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The Health Maintenance Organization (HMO) Act of 1973 provided for a Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMOs. Through December 31, 1977, the Department of Health, Education, and Welfare (HEW), had awarded \$131.3 million in grant and loan assistance under the act to 1972 organizations, and 2 additional organizations received loan guarantees for \$2.2 million. As of the same date, there were 51 federally qualified HMOs. A review of 14 HMOs which had obtained Federal financial assistance under the act indicated that each of the HMOs is generally providing health services as required by the act and that each generally has been organized and operated according to the act's provisions. Exceptions exist in the area of enrollment of elderly, indigent, or medically high-risk people. One of the HMOs reached its financial breakeven point during the quarter ended December 1977. Six of the remaining 14 HMOs have a poor chance of breaking even within 5 years, and 6 have a fair to good chance of breaking even. No conclusion was reached about the other HMO. Concern remains over HEW's ability to issue regulations and guidelines needed to implement the act and to organize the program effectively. HEW has made a concerted effort to issue regulations in a timely manner, but the agency does not have the numbers and types of personnel needed to implement the HMO program effectively. (RRS)

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Statement of
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Committee on Human Resources
United States Senate
on the
Implementation of the
Health Maintenance Organization
Act of 1973, as Amended

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss our current review of the implementation of the Health Maintenance Organization (HMO) Act of 1973, as amended. This review was initiated to satisfy the requirements placed on GAO by section 1314 of the HMO Act and to respond to the specific directives contained in the Senate report on the Health Maintenance Organization Amendments of 1976. In addition, I have a few comments on the HMO Act amendments proposed by S.2534.

THE HEALTH MAINTENANCE ORGANIZATION
ACT OF 1973, AS AMENDED

The HMO Act of 1973 (87 Stat. 914) approved December 29, 1973, amended the Public Health Service Act to provide 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 HMOs.

The original act spells out in considerable detail, the definition of and requirements for an HMO. Among other things, the act specified basic and supplemental health services to be provided to the HMO members, the basis for fixing the rate of prepayment, the requirement that HMOs have open enrollment periods for individual members without restrictions (such as on pre-existing 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 HMOs and the expansion of existing HMOs by

- providing financial assistance through grants, contracts, and loans;
- providing a market for HMOs 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 HMOs 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 months to 60 months.

BASIS FOR AND
SCOPE OF GAO REVIEW

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

- evaluate HMOs 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 the option of enrolling in a qualified HMO; and
- evaluate and compare HMOs 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 HMOs federally qualified by December 31, 1976. At that time

27 HMOs were so qualified by HEW and we are reviewing the activities of 14 of these HMOs. 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 HMOs 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 HMOs have defaulted on Federal loans or loan guarantees. There were 80 inactive grantee organizations, which had obtained grants totalling \$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 HMOs. 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.

PRELIMINARY FINDINGS
BASED ON OUR REVIEW

In compliance with the act as amended in 1976, we are reviewing the activities of 14 HMOs 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 HMOs 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 HMOs 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 HMOs' 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 HMOs' 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 HMOs reached its breakeven point during the quarter ended December 1977. Our preliminary conclusions about other HMOs 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 HMOs center around the reasonableness of their cost and revenue projections and their managerial capability.

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 HMOs. 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 HMOs 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 HMOs was mixed but mainly favorable.

No commonly accepted standards or techniques exist to evaluate quality of care provided by HMOs. 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 HMOs and noted that the types of quality assurance programs varied. Further, we found that seven had not fully implemented their quality assurance programs.

IMPLEMENTING THE HMO ACT--
MORE NEEDS TO BE DONE

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 HMOs 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 HMOs 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 HMOs to establish premiums based on a community rate rather than on an experience rate. HMOs 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 HMOs 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 HMOs 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 HMO 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 HMOs, 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 HMOs in the qualification review process. Not only has this delay had an adverse impact upon the development of HMOs, 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 totalling \$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 HMOs. However, we have reservations about expanding the loan assistance available to HMOs 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 HMOs 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 HMOs 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 HMOs. 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 1978-1979, 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.

Financial disclosure

We support section 10 of S.2534 which deals with financial disclosure because as a result of several reviews of 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 inter-relationships--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 HMOs. 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.

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