We have seen situations in California where plans have virtually abandoned Medicare/ Medicaid marketing in order to concentrate on the commercial membership. This is a garish example of the cure being worse than the disease. Consequently, I agree with Mr. Pepper's position that the 50 percent rule be waived for qualified contractors in certain types of service areas. However, I suggest taking it a step further, recommending that it be supplanted totally by a requirement which, by recognizing the diversity of discrete service areas, requires "service area-specific parity" to become the rule. This would preserve the stated goals of the 50 percent rule, but accomplish them in a different manner. Plans would, as a condition of their HMO qualification, design a plan to reach "parity" as that term fits their circumstances.

B. Elimination of Title XVIII Disincentives

Current law regarding the disposition of Medicare funds paid to HMOs removes any monetary incentive to provide economical care. Such a situation seemingly limits the amount of interest in procuring Medicare memberships. Assuming that the Federal Government is desirous of making HMO care an option to Medicare eligibles, it is imperative that there be a "carrot" (profit or retainable earnings) at the end of the stick. When a contractor voluntarily assumes the financial risk for providing services, the required counterbalance is some sort of reward for efficient performance. I support the general concept included in the Pepper bill which allows an HMO to share in the savings that they are able to realize. This is a complex area, however, and must be dealt with carefully.

C. HMO-Medicaid Involvement

California is one of 14 or so states which contract with HMOs to provide Medicaid services. Despite a long history of program problems, we are still convinced that the prepaid, at-risk contract model is a valid vehicle for medical care. Mr. Pepper's bill would require states to offer the option of HMO membership to Title XIX eligibles. While I am in support of such a concept, I want to be cautious about supporting this provision without a full delineation of the duties of the State and DHEW. Currently, the State has the responsibility to ensure that Medicaid services are available, accessible, of reasonable cost, and of adequate quality. On the other hand, HEW is largely responsible for the control of HMOs. I would encourage Congress to delegate the same responsibilities to the states for Title XIX services provided through HMOs. This would require some essential changes to the current HMO system, including some state involvement in deciding which HMOs will be Title XIX certifiable, and giving the states the right to monitor the care provided in such a setting. Mr. Pepper's provision also requires some deep thinking about the responsibility for Title XIX-HMO rate setting. Will this be incumbent upon DHEW or the State?

D. Loans and Grants

To foster HMO growth, it has been proposed that the Federal Government institute a broadened program of grants and loans for construction of ambulatory care facilities. I am in favor of this concept; however, I am not sure of its potential effectiveness in light of the restrictions imposed by P.L. 93-641 (Certificate of Need Requirements). If DHEW is desirous of making seed money available, it would behoove them to give special consideration to HMO building and expansion efforts at the health planning level. California has done so while remaining in general compliance with P.L. 93-641. California comprehensive group practice prepayment health care services plans are allowed some special statutory and regulatory considerations which short-circuit some, but not all, of the present CN review and approval criteria. I agree with the need for cautious health planning efforts, however, I would urge that HMOs be given special consideration if the Federal Government is truly interested in supporting HMO growth nationwide.

E. Restrictive State Law

The Pepper Amendment would allow federal statutes to supersede state law with regard to qualified HMOs. This provision will be acceptable only if the State is left the flexibility to fully execute its duties and responsibilities.

F. HMO Tax-Exempt Status

The final portion of Representative Pepper's remarks to the House addresses the advisability of allowing nonprofit HMOs to qualify as tax-exempt organizations under Section 501 (c) (3) of the Internal Revenue

Code. I concur with this provision of his amendment, if solely to make the HMO more attractive to financial donors, physician providers, and to the operators themselves. I will address the issue of incentives a bit later.

Having concluded my comments regarding the Pepper Amendment, I would like to proceed with some short exploratory discussions of situations which have been, in varying degrees, irritants to the HMO model of delivery in California and perhaps elsewhere.

A. Multiple Regulatory Authority

As the HMO concept bloomed in the late 60s and early 70s both Federal and State Governments began to enact laws, regulations, and guidelines which purported to control this "new and innovative" delivery system. As the industry grew, problems arose which had been unforeseen. The reaction of government was to enact more statutes and regulations to fill in the apparent voids. This escalation has proceeded apace until, today, we have a bewildering number of rules. The following is only a partial listing of such codifications relating to California PHPs:

- Title XIX of the Social Security Act
- Title XVIII of the Social Security Act
- HMO Act of 1973 (Title XVIII, Public Health Service Act)
- 1975 Amendments to the HMO Act
- 1976 Amendments to the HMO Act
- 1975 Medicaid Amendments
- 1972 Medicare Amendments
- California Health and Safety Code (Knox-Keene)
- California Welfare and Institutions Code (Waxman-Duffy)
- California Business and Professions Code
- California Administrative Code (regulations)
- 45 CFR 249.82 (now 42 CFR 449.82)
- 45 CFR 228.110
- Clean Air Act of 1970
- Civil Rights Act of 1964

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To enforce these provisions there are at least four very active agencies; California Department of Health, California Department of Corporations, the Department of Health, Education, and Welfare's Region IX administrators, and the Public Health Service. You can well imagine the complexities of doing business as an HMO in 1978 and the difficulties in regulating HMOs from a government standpoint. Much can be done to simplify the process. As a starting point we should move to consolidate authority (if not the laws) into one body. This could take the form of absolute federal control, or delegation of authorities to the states. The obvious benefits are greater consistency of operation, quicker response and elimination of duplicative efforts. There probably would be some savings to accrue if the regulation of HMOs could be streamlined.

B. Overly Strict Participation Requirements

Existing qualification requirements effectively dissuade the participation of some potentially valuable organizations such as Kaiser, Ross-Loos, and county governments. (These restrictive provisions appear at both the state and federal levels). For example, a current requisite demands that HMOs have consumer representatives seated on the governing boards of the organization. In the case of a county governmental body this is unrealistic since the governing board is the panel of democratically elected supervisors. The governing board is, at once, wholly representative of the consumer populace, yet out of compliance with the letter of the requirement. Another impediment to county participation is a requirement that the corporate entity maintain certain minimum tangible net equity levels and working capital ratios to demonstrate its fiscal integrity. Such a requirement discourages the inclusion of county government in the HMO field.

Overly strict requirements have also stifled the participation of large, experienced prepaid group practices such as Ross-Loos and Kaiser in Title XIX programs. This irony stems from strict requirements in the areas of emergency services reporting, subcontract requirements, mandatory minimum benefit packages, noncommunity-based rates, hospital bed ratios, dental care, EPSDT services, working capital ratio (1:1), medical records, and employment physicals. The point to be made here is that we are limiting the growth of HMOs by setting standards which are not flexible enough to allow the participation of either the pioneers in the industry or the local governmental entity responsible for the welfare of its constituency. Significant progress might be made in easing this situation by first granting broad waiver authority and eventually by changing statutes and regulations.

C. Incentives for Participation

Incentives for HMOs to participate in federally funded medical programs are few. It has even been said that the complexities involved in such participation outweigh the advantages. To some extent the same might be said for consumer participation. In order to promote HMOs, government will have to make the programs more attractive to their participants. Loans and grants as proposed in the Pepper Amendment are good ideas.

Minimization of red tape and unnecessary governmental intervention are others. Rate structuring can always be used to attract operators, as can governmental assistance in marketing the HMO concept to potential members. Members can be attracted to HMOs through packages which offer the gamut of medical services "under one roof", and by offering additional services not normally available (alcohol or drug detox), or those not thought of as strictly medical services (social work, occupational and speech therapy, rehabilitation, home care including domestic services which allow the patient to remain at home, etc.). All of these ideas have been discussed before and could be made a reality but for our existing philosophies and the statutes which reflect them.

D. Beneficiary Eligibility Problems

One of the significant problems for California PHPs has been the mercurial nature of beneficiary eligibility. Linkage of PHP eligibility to public assistance (cash grant) status which is redetermined monthly allows patients to be eligible one month and ineligible the next. This is a nonoptimal situation for the patient, the plan, and the State. The most severe consequence is the possible interruption of care to patients. Cash flow problems and associated administrative complexities, though a reality, must be considered secondary to those concerning continuity of care. This problem is resolvable by guaranteeing eligibility; however, the associated cost could be enormous. In the short run I would suggest some pilot studies funded by grant and research money to test the solutions to this problem.

E. State/County Medicaid Cooperation

Prior to California's implementation of a Medicaid program in 1966, health care was provided to low-income recipients by the 58 county medical services systems. Most of these systems are still functioning (as providers); however, they manage the care of only a very small percentage of county eligibles with the at-large medical community assuming the brunt of the business. We believe that the county medical systems are a fertile and abundant resource for medical care delivery which is going begging in the State's Medicaid system. To synopsize the problems extant in county/Medicaid involvements we can itemize the HMO qualification requirements and California PHP participation requirements which are seen as barriers:

1. Consumer policy-making positions on the governing board.

2. Tangible net equity and working capital ratio requirements.

3. Fifty percent mix requirements.

4. Tax exemption questions.

5. Conflicting licensing laws.

6. Subcontract problems.

7. Rate level problems.

8. Financial security.

On the other hand, there are a number of real advantages to utilizing county medical service systems which make them prime candidates for prepayment contractors:

1. Providers are almost invariably salaried. This condition eliminates the tendency to overutilize services which is so prevalent in fee-for-service operations. Underutilization, a problem unique to prepayment situations, is also minimized because of the lack of decision-making authority in the hands of a corporate profit-minded entity.

2. Medical services are organizationally linked to patient eligibility and to other nonmedical services allowing both rapid communications and the possibility of a more comprehensive approach to caring for county residents' needs.

3. By involving counties intimately with the provision of medical services, the philosophical need for control is satisfied, and the county is better able to plan and synthesize a rational universe of services for its constituency.

4. County prepaid systems would allow the development of service planning on a geographically large scale. Normal PHP development has been tied, heretofore, to a circumscribed base of influence reflective of the organization's operational capacity. The resulting network of PHPs then appears to be somewhat of a patchwork of rather parochial and functionally small health service systems.

5. The financial position of county government virtually assures the reasonableness of costs both on the administrative side (especially salaries) and on medical services. Another related advantage is the possibility of volume purchasing of needed supplies and equipment and the built-in advantages of county government access to federal and state funds through revenue sharing and grants.

The points add up to a need for at least a relaxation of participation requirements, if not an actual endorsement of county HMO development through waivers or special legislation.

In summary I see a number of areas in which legislation might be pursued in order to further the cause of the Health Maintenance Organization. They are:

1. Modification of membership diversity requirements to truly reflect the marketplace in which the organization has chosen to operate.

2. Modification of rate-setting methodologies to allow full exploitation of an HMO's ability to operate economically.

3. Full scale expansion of HMO operations into Medicaid and Medicare programs through a mandatory HMO option.

4. Expansion of loan and grant programs to HMOs for construction and rehabilitation of ambulatory care facilities, with special consideration given to HMOs at the health planning level.

5. Allowance of tax-exempt status for certain organizations with assurances that the advantages are not abused.

6. Elimination of duplicative and superfluous regulatory authorities by streamlining and coordinating existing statutes and regulations.

7. Loosening qualification requirements to allow participation of existing prepaid group practice plans and other organization entities.

8. Building incentives for participation for organizations, providers, and consumers.

9. Stabilizing eligibility of the membership to ensure continuity of care and to minimize associated administrative disruptions.

10. Involving county medical systems in direct patient care under prepayment contracts.

I appreciate this opportunity to present these remarks to the Committee and I am hopeful that the receptive spirit of these hearings is indicative of a willingness to explore the advantages of the Health Maintenance Organization in providing high quality health care at a reasonable cost to the consumer.

AMERICAN DENTAL ASSOCIATION

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March 24, 1978

The Honorable Edward M. Kennedy
Chairman
Subcommittee on Health and Scientific
Research
Committee on Human Resources
4230 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Kennedy:

I am writing on behalf of the American Dental Association to comment on S. 2534 and S. 2676, proposals which would amend and extend the Health Maintenance Organization Act. I request that these comments be included as part of the record of the hearings which your Subcommittee held on S. 2534.

As you know the Association has testified and offered written comments on both the original Health Maintenance Organization Act and the 1976 Amendments to that law.

It has been the position of our Association from the first consideration of health maintenance organization legislation that HMOs should compete with the more traditional forms of health care delivery on an equal basis. An impartial evaluation of such competition would provide the public with valuable experience data on which to make choices regarding the delivery of health care.

For the purpose of testing an experimental delivery system, it was determined that some support by the federal government for these organizations in their developmental stage was not inappropriate although numerous questions were, and continue to be raised because of the competitive advantages provided to HMOs by this assistance.

The Association has always maintained that the HMOs supported by federal assistance should conform to the commonly accepted definition of an HMO

as a structured system for the delivery of comprehensive health care, both ambulatory and institutional, on a prepaid capitation basis in which the health care providers are at risk. Without such conformance it is difficult to justify the expenditure of public funds in support of an experimental alternative to the present system.

Based on this understanding of the rationale for federal support to HMOs, we have strong objections to the approaches taken in both S. 2534 and S. 2676.

Each of the bills before you would double the amount of federal assistance which could be received by an HMO for initial development and for initial costs of operation. In addition S. 2534 would provide continuing support for costs of operation rather than limiting this support to an initial period. Although the proposed increases in the levels of assistance which could be provided to HMOs do not appear to bear any relationship to recent inflationary rates, we do see the possible necessity for increasing upper funding limits to reflect inflationary pressures. We do not object to such increases. But we do object to the limits proposed in the bills because of their lack of relationship to actual cost increases and because of the overall context of the legislation. It is clear that these proposed increases are a necessary part of an apparently growing attempt to insure that HMOs succeed through the guarantee of continuing availability of large amounts of federal funds rather than on their merits.

We also object to the change proposed in S. 2534 which would permit continuing assistance for the costs of operation of an HMO rather than assistance only for initial operating costs as at present. Certainly the entire history and intent of the federal program of support to HMOs was to develop an experimental program with assistance at the initial stages in order to determine whether HMOs could become self-sufficient in the long run. A change in the law permitting continued assistance to an HMO beyond an initial development stage appears to concede that many HMOs may lack the potential for independent operation. Further, a change of this kind would be plainly contrary to the intent of Congress to foster true competition among alternative delivery systems.

The proposed authorization in both bills of support to HMOs for the construction and equipping of ambulatory care facilities and in S. 2534 for improving health services of the HMO and for the training of HMO management personnel seem to us simply to be additional mechanisms for justifying potentially large new expenditures to help assure the economic success of HMOs. It would appear to us that the provision of ambulatory care is a basic element in the HMO concept and that special additional funding is inappropriate to provide these services.

Also we would hope that all providers of health care would constantly be attempting to improve their health services. We do not think there should be a special subsidy to carry out this very basic and necessary obligation.

As with many of the other forms of assistance authorized under the HMO law, the authority to provide funding for the training of management personnel would apply to HMOs but not to other health care delivery systems. New personnel constantly are needed in all health delivery systems and to authorize special funding for training of those who will enter one form is extremely inequitable.

There are provisions in each bill which would authorize HMOs, with the approval of the HEW Secretary, to limit the services which are offered. This includes authority for an HMO not to offer one or more basic health services.

We cannot state too strongly our concerns with the apparent and continuing erosion of the original concept of the health maintenance organization which was to provide comprehensive high quality services to all eligible persons in an efficient and cost saving manner. It is untenable to maintain that it is this comprehensive system which is to be provided federal funds when there are provisions to authorize HMOs to eliminate basic health services from those which should be available to their enrollees. Provisions which allow exclusion of some of these services invalidate the entire concept of the HMO effort.

The Administration bill also would make a series of amendments relating to priorities for federal assistance to HMOs and to general requirements which must be met before federal assistance can be provided. In particular the Administration bill would repeal current provisions which give priority to assistance for entities serving medically underserved and rural populations. With the continuing concerns expressed by Congress and others with the availability of services to individuals in medically underserved areas we cannot understand why such a provision would seriously be proposed.

S. 2676 also would delete current provisions which require that before federal assistance can be provided to an HMO, or an entity attempting to become an HMO, there be a determination that the project applied for could not be completed without this federal assistance. The Administration bill also would repeal the current provision that stipulates that only funds appropriated under the HMO law could be used to assist HMOs. Under the Administration bill's new provision, funds available under other Public Health Service Act programs could be provided to HMOs.

It would seem totally improper to delete the requirements in the existing law that before federal assistance be provided there be a showing that this assistance is in fact necessary for completion of the project. We are aware of the major efforts on the part of the Administration and others to induce greatly expanded development of health maintenance organizations. However to authorize the expenditure of federal funds as an incentive to major, economically sound corporations for example to begin HMOs is improper. The HMO concept must stand or fall on its own merits when corporations or other major entities are considering their development. It is an invalid use of federal taxpayer funds to make monies available to such entities as an incentive to adopt the HMO concept.

With regard to the funding procedures of HMOs we also are extremely concerned with the authority in S. 2676 which would permit funds other than those under the HMO law to be used to assist in the development of health maintenance organizations. You may recall that one of the reasons for initial enactment of the HMO law in 1973 was concern with the expenditures for support of HMOs which were being made from general funds available to the Department of HEW. The loss of accountability of expenditures for HMOs alone should prevent the Congress from adopting such a provision.

The issue of an HMO exemption from health planning law requirements, as proposed in both bills, is complex and is being addressed in legislation which would extend the National Health Planning and Resources Development Act. It is within the context of that legislation that this issue should be addressed.

The Administration proposal also makes a series of suggested changes in medicare policy for reimbursement to HMOs. These provisions also are complex and should be thoroughly studied in order to insure that they do not in fact increase costs under the medicare and medicaid programs.

We believe that the provisions relating to financial disclosure of transactions by HMOs as proposed in both bills would be beneficial in assuring the integrity and proper public perception of HMO activities.

In conclusion we stress again that the Association support of the existing private delivery system does not indicate a reluctance to test alternatives. We do however object strenuously to legislation which would effectively override competitive market place realities thereby misleading the public in its consideration of options available to it with regard to health care services. We believe that significant alterations of the approach now being proposed for federal assistance to HMOs must be made in order to equitably and effectively allow full competition among all viable health care delivery systems.

Sincerely,

Sidney R Francis

Sidney R. Francis, D.D.S.
Chairman
Council on Dental Care Programs

SRF:cs

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March 6, 1978

David C. Main, Jr.
Subcommittee on Health
Minority Staff
Senate Office Annex Courts Bldg.
Washington, D.C. 20510

Dear Mr. Main:

Many thanks for your advice during our recent phone conversation regarding the Seante public hearing on S.2534, the HMO Amendments of 1978.

I also appreciate the summary of S.2534 as well as the bill itself, which you were kind enough to send me.

Enclosed is a copy of Dr. E.J. Cunningham's remarks on HMO legislation. Please have these remarks made part of the official public hearing record.

Many thanks,

Tom Ernst

Thomas J. Ernst
Vice President

TJE:lde

Enclosure

st louis metro health plan

(To be published in St. Louis County Medical Society Journal, Spring 1978)

KEY FACTORS TO HMO SUCCESS

As a private, practicing physician, I share the concerns of thousands of doctors about the rising cost-plus spiral which continues to plague the economy and health care industry in the United States. Physicians can, should and must play a real leadership role in reducing and reversing this cost-plus spiral.

Forty of St. Louis' leading private physicians[1] viewed this economic situation as an opportunity, not a problem. My fellow physicians joined me in developing a positive alternative to existing methods of health care financing. St. Louis physicians personally have committed $250,000.00 to start a prepaid health plan. These doctors clearly recognized that the key issue is basic economics and that the cost-plus spiral can only be reversed if the self interests of everyone are to reverse the spiral and reduce the costs. Private physicians did not want to assume the risk of hospitalization alone. The physicians were willing to accept the total risk of limiting the cost of physician care, in outpatient hospital care and providing the professional concurrent utilization review of services, but wanted a program which allowed all traditional health insurance carriers and every employer the opportunity to participate. The result is a program which allows each insurance carrier to participate by selling the plan to their existing clients and sharing with those clients and the physicians the financial risk and rewards of developing appropriate controls of the utilization of inpatient and outpatient services.

This open panel, multi-site Individual Practice Association provides every employer the opportunity with his existing insurance carrier to offer all employees their individual choice of insurance programs without having to change physicians. In this manner, the best elements of the traditional relationships with which each participant is familiar and accustomed are saved and a new common interest to reverse costs is introduced.

Quite simply, in the best tradition of America, it interferes with no one's rights. Every insurance company may choose to participate. Every consumer may elect to join the Plan. Every physician may participate. Every industry may offer this alternative. The role of the private insurance carrier is preserved. But the Plan's emphasis on outpatient care, preventive care, cost controls and health care education will dramatically reduce the total cost of care. Equally important, the Plan has been designed so that everyone shares in those savings.

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[1]Physicians sponsoring the Saint Louis Metro Health Plan include: President-Elect of the St. Louis County Medical Society; President of Missouri State Board of Healing Arts; Past President of Filipino Physician Association; President-Elect of St. Clair County; Five Hospital Staff Presidents; Past President of the National Medical Association; Missouri Delegate to American Medical Association; President, Southwestern Surgical Congress and thirty other leading physicians.

CURRENT AND SUCCESSFUL ACTIONS:

To assure physician participation a plan must:

(1) Preserve the fee-for service concept, in that reimbursement should be made for each service rendered.

(2) Accommodate all types of medical practice, from the solo or small partnership to the large multi-specialty group.

(3) Afford those enrolled free choice of participating physician, regardless of specialty or practice setting.

(4) Pay in full for nearly all medically related expenses, whether for inpatient or outpatient care.

(5) Pay for preventive as well as curative services.

(6) Streamline administration and eliminate patient billing and costly paperwork.

To assure industry and labor support, the plan must:

(1) Provide the credibility of participation by major health insurance carriers.

(2) Provide employers and unions the option of retaining their present hospitalization carrier.

(3) Provide employees the option to retain their present physician.

(4) Reduce the cost of administering their health benefit program.

(5) Not require employers to determine the appropriateness of care.

To assure everyone's support, we urge that the plan, through the use of the free enterprise system, should set the existing facilities, human resources and financial resources of the industry into an economic dynamic which will reverse the present incentive which results in a cost-plus spiral.

No amount of community planning, government regulation or control will be as effective in reducing cost as a economic dynamic based on the self interest of all concerned. The viability and responsibility of the free enterprise system are being tested and, in St. Louis, physicians and industry have clearly demonstrated a desire to rise to the challenge. We want our children and their children to have the same freedom to choose their doctor, but we also want them to be able to afford the care they need. To meet these medical needs, the responsibility is not for government to provide us the solution, but for physicians and industry to provide the solution.

By providing existing carriers the appropriate role of marketing, risk assumption and claims processing, and by utilizing a health management firm with experience in dealing with the problems of physicians as well as with the development and management of alternate health care delivery systems, we feel we are maximizing our utilizations of existing human resources in the management of the Plan. This straight foward, non-threatening approach is meeting with the enthusiastic support from every major segment of the health care providers in the community.

By utilizing existing facilities and community physicians, NO provider is excluded and each provider can participate to the extent they wish. By developing the program with the participation of the community's leading physicians, hospitals, insurance carriers and employers, the self interest of all will assure continual provider support. Marketing responsibilities will be shared by the Management[2] Company which has proven ability to develop and sell the prepaid alternative in other markets. The community's largest insurance carrier has agreed to agressively market the Plan to existing customers and to participate with any employer whose present carrier does not want to assume their appropriate resonsibilities by participating in the Plan.

Numerous Corporations and Unions have indicated their desire to participate and encourage their employees and members to participate. Existing closed panel HMO's in St. Louis operating from single sites have not been able to cope with the demand for prepayment. This community wide program will help meet the existing demand. Through inclusion of a wide spectrum of physician leaders as founders, we have been able to receive strong support of our fellow practitioners.

Why has such a unique response been experienced in St. Louis, known as a conservative bastion of private medicine? Can such a response be developed in other communities? We believe it can, but only with a non-threatening approach which clearly recognizes the importance of providing everyone an opportunity to participate and a reward for their participation. Because physicians both provide and determine the proper course of care, they are in effect both the provider and the consumer. The other key parties are labor and industry, who pay for the care.

PAST EXPERIENCE:

St. Louis physicians know and HEW knows why HMO's have developed very slowly:

(1) lack of commitment by sponsors

(2) lack of management capability

(3) lack of providers

(4) failure to supply marketing support

(5) strong physician opposition

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[2] Medserco Incorporated. Its Primary Care Systems Division, directed by Mr. James Dyer who managed five successful I.P.A. operations in Wisconsin, is responsible for all management support.

CONCLUSION

If the continual support and development of federally funded programs are needed to stimulate an appropriate response, then so be it. In St. Louis, this is not the case, and it need not be in other communities. We hope by our example we will help others to recognize the opportunity.

BY E. J. Cunningham, M.D.

Wednesday February 8, 1978 ST. LOUIS MEDICINE

Guest Editorial

IPA Proposed

by Francis X. Lieb, M.D.

Recently, the physicians of St. Louis were introduced to the St. Louis Metropolitan Prepaid Health Plan, a developing alternative to traditional indemnity insurance protection.

The program represents an organized effort by physicians in Metropolitan St. Louis which will prove that physicians can provide the necessary leadership to help solve an important economic problem in our community - the rising cost of health care. The Plan provides a promising opportunity to demonstrate that a physician solution, rather than a political solution, can make the free enterprise system work.

Industry has been, and will continue to be, involved with the development of the Plan. Since the cost of health care is an important issue for industry, the Plan is structured so that physicians, who deliver care, and employers, who finance care, become a team to reverse the health care cost spiral.

The Plan is an "Individual Practice Association" of physicians. Unlike Group Practice Plans, the St. Louis Metro Health Plan will utilize existing facilities and practicing physicians in the area. Since the patients who enroll will have the freedom to select any participating physician, there will be no disruption of the normal physician-patient relationship. In addition, participating physicians need accept patients only as their appointment calendar permits.

This is an ambitious and intelligent program which will preserve the fee-for-service practice of medicine while assuring that health care continues to be affordable. The program will accommodate all types of medical practice, from solo physician or small partnership to the large multispecialty group. The Plan will eliminate a number of the administrative problems now existing in the health care industry, such as patient billing with the accompanying accounts receivable and other costly paperwork.

For enrollees, the Plan will maintain free choice of participating physician and will provide full payment for nearly all medically related expenses, whether for inpatient care, outpatient care, preventive or therapeutic services. It also contains an ongoing program of health and plan educaton so vital to preventive care.

The St. Louis Metro Health Plan represents a very real opportunity for physicians to provide a workable solution to the economic realities of health care delivery. The system will encourage "financial responsiblity" and will not be tied to a single insurance carrier or employer. The St. Louis Metro Health Plan deserves your support and participation. It is a program which addresses a physician solution to the future of health care.

Dr. Cunningham is a practicing St. Louis physician specializing in internal medicine. He is also President-Elect of the St. Louis County Medical Society, Delegate to the Missouri State Medical Association as well as President of the Saint Louis Metro Health Plan.

Dr. Lieb is a practicing pediatrician and immediate past president of the St. Louis City Medical Society. He has also served as a Delegate to the American Medical Association and Chairman of the Board of the American Academy of Pediatrics. He is currently Chief of Pediatrics for St. Johns Hospital in St. Louis.

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Testimony of Steven Epstein on Behalf of
the American Association of Foundations
for Medical Care in Connection with S.B. 2534

Mr. Chairman and ~~Members of the Committee~~ Senator Schweiker, my remarks will be brief.

My name is Steven Epstein and I am counsel for the American Association of Foundations for Medical Care ("AAFMC"). AAFMC is a nonprofit national association consisting of approximately 90 member foundations representing approximately 120,000 physicians. Many of our foundation members consist of existing and developing state and federally qualified individual practice association-type health maintenance organizations. AAFMC appreciates this Committee's continued efforts to encourage the growth and development of HMOs, and to make the federal HMO effort more equitable and workable. In this connection, AAFMC supports Senate Bill 2534 as beneficial to the continued development of health maintenance organizations and urges the Committee to act favorably on such Bill.

AAFMC will also submit to the Committee, at a later date, a brief letter for the record concerning two issues specifically affecting individual practice association-type health maintenance organizations under P.L. 93-222, as amended, which we feel should be brought to the attention of the Committee.

I thank you for your kind attention.

Steven B. Epstein

ENCLOSURE

The 37 positions will be used as follows:

-- Qualification - (13 positions)

This function entails the review of applications submitted by prospective HMOs for Federal qualification. The applications are reviewed for: legal and administrative aspects, marketing realism and capabilities, financial viability, and adequacy of the health care delivery and quality assurance systems of the HMO. The review process is both thorough and extensive, consisting of the following six elements: (1.) Screening for application completeness, (2.) Desk review, (3.) Site visit to project, (4.) Post-site visit analysis, (5.) Qualification determination, and (6.) Report preparation and file completion

Due to the comprehensive nature of the review process and recent interest in HMO development throughout the country, the current staff of only 12 employees has not been able to review qualification applications as rapidly as they have been received.

There is currently a backlog of 32 qualification applications, which we expect will increase to about 47 by the beginning of fiscal year 1979 if additional positions are not made available.

-- Compliance (+19 positions)

As the total number of qualified HMOs increases, the workload required to ensure that these projects continue to meet statutory and regulatory requirements also increases. The HMO Compliance Function consists of:

1. Evaluating reports submitted by qualified HMOs on a quarterly, annual, and, when necessary, ad hoc basis.

2. Site visits to qualified HMOs to verify compliance

3. Site visits to qualified HMOs when specific problems are detected that require on-site assessment and verification.

4. Responding to HMO requests for changes in the approved plan.

5. Responding to inquiries pertaining to HMOs.

6. Handling HMO qualification hearings and HMO compliance lawsuits against the Department.

A total of 51 HMOs have been Federally qualified to date. This number is expected to increase by about 50%, to 75, by the end of the current fiscal year. Further, we will be responsible for monitoring compliance of approximately 125 HMOs by the end of fiscal year 1979. It will be nearly impossible to fulfill the responsibility to ensure compliance of this increased number of HMO projects with the 9 positions currently allocated to the compliance function. The reprogramming, therefore, includes 19 positions for this activity in 1978.

Dual Choice Provision (Employer Compliance) (4 positions)

Section 1310 of the PHS Act requires the Secretary to ensure that employers affected by the dual choice provision (the mandatory offering of the HMO alternative when 25 or more of their employees reside in the service areas of a qualified HMO) comply with the requirements of this provision. No positions are currently provided for this function, even though approximately 400,000 employers are now affected by the legislative requirements. Moreover, as more HMOs achieve Federal qualification status, we expect the number of employers whose employees reside in the HMO catchment areas to increase substantially. To handle the employer compliance workload, 4 positions are requested in fiscal year 1978 through the reprogramming request.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

MAR 6 1979

The Honorable Edward M. Kennedy
Chairman, Subcommittee on
Health and Scientific Research
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This letter is in response to your letter of February 23 regarding the Department's policy on HMO development. At the Senate hearings to be held this week, the Department plans to express a strong commitment to HMO development. We anticipate having a frank discussion of the potential problems of fraud and abuse which are of understandable concern to your Committee.

Your letter raised two specific questions. The first dealt with our policy regarding HMO compliance. During the past few months, the Department has developed a comprehensive plan for HMO compliance. Currently, we plan to issue proposed regulations within the next ten weeks. These regulations will be based upon the following principles:

1. The qualification process should ensure that only reasonable financial risks are approved, that self-dealing relationships are disclosed, and that all HMOs have a viable quality assurance system.

2. To the extent possible, routine reporting requirements should be minimized and targeted to detect problems of financial instability and poor quality.

3. Other reports should be required on an exceptions basis only. For example, reports should be provided if an HMO changes the composition of its board.

4. Emphasis should be placed upon site visits.

The proposed HMO compliance system will contain four primary functions:

1. Intelligence--Information will be gathered on the status of qualified HMOs through a) revised routine reports dealing with financial stability, marketing, utilization, and quality assurance. The frequency of reporting would be a function of an HMO's financial status; b) special reports provided in the event that an HMO diverges from its proposed plan; c) annual questionnaires; d) site visits; and e) complaints investigation.

2. Analysis--This would include a) the use of explicit standards and criteria; b) compilation of data; c) identification and analysis of deviations; and c) formal communication with the HMO regarding a potential problem (through written reports from the HMO, site visits, or public hearings, if necessary).

3. Determination (positive or negative)--This would include a) formal assessment of conformance with qualification requirements and b) identification of deficiencies and deadlines for correction.

4. Remedies--In the event that a negative determination is reached, the following steps would be taken: a) the HMO would be issued a notice of intent to suspend qualification. Technical assistance would be offered to the HMO and a plan of corrective action proposed. If this is unacceptable, the HMO may request a reconsideration and a hearing to appeal the determination; b) in the event that a negative determination is reached after a hearing and the HMO fails to comply, the Department may suspend qualification, bring legal action to compel compliance, or revoke qualification; c) suspension of qualification would be time limited and lead to a revocation of qualification unless appropriate corrective actions were taken. Also, during this time period, the HMO would not be permitted to exercise "the dual-choice option" to open new markets; and d) revocation of qualification would mean the HMO would be prohibited from exercising the "dual-choice option"; the HMO would be required to notify its members in writing of the Secretary's determination; and the Department could prohibit any additional Federal subsidy.

Resources required to implement this plan are a function of the number of qualified HMOs, productivity of staff, and the type of system finally implemented. Currently, there are nine staff assigned to the compliance branch. Our expectations are that there will be 114 qualified HMOs by the end of FY 1979. To meet this demand, we plan to expand the staff resources in the compliance area. As you know, we have just been granted permission by the Congress to reprogram $2 million from HMO grant funds. A portion of this money will be used to underwrite 37 new positions for the HMO program. Special preparations are being made to hire these people quickly so that they can bolster our qualification and compliance activities in a timely manner. More details regarding our staffing plans are included in the reprogramming letter to Senator Magnuson which is enclosed.

The second question raised in your letter dealt with the issue of fraud and abuse. We share your concern that the fraud and abuse evidenced in the prepaid health plans in California not recur. However, we are also very concerned that HMOs not be regulated to the point where long-term development potential is severely constrained. We are in substantial

agreement with the anti-fraud and abuse provisions of S. 2534 and will propose similar provisions in our bill. We share your view that the best way to reduce undesirable self-dealing without discouraging appropriate corporate relationships is to require open disclosure of all such transactions and to monitor them for abuse.

Legislation alone cannot solve these problems. As a result, we plan to build a vigilant, effective, and yet reasonable qualification and compliance program. Our efforts will be based upon the assumption that we can protect the Federal interest and the HMO enrollee without constructing requirements that would burden HMOs and hinder growth.

The primary thrust of the Medicare and Medicaid amendments is to promote the enrollment of Medicare and Medicaid beneficiaries in HMOs. As you know, we believe these services will be more comprehensive and of higher quality than traditionally available. Increasing Medicare and Medicaid enrollment in HMOs is unlikely to increase the incidence of fraud or abuse, because, under this circumstance, HMOs must sign contracts and become subject to the Medicare-Medicaid anti-fraud and abuse amendments (P.L. 95-142).

Thank you for your interest in the HMO program. I know that Under Secretary Champion looks forward to discussing the issues raised by your letter at the hearing to be held on March 3.

Sincerely,

Joseph A. Califano, Jr.

Enclosure

United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

February 23, 1978

The Honorable Joseph A. Califano, Jr.
Secretary
Department of Health, Education, and Welfare
Room 615 F Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Califano:

On February 10, 1978 we were pleased to introduce S. 2534, a bill which would amend the Title XIII of the Public Health Service Act to promote HMO development, improve the administration of the federal HMO program, and enhance the level of managerial effectiveness in the HMO field. As you are aware, we were primary sponsors on past HMO legislation and wholeheartedly support further development of this important health care reform.

As Senate consideration of this legislation proceeds, however, we remain seriously concerned about a number of abuses and inefficiencies in the HMO program which have come to light in recent years. Past practices of a small number of prepaid health plans in California continue to stigmatize the HMO movement, despite the passage in 1976 of significant provisions aimed at ending such abuses. Past inadequacies in the administration of the HMO program - particularly the lack of effective compliance programs - have caused the specter of these abuses to linger in the minds of many would-be HMO proponents and threaten to erode essential Congressional support for expansion of the federal program.

We are aware of, and appreciate your enthusiasm for HMO development and your dedication to a complete restructuring of the administration of the program by HEW. We know that you have already taken steps to implement these policies. As Senate oversight hearings approach, however, it is essential that legitimate concern about potential abuses of the program be responded to.

In particular, we would ask you to provide us with the following information prior to upcoming Senate hearings on HMOs:

1. Detailed information on the Department's plans for implementing the compliance program required under section 1312 of the PHS Act and the anticipated date regulations under that section will be promulgated. We are interested in knowing the numbers, fields of expertise, and tasks of various personnel to be assigned to compliance activities, as well as the number of site visits to be conducted annually. We are also interested in knowing what criteria would be used to de-qualify an HMO should that become necessary. We would like to know of any past instances where de-qualification was considered and the outcome of those deliberations. Finally, we are particularly interested in the Department's plans for improved monitoring of the quality of care in federal HMOs.

2. The Department's assessment of the continued danger of HMO fraud and abuse such as occurred in connection with PHPs in California as documented in the 1974 and 1976 reports on that subject by the General Accounting Office. We have proposed new anti-fraud and abuse provisions in S. 2534 which we hope, when added to existing law, will provide HEW with ample monitoring authority. We would appreciate having the Department's views on whether these authorities will be sufficient to prevent recurrence of abuses in the context of the federal program, particularly if the Department's proposed revisions of Medicare and Medicaid laws relating to HMOs should be enacted.

We appreciate your commitment to a complete revitalization of the federal HMO activities and look forward to receiving the Department's testimony at Senate hearings in the near future.

Sincerely,

Edward M. Kennedy
Chairman
Subcommittee on Health and
Scientific Research

Richard S. Schweiker
Ranking Minority Member
Subcommittee on Health and
Scientific Research

Statement of the

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA

on: Health Maintenance Organization Assistance Act Amendments (S. 2534)

to: Subcommittee on Health and Scientific Research, Senate Committee on Human Resources

by: Jan Peter Ozga

date: March 31, 1978

STATEMENT
on
HEALTH MAINTENANCE ORGANIZATION ASSISTANCE ACT AMENDMENTS (S. 2534)
for submission to the
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH
of the
SENATE COMMITTEE ON HUMAN RESOURCES
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
Jan Peter Ozga*
March 31, 1978

The Chamber of Commerce of the United States is pleased to have the opportunity to comment on S. 2534 on behalf of its 73,000 members, which include business firms, associations, and state and local chambers of commerce.

The National Chamber supports Health Maintenance Organizations (HMOs) as a competing alternative to other health care delivery systems. We believe that the HMO provides an opportunity to control health care costs while providing quality care. We also believe that it is appropriate to provide federal funds as seed money to encourage HMO experimentation. However, S. 2534 extends the federal government's participation beyond this limited role, creating what could become an indefinite period of HMO dependency on federal subsidies. These subsidies also have created the illusion that some HMOs are saving money when health costs are merely being transferred from the private to the public sector.

Therefore, the National Chamber recommends only a limited extension of the existing federal program to support HMOs, with the hope that private support for HMOs will enable them to flourish and be truly competitive in the marketplace. We support several provisions of the bill, but we oppose the bill's unwarranted and possibly counterproductive level of public funding for prepaid health care plans, which are designed to exist without governmental financial support.

BUSINESS AND HEALTH CARE

Business' interest in health care is underscored by the fact that it is the largest private purchaser of health care in the United States. Last year

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* Associate Director, Health Care, Chamber of Commerce of the United States

business invested about $60 billion in health care.

This figure includes some $33 billion spent by employers on group health insurance for employees and their dependents and workers' compensation medical benefits.

Over the last quarter century employer contributions for health-related benefits have risen so that now 80 percent of all private health insurance is bought through the workplace. About 70 percent of this insurance is paid for by employers. In 40 percent of the cases, employers pay for the entire cost of health insurance. In only 10 percent of the cases is the employee required to pay the entire bill. This is the reverse of the situation about 25 years ago.

Although wages increased 85 percent between 1965 and 1975, health-related benefits rose nearly 200 percent during the same time period. Health benefits now represent about six percent of employer costs.

Business spends another $27 billion in taxes for public health programs (e.g. Medicare, Medicaid), company-sponsored health programs (e.g. drug abuse treatment, mental health counseling and physical fitness projects) and corporate philanthrophy for health.

All told, business pays for about 40 percent of the Nation's $160 billion health bill. Clearly, business has a major stake in American health care.

NATIONAL CHAMBER POSITION ON HMOs

The National Chamber supports the development and operation of HMOs as a competing alternative to other forms of health care delivery, including solo or group practice fee-for-service modes. HMOs appear to save scarce health care dollars while maintaining quality health care services. The federal government, through incentives, and employers and insurance carriers should encourage expansion and improvement of existing methods for providing health care services, and the development of new delivery arrangements.

Also, through health care benefit programs, employers should enable employees to have a choice of delivery arrangements, such as prepaid, group practices where available. Numerous studies have shown that competition in health care--as with other sectors of the economy-- tends to improve service and lower cost.

BUSINESS AND HMOs

Business support for prepaid health care can be traced to the origins of the American HMO movement. For example, over 40 years ago, Kaiser Industries and firms associated with the Tennessee Valley Authority hired physicians to effectively keep isolated employees healthy,as well as to treat them when they became ill or injured.

With a few notable exceptions, the spread of the HMO phenomenon was slow in this country, until the early 1970's when the federal government embraced HMOs as a major method of controlling rising health costs. Since that time, the federal government has spent about $100 million to develop HMOs, through the funding of feasibility studies, planning and development grants and deficit loans. As a result, there are now about 180 HMO-like plans in the United States with a total enrollment of seven million persons.

Although this growth record seems impressive, the current census of HMOs is far less than the 1,700 predicted for 1980, which were to be available to some 90 percent of the American people. Ironically, one of the major deterrents to the wider proliferation of HMOs was the original HMO law, a situation which has been corrected partially by P.L. 94-460. In effect, this corrective legislation made HMOs more competitive with existing health plans, by reducing the required package of services and certain organizational standards.

Currently, there are over 1,000 firms which are offering HMOs as an option to traditional health insurance plans. Although some of these firms are required to offer HMOs under the provisions of P.L. 93-222 as amended, many of these business enterprises have voluntarily offered the HMO option, primarily because of its ability or potential to control rising health care costs. These savings are the result of the HMOs emphasis on preventive care and reduced hospitalization.

One impressive example of cost savings by HMOs is reported by Employers Insurance of Wausau (Wisconsin). According to the plan, 64 business firms achieved a 21 percent saving in total health costs, primarily from controls and incentives for hospitals and physicians provided by the HMO arrangement.

Another cost saving feature of HMOs is suggested by a recent study by the Federal Trade Commission showing that the presence of an HMO also lowers premiums of other health plans in the same community.

At the same time, cost savings by HMOs which are being heavily subsidized by the federal government are in actuality not cost savings but cost transfers from the private to the public sector. For example, the premium of a federally supported HMO may be lower than that of a traditional health insurance plan or another HMO, but this saving may disappear as soon as government support is withdrawn. In the meantime, true competition among health plans is impaired.

It appears that private support holds the most promise for establishing self-sufficient HMOs. Indeed, the recent conference on HMOs for business and labor leaders sponsored by DHEW highlighted the need for non-governmental initiatives to promote and sustain the HMO movement. To this end, the National Chamber Foundation (an affiliate of the U.S. Chamber) has been sponsoring a comprehensive study on business and health. This study will produce a series of monographs on a variety of health care issues, including HMOs.

NATIONAL CHAMBER POSITION ON S. 2534

The National Chamber supports HMOs as a competing alternative form of health care delivery and federal support to experiment in the growth and development of these prepaid health plans. Accordingly, we favor a limited extension of the federal HMO program. But, we oppose supporting this program for another five years and at the level of funding proposed in S. 2534.

Our original support for HMOs was based on the opportunity to experiment with alternative delivery systems as a means of controlling health care costs and improving the health care delivery system. After a reasonable amount of federal financial assistance, HMOs were supposed to be able to compete independently in the health care marketplace--the true test of their ability to offer an alternative to existing delivery modes. Support for HMOs began in the very early 1970's before the first HMO law was passed. Since that time over $100 million has been spent by the federal government on the program.

S. 2534 would add another $400 million to this expenditure. The amount is excessive and should be reduced. Also, the life of the program should be extended only for another two years. This would permit a reasonable number of new HMOs to be developed, so that more Americans could have the option of seeking such care.

The National Chamber also opposes S. 2534's providing additional grant monies to HMOs after they become operational, even if these plans did not expend previous grant funds. Similarily, we oppose S. 2534's provision to establish a $40 million revolving loan fund, from which an HMO could receive up to $2.5 million for construction and guaranteed loans.

We offer the following comments on other provisions of S. 2534:

Training Program for HMO Directors

The National Chamber supports S. 2534's provision to help train both medical and executive directors, so that health professionals are available who are knowledgeable about the unique operations of prepaid health care plans. Heretofore, a major criticism of HMOs centered on their lack of sufficient managerial expertise. Such training would alleviate much of this problem.

Broader Discretion in HMO Approval

The National Chamber supports S. 2534's incorporating reasonable limitations and exclusions in the HMO benefit packages, to make these plans more competitive with traditional health insurance and other health care plans. For example, HMOs should not be required to provide protection against uninsurable risks, just as other health plans are exempted from providing such coverage. Thus, HMOs will be able to compete with other health plans.

Administrative and Reimbursement Reforms

The National Chamber supports S. 2534's provisions to improve the administration of the federal HMO program. The bill would allow for the unification of all phases of the federal HMO operations, including the blending of the qualification and compliance sections of the program. Also, the bill would require disclosure and reporting by federally funded HMOs in order to demonstrate their fiscal soundness and to clarify any suspicious transactions. This requirement appears consistent with the intent of P.L. 95-142, which seeks to eliminate fraud and abuse in the Medicare and Medicaid programs. Many HMO enrollees also could be beneficiaries of these two public health programs and this reporting requirement would eliminate or reduce many instances of payment for fraudulent or abusive practices.

These reforms will improve the effectiveness and efficiency of the federal program responsible for the development of HMOs.

Planning Act Exemption

The National Chamber opposes S. 2534's exemption of HMOs from certificate-of-need and project review authorities. Again, to be truly competitive in the health care market, HMOs should be subject to the same fiscal scrutiny as other health providers, to avoid wasteful and duplicative spending on facilities and equipment. Unnecessary capital investment should be avoided by all health service organizations, including HMOs.

Contracting for Services

The National Chamber opposes S. 2534's provision to restrict contractual services to physicians. Even as care provided in-house by the HMO professional staff includes non-physician services, so should services sought outside the plan allow for multiplicity of providers to assure patients the freedom to choose their own type of practitioners.

Employer Deductions for HMO Premium

Last but not least, the National Chamber opposes S. 2534's provision to require employers to deduct the employees' share of the HMO premium (from the employee's salaries if the employee agrees and the employer is able). The need for the provision supposedly is based on the contention that some employers are not deducting this contribution from workers' wages. However, we must assume that these employers are in the minority, considering the number of firms which offer the HMO option. Also, there is no such requirement for Blue Cross/Blue Shield or commercial insurance premiums. In short, the need for mandated salary deductions for HMOs is unnecessary.

SUMMARY

The National Chamber supports the growth and development of HMOs and has urged its members to consider involvement in these prepaid health care plans. We support limited federal financial assistance to these types of plans on an experimental basis and favor a limited extension of the federal program.

However, we oppose S. 2534 in its present form. If the extension of the act were limited in time and in the amount of funding and if there were no planning act exemption, no restriction of contractual services, and no mandatory requirement for employer deductions, we could support the bill.

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Statement

of the

American Medical Association

Submitted to the

Subcommittee on Health and Scientific Research
Committee on Human Resources

United States Senate

Re: S. 2534 - Health Maintenance Organization Act

Amendments of 1978

and

S. 2676 - Health Maintenance Organization
Amendments of 1978

March 30, 1978

The American Medical Association would like to take this opportunity to present its comments on S. 2534, the Health Maintenance Organization Act Amendments of 1978 and on the Administration's proposal S. 2676, the Health Maintenance Organization Amendments of 1978.

Background

Before offering our formal comments on the legislation, we would like to make clear the position of the AMA on prepaid group practice programs. The AMA has long recognized such prepaid programs as one form of health care delivery. Prepaid programs have an appropriate role in the delivery of health care and as such their presence in a community provides greater choice to the individual patient as to how his or her health care will be delivered, whether it be through such an organization, through fee-for-service, or through some other form of medical care delivery.

The history of prepaid programs in this country is rather lengthy, and in many areas prepaid organizations have existed side-by-side with fee-for-service and other organizations for a long period of time.

However, since 1973 a great deal of confusion has arisen in the public mind, and perhaps even in the mind of Congress, as to the position of the AMA concerning prepaid programs and the "Health Maintenance Organization". It was in 1973 that Congress enacted the Health Maintenance Organization Act. At that time Congress determined that it was more appropriate, since many differing prepaid programs were already in existence and had been for a long period of time, to enact legislation designed and intended to create a new and special program and establish it along the lines of an experimental program.

Confusion arose when legislation was introduced entitling this "new" entity a Health Maintenance Organization. When it did so, proponents sought to identify the HMO with prototype prepaid group practice organizations, such as Kaiser-Permanente. During the consideration of the Act the AMA was active in pointing out that unless the Administration and other proponents were in fact proposing a federal financing program for a new type of entity there was no justification for any federal funding. Enactment of a program to support already existing delivery systems could eventually effectively eliminate choice from individuals since no other health delivery method could compete against an organization which was allowed both to charge premiums to individuals to cover services and to receive an influx of special federal funds.

However, we supported at that time the HMO program as an experimental program as it evolved in the legislative process and was finally intended by Congress. It was not the intent of the Congress, at that time, nor was it the recommendation of the AMA, that an extensively expanded system of prepaid group practices of a type long established be assisted through federal funding.

However, less than two years ago, the HMO Act was amended and in that amendment the experimental program was substantially liberalized by moving the program further toward what a prepaid program had always been and detracting substantially from the experimental nature of the HMO.

The present amendments of S. 2534 and S. 2676 move the HMO even further away from an experimental concept, and move it to support of what one would only label prepaid programs that have long existed without special federal funding. However, notwithstanding these changes in the HMO programs, the current bills even call for extensive increases in federal funding. Moreover, the funding authority under S. 2534 set at five years evinces a permanent program.

RECOMMENDATIONS

We believe that in their present form S. 2534 and S. 2676 should not be adopted.

Under S. 2534 the HMO program -- still temporary at present -- would be extended for five years. New provisions would be added to allow the HMO special financial assistance in establishing ambulatory care facilities. The health planning law would be amended to require that "diagnostic and therapeutic equipment", irrespective where located (even in a physician's office), would be subject to certificate of need. Given preferential treatment, however, equipment of an HMO would be excluded except under unusual circumstances.

The amendments of S. 2676 contain many changes similar to those of S. 2534. There are, however, two significant additional amendments on which we will comment. One would remove the present priority funding consideration for those HMOs intended to serve medically underserved areas. The other addition would amend the reimbursement determinations for HMOs recognized under Medicare and Medicaid.

In lieu of further amendments to the HMO programs at this time, we suggest the completion of the evaluation of the existing HMO program contemplated under current

law so as to assure a clear evaluation of its impacts upon health care. Such a study should analyze the true cost of providing care through the HMO, including premiums paid by the individual as well as federal funding to that entity, in comparison with costs of health care provided through other health care delivery methods. In addition, Congress should exercise its oversight of the HMO program and HEW should develop its studies of HMOs called for under the law.

We believe also that an analysis should be made of patient evaluation of medical care received through an HMO as compared with other forms of care. The evaluation should also include an analysis as to whether further federal funds should be used to stimulate HMOs. By this we do not mean whether use of federal funds would encourage HMOs to develop at a faster pace but rather an evaluation as to whether, in order for an HMO to be initially established in a free market society, federal funds are in fact needed. The fact that it becomes easier for an HMO to be established by the use of, or it is convenient to use, federal funds does not in our view justify alone the use of federal funds. The health care priorities in our society are too demanding to permit massive federal funds to be committed to a program which may be found not to need such funds.

It is only after such an evaluation takes place, an evaluation which has never fully occurred, that Congress will have the facts on which to base any additional changes to the HMO Act. To do otherwise would result in each new Congress considering new amendments to the HMO program and to move it further and further from the limited experimental process to one which is in direct competition with all other providers of care but which has the added preferential advantage of massive federal funding. We do not believe that this is desirable nor that the public truly desires such a federal program.

We will now comment on specific portions of S. 2534 and S. 2676.

SPECIAL COMMENTS

Benefit Changes

One significant change that the bills would make would be to modify the present limitations on costs and benefits required under the Act.

Under the present law the HMO must provide services and benefits with no restrictions on cost or time limitations except as specifically stated in the law. However, the amendments would change this prohibition to allow the Secretary to eliminate services from basic coverage, and to establish limitations and exclusions on costs and extent of time during which benefits must be given by the HMO.

These amendments go too far in permitting the Secretary's authority to relax HMO requirements. As a matter of fact, under the discretionary language of the amendment it would be possible for contiguous HMOs to have varying types of copayments and extra payments for the same services and to have varying lengths of time that services would only have to be provided. We believe that such an authority on the part of the Secretary could undermine the entire HMO Act.

Could not the Secretary on his own, for instance, allow a federally funded HMO to be identical to any other prepaid health plan that does not receive such funding? Why should Congress establish in the law what the benefits and cost limitations must be and then allow the Secretary to vary them in the manner he pleases? We think such a provision is entirely inappropriate and should not be approved by this Committee.

Requirements for HMO

The bills would make certain HMO staffing and contractual limitation modifications. The effect of these modifications would, in our opinion, be a further movement away from the experimental nature of the HMO as defined under the act and as originally conceived by Congress.

We do not understand the rationale for these proposed changes and believe they are inappropriate and would not serve as a basis for providing the needed data to determine whether an HMO as conceived by Congress is in fact a preferred form of health care delivery.

The present provision of law pertaining to HMO staffing and contractual limits should not be changed.

Development Grants, Initial Operating Loans, and Authorization of Appropriations

Under the bills we note that initial development grants and initial operating loans for individual HMOs would be doubled from, respectively $2.5 to $5.0 million and from $1.0 million to $2.0 million. Also under S. 2534 total program appropriations would be extended for an additional five fiscal years and would be more than doubled, from $45 million to $95 million, and funds would be available to fund expansion of HMO services.

We believe that the doubling of these funds and the extension of five years of the program as contemplated under the bills are, under existing circumstances, premature and should not be supported.

There has been no justification to show that an individual HMO needs twice the amount of money for which it can now qualify or that the program should be extended for five years with a doubling of authorizations. The HMO itself is, under the bills, contemplated to be changed significantly. To allow entities that are less than HMOs as originally intended by Congress to use federal funds to show that they can deliver what other entities have long delivered (without federal funding) is futile. Funding should be restricted to limits which are presently under the law and an analysis should be made as to whether even these sums are appropriate for supporting entities that may not need such support.

In addition, we do not believe it is appropriate at this time to extend the program for five fiscal years. The HMO program, in our opinion, should be studied and evaluated very closely as we indicated earlier in our statement.

Ambulatory Care Facilities

The bills would add a new provision that would make available to HMOs and to entities loans and loan guarantees to assist in meeting the cost of equipping, constructing, acquiring and renovating ambulatory care facilities. Special funds would be authorized under the HMO Act.

We do not believe that the ambulatory care facilities provision should be added to the HMO at this time. This would compound the undesirability of further preferential treatment. Moreover, the bills would revise the current limitation which prohibits the funding of HMOs from funds outside the HMO Act.

Health Planning Amendments

S. 2534 would require extension of certificate of need to the physician's office by covering purchases of "diagnostic and therapeutic equipment."

Such a step represents a dramatic extension of the health planning law and must be examined most carefully.

Any hasty action could have long range unintended effects. For example, restriction of the physician's use of new medical technology could clearly impede or even undermine development.

There is as yet little evidence to support the notion that certificate-of-need results in significant cost savings, even for those services presently covered. Until such evidence is compiled, consideration of extension of certificate-of-need as proposed would be inappropriate. Moreover, we all must recognize that cost considerations cannot be isolated from the necessity of maintaining quality.

We also note that S. 2534 would redefine the phrase "institutional health services" so as to include not only certain "diagnostic or therapeutic equipment" (irrespective where located) and specifically include such equipment used in the delivery of services by "any person, institution, or other entity," but also to include "health services provided through health care facilities as defined in regulations of the Secretary including, but not limited to, private and public hospitals and nursing homes" (emphasis added).

This definition is so broad that the Secretary might seek to assume authority to include virtually any service depending solely upon his definition of "health care facilities." Under the proposed definition there are no criteria establishing "health care facilities." Experience has shown that the Secretary will seek to define terms in the broadest sense possible. Therefore, the proposed definition, we believe, might be used as an attempted basis by HEW as including services in physicians' offices. Clarification should be made in bill language to preclude such result.

Furthermore, the bill contemplates that the certificate of need would not be applicable to "diagnostic and therapeutic equipment" purchased by an HMO "except in unusual circumstances". Such an exemption would allow virtually a free hand in purchase of equipment perhaps duplicative of existing equipment. We also note that such an exclusion would apply to HMO purchase of equipment irrespective of whether equipment was to be used on an inpatient or outpatient basis. We believe such an exclusion subject only to undefined "unusual circumstances" would provide an unjustified and unfair advantage to the HMO and should not be supported.

We urge that provisions relating to extension of certificate-of-need to physicians' offices be deleted.

Repeal of Shortage Area Priorities

S. 2676 would repeal present provisions of law giving priority consideration of certain funding for HMOs intending to serve medically underserved areas and rural areas. We believe that the original inclusion of the provisions of the law was beneficial in that it intended to establish priorities as to areas in which experimental HMOs could have an especially significant impact. These provisions are still beneficial and should be retained.

Medicare/Medicaid Amendments

S. 2676 would make several significant changes to Medicare/Medicaid. Among the changes that would be made is one pertaining to payments to HMOs on the basis of a new mechanism. This would allow HMO per capita payments at 95% of an "adjusted average per capita cost". This "cost" would be based on the average per capita amount that Medicare or Medicaid would have expended for services (inpatient and outpatient) furnished "by other than" an HMO.

We believe that this provision would have the effect of providing an unjustified windfall to the HMO. The Administration contends that HMOs can generate significant savings. Yet the Administration here proposes that the HMO will be paid, not on a basis of costs and not on a basis of charges, as are all others under Medicare and Medicaid, but on the basis of 95% of what charges and costs would be if services were not provided by an HMO.

Moreover under this proposal the maximum the HMO would save over other forms of delivery would be 5%, at the most, yet claims are made of the HMO ability to save much greater amounts. Where are the savings? To whom do the savings go? How will average per capita amounts spent for other than HMO delivery be determined?

What kind of true comparison between HMOs and other forms of delivery of service can be made?

It would be only proper for the Administration, in proposing this mechanism, to state clearly that either the HMO program cannot generate significant savings for providing services or that the Administration intends to provide federal reimbursement in excess of real costs or charges to the benefit and preference of the HMO. We believe that if in fact there are significant savings (30% to 60% reduction in hospital costs alone are alleged by HEW) these should benefit the Medicare program and not the HMO. Medicare and Medicaid (to the detriment of care for the aged and the poor) would thus be used to enrich the HMO and finance care for all enrollees of the HMO.

This proposal is unfair, would twist free market competition, and should be deleted.

Other Amendments

There are also several amendments made under S. 2534 that we believe would be quite beneficial to the program. However, it should be noted that the nature of these amendments would not change the thrust of the present program but would merely make more efficient the operation or the administration of the program. Benefits we think should be adopted include the one providing for the employer to deduct HMO premium from the salary of the enrolled employee and provisions requiring disclosure of certain business transactions between HMOs and others. As to the employer deduction, however, we do not believe this should be mandatory as S. 2534 would require.

Conclusion

In conclusion, we again reiterate our support of a pluralistic system of health care delivery within which prepaid programs have long existed successfully without federal subsidy, and our support of the HMO program as an experimental program.

We are concerned about the increasing shift in the HMO Act away from the experimental program originally intended by Congress. The HMO would become merely the image of long-existing prepaid programs while receiving extensive federal funding. We do not believe that such a changed program is desirable, nor would it allow a true evaluation of the effects of an HMO as compared with other means of delivering health care. The legislation removes the HMO from free market competition and accords it additional artificial, preferential treatment.

In their present form, S. 2534 or S. 2676 should not be adopted. The amendments are in fact quite significant and would further detract from the central nature of the HMO program as originally advocated. The Secretary should not be given the broad discretionary authority proposed. Amendments in S. 2676 would even provide preferential Medicare/Medicaid "windfall" payments to HMOs. The HMO program should be maintained as an experimental program at this time. In addition, we again recommend that indepth evaluation and study of the effect of the presently funded HMOs be made prior to any further amendments to the HMO Act.

Senator SCHWEIKER. This concludes our hearing this morning on HMO legislation. The Senate Subcommittee on Health and Scientific Research stands adjourned subject to the call of the chair.

[The committee adjourned at 11:45 a.m.]

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