REPORT BY THE

Comptroller General

OF THE UNITED STATES

Portland Metro Health Plan, Inc. —A Federally Qualified Health Maintenance Organization

Portland Metro Health Plan, Inc., Portland, Oregon, was the first qualified health maintenance organization to contract for health care with an individual practice association. As of June 30, 1977, Portland Metro reported it had enrolled 7,285 members.

The plan offers the specified health benefits, meets the organizational requirements, and generally satisfies the operational requirements of the Health Maintenance Organization Act of 1973. It did not, however, have an open enrollment period nor did it enroll members to broadly represent its service area. Its policies tend to exclude or discourage certain groups from becoming members.

Unless Portland Metro increases premium rates and reduces administrative costs substantially, it will not be fiscally sound as required by the act. GAO doubts Portland Metro's ability to do this. Thus, it will not be able to operate beyond its loan subsidy period without additional Federal financial assistance.

HRD-78-89
AUGUST 8, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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Chairman and Ranking Minority Member
Subcommittee on Health and Scientific
Research
Committee on Human Resources
United States Senate

Chairman and Ranking Minority Member
Subcommittee on Health and the
Environment
Committee on Interstate and Foreign
Commerce
House of Representatives

This report discusses our findings and conclusions on the Portland Metro Health, Inc., Portland, Oregon, a federally qualified health maintenance organization. A draft report was sent to the organization's officials for review and comment and their comments have been included in the report.

This is the third in the series of 14 individual reports to be issued in compliance with section 1314 of the Health Maintenance Organization Act, as amended. Our report entitled "Can Health Maintenance Organizations Be Successful?--An Analysis of 14 Federally Qualified 'HMOs'" (HRD-78-125, June 30, 1978), summarizing all our evaluations initiated under section 1314 was submitted to the Congress.

As requested by the Chairman and Ranking Minority Member of the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources, we are forwarding separate reports on each health maintenance organization evaluation to them and also to the Chairman and Ranking Minority Member of the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce.

We are also sending copies of our individual reports to the Department of Health, Education, and Welfare. The Civil Service Commission will be provided copies of reports on health maintenance organizations participating in the Federal Employees Health Benefits Program.

While we hope that this and our subsequent evaluations of federally qualified health maintenance organizations will be of use to the Subcommittee(s) and the responsible Federal agencies, we believe that the public disclosure of our discussion of several issues in the report may inadvertently and inappropriately have an adverse effect upon the health maintenance organization's marketing capability and financial viability. Therefore, we have limited the distribution of this report, and unless released by the Subcommittee(s), we will restrict public release of this and other reports in this series.

Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

PORTLAND METRO HEALTH PLAN, INC.--A FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATION

D I G E S T

This report, on the Portland Metro Health Plan, Inc., of Portland, Oregon, is 1 in a series of 14 evaluations of individual health maintenance organizations. A health maintenance organization provides health care services to its members based on prepaid rates. This provides an incentive for an organization to emphasize preventive medicine to reduce overall health care costs.

The Health Maintenance Organization Act permits a health maintenance organization to provide health care services through health professionals who are members of its staff or through medical groups or individual practice associations with which the organization has entered into service agreements. Portland Metro Health Plan, Inc., contracts with an individual practice association--Portland Metro Health Physicians--to provide health care services to its members.

Portland Metro appears to be providing comprehensive prepaid health care to its members in accordance with the Health Maintenance Organization Act. However, it has not enrolled members broadly representative of its service area. Its policies and practices tend to discourage enrollment of low income, old, sick, and pregnant individuals.

Portland Metro does not have a fiscally sound operation as required by the act. In December 1975 it was awarded an operational loan of $1 million to cover projected operating losses during its initial 36 months; it spent the $1 million during its first 14 months. Portland Metro requested and was granted an additional $1.5 million loan by the Department of Health, Education, and Welfare (HEW) in March 1977. In its first 12 months of operation (to December 31, 1976), it realized only 48 percent of its projected income and incurred operational losses of $835,080 or $380,954 more than projected in its initial loan application.

GAO believes that unless Portland Metro increases premium rates and reduces administrative costs substantially, it will not be fiscally sound as required by the act.

GAO doubts that Portland Metro has the ability to do this. Thus, it will not be able to operate beyond its loan subsidy period without additional Federal financial assistance.

In commenting on this report in December 1977, Portland Metro disagreed with GAO's conclusions that it had not enrolled persons broadly representative of its service area and that it does not have a financially sound operation. (See app. II.)

On June 30, 1978, HEW formally notified Portland Metro of its intent to revoke Portland Metro's Federal qualification. Specifically, Portland Metro had failed to comply with the requirement that a qualified HMO have a fiscally sound operation.

GAO revised and updated certain sections of the report based on Portland Metro's review comments and specifically addresses other comments in chapter 6.

Employers in the Portland Metro service area are required to include a health maintenance organization in their employees' health benefit plans. Although some employers resent this Federal requirement, those contacted said the added administrative costs of offering employees a health maintenance organization were negligible.

Although many employees in the Portland Metro service area receive health benefits through union trust programs, as of June 30, 1977, Portland Metro had been unable to negotiate contracts or enroll members through union trusts. However, Portland Metro reported that it has begun enrolling members of the Oregon-Teamster Trust for coverage effective January 1, 1978.

GAO believes that the public disclosure of our discussion of several issues in the report may inadvertently and inappropriately have an adverse effect upon the health maintenance organization's marketing capability and financial viability. Therefore, GAO has limited the distribution of this report.

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	health maintenance organization

CHAPTER 1

INTRODUCTION

The Health Maintenance Organization (HMO) Act of 1973, as amended, requires us to evaluate the operations of certain HMOs which have been certified by the Department of Health, Education, and Welfare (HEW) as complying with the act's organizational and operational requirements and which have received financial assistance under the act.

Section 1314 of the act, as amended, requires us to report to the Congress on the ability of these qualified HMOs

--to meet the requirements of the act regarding their organization and operation, including the HMOs' ability to include medically indigent and high-risk individuals in their membership and to provide services to medically underserved populations and

--to operate on a fiscally sound basis without continued Federal financial assistance.

The act directs us to study and report the economic effects on certain employers required by section 1310 of the act, as amended, to offer membership in qualified HMOs as an optional health benefit plan, an option referred to as dual choice.

The act also requires us to evaluate (1) the operations of distinct categories of HMOs in comparison with each other, (2) HMOs as a group as compared with alternative forms of health care delivery, and (3) the impact that HMOs, individually, by category, and as a group have on the public health. To the extent possible, we have included such information in our summary report to the Congress. However, as noted in our report, "Factors That Impede Progress in Implementing the Health Maintenance Organization Act of 1973" (HRD-76-128, Sept. 3, 1976), no state-of-the-art agreement exists on what methods have been developed to provide comparative and health status information to be used for such evaluations. For this report, we will describe the HMO's quality assurance program.

This evaluation concerns Portland Metro Health Plan, Inc., Portland, Oregon, and is one in a series of evaluations of HMOs to be made in compliance with the act. At the request of the Chairman and Ranking Minority Member, Subcommittee on Health and Scientific Research, Senate Committee on Human Resources (formerly the Subcommittee on Health, Senate Committee

on Labor and Public Welfare), separate reports on each HMO evaluation will be issued to them and to the Chairman and Ranking Minority Member, Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce. Our report entitled "Can Health Maintenance Organizations Be Successful?--An Analysis of 14 Federally Qualified 'HMOs" (HRD-78-125, June 30, 1978) summarizing all our audits initiated under section 1314, as amended, was submitted to the Congress.

PORTLAND METRO HEALTH PLAN, INC.

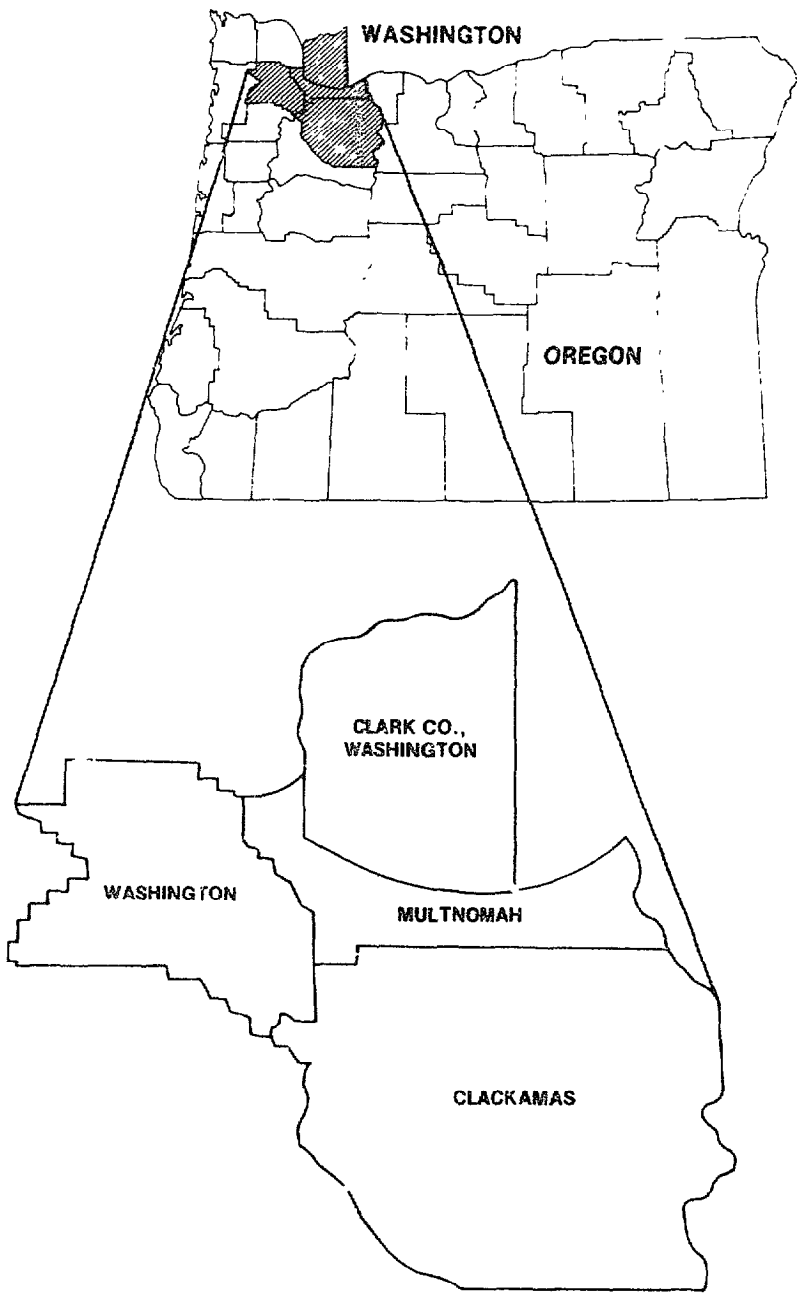
Portland Metro was incorporated in December 1972 as a nonprofit corporation under Oregon State laws. HEW tentatively certified Portland Metro as a qualified HMO in July 1975. Portland Metro received a direct operating loan of $1 million from HEW in December 1975 and began providing health services to its members on January 1, 1976. Upon becoming operational, Portland Metro was also qualified for mandatory dual choice under section 1310 of the act. See ch. 4.)

Portland Metro was the first individual-practice-association type HMO to be qualified under the act. As an individual-practice-association type HMO, Portland Metro does not own or operate health care facilities. Instead, it contracts with an individual practice association, Portland Metro Health Physicians, Inc., and with institutional health care providers, such as hospitals and skilled nursing facilities, for delivery of health care to its members. As of May 1977 Portland Metro had individual contracts with 754 participating physicians, 23 participating hospitals, and 6 urgent care centers. Thus, Portland Metro does not directly control or manage the amount of health care provided to its members.

Portland Metro pays physicians and other health care providers on a fee-for-service basis which is similar to a service benefit plan, such as Blue Cross-Blue Shield's. After serving the member, the provider bills and receives payment from Portland Metro.

Portland Metro serves a standard metropolitan statistical area of Multnomah, Clackamas, and Washington Counties in Oregon, and Clark County in Washington. (See map on p. 3.) Certain census tracts within the service area have been designated as medically underserved areas, but Portland Metro does not specifically direct enrollment efforts to these areas.

PORTLAND METRO HEALTH PLAN, INC.
SERVICE AREA



FEDERAL FINANCIAL ASSISTANCE

Federal financial assistance to prepaid health care delivery programs was available before the HMO Act under several sections of the Public Health Service Act (42 U.S.C. 246(e) (repealed by Public Law 94-63), 42 U.S.C. 242b (1970 and Supp. V, 1975), 42 U.S.C. 229b (1970), 42 U.S.C. 299j (1970)). During the period April 1972 through June 1974, Portland Metro Health Plan, Inc., and its predecessor agency, Emanuel Hospital, received three grants totaling $309,800 under section 314(e) of the Public Health Service Act (repealed by Public Law 94-63). This section provided for grants to any public or nonprofit private agency, institution, or organization to cover partially the cost of (1) providing services to meet health needs which are limited by geographic scope or of specialized regional or national significance or (2) initially developing and supporting new health services programs. Portland Metro received additional planning grants totaling $455,188 from July 1, 1974, through December 31, 1975, under the HMO Act.

The act requires each HMO to be fiscally sound. However, because developing HMOs may have difficulty meeting operating expenses, the act provided for Federal loans to assist them during their first 36 months. The HMO Amendments of 1976 extended the loan subsidy period to 60 months. Interest accrues from the date of the loan closing and is to be paid in accordance with the loan agreement, which requires repayment of the principal beginning between the fourth and fifth anniversaries of the direct loan closing.

In December 1975, after 4 years of developmental activities supported by section 314(e) and HMO Act grants, Portland Metro received an operating loan of $1 million to cover projected losses during its initial 36 months. Portland Metro used the $1 million to cover losses during its first 14 months of operation. Portland Metro requested and received an additional $1.5 million loan from HEW in March 1977.

The loan agreements state interest and principal shall be repayable over a period not to exceed 20 years, beginning on the loan closing date. However, principal payments are to begin in July 1980 for the $1 million loan and between March 4, 1981, and March 4, 1982, for the $1.5 million loan. Annual interest rates are 8.25 percent and 7.25 percent for the $1 million and $1.5 million loans, respectively.

As shown on the following page, Portland Metro has received Federal financial assistance totaling $3,264,988--of which about 91 percent was under the HMO Act.

Federal Financial Assistance

Type	Authority	Date awarded	Amount	Purpose
Grant	Public Health Service Act, section 314(e)	12/29/71	$ 100,000	Planning and development
Grant	Public Health Service Act, section 314(e)	4/18/73	184,800	Planning and development
Grant	Public Health Service Act, section 314(e)	4/10/74	25,000	Planning and development
Grant	HMO Act	7/25/74	111,381	Planning and development
Grant	HMO Act	3/28/75	307,244	Planning and development
Grant	HMO Act	6/27/75	36,563	Planning and development
Loan	HMO Act	12/11/75	1,000,000	Initial operating deficit
Loan	HMO Act	3/04/77	1,500,000	Initial operating deficit
Total			$3,264,988	

SCOPE OF EVALUATION

We made our review at Portland Metro Health Plan, Inc., Portland, Oregon; HEW's Health Services Administration, Rockville, Maryland; and HEW region X offices in Seattle, Washington. We also interviewed employer representatives at their offices in the Portland area.

To determine Portland Metro's ability to be fiscally sound without continued Federal financial assistance, we

--compared Portland Metro's financial history to the financial projection it submitted in applying for qualification and for Federal loans;

--reviewed the actuarial projections used by Portland Metro and projections contained in its application for an additional $1.5 million loan from HEW; and

--reviewed Portland Metro's marketing program, its financial operations, and its systems to control overutilization of services.

To evaluate Portland Metro's ability to meet the other requirements and purposes of the act, we

--compared its organizational structure and level of health services provision to the requirements of the HEW regulations which had been used in qualifying Portland Metro and

--evaluated its health services programs to medically underserved areas, high-risk individuals, and the indigent.

Summarized in appendix III are our determinations on Portland Metro's compliance with the act.

CHAPTER 2

HAS PORTLAND METRO BEEN ABLE TO MEET THE ORGANIZATIONAL AND OPERATING REQUIREMENTS OF THE HMO ACT?

The HMO Act directs qualified HMOs to be fiscally sound; offer specified health benefits; and meet certain other organizational and operational requirements, including use of a community rating system to develop premium rates. Portland Metro's financial viability is discussed in chapter 3. Portland Metro offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of a federally qualified HMO. (See app. III.)

Provisions not met include

--the open enrollment requirement of the original act which was never fully implemented by Portland Metro nor formally waived by HEW and

--the requirement that membership be broadly representative of the various age, social, and income groups within its service area.

HEW has not published program guidelines for interpreting some operational requirements. For example, although HMOs must establish a community rating system for fixing periodic payments, HEW has not published guidelines to be used in developing such a system. (See p. 11.)

HEW encourages, but does not require, an HMO to implement certain other program objectives of the act. Guidelines have not been established, thus leaving the interpretation to each HMO. An example of such an objective would be in the ways services should be directed toward medically underserved areas.

OPEN ENROLLMENT PERIOD NOT HELD

Prior to the 1976 amendments to the act, section 301(c)(4) stated that each HMO shall:

> " * * * have an open enrollment period of not less than thirty days at least once during each consecutive twelve-month period during which

enrollment period it accepts, up to its capacity, individuals in the order in which they apply for enrollment.* * *"

Exceptions to this provision could be authorized by the Secretary if the HMO demonstrated, to HEW's satisfaction, that it had enrolled or would be forced to enroll a disproportionate number of individuals who were likely to make excessive use of its services and that enrolling more such individuals would jeopardize the financial viability of the HMO.

Portland Metro determined that an open enrollment period during the first year of operation would jeopardize its financial viability and requested a waiver from HEW. According to its president, Portland Metro interpreted HEW's lack of response as tacit approval of the request. HEW did not formally acknowledge receipt of the request or respond to it. The president of Portland Metro stated open enrollment would not be held during the loan period.

HEW has not issued final criteria for considering requests for waivers. The amendments to the HMO Act changed the open enrollment requirements so that open enrollment is now required for only those HMOs which

--have been providing comprehensive health services on a prepaid basis for 5 years or have 50,000 members and

--did not incur a financial deficit in their most recent fiscal year.

Because of these amendments, Portland Metro will not have to have an open enrollment in the near future because it (1) will not have been providing comprehensive health services on a prepaid basis for 5 years until January 1981, (2) had 7,285 members as of June 30, 1977, and (3) continues to incur deficits.

HMO MEMBERS NOT REPRESENTATIVE OF AREA SERVED

Section 1301(c) of the act requires an HMO to enroll persons broadly representative of various age, social, and income groups within the area served. Federal implementing regulations provide no guidelines defining a "broadly representative" membership. Portland Metro attempts to direct marketing efforts toward low health care user groups and away from high

user groups. In practice, this marketing strategy discriminates against older persons, the poor (Medicaid recipients), groups with high health care needs such as Medicare recipients, and women who are (or intend to become) pregnant. As a result, Portland Metro

--serves proportionately fewer persons over age 45 than are in its service area (see p. 10),

--has not contracted with the States in its service area to provide health care to Medicaid recipients,

--has established a rate structure that discouraged older persons and pregnant women from becoming members, and

--has actively screened employer groups to eliminate potentially high utilizer groups from enrolling in it.

Medicare enrollees

Portland Metro discourages older persons from enrolling in its health plan. For example, its marketing brochure states that:

> "If you are covered by Medicare, PLEASE NOTE: PMH Plan will coordinate benefits for members covered under Medicare or other state, municipal, or federal programs. Generally, however, the PMH Plan is not appropriate when Medicare or similar programs apply, and a benefit package specifically designed for those programs will be more advantageous as a health plan alternative."

Portland Metro also attempts to discourage older persons from enrolling by charging them a higher premium on two-person contracts based on the premise that adults in two-person contracts are older than adults in single-person or family contracts. The January 1977 premium rate for two-person contracts ($72.69) was more than twice the rate applicable to single-person contracts ($34.61).

Medicaid enrollees

Portland Metro had not contracted with States in its service area to provide health services to Medicaid beneficiaries. The Portland Metro director stated Portland Metro was not interested in providing services to Medicaid beneficiaries because

--it does not wish to have a "government subsidized, welfare image;"

--the adminstrative red tape involved in securing and maintaining such contracts is greater than the benefit to be gained from them; and

--high utilization of health services by Medicaid beneficiaries could adversely affect its financial viability.

In commenting on our draft report, the Portland Metro director stated that Portland Metro has contracted with Project Health, a Multnomah County project established to provide health care to the working poor. As of December 1, 1977, Portland Metro had enrolled 184 medically indigent persons under this contract which was effective July 1, 1977.

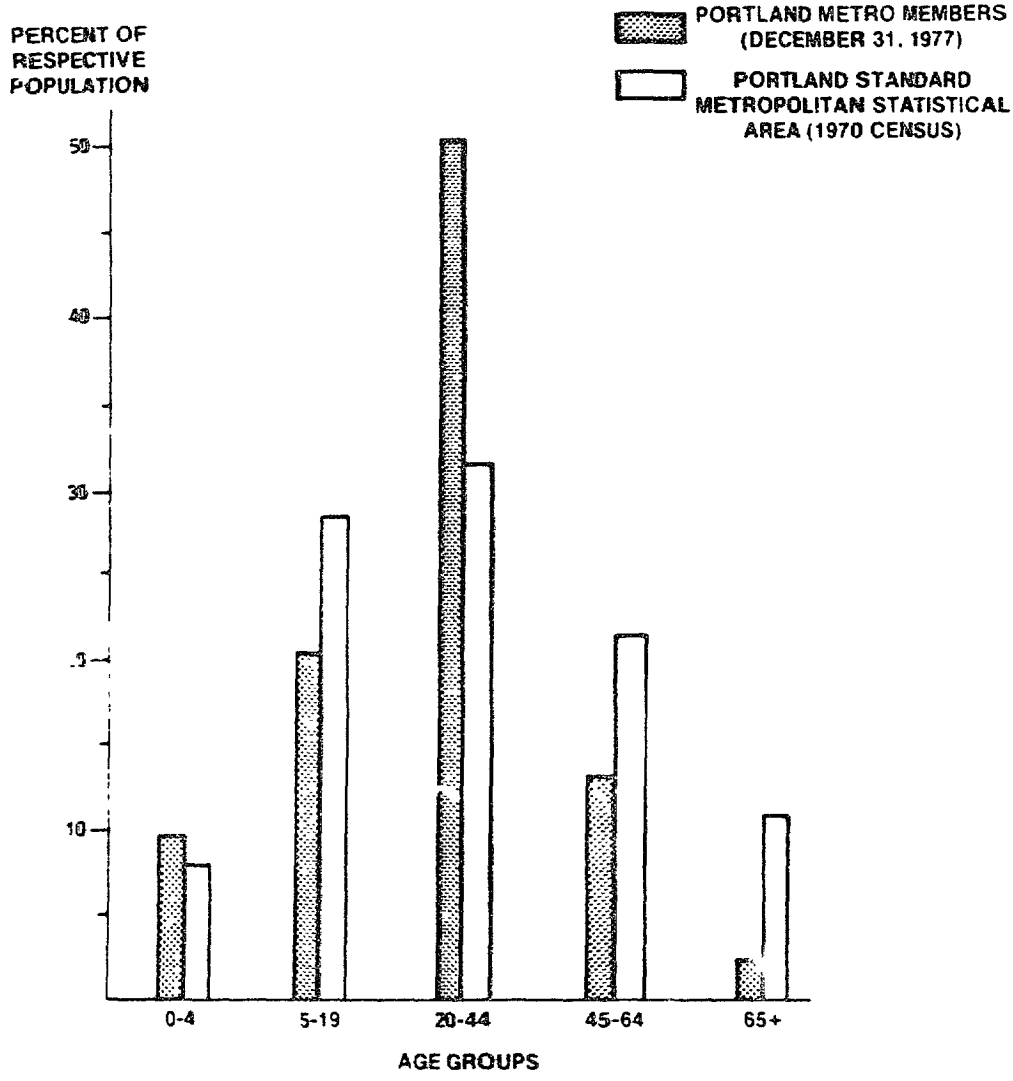
Discrimination against high health service utilizers

In its qualification application, Portland Metro stated it would not attempt to screen out individuals based on their past or present health status. However, it has used both group selection and price to control the size and quality of its enrollees. Portland Metro officials said they have attempted to enroll employer groups representative of industries and types of work in its service area.

In commenting on our draft report, the Portland Metro director acknowledged screening employer groups based upon their health care utilization record. However, he said that the main criteria used in selecting new groups were (1) the premium differential between Portland Metro and other carriers used by the group and (2) the employer's attitude toward Portland Metro.

In addition to group selection, Portland Metro has also tried to control enrollment through price. As discussed above, the two-person contract rate has been used to discourage enrollment of older persons. During 1977, Portland Metro established a $150 maternity copayment. This copayment was intended to reduce the proportion of pregnant women joining Portland Metro to a figure closer to the community average. In commenting on our draft report, the Portland Metro director stated that the birth rate among Portland Metro enrollees did not decline following the implementation of the $150 copayment, and partly as a result of this, Portland Metro eliminated

AGE DISTRIBUTION



the maternity copayment for enrollments and re-enrollments beginning in January 1978.

THE COMMUNITY RATING SYSTEM

Originally, section 1301(b)(1) of the act required that payment for basic health services provided by the HMO be fixed under a community rating system. Section 1302(8) of the HMO Act, as amended, defines a community rating system as

> "* * * a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but * * * such rates must be equivalent for all individuals and for all families of similar composition."

Portland Metro established its initial premium rates from projections developed with the assistance of an actuarial consultant. Premium rates have been adjusted based on utilization and cost experience.

HEW has not published, nor has it any specific plans for publishing, program guidelines to interpret how community rating should translate into a premium structure. As a result, we could not determine if Portland Metro's rate structure complies with the act's requirements for a community rating system. The HMO amendments have deferred application of the community rating requirement to after the HMO has been qualified for 48 months.

INADEQUATE REVIEW OF LOAN APPLICATION

Section 1306(b)(5) of the original act stated that HEW may not approve a loan application unless the applicable health planning agency has had an opportunity to review the application and submit recommendations.

A health planning agency official stated the agency was not given sufficient information to adequately review the $1 million Portland Metro loan application. Although the agency protested this situation several months before the loan was approved, the executive director of the planning agency said HEW did not respond to the request that it be permitted to review the complete loan application before approval.

OTHER REQUIREMENTS

The act contains other requirements designed to encourage HMOs to provide comprehensive, quality health care to a broad spectrum of the population and to promote a managed health care delivery system. However, HEW has not developed standards and definitions for these requirements.

Portland Metro's approach to these requirements is set forth below.

An HMO must provide health education and medical social services for its members

HEW has not defined the level of service required to comply with this provision. Portland Metro relies on the medical social services departments of participating acute-care hospitals to provide services to members. In the absence of minimum standards, we could not determine whether the level of service provided to Portland Metro members was adequate.

An HMO must provide, or make arrangements for, continuing education for its health professional staff

As previously stated Portland Metro does not directly employ health professionals, but it does provide health services through contracts with physicians and other health care providers. It does not monitor the continuing education of its participating health professionals. Each physician contracting with Portland Metro agrees that to the extent feasible he will cooperate with programs of continuing education. However, in its qualification application, Portland Metro stated it was not practical or economically feasible for an individual-practice-association type HMO to have such a program. Portland Metro has not conducted any continuing education activities to its physicians.

CONCLUSIONS

Portland Metro was in compliance with organizational requirements and generally satisfied operational requirements of the act.

CHAPTER 3

WILL PORTLAND METRO BE ABLE TO OPERATE WITHOUT CONTINUED FEDERAL FINANCIAL ASSISTANCE?

As stated in chapter 1, the HMO Act requires each qualified HMO to be fiscally sound. In our opinion, unless Portland Metro increases premium rates and reduces administrative costs substantially, it will not be fiscally sound as required by the act. We doubt Portland Metro's ability to do this. Thus, Portland Metro will not be able to operate beyond its loan subsidy period without additional Federal financial assistance because it

--continues to incur administrative costs in amounts disproportionate to its enrollment size and

--lacks effective control over utilization and costs of health care provided to members.

In addition, HEW has not encouraged Portland Metro to adhere to financial projections which were the basis on which Federal loan assistance was provided. HEW was aware that Portland Metro was incurring greater than anticipated losses only 3 months after it became operational, and approved several increases in the scheduled spending of the $1 million operating loan. As a result, the $1 million loan which was to subsidize Portland Metro's losses for 3 years was used in only 14 months. HEW initially concluded in February 1977 that it could not approve Portland Metro's request for an additional $1.5 million loan. In March 1977, after making adjustments based on HEW suggestions, Portland Metro's request for additional loan money was approved in order for it to continue operations. HEW approved the additional loan even though (1) its marketing analysis showed Portland Metro would not obtain its projected enrollment and (2) its financial analysis concluded Portland Metro was unlikely to attain financial self-sufficiency as projected. In a letter dated February 11, 1977, we advised HEW that Portland Metro could not achieve the requirement to be financially viable under its current mode of operation.

ADMINISTRATIVE AND OPERATING COSTS

The financial problems of Portland Metro are due primarily to excessive administrative and operational expenditures.

Although membership income for the first 12 months of operation offset health care costs, Portland Metro spent about $365,000 more for administration and interest than projected in its initial loan application. Portland Metro's operating results during its first 12 months are summarized below.

Income and Expenses
January 1 through December 31, 1976

Item	Projection	Actual	Difference (projection less actual)
Membership	7,500	4,100	-3,400
Income	$1,219,418	$ 588,480	$630,938
Expenses:			
Health care	1,200,232	585,384	614,848
Administration	467,312	740,011	-272,699
Interest	6,000	98,165	-92,165
Total expenses	1,673,544	1,423,560	249,984
Net income (loss)	$ -454,126	$ -835,080	$380,954

From January 1, 1976, through September 30, 1977, Portland Metro experienced continuing high administrative costs--averaging about $70,000 per month in 1976 and $81,000 for the first 9 months of 1977. Net operating losses averaged about $70,000 per month during 1976 and $69,000 per month during the first 9 months of 1977.

In January 1977 an HEW official reviewed the Portland Metro operation and concluded that it had inadequately managed its administrative costs. He stated that

--Portland Metro's personnel structure resembled that of an individual practice association with 25,000 to 40,000 members, when actual membership was only 5,130 and

--although membership had lagged far behind original projections, the executive director had increased the size of the administrative staff without regard to slow membership growth, as long as Federal funds were available.

HEALTH CARE COSTS

Portland Metro recognized, in its qualification application, that an individual practice association cannot establish direct cost and utilization controls over health care providers. As an individual-practice-association type HMO:

--Portland Metro does not employ health care staff. Portland Metro signs written agreements with providers who accept the health plan's payment for providing health care.

--Portland Metro pays participating providers their usual and customary fees for covered services.

--Portland Metro does not own or operate health care facilities. Services are obtained in the offices and facilities of participating providers. Therefore, no savings are gained through consolidating and sharing facilities and equipment or through pooling medical or administrative support staffs.

--Portland Metro requires that providers submit itemized claims for payment and collect applicable copayments from the patient.

Portland Metro proposed to control health care costs by reimbursing participating physicians according to the physicians' approved fee schedules. A January 1977 HEW financial review disclosed that although Portland Metro had an approved fee schedule for each participating physician, they were not being used to determine whether each physician was submitting appropriate claims. In commenting on our draft report, a Portland Metro official stated that a system to compare physician billings with approved fee schedules was initiated September 1, 1977.

UTILIZATION OF HEALTH CARE

In applying for qualification, Portland Metro emphasized the need to achieve its health care utilization goals to be fiscally sound. During Portland Metro's first 7 months of operation, utilization was higher than anticipated for hospitalization, X-rays, and emergency room visits. These three services accounted for over 50 percent of total health care costs. Portland Metro also incurred a higher than anticipated cost per service.

Portland Metro proposed to control utilization by (1) monitoring inpatient and outpatient care, to eliminate unnecessary and inappropriate treatment, (2) establishing incentives for provider efficiency by having the providers be responsible for utilization of the HMO, and (3) educating its members and providers in the appropriate and most cost-effective use of health care delivery systems.

Initial experience indicates controls have been ineffective in reducing hospital utilization below levels attained by a major private health insurer and a group practice HMO in the area. Portland Metro's utilization controls are discussed below.

Controls to eliminate unnecessary and inappropriate treatment

Portland Metro subscribes to a commercial hospitalization review program which monitors care and lengths of stay for inpatients. This program has reportedly reduced the average length of hospital stay by 2.5 days for some subscribers.

This program monitors length of stay but does not control admission. In commenting on our draft report, the Portland Metro president stated that a hospital admission review program was initiated on May 1, 1977.

Portland Metro screens outpatient claims submitted by providers for appropriateness of treatment. If tests administered or treatment provided appear excessive or inappropriate, Portland Metro refers the claim to the Health Services director who discusses it with the provider. If agreement is not reached, the claim is referred to the professional review committee (a group of member physicians) for resolution. Portland Metro officials said some claims were rejected or the amounts were reduced as a result of this review. However, Portland Metro officials stated the review's main purpose is to provide education, not to recover funds, and claims actually adjusted have been small in number and in total dollar amount.

Provider incentives and risk pool

Portland Metro has established a "Physicians' Risk Pool" to give physicians an investment or stake in the HMO's welfare. Portland Metro withholds 10 percent of physicians' billings for outpatient services and 15 percent for inpatient services. These funds are pooled for later distribution to the physicians. A physician is reimbursed based on the amount

in the risk pool, the physician's contribution to the pool, and the average total cost per patient of the physician compared to average total cost of all participating physicians of the same specialty. The December 1976 minutes of the Portland Metro negotiating committee state no criteria exists for establishing an efficiency factor on which to base distributions from the pool. The committee recommended that $18,000 to $20,000 of the risk/incentive pool be distributed on a dollar-for-dollar basis--based on the physician's contribution. We believe this practice removes any incentive for physicians to reduce member utilization of health care and eliminates any risk that physicians would receive less than their usual and customary fees.

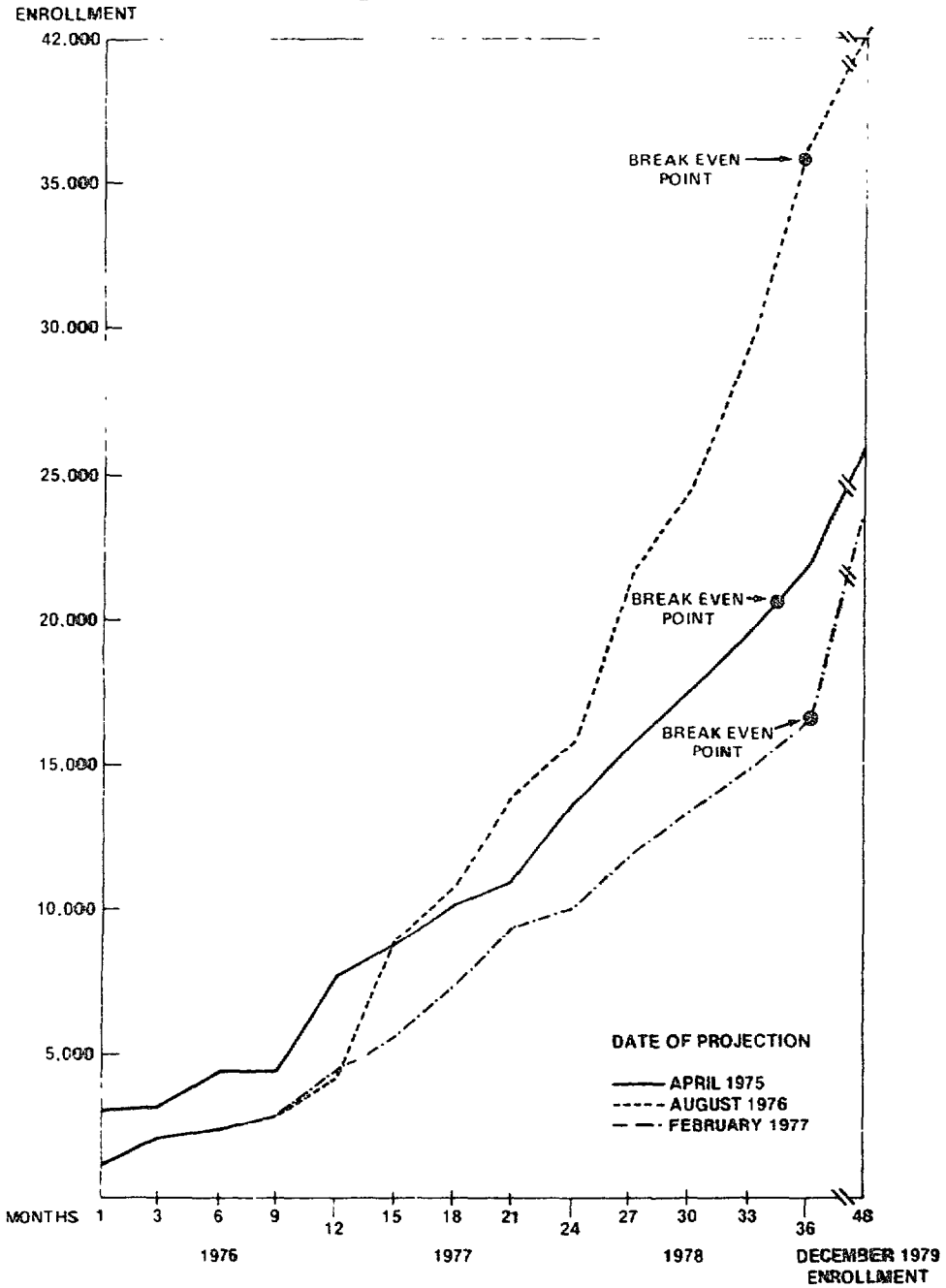
OPTIMISTIC ENROLLMENT PROJECTIONS

Portland Metro failed to meet original projected enrollment levels. The projection submitted with Portland Metro's first loan application was prepared in April 1975 and assumed an operational date of October 1975. However, Portland Metro did not begin operating on schedule, so the projection was updated in November 1975 to reflect starting in January 1976.

Portland Metro again revised its enrollment forecast in August 1976 to support requests for an accelerated drawdown of the initial $1 million operating loan and an additional loan of $1.5 million. When HEW did not approve the additional loan, Portland Metro reduced projected enrollment from 36,000 to 27,000 in January 1977 and again in February 1977 to 16,400 (see p. 18).

In commenting on our draft report, a Portland Metro official stated that enrollment has been close to the goals approved in Portland Metro's second loan application. Portland Metro reported that, as of November 1977, planned enrollment was 9,875 and actual enrollment was 9,639.

PORTLAND METRO HEALTH
ENROLLMENT PROJECTIONS



Portland Metro's financial projections were also changed to support its varied enrollment projections.

Enrollment Projections

Date of projection	Projected enrollment December 1978	Financial break-even point Enrollment	Financial break-even point Date
April 1975	23,357	20,497	3d quarter 1978
August 1976	36,268	35,978	4th quarter 1978
February 1977	16,400	20,495	3d quarter 1979

RATE COMPARISON

Although health benefits varied under different plans, Portland Metro's 1976 premium rates were generally in line with competitors' rates, as the table below shows.

Portland Metro Rates Compared to Three Competing Health Plans

Type of contract	Monthly rates - July 1976 Portland Metro	Competitors A	Competitors B	Competitors C
Employee only	$27.29	$24.64	$28.70	$31.00
Employee and spouse	65.60	49.28	62.25	64.00
Employee and family	85.86	73.73	74.35	87.30

As the following table shows, Portland Metro's rates for Oregon State employees were the highest for each type of contract of the health plans offered.

Rates Charged Oregon State Employees

Type of contract	Monthly rates Portland Metro	Competitors A	Competitors B	Competitors C
Employee only	$27.43	$23.76	$24.50	$23.83
Employee and spouse	65.93	47.52	52.33	50.37
Employee and family	86.29	69.77	75.22	69.13
Employee and children	-	-	46.87	42.59

Portland Metro has significantly increased its rates from those applicable to the general public effective in July 1976, as shown below:

Premium Rate Increases

Type of contract	Premium rate July 1976	Premium rate January 1977	Premium rate January 1978	Percent increase from July 1976 rate
Employee only	$27.29	$ 34.61	$ 41.83	53.3
Employee and dependent	65.60	72.69	85.82	35.4
Family	85.86	100.38	113.95	32.7

CONCLUSIONS

Under existing operational conditions, we do not believe Portland Metro will achieve financial viability as required by the act.

Portland Metro's utilization control program has been unsuccessful in controlling health care use. Initial experience indicated that the utilization of health care was generally higher than anticipated and the hospitalization rate was higher than some other health plans in its service area.

Income and expenditure data for the first 18 months of operation indicate Portland Metro will not become self-supporting unless it increases premium rates and reduces administrative costs to a level commensurate with enrollment and premium revenues. Past experience indicates that administrative costs have consistently exceeded projections. We do not believe Portland Metro can become financially viable at the expiration of the loan subsidy period if it fails to significantly reduce administrative costs and increase revenues.

CHAPTER 4

WHAT IS THE EFFECT OF DUAL CHOICE ON EMPLOYERS AND PORTLAND METRO?

Section 1310 (the dual-choice provision) of the HMO Act, as amended, provides that every employer which (1) has at least 25 employees in the HMO's service area, (2) is required to pay the minimum wage, and (3) provides health benefits to employees, must offer employees the option of joining a qualified HMO. The act relieves an employer from contributing more to the cost of the HMO plan than it contributes to other health benefits plans.

The act also provides that employers are not required to offer HMO membership to individual employees represented by a collective bargaining agent if the bargaining agent rejects dual choice for his group. Further, union trusts are not required to offer dual choice to members receiving health benefits through the trusts.

We contacted nine employers in the Portland area, the Portland Metro project officer at HEW region X, an official on the HMO committee which had been established by the local Teamster union, and Portland Metro officials to determine

--economic effect on employers of offering Portland Metro membership to their employees as an optional health benefit plan in compliance with the act,

--employer reaction to the act,

--how Portland Metro has used the dual-choice provisions and its effect upon Portland Metro, and

--the likelihood of Portland Metro being offered as a health benefit plan option by union trusts and employers in the Portland area.

Employers contacted in the Portland Metro service area reported no significant economic impact from the requirement that Portland Metro membership be included as an option to employees in their health benefit programs, and none of the employers had measured the effects of Portland Metro membership on the health of their employees. Most employers contacted favored dual choice; however, some employers expressed initial resentment or passive resistance.

ECONOMIC IMPACT ON EMPLOYERS

Six employers contacted had offered Portland Metro membership to their employees. Employer representatives said offering Portland Metro added some administrative costs initially, but the costs were not recurring. Only one employer stated it had incurred increased costs due to a voluntary increase in employer contribution.

Employer objections to offering Portland Metro as a dual-choice option included:

--Changes in the payroll system to accommodate an additional payroll deduction and in employee contribution rates for those subscribing to Portland Metro.

--Changes in insurance plans offered to employees require additional reporting under Federal guidelines.

--Adequate health coverage is being offered and employees are satisfied with current health benefit programs.

--Portland Metro has not established its financial viability.

--Portland Metro would not be competitive because its rates are considerably higher than other plans.

As of July 23, 1976, Portland Metro had sent promotional sales packets, including official notification of its qualification as an HMO under section 1310 of the act, to 145 employers in its service area. Portland Metro officials told us they do not plan to enforce dual-choice provisions because an employer can greatly influence the outcome of any attempt to obtain enrollment of the employee group involved. They said the primary benefit of dual choice is that employers are willing to discuss Portland Metro since they are legally bound to offer dual choice.

All employers contacted told us Portland Metro emphasized health plan benefits, rather than the employer's obligation under the law, as a basic sales approach.

PARTICIPATION BY UNION TRUSTS

As of January 1977, Portland Metro had not contracted with union trusts to provide health benefits to union members represented by trusts. However, in commenting on our draft

report, Portland Metro stated that certain problems which precluded it from being made available to members of the trust had been resolved and it was enrolling members of the Oregon-Teamsters Trust for coverage beginning January 1, 1978.

CONCLUSIONS

The requirement that Portland Metro be offered to employees as an alternative health benefit plan, as required under section 1310 of the HMO Act, has had a negligible economic impact on Portland area employers. However, the mandatory dual-choice provision has allowed many employees to gain access to the Portland Metro health plan.

CHAPTER 5

QUALITY ASSURANCE PROGRAM

Section 1301(c)(8) of the act requires each HMO to establish an ongoing quality assurance program which stresses health outcomes and provides for review by physicians and other health professionals of methods for providing health services. HEW regulations state that each HMO shall have a quality assurance program which

--collects systematic data on performance and patient results and

--is designed to meet the professional standards review requirements established in the Social Security Act for services provided by hospitals and other operating health care facilities and organizations.

Portland Metro's quality assurance program is comprised of the following elements:

Review of inpatient care--Portland Metro contracted with the Multnomah Foundation for Medical Care (the Professional Standards Review Organization for the area) to evaluate and monitor patient care in hospitals and other health care facilities. Commercial health insurance carriers and health providers also contract with the Foundation for this service. Portland Metro requires participating physicians, hospitals, and skilled nursing facilities to cooperate with Multnomah in this review program. The Foundation furnishes statistical data summarizing the utilization of inpatient facilities by Portland Metro members to Portland Metro.

Management information system--Portland Metro receives claims for its members from providers of health care. It screens claims for appropriateness of treatment and for items of interest to its professional review committee and the Health Services director. Claims approved for payment are entered in Portland Metro's computerized health care utilization data base from which reports are prepared showing provider activity and member utilization.

Organizational elements--Portland Metro has incorporated the following elements into its management structure to assure quality health care:

--Portland Metro employs a physician as Health Services director to review and discuss questionable claims with providers, develop review procedures for claims processors, review patient and provider profile reports developed by the management information system, and serve on a hearing board which is authorized to impose sanctions against health care providers.

--An evaluation council, composed of subscribers, employer representatives, and providers, serves as a review board for disputes concerning the delivery and utilization of health care.

--A professional review committee of nine physicians, appointed by the independent practice association Board of Directors, reviews cases and establishes standards and guidelines for participating physicians. The committee chairman serves as a provider representative on the evaluation council.

--Specialty providers, such as podiatrists, clinical psychologists, and physical therapists, have three-member evaluation committees implementing standards for their own specialty groups and representing their groups within Portland Metro and the individual practice association.

--Portland Metro member relations staff assist members in obtaining proper care and in initiating and resolving grievances.

The Portland Metro director said physicians are carefully reviewed before becoming Portland Metro health plan members and all physicians are licensed and qualified to render medical services.

In addition to these quality assurance elements, Portland Metro plans to survey its members to obtain feedback on their needs.

The Portland Metro member relations director stated only two formal health care grievances had been filed.

APPENDIX V

HMO COMMENTS AND OUR EVALUATION

On December 15, 1977, the president of Portland Metro provided us with his review comments on our draft report. We revised certain sections of the report based on his comments and more current Portland Metro operational data.

Portland Metro disagreed with our findings that

--it has not enrolled members broadly representative of its service area and

--it does not have a financially sound operation.

PORTLAND METRO COMMENT

The Portland Metro president believed that Portland Metro was serving a membership representative of its service area. He stated that Portland Metro had contracted with the Multnomah County Project Health program and as of December 1, 1977, had enrolled 184 medically indigent persons. He also reported that Portland Metro was developing a Medicare contract which would be effective July 1, 1978, and the maternity copayment provision was eliminated on January 1, 1978.

OUR EVALUATION

Although Portland Metro appears to be attempting to broaden its membership base, its enrollment was not representative of the age or income groups in its service area as of December 1977. Portland Metro has not contracted to serve Medicaid recipients with either of the States in its service area. Portland Metro has begun enrolling the medically needy individuals under the Project Health program, but these enrollees represented only about 2 percent of its December 1977 enrollment. Portland Metro has also started negotiating a contract with the Social Security Administration to serve Medicare recipients, however, its marketing policies tend to discourage enrollment of these recipients.

Because Portland Metro has enrolled virtually none of the approximately 66,000 Medicaid recipients and 127,000 Medicare beneficiaries in its service area, we continue to believe its membership is not broadly representative of its service area.

PORTLAND METRO COMMENT

The Portland Metro president stated that Portland Metro has a sound financial plan. He indicated that actual performance in 1977 was close to the plan submitted with Portland Metro's second loan application to HEW.

OUR EVALUATION

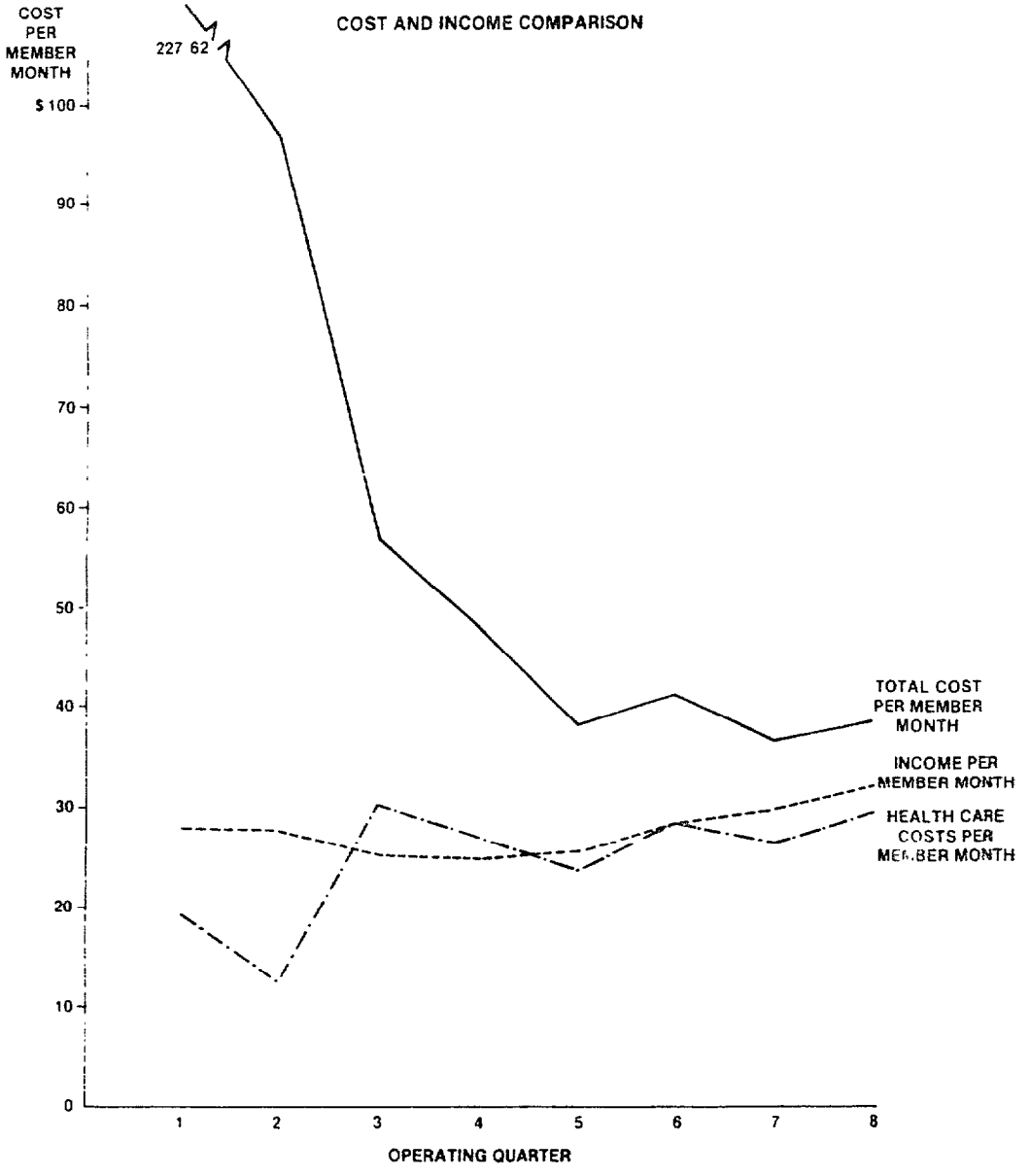
For Portland Metro to become financially sound, income from members must be sufficient to cover the health care costs of members and the administrative costs of Portland Metro--including debt service costs.

After 18 months of operation (to June 30, 1977), cumulative member health care costs have been about equal to the income from member premiums. Portland Metro's cumulative deficit of about $1.3 million was nearly equal to its administrative and debt service costs during the 18-month period.

As discussed on page 15, Portland Metro has limited control over utilization and health care costs. However, it can adjust income through its member premium rates and control administrative costs. Portland Metro increased its premium rates--effective January 1, 1978--which may improve its financial position. We believe it can also significantly reduce its administrative costs which are more than some other individual-practice-association type HMOs of comparable size.

In our opinion, unless Portland Metro increases premium rates and reduces administrative costs substantially, it will not be fiscally sound as required by the act. We doubt Portland Metro's ability to do this. Thus, it will not be able to operate beyond its loan subsidy period without additional Federal financial assistance. The following graph shows that the gap between costs and income--on a per-member-month basis--narrowed during the 7th quarter of operation ended September 30, 1977. However, both costs and income increased proportionately in the 8th quarter of operation.

We originally concluded that Portland Metro was unable to break even and, recent events support this conclusion. On October 7, 1977, HEW informed Portland Metro that it had determined that Portland Metro did not have a fiscally sound operation as required by the HMO Act. More specifically, Portland Metro had established a goal of attaining revenues which would exceed fixed costs by a predetermined ratio. HEW concurred with the goal and recognized the goal when


COST AND INCOME COMPARISON
COST PER MEMBER MONTH
227 62
$100
90
80
70
60
50
40
30
20
10
0
1
2
3
4
5
6
7
8
OPERATING QUARTER
TOTAL COST PER MEMBER MONTH
INCOME PER MEMBER MONTH
HEALTH CARE COSTS PER MEMBER MONTH

it approved Portland Metro's second HMO loan. Subsequently, HEW noted that Portland Metro was not generating the desired revenues in relation to its fixed costs and concluded that Portland Metro will have difficulty reaching its financial break-even point before the $2.5 million Federal loans are exhausted.

HEW officials visited Portland Metro in February 1978 and noted that while some improvements have been made, it appeared that Portland Metro's situation had become very tenuous. HEW reported that Portland Metro was (1) able to control health care costs and (2) created a very undesirable marketing situation by firing the marketing manager. The report also indicated that Portland Metro's high premiums would greatly affect its ability to market the plan. Also, while HEW concluded that the measures taken by Portland Metro to improve its utilization control and quality assurance were beginning to take hold, HEW still doubted that Portland Metro could break even before exhausting the maximum loan funding currently allowed under the HMO Act.

On June 30, 1978, HEW formally notified Portland Metro of its intent to revoke Portland Metro's Federal qualification. Specifically, Portland Metro had failed to comply with the requirement that a qualified HMO have a fiscally sound operation.

APPENDIX I

United States Senate
COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

May 24, 1976

B-164031(5)

The Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Staats:

In April, members of your staff provided information to our staff regarding the General Accounting Office's initital reviews of Health Maintenance Organizations under section 1314(a) of the Health Maintenance Organization Act of 1973. In addition to expressing the Subcommittee's appreciation for the assistance your staff has provided the Subcommittee in exercising its oversight responsibility and in its deliberation on S.1926, the purpose of this letter is to confirm the review approach presented by your staff.

We understand that GAO has started a review of two qualified HMOs as a beginning point for meeting its requirements under section 1314(a) as it would be amended by S.1926. Mr. James Martin's November 21, 1975 testimony before the Subcommittee has indicated that the slow rate of progress in establishing "qualified" HMOs along with the lack of an accepted or generally agreed upon methodology for evaluating the impact of HMOs on the health of the public would prevent GAO from meeting the reporting deadline (December 29, 1976) for the evaluations called for by sections 1314(b) and 1314(c). The Subcommittee acknowledges that in view of the unanticipated delays in implementing the HMO Act of 1973, the 36 month reporting requirements for sections 1314(b) and (c) now appear unrealistic and are virtually moot. However, the Subcommittee is pleased to note that GAO is planning to include elements of subsections (b) and (c), in its reviews of the individual "qualified" HMOs, specifically: (1) evaluations of the economic effects of section 1310 upon the employers that have included the "qualified" HMO in their employee health benefit programs and (2) descriptions of the quality of care assessments and evaluations in each HMO.

APPENDIX I

As your staff complete the reviews of each HMO, we would like reports on each review forwarded to us (and as previously discussed with our staff, copies to the Chairman and Ranking Minority Member of the House Subcommittee on Health and Public Environment, Interstate and Foreign Commerce Committee). You may supply copies of the individual reports to DHEW and to the Civil Service Commission to assist them in the performance of their regulatory and monitoring duties over HMOs. A summary report to the Congress would be submitted by June 1978 as called for by section 1314(a) as amended by S.1926.

Again, the work by your Manpower and Welfare Division staff on the implementation of the HMO Act by DHEW and the GAO questionnaire survey of prospective HMO grant applicants have greatly assisted us in our deliberations on the HMO amendments of 1975. We look forward to receiving the final report on this effort as well as the reports on your planned reviews on HMOs.

Sincerely,

Richard S. Schweiker
Ranking Minority Member
Senate Subcommittee on
Health

Edward M. Kennedy
Chairman
Senate Subcommittee on
Health

APPENDIX II

Portland Metro Health Plan

5201 S.W. Westgate Drive, Suite 111
Portland, Oregon 97221 • (503) 297-5561

December 15, 1977

Mr. Gregory J. Ahart
HRD Room 6864
U.S. General Accounting Office
441 G Street N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

Thank you for letting us review your November 1977 draft report on Portland Metro Health.

It is our understanding that this report is based on your auditor's initial site visits to PMH and excludes information from more recent site visits. We feel it would be more proper to have one GAO report based on all available information, not two reports - one based on extremely old information; the other on more recent information.

Our detailed comments are shown on the attached document: Comments from PMH Concerning the GAO November 14th Draft Report on Portland Metro Health. Our overall comments are as follows:

1. The draft report is in many places non-factual. Incorrect statements are pointed out in the attached document.

2. The draft report is definitely biased and many of the conclusions drawn are based on opinion, not fact. On the majority of issues, only some of the pertinent information, generally of a negative nature, is provided. The overall result is a biased and misleading description of PMH.

3. The information presented, upon which the conclusions are drawn, is extremely old and based on an inadequate number of member-months of experience. For example, data from the first seven months and first eleven months of 1976 -- the Plan's first year of operation -- are repeatedly cited whereas data from 1977 is largely ignored. We find this unacceptable for a draft report dated November 1977.

4. The standards used to evaluate PMH are more suitable for a mature HMO than a developing HMO less than two years old. To

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expect an HMO, now less than two years old to have enrollment completely representative of the community, to include union-trust, contracts with Medicare and Medicaid as well as many diverse employer groups, is unrealistic.

5. Many of the standards used to evaluate PMH, an Individual Practice Association (IPA) type HMO, are more suitable for Group Practice HMOs. The report fails to recognize important characteristics inherent to the IPA model; consequently, much of the criticism in the report is more a criticism of the IPA HMO model than of PMH.

We request that the draft report be rewritten to (1) include data gathered from more recent site visits (at a minimum to include data through September 1977) and (2) to provide more complete data recognizing positive as well as negative information where applicable; (3) use more appropriate standards for evaluation, and (4) the incorrect statements be corrected.

Please feel free to call us if there are questions concerning the attached "Comments" or if there is additional information we can provide.

We would appreciate receiving a copy of the final report. We agree with you that we should be permitted to have our comments attached to the final report when it is distributed. We want the opportunity, of course, to revise any of our comments based on the final draft's content.

Sincerely,

Paul J. Vogt
President

JJ/cd
Enclosure

COMMENTS BY PMH CONCERNING GAO'S
NOVEMBER 14 DRAFT REPORT ON PORTLAND METRO HEALTH

DIGEST - There are four statements in the Digest section which we either disagree with or are not up-to-date.

1. "broadly representative membership" - As will be discussed, our membership is broadly representative of the community that we serve.

2. "financial soundness" - As discussed, we feel we do have a sound financial plan.

3. "union trusts" - We are currently enrolling members of the Oregon-Teamster Trust for coverage effective January 1.

4. "competitive premium rates" - We feel we are competitive, as witnessed by the fact that we have continually met or have been close to our enrollment goals over the last ten months. See Exhibit A. More evidence of our competitiveness is discussed later on.

Chapter 1 - Introduction

On the top of page 3, the report states we were qualified in July of 1975. This is an incorrect statement. Although we were tentatively qualified in July 1975, we were not officially qualified until January 1, 1976 following the award of a one-million dollar loan. (See Federal Register and qualification certificate.)

On the bottom of page 3 of the report, it states that PMH's payment to physicians resembles indemnity plans. This statement is misleading because it does mention two important differences. First, PMH pays participating physicians directly, whereas most indemnity plans reimburse the member who in turn pays the provider. This is an important difference. Secondly, PMH withholds 10 to 15% of approved fees for the risk-incentive pool. We feel strongly that if the report is to mention similarities to indemnity plans it should also mention these significant differences from indemnity plans.

Chapter II - Organizational Requirements

The report states the opinion that PMH does not meet the requirement of enrolling persons broadly representative of various age, social and income groups in the area it serves. Four statements in support of this assertion are made. Our comments concerning each of these statements are shown below:

(1) "PMH services proportionately fewer persons over age 45." Although this is currently true, a complete explanation of why this is so is

APPENDIX II

not provided. We feel it should be. The reason we have had fewer persons over 65 is that we do not yet have a contract with Medicare (SSA). The report fails to recognize the operational time required before the Plan could contract with SSA. Nor does the report state that PMH is in the process of developing a Medicare contract to be effective July 1, 1978.

The reasons why there are fewer persons aged 45-54 are more complex. While there is no simple explanation, it is probably largely due to the fact that older adults are less inclined to change health care plans to join a new health plan than younger adults. This is not unique to PMH but is true of most other developing HMOs as evidenced by HEW's HMO census statistics. The report fails to compare us with other comparable HMOs but instead compares us with an unidentified non-qualified HMO in the Portland area which appears to be Kaiser. This could be a very unfair comparison if this is true because Kaiser is over 30 years old and therefore has a much older overall membership. A fairer comparison would be the Harvard Community Health Plan in Boston which is about six years old and like PMH has a large proportion of younger adults aged 20-44. If there is to be an age comparison in the final report, it should, in our opinion, be with a qualified HMO comparable to PMH in age, even if the HMO is from a different geographic region.

(2) "PMH has not contracted with the States or other groups to provide health services to Medicaid recipients or other needy persons."

This is an incorrect statement. PMH has contracted with Multnomah County's Project Health Program, effective July 1, 1977. As of December 1, 1977, 184 medically indigent and Medicaid persons have been enrolled into PMH as a result of this contract. Enrollment is planned to reach 400 or more by July 31, 1978. The statement in the GAO report that we have placed a limit on the number of Project Health members is incorrect. We have no such limit.

(3) "PMH has established a rate structure that discourages older persons and pregnant women from enrolling."

Evidence cited for this statement is that the two-person rate at PMH is slightly more than twice the single rate. (As of January 1, 1978, the ratio will be 2.05 to 1.00*.) We do not believe this rate structure represents a barrier to either older persons or pregnant women. As evidence of the latter, our birth rate has consistantly been around 33 per 1,000 which is 2½ times the community average.

* This is based on first quarter 1978 rates of $41.83 for singles, $85.52 for couples and $113.95 for families.

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During 1977, PMH did have a $150 maternity copayment. It was anticipated that this would alter the proportion of pregnant women joining PMH to a figure closer to the community average. However, the birth rate at PMH did not decline following the implementation of the deductible. Partly as a result of this, PMH elimimated the $150 copayment for all enrollments and re-enrollments in 1978.

(4) "PMH has screened employer groups to eliminate potentially high utilizer groups." This statement is partially true. Screening is done for two reasons: (1) to protect on a business basis the Plan's fiscal viability and (2) to help insure that the Plan's membership is representative of the service area. For example; we have temporarilly limited the number of hospital groups with PMH coverage to two. Current membership from these two hospitals accounts for 12% of total Plan membership, which is significantly higher than the proportion of the community's population employed by hospitals.

On page 14, the draft report states "in the interest of financial viability, PMH has selected groups within each industry with the best (lowest) health utilization records." This is untrue. In selecting new groups PMH's two main criteria are:

(1) Minimal premium differential between PMH and other carrier(s);

(2) Cooperative attitude by employer.

Groups meeting these two criteria have historically resulted in large enrollment penetrations which is the number one goal of marketing. While it is true that PMH sometimes requests data on age, sex and past utilization experience, this is of much less significance in selecting groups than premium differential and the employer's attitude toward PMH.

In summary, we feel the draft GAO report portrays a very misleading description of PMH's marketing selection process. To us this is a serious shortcoming. We request that the final report be written in such a way as to provide a more balanced and complete view of PMH's enrollment and marketing process.

Open-Enrollment - The draft report correctly reports that PMH has not had an open-enrollment period and that it does not plan to have one until after break-even has been reached. The draft report does not, however, give a complete explanation of PMH's reasons for postponing open-enrollment until after break-even. There are two main reasons:

(1) Based on the experience of other HMOs such as Northcare in Illinois, open-enrollment can have disastrous financial effects

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on a small, developing HMO.

(2) HEW counseled PMH during initial development on the potentially adverse effect on financial viability.

Chapter III - Financial Viability - There are several incorrect or misleading statements in this chapter. Each is discussed below.

In the first paragraph, the opinion is expressed that PMH "will not be fiscally sound within the 36-month period required by the loan agreement." The second loan agreement for PMH is based on a 45-month period. (The second loan superceded the first loan agreement; therefore, references or comparisons with the first loan agreement are, in our opinion, not useful.)

There are four reasons given for the opinion that PMH will not become financially viable; each is discussed below:

(1) "PMH continues to incur administrative costs in amounts disproportionate to its enrollment size." This is a misleading statement because it wrongfully implies that to incur high administrative costs prior to break-even is wrong. Actually, it is simply a statement of fact that applies to all HMOs (and in fact for most other businesses.) That is, administrative costs will, by definition, represent a larger percent of total costs prior to than after break-even.

Further, the GAO Report fails to provide current information on administrative costs. Exhibit B shows both the actual and planned monthly per member administration costs over the period January 1, 1977 to October 30, 1977. The exhibit also shows the actual and the planned total deficit. It will be seen that the monthly per member administration costs have steadily declined and also that the actual deficit has generally been close to planned.

(2) "PMH lacks effective control over utilization and costs of health care services." This is a matter of degree. Certainly PMH does not have total control over utilization and costs. The cost per service of medical care is strongly related to inflation of medical care in the community and the nation and it is true the Plan cannot control the rate of inlation. However, PMH does have an effective means of establishing each physician's approved fee schedule. On page 24 of the report, it states these approved fees are not being used to determine fees paid to physicians. This is an incorrect statement; each physician's billed fee is compared with his approved fee and fees above the approved fees are cut back. This system has been in effect since September 1, 1977.

As to controls over utilization, the GAO report states on page 26 that PMH does not have a program to control hospital admissions.

This is incorrect. A hospital admission review program (HARP) was implemented May 1, 1977. Under this program, the physicians must request prior authorization for all non-emergency admissions excluding normal maternities. This program has been helpful in controlling and monitoring hospital utilization although dramatic short-term reductions have not been realized. Likewise, another major factor in health care costs is the health status of Plan members and the requirement to provide all medically necessary services. When a new growing Plan has a majority of new members with existing health problems, it is unreasonable to expect denial or planned delays in providing those services.

(3) "PMH has been unable to achieve enrollment goals and has established premium rates for 1977 that are significantly higher than competitive health plans in its service area." Both of these statements are incorrect. PMH has met or been close to its enrollment goals used (and approved) in the second loan application. Figures demonstrating this are in Exhibit A, mentioned earlier.

Secondly, PMH's 1977 and 1978 rates are competitive when various factors determining competitiveness are considered. These include the following:

(a) price
(b) comprehensiveness of covered benefits
(c) accessibility - number of service locations
(d) satisfaction with existing carriers/plans
(e) service - method of delivering health care

We feel the premium rate comparison shown on page 34 is misleading and naive because it provides data only on the price while neglecting other factors (b through e above), which are equally important in marketing a health plan in an extremely competitive marketplace.

We believe PMH is competitive and will remain competitive. This is confirmed by our marketing "track record" which shows large initial penetrations and rapidly growing enrollment at many of the Plan's accounts including Tektronix, Fort Vancouver Plywood, Esco, Emanuel Hospital, Portland Adventist Hospital and the State of Oregon. Also, premium rates to be used January 1, 1978 for federal employees (the largest employer in Portland) are lower than Blue Cross, the major competitor, in spite of the fact that PMH's coverage is more comprehensive.

(4) "PMH has not changed the health care delivery to reduce health care costs." To support this opinion, the report states that the Plan does not employ its own physicians and in general

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does not resemble a group practice model HMO. The report therefore judges PMH, an Individual Practice Association type HMO on standards more applicable to group practice HMOs. The ways in which an IPA-HMO changes health care delivery are obviously much different than in group practice HMOs where structural organization are the main means as opposed to provider and member education as in an IPA.

The fact that the draft report does not recognize the inherent difference between the two HMO models is strong indication of the report's bias and lack of understanding of basic principles.

Another comment we have concerning this chapter on financial viability involves the statements made on page 21. The last sentence of the first paragraph reads, "PMH had only been in operation since January 1976, therefore the data base was too limited (for GAO) to prepare a detailed actuarial projection." (The data base referred to is the first eleven months of 1976.) Yet in the very same paragraph, two sentences previously, the report says that based on the experience of these first eleven months, the GAO concluded and informed HEW that PMH would not achieve the requirement of fiscal viability. It is totally incredible that the GAO could minimize the significance of the data base on one hand while on the other hand use this data base to reach such a sweeping and categorical conclusion.

On pages 24 and 25, statistics are provided on the actual versus planned utilization and cost per service for the first seven months of 1976. We find it appalling that this old and very limited data (based on a very small population base) be presented as indication that PMH is not capable of becoming financially viable.

On page 27, the report again cites data from the first seven months of 1976, this time with regard to risk-incentive pool. To update this, we report that based on the first 10 months of 1977, the risk-incentive pool represents 5.2% of total claims paid. This is considerably different than the 2% quoted in the GAO report. This 2% figure is much lower than what the Plan currently experiences or will experience in the future.

The GAO report goes on to say that because there is very little risk-incentive pool monies, it can not be used as an effective lever for influencing physicians' behavior. While recognizing that the risk-incentive pool is only one factor for changing physician behavior, we present the following data as evidence of its potential effectiveness. In the first 10 months of 1977, PMH has paid more than $5,000 to nine physicians. (Payment to these nine physicians represents 7% of total

APPENDIX II

physician reimbursement during this time period.) For these physicians, PMH does not represent an insignificant portion of their practice. Further, the Plan's membership is rapidly growing. Hence, by mid-1978, significantly more physicians will find that PMH members represent a significant portion of their practice. The risk-pool monies for physicians whose practices are between 5% and 25% PMH members will be somewhere between $500 and $2,400 assuming an average gross income of $80,000. Such sums of money are not insignificant to these doctors in our opinion.

APPENDIX II

EXHIBIT A

Planned and Actual Member Months, By Month

Month	Planned*	Actual
January, 1977	4900	5122
February	5150	5182
March	5675	5742
April	6200	5829
May	6725	6128
June	7250	6968
July	7775	712[illegible]
August	8300	8488
September	8825	8784
October	9350	9418
November	9875	9639

*Based on projections made for second HEW loan.

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EXHIBIT B

Planned & Actual Monthly Per Member Administration Cost
and Total Cumulative Deficit

	1977 Year to Date Per Member Administration Cost		1977 Year to Date Operational Deficit	
	Planned	Actual	Planned	Actual
January, 1977	$15.82	$14.22	$ 76,270	$ 58,091
February	16.20	14.56	159,059	134,619
March	15.43	14.24	234,527	203,700
April	14.64	13.67	321,060	298,851
May	14.04	13.61	385,845	386,393
June	13.38	13.18	445,668	466,497
July	12.75	12.60	507,110	502,755
August	12.10	12.34	565,744	571,753
September	11.89	11.67	621,521	622,853
October	11.38	11.18	676,309	671,233
November	11.00	10.87	720,750	755,988

PORTLAND METRO COMPLIANCE WITH ORGANIZATIONAL, OPERATIONAL, AND BENEFIT REQUIREMENTS OF THE HMO ACT

Requirements for health maintenance organizations in the HMO Act of 1973	Portland Metro Health		Comments
	In compliance	Not in compliance	
The HMO shall be a legal entity which provides to its members:	X		
Basic Health services for a basic health services payment which:	X		
--Is paid on a periodic basis without regard to the dates health services are provided:	X		
--Is fixed without regard to the frequency, extent, or kind of health service actually provided.	X		
--Is fixed under a community rating system.	X		As defined by Portland Metro. (See ch. 2.)

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Requirements for health maintenance organizations in the HMO Act of 1973	Portland Metro Health: In compliance	Portland Metro Health: Not in compliance	Comments
--May be supplemented by nominal payments except that such payments may not serve as a barrier to delivery of health services.	X		
Supplemental Health Services for a supplemental health service payment.	X		
Supplemental health service payments which are fixed on a pre-payment basis must be fixed on a community rating system.	X		As defined by Portland Metro. (See ch. 2.)
The services of health professionals which are provided as a basic health service shall be provided through a medical group(s) or individual practice association(s) unless the health professional's services are unusual or infrequently used or the service was provided because it was medically necessary and could not be provided by such a health professional.	X		
Basic and Supplemental Health Services shall, within the HMO service area, be available and accessible and be provided in a manner which assures continuity and:	X		
When medically necessary, be available and accessible 24 hours per day and 7 days per week.	X		

APPENDIX III

Requirements for health maintenance Organizations in the HMO Act of 1973	Portland Metro Health In compliance	Portland Metro Health Not in compliance	Comments
A member of an HMO shall be reimbursed by the HMO for his expense in securing basic or supplemental health services other than through the HMO if it was medically necessary that the services be provided before the member could secure them through the HMO.	X		
Each HMO shall:			
--Have a fiscally sound operation.		X	Under existing operational practices, Portland Metro will be unable to operate after the loan subsidy period without continued financial assistance. (See ch. 3.)
--Have an adequate provision against the risk of insolvency.	X		Portland Metro has $50,000 on deposit with the State Insurance Commissioner, $25,000 in a reserve account, individual stop-loss insurance coverage for costs over $7,500 per member, emergency health care stop-loss coverage, the provider's risk pool, and is required by State law to maintain a reserve account of 1/24 of annual claims incurred.

APPENDIX III

Requirements for health maintenance organizations in the HMO Act of 1973	Portland Metro Health: In compliance	Portland Metro Health: Not in compliance	Comments
Each HMO shall:			
Assume full financial risk on a prospective basis for the provision of health services, except that the HMO may obtain insurance or make other arrangements.	X		
Enroll persons who are broadly representative of the various age, social, and income groups within the area it serves.		X	Portland Metro policies and practices specifically discourage enrollment of the old (Medicare), the poor (Medicaid), and groups with high utilization experience.
Have an open enrollment period of not less than 30 days at least once during each 12-month period. During this period, the HMO will accept, up to its capacity, individuals in the order in which they apply unless the HMO demonstrates to the Secretary the need for a waiver from the open enrollment requirement.	X		Waiver of open enrollment requirement has been requested. However, no justification was submitted to support the request. HEW has not replied to the request for waiver. Under the 1976 amendments to the HMO Act, Portland Metro is not required to conduct an open enrollment period.
Not expel or refuse to reenroll any member because of his health status or his requirements for health services.	X		

APPENDIX III

Requirements for health maintenance organizations in the HMO Act of 1973	Portland Metro Health: In compliance	Portland Metro Health: Not in compliance	Comments
Be organized in a manner that assures that:			
--at least 1/3 of the membership of the policy-making body of the HMO be members of the HMO.	X		Portland Metro had seated 6 member representatives on the 18-person Board of Directors in February 1977.
--medically underserved areas are equitably represented.	X		
Each HMO shall:			
Be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the HMO (including providers) and the HMO members.	X		
Have organizational arrangements for an ongoing quality assurance program which:			
--Stresses health outcomes.	X		
--Provides review by physicians and other health professionals of the process followed in the provision of health services.	X		
Provide medical social services for its members.	X		Portland Metro relies upon the medical social services departments of participating provider institutions to provide service to members.

APPENDIX III

Requirements for health maintenance organizations in the HMO Act of 1973	Portland Metro Health: In compliance	Portland Metro Health: Not in compliance	Comments
Encourage and actively provide health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health.	X		Portland Metro relies on contract providers for health education services to members. Through its monthly newsletter, Portland Metro publicizes some health education programs.
Provide, or make arrangements for, continuing education for its health professional staff.	X		Portland Metro contracts for the provisions of all health services and does not monitor the continuing education provided to participating health professionals.
Each HMO shall:			
Provide an effective procedure for developing, compiling, evaluating, and reporting to HEW statistics and other information relating to:	X		
--Cost of operations.	X		
--Patterns of utilization of services.	X		
--The availability, accessibility, and acceptability of its services.	(a)		
--Developments on the health status of its members.	(a)		
--Other matters as required.	(a)		

a/ HEW has not completed reporting requirements.

APPENDIX III

PORTLAND METRO OPERATING RESULTS FOR THE QUARTERS ENDED MARCH 1976 THROUGH DECEMBER 1976

	Quarter ended March 1976	June 1976	September 1976	December 1976	Total 1976
Income:					
Member premiums	$ 15,458	$ 59,354	$196,840	$260,281	$ 531,933
Other income	2,456	15,593	14,359	8,406	40,814
Total income	17,914	74,947	211,199	268,687	572,747
Expenses:					
Medical:					
Direct service	2,185	14,626	137,229	163,769	317,809
Outside referral	151	1,294	9,423	16,335	27,203
Pharmacy	-	94	268	420	782
Dental	-	-	-	-	-
Optical	-	-	-	-	-
Hospitalization	4,028	17,283	105,599	112,963	239,873
Administration	115,576	205,952	190,855	203,318	715,701
Loan interest	24,872	22,062	29,279	24,392	100,605
Total expenses	146,812	261,311	472,653	521,197	1,401,973
Revenue (loss)	-$128,898	-$186,364	-$261,454	-$252,510	-$ 829,226
Average number of members	215	905	2,783	3,604	

APPENDIX IV

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APPENDIX V

PORTLAND METRO OPERATING RESULTS FOR THE

QUARTERS ENDED MARCH 1977 THROUGH DECEMBER 1977

	Quarter ended				
	March 1977	June 1977	September 1977	December 1977	Total 1977
Income:					
Member premiums	$407,537	$526,854	$719,062	$ 898,363	$2,551,816
Other income	10,047	23,034	28,952	37,180	99,213
Total income	417,584	549,888	748,014	935,543	2,651,029
Expenses:					
Medical:					
Direct service	198,229	294,576	360,845	448,739	1,302,389
Outside referral	16,724	18,194	19,216	48,902	103,036
Pharmacy	1,898	4,813	18,809	20,711	46,231
Hospitalization	170,223	232,171	270,105	330,485	1,002,984
Administration	206,313	206,196	210,331	247,228	870,068
Loan interest	24,838	40,610	40,453	40,877	146,778
Total expenses	618,225	796,560	919,759	1,136,942	3,471,486
Revenue (loss)	-$200,641	-$246,672	-$171,745	-$ 201,399	-$ 820,457
Average number of members	5,388	6,262	8,381	10,063	

APPENDIX V