089260

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

RELEASED

JANUARY 16, 1979

B-164031(5)

RESTRICTED — Not to be released outside the General Accounting Office except on specific approval by the Office of Congressional Relations.

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

The enclosures summarize our observations on 10 of the 14 health maintenance organizations (HMOs) that we reviewed in compliance with section 1314 of the Health Maintenance Organization Act, as amended. We issued separate reports to you on the other four HMOs. Our report to the Congress, "Can Health Maintenance Organizations Be Successful?--An Analysis of 14 Federally Qualified 'HMOs'" (HRD-78-125, June 30, 1978), summarized all our evaluations initiated under section 1314.

Section 1314 required 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.

The act required us to report to the Congress on the ability of these qualified HMOs

--to meet the act's requirements regarding their organization and operation, including their 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.

089260

GAO 00190
HRD-79-34
(102003)

503352

The act directed us to study and report on 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 required us to (1) compare the operations of distinct categories of HMOs, (2) compare HMOs as a group with alternative forms of health care delivery, and (3) evaluate 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 methods to provide comparative and health status information to be used for such evaluations.

Our review was made at HEW's Health Services Administration, Rockville, Maryland; applicable HEW regional offices; and each of the 10 HMOs. We also interviewed representatives of the employers and the unions in the HMOs' service areas. Although our work was done from 1976 through 1977, we have updated certain sections of this report to reflect the 1978 status of the HMOs and HEW's HMO program.

The 10 HMOs covered by this report are listed below.

HMO	Location
Florida Health Care Plan	Daytona Beach, Fla.
Rhode Island Group Health Association	Providence, R.I.
North Communities Health Plan (NorthCare)	Evanston, Ill.
Rocky Mountain HMO	Grand Junction, Colo.
Genesee Valley Group Health Association	Rochester, N.Y.
HealthCare of Louisville	Louisville, Ky.
Penn Group Health Plan	Pittsburgh, Pa.
Colorado Health Care Services, Inc.	Denver, Colo.
Health Alliance of Northern California	San Jose, Calif.
Prime Health	Kansas City, Mo.

A brief analysis of our observations about these HMOs follows.

ANALYSIS OF OBSERVATIONS

Benefits, organization, and operation

The HMO Act prescribes not only how HMOs must provide services but also how HMOs must be organized and operated.

Until amended in October 1976, section 1301(b)(3) of the act required that HMOs be organized as either (1) a staff model HMO, which delivers health services through its own staff of health professionals who are its paid employees, (2) a group practice model HMO, which contracts with a medical group, partnership, or corporation composed of health professionals licensed to provide health services, or (3) an individual practice association model HMO, which contracts with a partnership, corporation, or association, which in turn contracts with individual health professionals to furnish health care services. A combination of more than one of the models could not be used.

All 10 HMOs have provided their members the specified health services. Four HMOs were organized as staff models, three as group practice models, and two as individual practice association models. One HMO, Penn Group Health Plan, violated the original act by using a combination staff/group practice model. However, the 1976 amendments changed the requirement to allow such combinations, thus bringing Penn Group into conformance with the law.

Section 1301(c)(4) of the original act required that HMOs have an annual open enrollment period of at least 30 days, during which the HMO was to accept persons in the order that they apply for enrollment. The Secretary of HEW could authorize waivers to this provision 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 its financial viability.

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

--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.

None of the 10 have met the above conditions. Furthermore, none have held, or plan to hold, open enrollment until it is required.

Section 1301(c)(3) of the act requires an HMO to enroll persons broadly representative of various age, social, and income groups within the area served. Although Federal implementing regulations provide no guidelines defining a "broadly representative" membership, the fact that most HMOs have very few high-risk, elderly, or indigent members suggests that they do not meet this requirement.

HEW designated certain sections of the HMOs' service areas as medically underserved areas. However, the HMO Act only encourages and does not require HMOs to serve these areas. Only three HMOs are known to have enrolled some persons residing in the underserved areas. These enrollments seem to have occurred only incidentally; the HMOs did not consciously market the plan to residents of those areas. The three HMOs simply marketed to employers whose employees happened to reside in medically underserved areas.

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."

HEW has not published program guidelines stipulating how community rating should translate into a premium structure. As a result, we could not determine if the HMOs' rate structures comply with the act's requirements for a community rating system.

Financial viability

Federal financial assistance to prepaid health care delivery programs was available before the HMO Act under several sections of the Public Health Service Act. Although the original HMO Act required each HMO to be fiscally sound, it also provided for Federal loans of up to $2.5 million to assist the HMO during its first 36 (extended to 60 by the 1976 amendments) months of operation.

The amended act envisions HMOs as financially sound business enterprises that can operate independently--without Federal financial assistance--after their first 5 years of operation as qualified HMOs. This means that an HMO must be able to obtain enough revenues to cover operating costs and thereafter generate enough surplus to repay debts, replace facilities, and finance future growth.

The 10 HMOs we evaluated received Federal funds totaling $35,223,094--$14,313,094 in grants and $20,910,000 in operating loans. However, in our opinion, only three of them have a good chance of becoming financially independent after the specified period of subsidy, four have a fair chance, and three have a poor chance.

Effect of dual-choice provision

Section 1310 (the dual-choice provision) of the HMO Act, as amended, provides that every employer that (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 states that employers are not required to offer HMO membership to 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.

To determine the effect of the dual-choice requirement and views toward the HMO concept or the act, we interviewed certain employers and representatives of unions in the HMOs' service areas. According to the employers we contacted, offering dual choice had no significant effect on their costs, and HMOs have not relied heavily on the dual-choice requirement to market their plans. Unions' reactions toward HMOs were mostly favorable.

Quality assurance programs

Section 1301(c)(8) of the act requires each HMO to establish an ongoing quality assurance program stressing health outcomes and including 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 facilities and organizations.

However, HEW still lacks specific, definitive standards for evaluating quality assurance programs. As a result, we could not determine the adequacy of programs approved by HEW. Moreover, seven of those approved programs had not been fully implemented.

- - - -

We are sending copies of this report to the Secretary of HEW.

We believe that the public disclosure of our discussion of several issues in the report may inadvertently and inappropriately impair certain of the HMOs' marketing capability and financial viability. Therefore, we have limited the distribution and will restrict public release of this report.

Comptroller General
of the United States

Enclosures - 10

ENCLOSURE I

FLORIDA HEALTH CARE PLAN, INC. (FHCP)

PROFILE

--Located in Daytona Beach, Florida.

--Qualified in May 1975.

--Organized as a staff model.

--Had provided health care services to 7,577 members as of December 1977.

--Has received $3,109,450 in Federal funds--two grants totaling $609,450 and one operating loan for $2,500,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Generally offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act.

--Scheduled open enrollment period was not held although HEW did not grant a formal waiver of the requirement. HEW merely told FHCP in April 1976 it did not have to hold open enrollment. The 1976 amendments make it unlikely that FHCP will be required to hold open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has no indigent (Medicaid) or high-risk (Medicare) members. This suggests that it does not have a membership broadly representative of its service area.

--Has refused to enroll some persons age 65 or over who were part of certain covered employee groups with five or fewer employees. FHCP management believes such groups are too small to allow FHCP to enroll high-risk individuals; that is, those age 65 or over. This practice violates an HEW regulation.

--Has members who mostly reside in medically underserved areas. This has occurred because all of its primary service area is medically underserved, not because it has consciously directed its services to underserved populations.

ENCLOSURE I

--Did not provide maternity benefits to single women enrolled under the single rate category. In response to HEW instructions, FHCP now provides such benefits.

--We were unable to determine if FHCP met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

FINANCIAL EXPERIENCE AND FORECAST

--Has a poor chance of operating as a qualified HMO after May 1980 without some Federal or private financial assistance. We reached this conclusion because of FHCP's history of financial management weaknesses. Lack of sound management has led to inadequate planning, protection of assets, and financial management. FHCP needs an experienced HMO manager.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has made organizational arrangements for its quality assurance program but has not fully implemented them. The internal peer review committee and the executive review committee have met infrequently. Also, FHCP has not developed a reliable, effective data collection system.

ENCLOSURE II

RHODE ISLAND GROUP HEALTH ASSOCIATION

PROFILE

--Located in Providence, Rhode Island.

--Qualified in October 1975.

--Organized as a staff model.

--Had provided health care services to 23,400 members as of December 1977.

--Has received $5,692,916 in Federal funds--11 grants totaling $3,192,916 and 1 operating loan for $2,500,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers required health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act. However, because some of the required alcoholism services are paid for by a grant from the National Institute of Alcohol Abuse and Alcoholism, the rate structure does not contain an amount for providing such services. Therefore, when the grant funds are expended, the rate structure may have to be increased to cover the services.

--Is not required, as a result of 1976 amendments to the HMO Act, to offer open enrollment and will not be required to do so until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Does not have high-risk (Medicare) or indigent (Medicaid) members in proportion to the percentages of such persons in its service area. This suggests that it does not have a membership broadly representative of its service area.

--We were unable to determine if Rhode Island met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE II

FINANCIAL EXPERIENCE AND FORECAST

--Has a fair chance of operating as a qualified HMO after October 1980 without any Federal financial assistance, provided it meets revised enrollment projections and successfully controls costs. A plan official attributed its enrollment slowdown primarily to the 20-percent rate increase effective January 1977. In an attempt to improve its competitive position, it limited its 1978 rate increase to 10.75 percent instead of a planned 18 percent.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has fully implemented the quality assurance program described in its qualification application.

ENCLOSURE III

NORTH COMMUNITIES HEALTH PLAN (NORTHCARE)

PROFILE

--Located in Evanston, Illinois.

--Qualified in May 1975.

--Organized as a group practice model.

--Had provided health care services to 10,485 members as of December 1977.

--Has received $2,978,618 in Federal funds--three grants totaling $478,618 and two operating loans totaling $2,500,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act.

--Held a 31-day open enrollment period in March 1975, during which 1,183 members were enrolled, but requested a waiver of the open enrollment period during its second operating year. HEW did not formally grant a waiver, but as a result of the 1976 amendments, NorthCare will not be required to offer an open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Had no State contract to serve the indigent (Medicaid) or Federal contract to serve high-risk (Medicare) individuals. However, some persons eligible for Medicare were enrolled during NorthCare's open enrollment period and are being enrolled through employer groups and a nongroup enrollment program; also, attempts have been made to contract for public aid recipients. The absence of Medicaid members suggests that NorthCare does not have a membership broadly representative of its service area.

--We were unable to determine if NorthCare met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE III

FINANCIAL EXPERIENCE AND FORECAST

--May have a fair chance of operating as a qualified HMO after May 1980 without any Federal financial assistance. We reached this conclusion after considering recent favorable developments; such actions as terminating all part-time primary care physicians and hiring experienced managers have greatly improved NorthCare's financial picture. Management seems to have effectively controlled costs and increased revenues since deficits of $307,000 for the first quarter of 1977 plunged to about $40,000 a year later.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has not fully implemented the quality assurance program described in its qualification application. In our opinion, NorthCare should implement a more formal quality assurance program that includes an ongoing peer review program to assess the quality and outcome of medical care provided to its members.

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION

PROFILE

--Located in Grand Junction, Colorado.

--Qualified in December 1975.

--Organized as an individual practice association model.

--Had provided health care services to 10,316 members as of December 1977.

--Has received $1,207,728 in Federal funds--five grants totaling $552,418, three contracts totaling $323,310, and one operating loan for $332,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act.

--Applied for a waiver of the open enrollment requirement, but HEW terminated action on the request when the 1976 amendments changed the requirement. Rocky Mountain will not be required to hold an open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Serves both indigent (Medicaid) and high-risk (Medicare) individuals.

--Has an enrollment representative of the age groups in its service area.

--We were unable to determine if Rocky Mountain met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE IV

FINANCIAL EXPERIENCE AND FORECAST

--Has a good chance of operating as a qualified HMO after December 1980 without any Federal financial assistance. We reached this conclusion because Rocky Mountain's contingency reserve assets are adequate to liquidate all debts to private and Government lenders, enrollment has kept pace with projections, the rate structure is competitive, and costs and utilization of services are under control.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has not fully implemented the quality assurance program described in its qualification application. In our opinion, Rocky Mountain should implement a program for assessing health outcomes.

ENCLOSURE V

GENESEE VALLEY GROUP HEALTH ASSOCIATION

PROFILE

--Located in Rochester, New York.

--Qualified in January 1976.

--Organized as a group practice model.

--Had provided health care services to 33,385 members as of December 1977.

--Has received $3,550,317 in Federal funds--eight grants totaling $937,859, four contracts totaling $112,458, and one operating loan for $2,500,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the required health benefits and generally satisfies the organizational and operational requirements of the act.

--Is not required, as a result of the 1976 amendments, to offer open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has no indigent (Medicaid) and very few high-risk (Medicare) members. This suggests that it does not have a membership broadly representative of its service area.

--Has become dependent on Blue Cross-Blue Shield. Policymaking functions appear to be shared by Genesee, Blue Cross, and Blue Shield boards of directors; Genesee's vendor services agreement with Blue Cross-Blue Shield indicated that Blue Cross-Blue Shield marketed Genesee; and Genesee's subscriber contract was jointly issued by Genesee, Blue Cross, and Blue Shield.

--We were unable to determine if Genesee met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE V

FINANCIAL EXPERIENCE AND FORECAST

--Has a fair chance of operating as a qualified HMO by 1980 without further Federal financial assistance, if it increases its premiums per member per month by 9 to 15 percent from 1978 to 1980. We reached this conclusion because Genesee's 1977 performance indicates a continuing increase in operating costs.

--HEW's operating loan of $2.5 million to Genesee exceeds what the plan should have obtained. The loan was based on Genesee's projection of its needs, which included expenses not allowable under the HMO Act or HEW regulations. Moreover, despite having $1 million in cash on hand as of March 31, 1977, it has continued to draw down on the HEW loan.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has not fully implemented the quality assurance program described in its qualification application. In our opinion, Genesee should implement a program for assessing health outcomes.

ENCLOSURE VI

HEALTHCARE OF LOUISVILLE, INC.

PROFILE

--Located in Louisville, Kentucky.

--Qualified in April 1976.

--Organized as a staff model.

--Had provided health care services to 10,863 members as of December 1977.

--Has received $5,701,606 in Federal funds--six grants totaling $3,201,606 and two operating loans totaling $2,500,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act.

--Is not required, as a result of 1976 amendments to the HMO Act, to offer open enrollment and will not be required to do so until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has no indigent (Medicaid) and only a few high-risk (Medicare) members. This suggests that it does not have a membership broadly representative of its service area.

--Has enrolled persons living in medically underserved areas, but this has occurred incidentally rather than by design.

--We were unable to determine if HealthCare met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE VI

FINANCIAL EXPERIENCE AND FORECAST

--Has a poor chance of operating as a qualified HMO unless some Federal or private financial assistance is provided after April 1981. We reached this conclusion after considering its current and estimated operating costs in relation to its ability to generate revenues to pay such costs and have a sufficient surplus to repay debts, replace facilities, and finance future growth.

--Has experienced slower than anticipated membership growth and higher than anticipated costs for referrals to physicians not on its staff. HealthCare is planning to open an ambulatory care facility in a suburban location; the effect this could have on its enrollment is not evident.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has made organizational arrangements for its quality assurance program but has not fully implemented the plans.

ENCLOSURE VII

PENN GROUP HEALTH PLAN, INC.

PROFILE

--Located in Pittsburgh, Pennsylvania.

--Qualified in November 1975.

--Organized as a staff/group practice model.

--Had provided health care services to 16,717 members as of December 1977.

--Has received $4,072,886 in Federal funds--three grants totaling $2,022,886 and one operating loan for $2,050,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits and generally meets the organizational and operating requirements of the act.

--Has used a combination staff/group practice model to deliver health care services since it was qualified in November 1975. Before the 1976 amendments, HMOs were not allowed to use any combination of organizational models. Therefore, Penn Group operated in violation of HEW policy during that time.

--Assumed that a request for a waiver of the open enrollment requirement was approved, even though HEW did not approve or disapprove it. Penn Group will not be required, as a result of the 1976 amendments, to offer open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has not enrolled any high-risk (Medicare) or indigent (Medicaid) individuals. This suggests that it does not have a membership broadly representative of its service area.

--We were unable to determine if Penn Group met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE VII

FINANCIAL EXPERIENCE AND FORECAST

--Has a fair chance of operating as a qualified HMO after November 1980 without any Federal assistance. We reached this conclusion because the plan's costs per member increased steadily during the last 9 months of 1977 and probably will continue to increase because of expansion and addition of facilities and inflationary pressures. Also, competitive considerations may force the plan to hold rate increases to levels that would not generate revenues needed to cover costs, repay debts on schedule, replace facilities, and finance future growth.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has not fully implemented the quality assurance program described in its qualification application. Plans for utilization control and the peer review system have not been implemented.

ENCLOSURE VIII

COLORADO HEALTH CARE SERVICES, INC.

PROFILE

--Located in Denver, Colorado.

--Qualified in August 1976.

--Organized as an individual practice association model.

--Had provided health care services to 13,264 members as of December 1977.

--Has received $2,131,618 in Federal funds--two grants totaling $718,618 and one operating loan for $1,413,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operating requirements of the act.

--Requested a waiver of the open enrollment requirement, but HEW did not formally respond. However, as a result of the 1976 amendments, the plan will not have to offer an open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has no indigent (Medicaid) members and is serving only those high-risk (Medicare) individuals belonging to employers' groups which offer the plan. This suggests that it does not have a membership broadly representative of its service area.

--We were unable to determine if Colorado Health Care met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

FINANCIAL EXPERIENCE AND FORECAST

--Has a good chance of operating as a qualified HMO after August 1981 without any Federal financial assistance. We reached this conclusion because enrollment is well ahead of predicted levels and premium rates are very competitive with other plans. Moreover, even though

ENCLOSURE VIII

increases in enrollment will also increase expenses, we feel Colorado Health Care has the potential to increase the margin between per member revenues and direct health care costs so that fiscal soundness can be reached at an attainable enrollment level.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has fully implemented the quality assurance program described in its qualification application.

ENCLOSURE IX

HEALTH ALLIANCE OF NORTHERN CALIFORNIA

PROFILE

--Located in San Jose, California.

--Qualified in November 1976.

--Organized as a group practice model.

--Had provided health care services to 13,275 members as of December 1977.

--Has received $3,392,574 in Federal funds--four grants totaling $1,050,574 and one operating loan for $2,342,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operational requirements of the act.

--Is not required, as a result of 1976 amendments to the HMO Act, to offer open enrollment until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has enrolled some indigent (Medicaid) and very few high-risk (Medicare) individuals. This suggests that it does not have a membership broadly representative of its service area.

--Has its primary medical services provided by physicians belonging to the community medical group; the group receives a capitation payment from the plan as full payment for its services. This method may have contributed to increased use of services. For the 10-month period ended September 30, 1977, the group owed Health Alliance about $82,000 due to a 26-percent overutilization of referral health professionals.

--We were unable to determine if Health Alliance met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE IX

FINANCIAL EXPERIENCE AND FORECAST

--Has a poor chance of operating as a qualified HMO after November 1981, unless some Federal or private financial assistance is provided. We reached this conclusion because Health Alliance may not be able to increase premiums enough to cover costs and has had a history of management weaknesses.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has not fully implemented the quality assurance program described in its qualification application. In our opinion, Health Alliance should implement a program for assessing health outcomes.

ENCLOSURE X

PRIME HEALTH OF KANSAS CITY

PROFILE

--Located in Kansas City, Missouri.

--Qualified in November 1976.

--Organized as a staff model.

--Had provided health care services to 9,067 members as of December 1977.

--Has received $3,385,381 in Federal funds--two grants totaling $1,112,381 and one operating loan for $2,273,000.

BENEFITS, ORGANIZATION, AND OPERATION

--Offers the specified health benefits, meets the organizational requirements, and generally satisfies the operational requirements of the act.

--Is not required, as a result of the 1976 amendments to the HMO Act, to offer open enrollment and will not be required to do so until at least after its fifth year of operation as a prepaid health plan, provided it is financially solvent by then.

--Has enrolled very few high-risk (Medicare) and no indigent (Medicaid) individuals. This suggests that it does not have a membership broadly representative of its service area.

--Had not directed its marketing efforts toward the 35 designated medically underserved census tracts in its service area, but about 22 percent of its enrollees live in those areas.

--We were unable to determine if Prime Health met the community rating requirement because neither the Congress nor HEW has stipulated how it is to be implemented.

ENCLOSURE X

FINANCIAL EXPERIENCE AND FORECAST

--Has a good chance of operating as a qualified HMO after November 1981 without any Federal financial assistance. We reached this conclusion because Prime Health's actual enrollment has been about the same as originally projected and, although revenues have been lower than anticipated, so have expenses.

EFFECTS OF DUAL-CHOICE PROVISION

--Offering the plan as a health benefit plan option had no apparent significant effect on employers' costs.

QUALITY ASSURANCE PROGRAM

--Has fully implemented the quality assurance program described in its qualification application.