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Can Health Maintenance Organizations Be Successful? An Analysis of 14 Federally Qualified "HMOs". HRD-78-125; B-164031(5). June 30, 1978. 62 pp. + 4 appendices (10 pp.).

Report to the Congress; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Health Maint. Organization's Compliance with Law (1214). their Viability as Alternative to fee-for-service mode of Producing Care
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Department of Health, Education, and Welfare.
Congressional Relevance: House Committee on Interstate and Foreign Commerce; Senate Committee on Human Resources; Congress.
Authority: Health Maintenance Organization Act of 1973, as amended (42 U.S.C. 300e). Health Maintenance Organization Amendments of 1976 (P.L. 94-460). Social Security Act, as amended (P.L. 92-603). Public Health Service Act. S. Rept. 94-844. S. 2534 (95th Cong.). S. 2676 (95th Cong.). H.R. 9788 (95th Cong.). H.R. 11461 (95th Cong.). H.R. 11388 (95th Cong.).

Health maintenance organizations (HMO's) serve as alternatives to traditional fee-for-service health care delivery systems by providing health care to members based on prepaid rates. The Health Maintenance Organization Act of 1973 authorized a program to help develop new HMO's and expand existing ones by providing financial assistance and requiring certain employers to offer HMO's as an option to employees. Findings/Conclusions: A review of the operations of 14 HMO's showed that: the Department of Health, Education, and Welfare (HEW) has not defined specific methods for translating the community rating requirement of the act into subscriber rate structures; some subscriber rates of some organizations did not appear to be equivalent as directed by this requirement; some HMO's may not meet the act's financial soundness requirement; membership is not broadly representative of service areas, including few indigent or elderly persons; none of the 14 HMO's has held open enrollment periods nor has plans to do so until required to, resulting in limited access for high risk individuals; and none has implemented planned quality assurance programs. The dual choice requirement of the act has not had a significant effect on employer's costs. Problems in HEW's implementation of the act include: fragmented responsibility and uncoordinated efforts in operating the program, insufficient staff with needed expertise, and slow issuance of final regulations and guidelines for implementing and enforcing requirements of the act. Recommendations: The Secretary of HEW should: issue final regulations and guidelines and/or criteria

for defining how a community rating system should work, for evaluating requests for waiver of the open enrollment requirement, and for governing third-party relationships; develop and disseminate guidelines for designing quality assurance programs and implement procedures for reviewing compliance with quality assurance requirements; and obtain additional staff with needed expertise to effectively administer the program. The Congress should defer action on proposals intended to stimulate medicaid and medicare enrollments until HEW demonstrates that it could effectively administer proposed changes and implement effective compliance and on proposals to increase total loans available to HMO's until HEW demonstrates effective administration of the existing loan program. The Congress should enact the proposed financial disclosure requirements for third-party relationships and the proposed training program for HMO managers. (HTH)

6877

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Can Health Maintenance Organizations Be Successful?-- An Analysis Of 14 Federally Qualified "HMOs"

As required by the Health Maintenance Organization Act, as amended, GAO evaluated 14 federally qualified health maintenance organizations (HMOs). They generally have complied with the act's organizational and operational requirements, except that they lack broadly representative enrollments and several organizations may not be financially sound.

HMOs' compliance with requirements, such as the community rating system and quality assurance program, was unclear because HEW had not issued final program regulations or guidelines clearly defining all requirements for HMOs. Also, HEW had not established a uniform formal loan policy for administering its health maintenance organization loan program authorized by the HMO Act.

This situation can be attributed partly to the fact that 4 years after passage of the act the Federal program remains understaffed and organizational problems continue.

HRD-78-125
JUNE 30, 1978

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

B-164031(5)

To the President of the Senate and the
Speaker of the House of Representatives

This report summarizes the results of our evaluations of the operations of 14 selected health maintenance organizations which had been certified (qualified) by the Department of Health, Education, and Welfare as meeting the requirements of the Health Maintenance Organization Act, as amended, and which had received grants and/or loans under the act. The report also discusses the administration of the health maintenance organization program by the Department and certain aspects of the proposed amendments to the act being considered by the Congress.

Section 1314 of the Health Maintenance Organization Act, as amended, required that we evaluate the operations of certain health maintenance organizations and report to the Congress by June 30, 1978.

We are sending copies of this report to the Director, Office of Management and Budget; and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

CAN HEALTH MAINTENANCE ORGANIZATIONS BE SUCCESSFUL?--AN ANALYSIS OF 14 FEDERALLY QUALIFIED "HMOs"

D I G E S T

Fourteen health maintenance organizations, now well known under the acronym HMOs, generally have provided health services in the manner required by the Health Maintenance Organization Act of 1973. HMOs are an alternative to the traditional fee-for-service health care delivery system. HMOs provide health care to members based on prepaid rates, providing an incentive for an organization to emphasize preventive medicine and services to reduce overall health care costs.

GAO's review of the operations of the 14 HMOs showed that:

--HEW (the Department of Health, Education, and Welfare) has not defined specific methods for translating the community rating requirement of the act into subscriber rate structures; therefore GAO could not determine conclusively the HMOs' compliance with the community rating requirement. (See p. 8.)

--Some subscriber rates of some organizations did not appear to be equivalent as directed by the community rating requirement of the act. (See p. 9.)

--Some HMOs may not meet the act's financial soundness requirement. Three of the 14 have a good chance of achieving financial independence within their first 5 years of operation after qualification; 5 have a fair chance; and 6 have a poor chance. (See ch. 4.)

--They have not enrolled persons broadly representative of their service areas, as evidenced by the fact that their memberships include few indigent or elderly persons. (See p. 14.)

--Several should have held open enrollment periods under the original act but did not. None of the 14 is yet required to hold open enrollment under the act, as amended, and none definitely plans to hold open enrollment until required to do so. As a result, high medical risk individuals have not had, nor will have in the near future, ready access to HMO membership. (See p. 18.)

--HMOs have made plans for quality assurance programs but as of June 1977 only 7 of the 14 had implemented their planned programs fully. GAO could not assess the adequacy of their programs because standards for quality assurance still are being developed. (See ch. 6.)

A provision of the act, known as the dual choice requirement, mandates that certain employers offer their employees the choice of enrolling in a qualified HMO. Employers which GAO contacted reported no significant effect on their costs from offering dual choice. Rather than relying on the statutory requirement to force employer action in this area, the HMOs rely on marketing based on their merits. (See ch. 5.)

Several aspects of HEW's implementation of the act which GAO reported in September 1976 1/ still hamper development of the HMO concept. The problems include

--fragmented responsibility and uncoordinated efforts in operating the program,

--insufficient staff with expertise needed to administer the program effectively, and

--slow issuance of final regulations and guidelines for implementing and enforcing requirements of the act.

1/"Factors That Impede Progress In Implementing the Health Maintenance Organization Act of 1973" (HRD-76-128, Sept. 3, 1976).

HEW acknowledges these problems and has committed itself to restructuring and revitalizing the Federal HMO program. (See ch. 7.)

RECOMMENDATIONS TO HEW

The Secretary of HEW should

--issue all final regulations and guidelines and/or criteria for defining how a community rating system should work; for evaluating requests for waiver of the open enrollment requirement; and for governing third-party relationships in an HMO setting;

--develop and disseminate guidelines for designing quality assurance programs and implement procedures for reviewing HMOs' compliance with the quality assurance requirements of the act; and

--obtain additional staff with needed expertise to effectively administer the Federal HMO program.

RECOMMENDATIONS TO THE CONGRESS

Several bills have been introduced in the Senate and the House proposing amendments to the act. (See p. 5.) Specifically the Congress should defer action

--on proposals intended to stimulate Medicaid and Medicare enrollments until HEW demonstrates that it could effectively administer proposed changes in the reimbursement method and implement an effective compliance program and

--on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program.

The Congress should enact the proposed financial disclosure requirements for third-party relationships and the proposed training program for HMO managers.

AGENCY COMMENTS

HEW generally agreed with the findings and recommendations of the report and stated that it is generally accurate in its evaluation of the 14 qualified HMOs at the time GAO examined them. However:

--HEW disagreed with GAO's recommendation that the Congress defer action on proposed legislative amendments intended to stimulate Medicaid and Medicare enrollment in HMOs. HEW stated that it has initiated or proposed measures to correct problems cited by GAO.

--HEW also disagreed with GAO's recommendation that the Congress defer action on the proposed increase in total loans available to HMOs until HEW demonstrates that it can effectively administer the existing loan program. HEW pointed out that, although it has not developed a formal uniform loan policy and has not effectively monitored some HMOs' financial performance, improvements and changes are already in process.

--HEW concurred with GAO that there is a need for a training program to develop HMO managers. HEW disagreed with GAO's recommendation that the Congress enact the training program contained in a bill proposing amendments to the HMO Act. HEW believes that needed training can be provided under existing authorities.

HEW has formulated plans for, and is taking steps to, implement the changes GAO believes are needed. However, GAO continues to believe that the Congress should defer action on stimulating Medicare and Medicaid enrollment and increasing total loans available to individual HMOs until HEW takes sufficient action to demonstrate it has solved the problems GAO has pointed out.

Regarding the training of HMO managers, GAO continues to believe that good management is such an important part of the continued development of the HMO concept that it warrants the enactment of a special program to develop highly-skilled HMO managers.

Contents

ABBREVIATIONS

BC-BS	Blue Cross-Blue Shield
CPMM	cost per member month
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	health maintenance organization
IPA	individual practice association
PSRO	Professional Standards Review Organization
RPMM	revenue per member month

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CHAPTER 1

INTRODUCTION

A health maintenance organization (HMO) is a legal entity which provides specific health services to its members in return for a prepaid, fixed payment. HMOs are an alternative to the traditional health care delivery system which provides health care on a fee-for-service basis. The HMO concept provides a financial incentive for an HMO to emphasize preventive medicine and control use of health services to reduce overall health care costs.

The Health Maintenance Organization Act of 1973 (42 U.S.C. 300e (Supp. V, 1975)) authorized a program to help develop new HMOs and expand existing ones by

--providing financial assistance through grants, contracts, and loans and

--requiring certain employers to offer their employees the health benefit option of membership in HMOs which the Department of Health, Education, and Welfare (HEW) has "qualified" as complying with the requirements of the act.

Section 1314 of the HMO Act of 1973 required us to evaluate and report on the operations of at least 50 qualified HMOs which had been delivering health services for at least 3 years. However, as of June 1976, HEW had qualified only 17 HMOs, and, as acknowledged in the Senate report on the HMO Amendments of 1976 (S. Rep. No. 94-844), the slow progress in qualifying HMOs made the requirement to evaluate 50 qualified HMOs unrealistic. Therefore, in October 1976, the act was amended to require us to (1) evaluate at least 10 or one-half (whichever is greater) of the HMOs qualified as of December 31, 1976, and which had received financial assistance under the act and (2) report the results of our evaluations to the Congress by June 30, 1978. 1/

By December 31, 1976, HEW had qualified 27 HMOs. 2/ We selected 14 for review, and our evaluations are summarized in this report. Section 1314(a) of the act directed us to evaluate the HMOs in terms of their ability to:

1/The HMO Act of 1973 was amended in October 1976 by the HMO Amendments of 1976 (Public Law 94-460).

2/HEW had qualified 51 HMOs through December 1977.

--Provide health services in the manner prescribed by section 1301(b) of the act. (See ch. 2.)

--Meet the organizational and operational requirements of section 1301(c) of the act. (See ch. 3.)

--Include indigent and high-risk individuals in their membership and provide services to medically underserved populations. (See ch. 3.)

--Operate on a fiscally sound basis without continued Federal financial assistance. (See ch. 4.)

Section 1314(b) directed us to report on the economic effect of section 1310 of the act which requires certain employers, who offer employee health benefit plans, to give their employees the option of enrolling in a qualified HMO--dual choice. (See ch. 5.)

Section 1314(c) directed us to (1) evaluate HMOs' effect on the health of the public, (2) evaluate and compare operations of different types of HMOs (see below), and (3) evaluate and compare HMOs with alternative forms of health care delivery. As acknowledged in the Senate report on the HMO Amendments of 1976, the evaluations and comparisons required by section 1314(c) were precluded by the slow progress in qualifying HMOs. Thus, we have not studied specifically the issues raised by section 1314(c). However, in our evaluation of 14 HMOs, we examined their quality assurance systems, which could affect the health of HMO members. (See ch. 6.)

In September 1976, we reported on problems which HEW had in implementing and managing the HMO program. 1/ In this report, we present an update on HEW's progress toward solving some of these problems. (See ch. 7.)

DESCRIPTION OF THE 14 HMOs EVALUATED

The HMO Act recognizes three basic types or models of HMOs: staff, group practice, and individual practice association (IPA). Of the 14 HMOs we evaluated, 6 were qualified as staff models, 5 as group practices, and 3 as IPAs. (See p. 6.)

1/"Factors That Impede Progress In Implementing The Health Maintenance Organization Act of 1973" (HRD-76-128, Sept. 3, 1976).

As defined by HEW, the staff model HMO delivers outpatient health services at centrally located facilities through its own health professional staff which is employed directly by the HMO. The group practice HMO contracts with a medical group, partnership, or corporation composed of health professionals who provide health services on a salaried or fixed-amount-per-member basis. The IPA model HMO contracts with a partnership, corporation, or association, which in turn contracts with individual health professionals who provide health care on a fee-for-service basis. The IPA uses existing facilities of individual providers in contrast with the staff and group practice models which centralize delivery points.

None of the HMOs operated its own hospital. The HMOs depended on community hospitals to provide inpatient services under a variety of arrangements. The basis for payment ranged from a cost-based reimbursement to an arrangement under which the HMO paid each members' premiums to Blue Cross and Blue Cross paid members' hospital bills. None of the HMOs directly provided all medical services to its members. To varying degrees, each HMO used non-HMO health professionals on a referral basis for inpatient and outpatient care.

Eleven of the 14 HMOs had been providing health care services for between 0.4 and 4.3 years before becoming qualified. At December 1977, the 14 HMOs had been operating as qualified HMOs for between 1.2 to 3.2 years; their total enrollment was about 202,700; and their individual enrollments ranged from 7,577 to 33,385. 1/

As of June 1977, 10 of the HMOs provided some health care services on a fee-for-service basis. Such services generated from 0.3 to 8.2 percent of the HMOs' revenues during January through June 1977.

1/Of the 51 HMOs qualified at December 31, 1977, 24 were staff models, 14 were group practices, and 13 were IPAs. Their total enrollment was about 4 million, of which about 3.3 million were members of 4 Kaiser Foundation Health Plan organizations, which became qualified in October 1977. According to HEW, only the Kaiser plans control the hospitals which provide inpatient care to their members.

FEDERAL FINANCIAL ASSISTANCE UNDER THE HMO ACT

Through December 1977, the 14 HMOs had obtained grants and direct loans under the HMO Act totaling about $35.2 million or about 36 percent of financial assistance to HMOs qualified at that time. 1/ (See p. 6.)

The HMO Act authorizes grants to public or nonprofit organizations for feasibility studies, planning, and initial development. The act, as amended, also authorizes HEW to help a qualified HMO meet its operating expenses during its first 5 years of operation after qualification by (1) loaning up to $2.5 million to each public or nonprofit HMO or (2) guaranteeing non-Federal loans up to $2.5 million to each private HMO operated for profit which serves a medically underserved population.

Each HMO we evaluated was classified as nonprofit. Of the 51 HMOs qualified at December 31, 1977, only 3 were classified as private HMOs operated for profit and 2 of these had obtained loan guarantees totaling $2.2 million.

Before the HMO Act, planning and development grants for HMOs were awarded primarily under sections 304, 314(e), and 910(c) of the Public Health Service Act. From 1970 to 1976, such grants to the 14 HMOs totaled about $6.5 million.

SCOPE OF EVALUATION

We made our review at the Health Services Administration headquarters in Rockville, Maryland; the HEW regional offices in Atlanta, Georgia; Boston, Massachusetts; Chicago, Illinois; New York, New York; Denver, Colorado; Philadelphia, Pennsylvania; Kansas City, Missouri; San Francisco, California; and Seattle, Washington; and the offices of the 14 HMOs evaluated. To evaluate the HMOs' ability to meet the requirements and purposes of the act, we

- --compared their organizational structures and provision of health services to related requirements set forth in the act and HEW regulations;
- --determined what programs they have established to provide health services to medically underserved areas, high-risk individuals, and the medically indigent;

1/See app. II for a listing of all qualified HMOs which had received financial assistance as of December 31, 1977.

--reviewed each HMO's financial projections and related assumptions and compared each HMO's financial history to the financial projection it submitted when applying for qualification and/or a Federal loan;

--reviewed the performance of their marketing programs, financial management systems, and systems for monitoring utilization of services;

--interviewed selected employers which the HMOs had contacted regarding the offering of HMO plans as alternative health benefit plans; and

--determined what programs the HMOs have developed to assure and evaluate the quality of care provided to their members.

To evaluate HEW's administration of the Federal HMO program, we talked to headquarters and regional office personnel and reviewed records and files from the Division of HMOs and the Division of HMO Qualification and Compliance.

In addition, we reviewed the following proposed bills which were introduced to amend the HMO Act. Our review concentrated on the provisions which might affect our findings and conclusions.

Proposed HMO Amendments of 1978

1. S. 2534 introduced on February 10, 1978, by the Chairman and the Ranking Minority Member of the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources.

2. S. 2676 (Administration proposal) introduced on March 6, 1978.

3. H.R. 9788 introduced on October 27, 1977, by the Chairman of the House Select Committee on Aging.

4. H.R. 11461 (Administration proposal) introduced on March 10, 1978.

5. H.R. 11388 introduced on March 8, 1978, by the Chairman of the House Select Committee on Aging.

HMOs Evaluated by GAO

HMO	Date qualified (note a)	Type of HMO	Membership at December 31, 1977	HMO Act financial assistance as of December 31, 1977 Grants	Loans
Sound Health Assn.	11/74	Staff	10,963	$ 304,738	$ 2,500,000
Florida Health Care Plan	5/75	Staff	7,577	124,456	2,058,000
North Communities Health Plan	5/75	Group	10,485	478,618	1,250,000
Portland Metro Health Plan	7/75	IPA	10,063	455,188	2,500,000
Community Health Care Center Plan	10/75	Staff	22,989	362,461	2,090,000
Rhode Island Group Health Assn.	10/75	Staff	23,196	1,542,255	2,500,000
Penn Group Health Plan	11/75	Group	16,717	602,439	1,000,000
Rocky Mountain HMO	12/75	IPA	10,316	192,937	332,000
Genesee Valley Group Health Assn.	1/76	Group	33,385	298,500	2,500,000
Health Service Plan of Pennsylvania	4/76	Group	10,516	-	2,213,000
Health Care of Louisville	4/76	Staff	10,863	1,015,281	2,500,000
Colorado Health Care Services	8/76	IPA	13,264	548,417	1,413,000
Prime Health	11/76	Staff	9,067	1,112,381	2,273,000
Health Alliance of Northern California	11/76	Group	13,275	722,224	2,342,000
Total			202,676	$7,759,895	$27,471,000

a/Regulations governing the administration of section 1310 (dual choice provision) of the HMO Act were not published until October 28, 1975. HMOs qualified before that date were qualified for financial assistance only--not for using section 1310 as a marketing tool. Such HMOs were qualified for dual choice after the regulations were issued.

CHAPTER 2

HAVE HMOs BEEN ABLE TO COMPLY WITH REQUIREMENTS FOR PROVIDING HEALTH SERVICES?

Qualified HMOs must provide health services in the manner prescribed by section 1301(b) of the HMO Act. 1/ This section originally required, among other things, that HMOs (1) provide specified basic and supplemental health services, (2) provide basic health services through health professionals who are either HMO employees, members of a group practice or IPA, and (3) use a community rating system to establish fixed subscriber payments for basic health services.

The HMOs we evaluated generally have provided health services in the manner required by the act. However, during our evaluation, we noted the following:

--Some subscriber rates of some HMOs appeared to violate the community rating requirement, but we could not assess their overall compliance because specific methods for translating the requirement into subscriber rate structures have not been defined.

--Some amendments to the act which were designed to ease requirements for HMOs have had little effect on the 14 HMOs' modes of operation, i.e.:

(1) Although the act no longer requires children's preventive dental care or supplemental services, these HMOs generally have retained such services.

(2) Although HMOs may now use any combination of staff, group, or IPA health professionals as long as 35 percent of the hired medical group's professional activity is devoted to serving HMO members, these HMOs have not changed their modes of operation.

1/Each HMO we evaluated was qualified under Federal regulations which implemented the original act. Therefore, we evaluated their compliance with the original act, but we also assessed the effect of the October 1976 amendments on their continuing compliance, where appropriate.

METHODS FOR IMPLEMENTING COMMUNITY RATING ARE UNCLEAR

Traditionally, health benefit plans are offered by insurance companies. Premiums are based on past or expected health services utilization and costs. Employee groups with low utilization and costs have low premiums, and those with high utilization and costs have high premiums.

Section 1301(b)(1) of the act requires HMOs to break away from the traditional method of establishing subscriber payments. Qualified HMOs must establish rates of payment for subscribers based on the expected costs of providing health care to all enrollees--not for specific groups or individuals--so that health care costs are spread evenly among their members. However, in our opinion, the act does not clearly define how a community rating system should work.

Section 1302(8) defines community rating as a system of fixing subscriber rates which (1) may be determined on a per-member or per-family basis, (2) may vary with family size, and (3) must be equivalent for individuals and families of similar composition. 1/

The act, as amended, permits nominal rate differences for certain membership categories to reflect cost differences in marketing and in administrative procedures for collecting payments. HMOs may supplement the fixed subscriber payments by requiring nominal copayments for providing specific basic health services. In addition, HMOs are allowed to combine group rates to accommodate employers' purchasing practices as long as the differences are nominal.

A lack of clarity in the act's requirements for implementing the community rating system prevented us from conclusively assessing the HMOs' compliance. The act does not define certain terms, such as nominal and equivalent. HEW has approved the rate structures of qualified HMOs without defining these terms or adopting guidelines for translating the community rating requirement into a rate structure. In February 1978, the Director of the Office of HMO Qualification and Compliance said that HEW was developing guidelines for the community rating requirement.

1/The 1976 amendments allow HMOs which provided prepaid comprehensive health services before becoming qualified to wait 4 years after qualification to implement community rates.

Without guidelines, implementation of the community rating requirement is open to interpretation. As a result, HMOs have used a variety of approaches and rate structures to set community rates. We found one aspect of some rate structures which may violate the act. Seven of the 14 HMOs use both two- and three-step structures, such as the one below, to accommodate the purchasing practices of various employers. We believe this approach can result in rates which are not equivalent for couples.

Monthly group rates			
Two-step		Three-step	
Single	$30.50	Single	$30.50
Family	80.50	Couple	61.00
		Family	88.80

Under the three-step structure the couple rate is $61.00 a month, but the couple rate under the two-step structure is $80.50--about 32 percent more--because couples are classified as families. For the other HMOs which used two- and three-step rates, the couple rate was from 19 to 44 percent more under the two-step structure than under the three-step structure.

As previously mentioned, the act allows HMOs to establish composite group rates in a systematic manner to accommodate employers' purchasing practices, but only if differences in composite rates are nominal. We believe differences of 19 to 44 percent cannot be considered nominal and therefore, the rates for couples cannot be considered equivalent under the two- and three-step structures.

Confusion over community rating has affected not only the HMO program, but also the Civil Service Commission. The Commission informed HEW of problems it had in auditing rates under the Federal Health Benefits program. In addition, we reported in January 1978, that the Commission does not have criteria to determine the reasonableness and equity of the premium rates of community-rated Kaiser plans in California. 1/ In response to our report, the Commission stated that it was awaiting HEW's response to the issues it had raised concerning community rating.

1/"Civil Service Should Audit Kaiser Plans' Premium Rates Under The Federal Employees Health Benefits Program to Protect The Government" (HRD-78-42, Jan. 23, 1978).

AMENDMENTS HAVE HAD LITTLE EFFECT ON THE TYPES OF SERVICES OFFERED

Section 1302(1) of the act defines the basic health services which HMOs must provide directly or indirectly. Under the original act, basic health services included (1) physician services, (2) hospital services, (3) emergency services, (4) outpatient mental health services, (5) alcohol or drug abuse treatment, (6) diagnostic laboratory services, (7) home health services, and (8) preventive health services, including voluntary family planning services, infertility services, and preventive dental care and eye examinations for children.

As we reported in September 1976, over 50 percent of the respondents to our questionnaire believed that certain basic and supplementary services could make HMOs noncompetitive. 1/ They were concerned especially about two basic services--alcohol or drug abuse treatment and children's preventive dental care.

The 1976 amendments deleted children's preventive dental services as a required service, but alcohol and drug abuse treatment was retained because available evidence did not indicate it was an economic burden to the HMO. Seven of the 14 HMOs planned to drop children's preventive dental care as a result of the amendments, but the remainder planned to retain it as a basic benefit.

Section 1301(b) originally required HMOs to either provide supplemental health services or arrange for them to be provided, regardless of whether members had contracted for the services. In such cases, an HMO could require payments and fixed monthly payments for basic services. As defined by section 1302(2), supplemental services include (1) intermediate and long-term care, (2) vision, dental, and mental

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1/During a prior review of HMOs under the act, we sent a questionnaire to 809 entities which, according to HEW regional officials, had been sent grant application packages between January and May 1974. The purpose of our questionnaire was to determine

--why potential HMOs had not requested financial assistance and

--what problems were encountered by successful HMO applicants in complying with the act.

health care not included in the basic benefit package, (3) long-term rehabilitative services, and (4) prescription drugs.

The 1976 amendments made supplemental services optional for HMOs. None of the HMOs we evaluated planned to drop supplemental services as a result of the amendments. In fact, officials of 10 HMOs said they had already included some or all of the supplemental services in their basic benefit packages.

AMENDMENTS HAVE HAD LITTLE EFFECT ON MODE OF HEALTH SERVICE DELIVERY

Section 1301(b)(3) originally required each HMO to provide basic health services through either (1) its own health professionals who were HMO employees, (2) a group practice with which the HMO had contracted for services, or (3) an IPA with which the HMO had contracted for services. An HMO could not use a combination of the three modes of health care delivery. However, the 1976 amendments, made it permissible for an HMO to use a combination of any of the three types of health professionals. Only one of the HMOs we evaluated foresaw the possibility of changing its mode of operation in the near future as a result of the amendments.

The amendments also eased a restriction on use of medical groups to provide health care. Section 1302(4) defines a medical group as a partnership, association, or other group of licensed health professionals whose principal professional activity is serving HMO members. HEW regulations interpreted "principal professional activity" to mean more than 50 percent. The intent of the amendment is to reduce the requirement from 50 to 35 percent. Only one HMO--a medical group model--said it might reduce the average percent of activity devoted to HMO members as a result of the amendment.

CONCLUSIONS

The HMOs we evaluated generally have provided health care services in the manner required by the act. However, we found that:

--HEW has not issued guidelines for establishing rate structures; therefore we could not conclusively determine the HMOs' compliance with the community rating requirement.

--Some HMOs have two- and three-step rate structures under which the rates for couples do not appear to be equivalent.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to develop and disseminate guidelines for use by HMOs in implementing the community rating requirement of the HMO Act.

AGENCY COMMENTS

HEW concurred with our recommendation but pointed out that, although written guidelines have not been available, it has consistently applied a proper interpretation of community rating during the past 18 months. Guidelines are being prepared and will be issued in about 2 months.

CHAPTER 3

HAVE HMOs BEEN ABLE TO COMPLY WITH THE ACT'S ORGANIZATIONAL AND OPERATIONAL REQUIREMENTS?

The HMO Act prescribes not only how the HMOs must provide services but also how HMOs must be organized and operated. Section 1301(c) of the original act required, among other things, that HMOs (1) have a financially sound operation (see ch. 4), (2) enroll persons who are broadly representative of the various age, social, and income groups in their service area, (3) have an annual open enrollment period of at least 30 days during which the HMO accepts persons in the order that they apply for enrollment, and (4) have organizational arrangements for an ongoing quality assurance program. (See ch. 6.)

Although the act does not specifically state that an HMO must enroll elderly or indigent individuals; this is implicit in the requirement that HMOs enroll persons broadly representative of all age, social, and income groups. Also, the act does not specifically require an HMO to enroll high-risk individuals, such as the chronically ill and permanently injured, but open enrollment periods would give these individuals the opportunity to enroll.

The act also encourages--but does not require--HMOs to provide health services to persons in areas which HEW classifies as medically underserved.

The HMOs we evaluated generally have been organized and operated in the manner described by section 1301(c), except for the matters described below.

--HMOs have not enrolled persons broadly representative of their service areas, as evidenced by the fact that their memberships generally included few elderly or indigent persons.

--Although several of the 14 HMOs should have held 30-day open enrollment periods under the original act, none did. None of the 14 HMOs is yet required to offer open enrollment under the act, as amended, and none definitely plans to offer open enrollment until it is required. Consequently, high-risk individuals have not had ready access to membership in these organizations.

We also found that merely encouraging HMOs to serve medically underserved areas does not insure that they will enroll persons residing in such areas. Some HMOs are serving underserved populations to some extent, but that has occurred unintentionally.

HMO MEMBERSHIP IS NOT BROADLY REPRESENTATIVE

Section 1301(c)(3) requires HMOs to enroll persons broadly representative of the various age, social, and income groups in their service areas. However, most HMOs market their plans mainly to employee groups, and, therefore, they generally enroll few elderly or indigent individuals.

Section 1310 of the act requires certain employers with 25 or more employees to include in their employees' health benefits the option of joining a qualified HMO. Under this provision, HMOs have access to a large segment of the population--employed citizens whose employers offer a health benefit program. As of June 1977, employee group contracts supplied about 94 percent of the membership of the 14 HMOs we evaluated.

The act, however, does not give HMOs a specific mechanism for actively enrolling elderly or medically indigent persons, who generally depend on the Medicare and/or Medicaid programs to pay for their health care needs. To provide prepaid services to elderly or indigent persons, HMOs must contract with HEW to provide Medicare benefits and with States to provide Medicaid benefits. However, neither the HMO Act nor the Social Security Act requires HEW or States to contract with qualified HMOs.

Proposals intended to stimulate enrollment of Medicare and Medicaid beneficiaries in qualified HMOs were included in proposed HMO Amendments of 1978 (S. 2676, H.R. 9788, H.R. 11388, and H.R. 11461). Although we support the proposals in principle, we believe practical problems within HEW have to be solved before the proposals could be implemented effectively.

Service to elderly individuals

As of March 28, 1978, only 3 of the 14 HMOs had contracted with HEW to provide covered health services to Medicare recipients. As of December 1977, persons age 65 or over represented only about 2.5 percent of the 14 HMOs' total members. Persons age 65 or over comprise about 10 percent of the population nationwide.

Age Distribution for 13 (note a) HMOs as of 12/31/77

Age group	Percent of total membership
0-14	26.7
15-44	54.9
45-64	15.7
65 and up	2.5
Not reported	0.2
	100.0

a/Data for one HMO was not available.

The 1972 amendments to the Social Security Act (Public Law 92-603) authorized HEW to award cost reimbursement contracts to HMOs to provide Medicare services. Under the amendments, HEW has several methods for determining an HMO's cost reimbursement for Medicare. Basically, an HMO is paid an interim rate per enrollee, and, at the end of the contract period, a retroactive adjustment is made based on the actual cost of providing covered services. According to HEW, actual final payments are so unpredictable as to discourage HMOs' interest in Medicare contracts. Other HEW officials stated that eight HMOs have contracted to serve Medicare recipients, and none of them has experienced any adverse effects.

Amendments proposed in S. 2676, H.R. 11461, H.R. 9788, and H.R. 11388 would allow HEW to reimburse an HMO a predetermined, fixed amount per Medicare enrollee. The amount would be set at 95 percent of the estimated average cost to provide Medicare services through the fee-for-service system in the HMO's service area. Under S. 2676 and H.R. 11461, HEW would also estimate the amount that the HMO would charge Medicare members if the HMO billed them on the basis of a community rate, adjusted for Medicare population characteristics, such as age and sex. If the adjusted rate is lower than the "95 percent" payment, the HMO must return the difference to its members through some combination of extra services or reduced premiums.

Service to the medically indigent

As of December 1977, only four of the HMOs we evaluated had contracted with States to enroll Medicaid recipients. These recipients totaled about 3,900 of the 4 HMOs' total membership of about 58,000. On an individual basis, Medicaid recipients comprised 19, 10, 6, and 0.5 percent of the members of the four HMOs.

The director of one HMO which had no Medicaid members said the HMO did not want Medicaid enrollees because it did not want a "government subsidized, welfare image." The president of another HMO said Medicaid was the HMO's "lowest priority" because the "bad image" of a "poor people's program" might jeopardize marketing efforts.

In contrast, officials of seven HMOs said they had tried unsuccessfully to contract with States to serve Medicaid recipients on a prepaid basis. In one instance, an HMO began negotiating an agreement in 1972, but, as of September 1977, it had not been successful. State officials, in this instance, told us that they had tried to formulate a standard agreement for all HMOs in the State. According to the HMO executive director, the standard agreement was unworkable because it failed to recognize differences among HMOs.

Section 202 of the HMO Amendments of 1976 may partially alleviate problems faced by HMOs which have not been able to get State Medicaid contracts. Under the amendments, the Federal Government will, with certain exceptions and conditions, share in Medicaid costs under prepaid risk contracts only if the contracts are with qualified HMOs. The 1976 amendments, however, do not require States to contract with qualified HMOs to serve Medicaid recipients, and each State establishes its own reimbursement policy.

Amendments proposed in S. 2676, H.R. 11461, H.R. 9788, and H.R. 11388 would require States to contract with qualified HMOs which seek Medicaid enrollment. The Administration's amendments, S. 2676 and H.R. 11461, also propose that States be required to pay an HMO a predetermined fixed amount per enrollee. The amount would be set at 95 percent of the estimated average cost to provide Medicaid services through the fee-for-service system in the HMO's service area. Under S. 2676 and H.R. 11461, HEW would estimate the amount that the HMO would charge Medicaid members if the HMO billed them on the basis of a community rate, adjusted for Medicaid population characteristics, such as age and sex. If the adjusted rate is lower than the "95 percent" payment, the HMO would have to return the difference through extra services as agreed to with the State.

Action on proposed methods for determining Medicare and Medicaid payments to HMOs should be deferred

The proposed methods (S. 2676 and H.R. 11461) for determining Medicare and Medicaid payments to HMOs would

require HEW to (1) estimate the cost to provide Medicare and Medicaid services in the fee-for-service sector in each HMO's service area and (2) estimate for each HMO a community rate, adjusted for age and sex characteristics. We question HEW's ability to make these estimates and to monitor the activities of HMOs serving Medicare and Medicaid enrollees. Until HEW demonstrates that it can deal effectively with these problems, we believe action on these proposals should be deferred.

Fee-for-service estimates

In 1971, California enacted legislation which permitted the State to contract with HMOs to provide prepaid health services to Medicaid recipients in return for a fixed, monthly premium per enrollee. Under Federal and State regulations, the premium is not to exceed the average cost-per-person which the State estimates would be paid in the fee-for-service sector.

However, in September 1974 1/ and August 1975 2/ we reported that California had significant problems in accurately estimating fee-for-service costs. For example, we found that fee-for-service estimates were based on cost data as much as 2 years old. We believe that similar difficulty would exist in estimating costs under the Medicare program because as of March 1978, HEW's most recent Medicare cost data was for calendar year 1976.

We also found that California's estimates did not allow for the possibility that HMOs were excluding high-risk, high-cost Medicaid recipients; thereby, keeping them in the fee-for-service sector, while healthier, lower-cost recipients were joining HMOs, thereby causing higher average fee-for-service costs. As discussed later, high-risk individuals generally do not have access to membership in qualified HMOs. HEW does not know the extent to which this factor makes HMO utilization data not comparable to fee-for-service utilization data.

1/"Better Controls Needed For Health Maintenance Organizations Under Medicaid in California" (B-164031(3), Sept. 10, 1974).

2/"Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program" (MWD-76-15, Aug. 29, 1975).

Adjusted community rates

Earlier in this report, we noted that we could not assess compliance with the community rating requirement because HEW has not issued guidelines to translate the requirement into a rate structure. Without such guidelines, we question whether HEW can properly estimate adjusted community rates for every HMO serving Medicare and Medicaid recipients.

Compliance functions

In our 1974 report on California's Medicaid program, we noted that there were significant questions about the propriety and/or adequacy of HMOs' marketing and disenrollment practices, grievance procedures, and quality of care. As discussed later, we found that HEW has not developed an effective compliance function to assure systematically that similar problems do not exist in qualified HMOs. Before proposals are enacted to stimulate Medicare and Medicaid enrollment in HMOs, HEW should demonstrate it has an effective compliance function.

LACK OF OPEN ENROLLMENT MEANS LACK OF ACCESS FOR HIGH-RISK INDIVIDUALS

Section 1301(c)(4) originally required an HMO to have an annual 30-day open enrollment period. During that period the HMO had to enroll individuals, up to capacity, in the order they applied for membership, without regard to preexisting illness, medical condition, or degree of disability. Thus, open enrollment provided a way for high-risk individuals (those likely to use HMOs' services more than usual) to enroll in HMOs. However, the act authorized HEW to waive the requirement if an HMO could demonstrate that its financial soundness was, or would be, jeopardized because it had enrolled, or would be forced to enroll, a disproportionate number of high-risk individuals.

In November 1975, we testified before the Subcommittee on Health, Senate Committee on Labor and Public Welfare, that many respondents to our April 1975 questionnaire believed open enrollment could make qualified HMOs noncompetitive. 1/ The experience of two HMOs which we evaluated confirmed the respondents' concerns.

1/Forty-six percent of the respondents (562 responded) agreed that requiring open enrollment periods would make HMOs noncompetitive; 23 percent disagreed and 31 percent had no opinion. (See also footnote 1, p. 10.)

One HMO offered open enrollment for 30 days shortly before it became qualified and enrolled 1,183 persons during the period. During the first 8 months after qualification, the HMO's cost per-open enrollee was 52 percent higher than for persons enrolled through group enrollment. Persons who joined during open enrollment needed more hospital services, outpatient services, referral services, and other services such as ambulance and private nursing. For instance, group enrollees used 515 hospital days per 1,000 members in contrast with 1,071 days for open enrollees.

Another HMO offered open enrollment after becoming qualified but discontinued it after only 8 days because about 30 of the 40 open enrollees had preexisting and/or chronic medical conditions. The conditions included hypertension, cancer, heart problems, diabetes, cataracts, arthritis, and alcoholism. On an annualized basis, as shown below, the open enrollees' utilization rates were significantly greater than the total membership's rates from October 1974 to March 1976.

	Annualized utilization rates	
Type of service	Open enrollment members	All members
Hospital days per 1,000 members	1,350	495
Office visits per member	6.9	5.9

In October 1976, amendments to the HMO Act relaxed the open enrollment requirement. In our opinion, the amended requirement does not threaten HMOs' financial soundness because open enrollment is required only for HMOs which

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

--did not incur an operating deficit in their most recent fiscal year.

To provide further fiscal protection, the amended requirement lessens an HMO's exposure to possible enrollment of high-risk individuals. More specifically, an HMO may terminate an open enrollment period either when the number of open enrollees equals 3 percent of its net enrollment increase for the prior fiscal year or when the open enrollment period has lasted for 30 consecutive days.

HMOs are still required to enroll persons in the order they apply, without regard to preexisting illness, medical condition, or degree of disability, but not if the person is confined to an institution. As a further safeguard, HEW may waive the open enrollment requirement if an HMO demonstrates that open enrollment would threaten its financial soundness.

As of June 30, 1977, none of the HMOs we evaluated were required to offer open enrollment under the amended criteria, and only two stated they might offer open enrollment before being required to by law. Therefore, high-risk individuals generally will not have access to membership until the HMOs are required to offer open enrollment. 1/

Under the original requirement, 6 of the 14 HMOs should have offered or begun offering open enrollment before the 1976 amendments relaxed the requirement, or they should have obtained a waiver from HEW. However, we found that only one had held open enrollment (a total of 8 days) after becoming qualified. Each of the six HMOs had requested a waiver from HEW, and some said HEW had approved their requests tacitly. HEW had not approved the requests formally because it had no formal criteria for approving or disapproving waiver requests.

As of February 1978, HEW still had not established formal criteria. However, under the amended requirement, 11 of the 51 HMOs qualified at that time will have to offer open enrollment if HEW does not waive the requirement. Therefore, HEW must establish criteria for considering waiver requests.

MEDICALLY UNDERSERVED AREAS ARE NOT SPECIFICALLY COVERED

HEW designates geographic areas or population groups with a shortage of personal health services as medically underserved. The HMO Act encourages, but does not require, HMOs to serve these areas. Under the act, HEW provides grants for up to 100 percent of the costs of feasibility surveys, planning, and initial development for HMOs which will draw at least 30 percent of their members from medically underserved areas or populations. Grants for HMOs drawing less than 30 percent of their members from medically underserved areas or populations may not exceed 90 percent of costs.

1/A high-risk individual can enroll in an HMO if he is employed by an employer who offers an HMO as part of a health benefits program, because HEW regulations (42 CFR 110.108(f)) require an HMO to accept all individuals who are part of a covered employee group, regardless of health status or health care needs.

None of the HMOs we evaluated obtained grants for more than 90 percent of costs. Therefore, none has an obligation to enroll 30 percent or more of its members from medically underserved areas or populations.

Eleven of the HMOs' service areas include medically underserved areas, but they have not specifically directed their services to such areas. Instead, the HMOs have generally focused their primary marketing efforts on employee groups, without regard to where employees reside. As a result, the HMOs have enrolled some persons residing in underserved areas, but it has occurred incidentally rather than by design. Without a specific requirement to serve persons living in medically underserved areas, we believe HMOs will not consciously direct their services to those areas.

CONCLUSIONS

The HMOs we evaluated generally have been organized and operated as required by the act; however, we found the following situations.

--Mainly because of problems in contracting with HEW and States to serve Medicare and Medicaid recipients, HMOs generally have enrolled few or no elderly or indigent persons.

--Six of the HMOs should have offered open enrollment under the original act but did not. Under the act, as amended, none of the 14 is yet required to offer open enrollment, and none definitely plans to offer open enrollment until required to by the act, as amended. This has, and will, limit access to membership for high-risk persons. Also, 11 qualified HMOs which we did not review, are required to offer open enrollment under the act, as amended, unless HEW waives the requirement. However, HEW has not established waiver criteria.

--Some HMOs have enrolled persons from medically underserved areas in the course of marketing to employee groups, but HMOs have not specifically directed their services to medically underserved areas.

RECOMMENDATION TO THE SECRETARY OF HEW

The Secretary of HEW should direct the Assistant Secretary for Health to develop criteria for approving and disapproving requests for waiver of the open enrollment requirement.

RECOMMENDATION TO THE CONGRESS

Amendments to the HMO Act proposed in S. 2676, H.R. 11461, H.R. 9788, and H.R. 11388 would institute new methods to pay HMOs for providing prepaid health services to Medicare and Medicaid recipients. Because these amendments would likely stimulate enrollment of Medicare and Medicaid recipients in HMOs, we support them in principle; however, there are practical problems which, in our opinion, must be solved before the proposals can be implemented effectively. HEW has not demonstrated that it can accurately determine average fee-for-service costs per Medicare and Medicaid enrollees; HEW has not issued guidelines for establishing community rates; and HEW has not established an effective compliance function to assure Medicare and Medicaid enrollees would be served properly. Accordingly, we recommend that the Congress defer action on proposals intended to stimulate Medicaid and Medicare enrollments until HEW demonstrates that it can effectively administer proposed changes in the reimbursement methods and implement an effective compliance program.

AGENCY COMMENTS AND OUR EVALUATION

HEW disagreed with our recommendation that the Congress defer action on proposed legislative amendments intended to stimulate Medicaid and Medicare enrollment in HMOs. HEW stated that it has initiated or proposed measures to correct problems cited in our report.

In its comments, HEW listed the principles it will follow in developing a methodology for determining reimbursement rates under Medicare and Medicaid and stated that it has developed a comprehensive compliance plan. In addition, HEW stated that it had funded a demonstration grant for the State of California which had resulted in manuals to assist States in more accurately determining fee-for-service costs for Medicaid enrollees.

However, HEW did not specifically indicate how the methodology for determining reimbursement rates would be developed and applied or how its compliance plan will be implemented. We continue to believe that the Congress should defer action on proposed legislation until HEW

- --demonstrates that it can accurately estimate the fee-for-service costs of serving Medicare and Medicaid recipients,
- --implements community rating guidelines, and
- --implements an effective compliance program.

HEW concurred with our recommendation to develop criteria for approving and disapproving requests for waiver of the open enrollment requirement and stated such criteria are being established in the form of guidelines to take effect on July 1, 1978.

CHAPTER 4

CAN HMOs OPERATE WITHOUT CONTINUED FEDERAL FINANCIAL ASSISTANCE?

The HMO Act, as amended, envisions qualified HMOs as financially sound business enterprises which can operate independently--without Federal financial assistance--after their first 5 years of operation as a qualified HMO. This means that an HMO must be able to obtain enough revenues to cover operating costs (break even) and thereafter generate enough surplus to repay debts, replace facilities, and finance future growth. Of the 14 HMOs we evaluated

--3 HMOs have a good chance of achieving financial independence within 5 years,

--3 HMOs have a fair chance, and

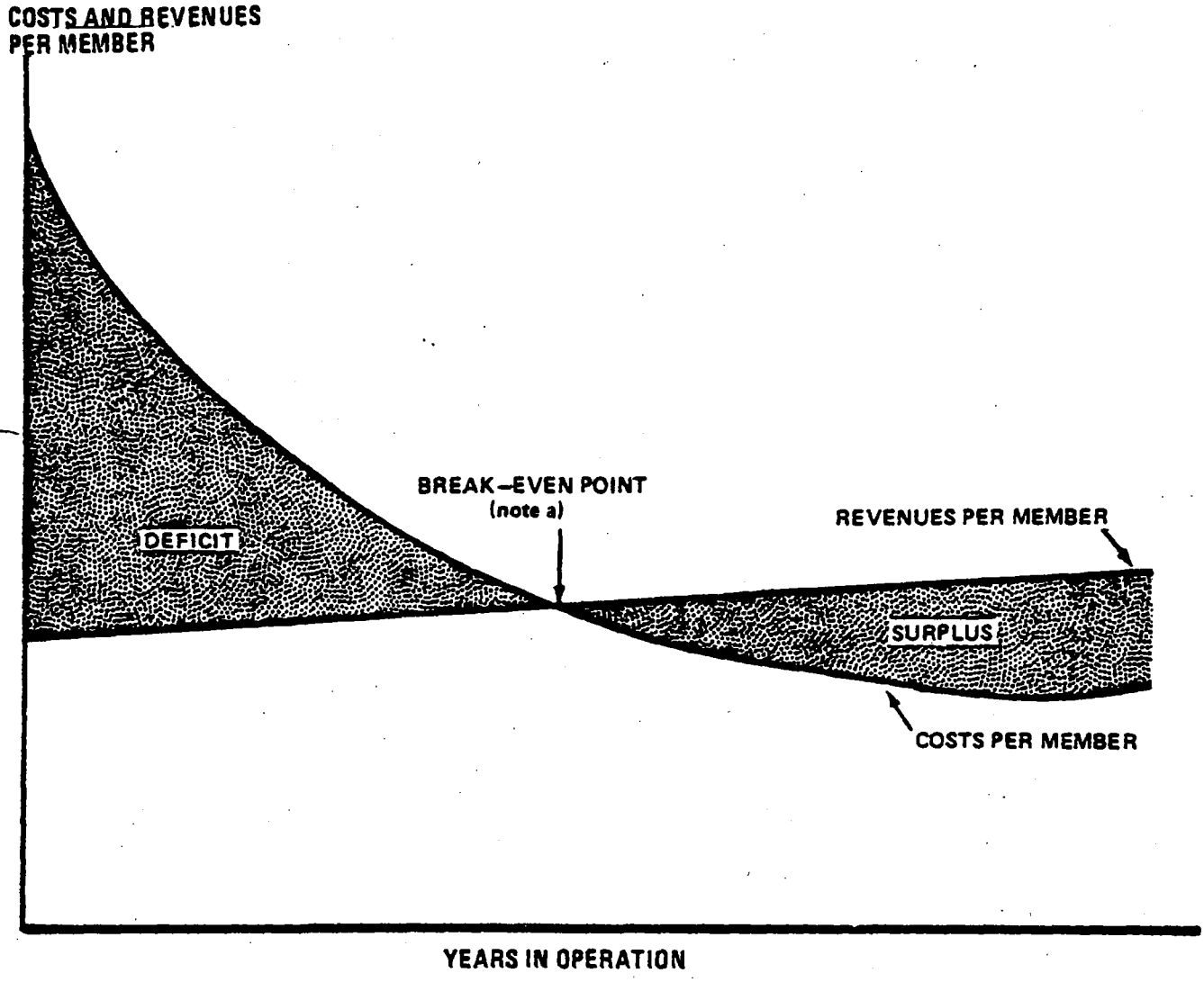
--6 have a poor chance.

To help public or nonprofit HMOs cover operating deficits during their first 5 years of qualified operation, section 1305 of the act authorizes HEW to loan each qualified HMO up to $2.5 million. 1/ A private, for-profit HMO which serves a medically underserved area can obtain a Federal guarantee of up to $2.5 million for loans from private lenders to cover deficits during this time period. Each HMO we evaluated was nonprofit and had obtained a Federal loan which was repayable, with interest, over a period not to exceed 20 years from the time of the loan. Repayment of the loan principal may be deferred for the first 5 years of operation.

The illustration on page 25 shows the revenue and cost curves for a hypothetical HMO which would generate sufficient revenue to pay current costs and sufficient surplus to repay debts, replace facilities, and finance future growth. Ideally, an HMO initially should establish subscriber rates which would require raising these rates only enough to match future inflationary cost increases. Assuming that management adequately controls costs, the HMO's costs per member should gradually decline as enrollment grows, until costs per member equal revenues per member (break even).

1/Amendments proposed in S. 2534 and S. 2676 would increase the ceiling on operating loans to $5 million. S. 2534, S. 2676, H.R. 11461, H.R. 9788, and H.R. 11388 propose to establish a loan program for ambulatory care facilities.

GENERAL PATTERN OF COSTS AND REVENUES PER MEMBER FOR A HYPOTHETICAL HMO WHICH IS ABLE TO ACHIEVE FINANCIAL INDEPENDENCE WITHIN ITS FIRST 5 YEARS OF OPERATION AFTER QUALIFICATION



a/ A QUALIFIED HMO IS EXPECTED TO REACH THE BREAK–EVEN POINT WITHIN ITS FIRST 5 YEARS OF OPERATION AS A QUALIFIED HMO.

In our HMO evaluations, we found that conclusive criteria have not been developed for HEW evaluators to judge whether a developing HMO can become financially independent. However, we reached several general conclusions about the ability of HMOs to become self-sustaining business entities.

--HMOs which lack management control over health care resources--such as hospitals and health care providers--are limited in their ability to control health care costs.

--HMOs may be too optimistic about future cost levels.

--Much attention is focused on HMOs' cost reduction potential, but the HMOs' ability to become financially independent also depends greatly on if they can generate sufficient revenues through their pricing strategy.

--HMOs must be managed effectively as independent business entities to ensure financial soundness.

--Third-party relationships may have aided some HMOs, but the potential for abuse exists.

HMOs WHICH LACK CONTROL OVER HEALTH CARE RESOURCES LACK CONTROL OVER COSTS

According to an HMO financial planning manual published by HEW, an HMO must implement a management system which adequately controls costs and utilization of health care resources. As discussed later, we found some instances in which HMOs had not adequately managed costs or utilization of resources within their control. Moreover, we found that, to a great extent, HMOs use fee-for-service health providers over which the HMOs have no management control.

Some HMO proponents have characterized the fee-for-service health care delivery system as too expensive and have concluded that medical resources in the system are maldistributed. One proponent, an official of a large, financially successful HMO, stated in 1969 that his HMO had experienced cost savings over the fee-for-service system because it had operated more efficiently and effectively and minimized hospital use. He explained that, among other things, the HMO

--used medical personnel effectively and benefits from economies of scale;

--stressed innovative management which uses modern management, planning, and budgeting skills; and

--operated the outpatient and hospital facilities as an integrated unit, thereby allowing the plan to unify laboratory services, purchasing, accounting, and administrative functions involved in delivering outpatient and inpatient services.

In other words, the HMO has benefited by operating in a fasnion different from the fee-for-service system.

In contrast, the HMOs we evaluated relied completely on local hospitals to provide hospital services. Costs of referrals for the staff and group practice HMOs to non-HMO practitioners constituted 9 to 74 percent of medical services cost (other than hospitalization, health center, and administration) during 1977. IPAs relied completely on individual fee-for-service practitioners to provide medical services.

The HMOs we evaluated are not providing inpatient and outpatient services in the same fashion as the successful HMO described earlier and, as a result, cannot be expected to operate in the most efficient manner possible. We realize, however, that it would be unrealistic to expect HMOs of all sizes and ages to operate their own hospitals and depend minimally on fee-for-service providers.

Although the HMOs we evaluated lack control over hospital and referral physician charges, HMO proponents maintain that HMOs bring about major cost savings by reducing hospital utilization. In March 1978, HEW testified before the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources, that in fiscal year 1977, qualified HMOs used an average of 529 hospital days per 1,000 members, adjusted for age and sex differences, as compared to the national yearly average of 1,022 days per 1,000 persons. The difference between 529 and 1,022 days cannot be attributed solely to the efficacy of the HMO concept for the following reasons:

--Qualified HMOs generally have not held open enrollment and therefore have not provided access to enrollment for high-risk individuals who cannot work; whereas, the national data include all high-risk persons.

--Even if an HMO holds open enrollment, it does not have to accept institutionalized persons; whereas, the national data include persons institutionalized for as much as 365 days per year.

HMOs MAY BE TOO OPTIMISTIC ABOUT FUTURE COST LEVELS

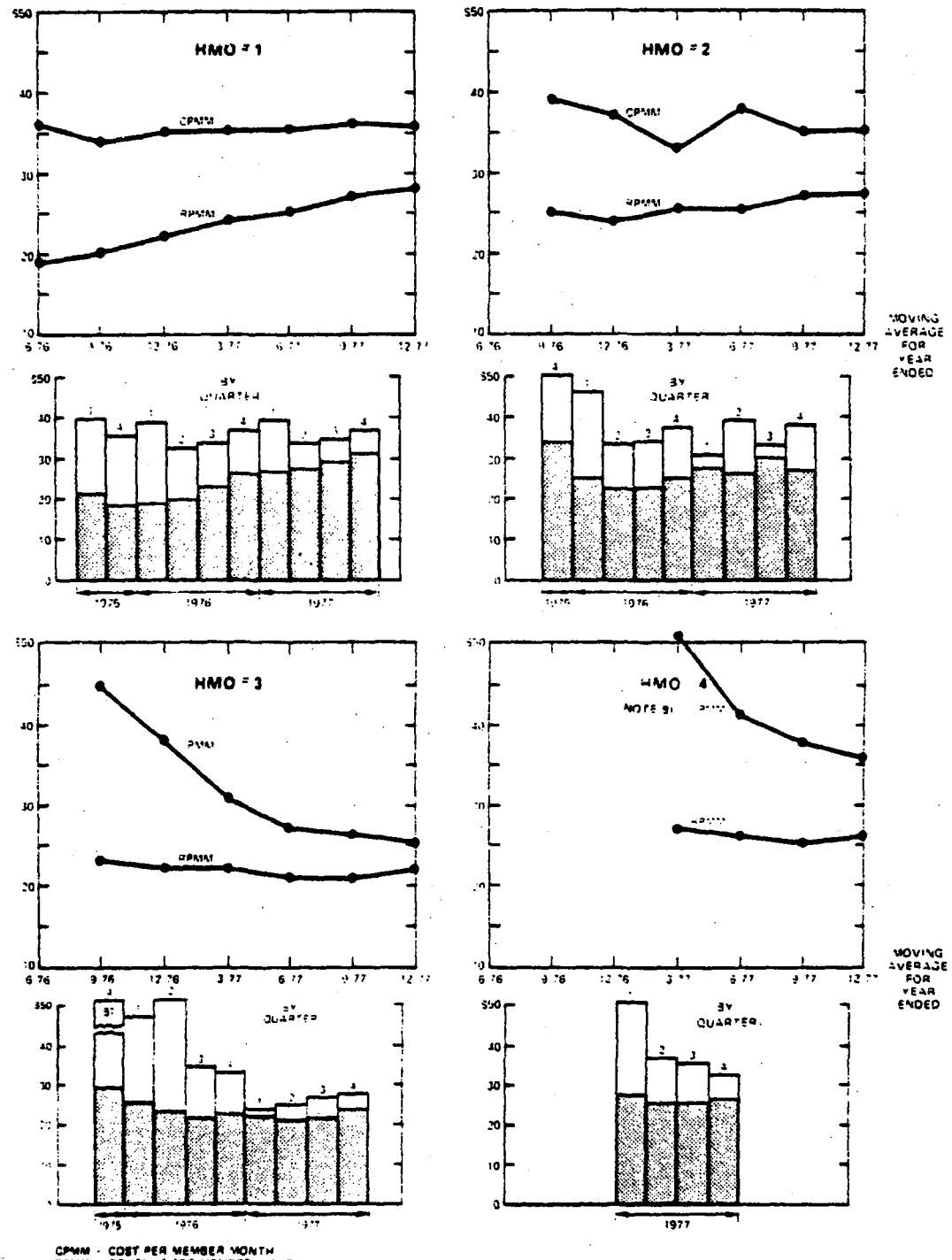
The charts on pages 29 and 30 depict the post-qualification cost experience of 8 HMOs; each had fewer than 2,200 members and had been in operation from 0 to 2 years at the time of qualification. Their average monthly costs per member generally declined rapidly, but the rate of decrease soon slowed and their cost curves began to level out.

The charts on pages 31 and 32 display the post-qualification cost experience of the other 6 HMOs, which had been in operation from 1.75 to 4.3 years and had 5,100 to 21,300 members at qualification. At qualification, the six HMOs apparently already had experienced an early sharp decline in costs per member, and their cost curves already had leveled or started to level.

At December 1977, cost curves for 12 of the 14 HMOs had leveled or begun to level. In some cases, after leveling, the curves had begun to rise. These HMOs' experience indicates that, once an HMO's cost curve levels out, the HMO should not expect significant, if any, decreases in costs per member. The experience of the three largest HMOs (numbers 9, 10, and 11), in particular, indicates that HMOs could expect a generally rising costs per member trend sometime after leveling.

As shown on the following page, in 1977 the average monthly costs of the 12 HMOs with level or leveling cost curves generally were in the vicinity of $30 to $35 per member. Also, the HMOs' average monthly costs per member do not correlate closely with size of enrollment or number of years in operation. From these 12 HMOs' experience, we conclude that, regardless of enrollment size or length of operation, HMOs operating similar to these generally should not expect their monthly costs to decline to less than about $30 to $35 per member. Moreover, because these were 1977 costs, the $30 to $35 cost floor could rise substantially by 1980, assuming health care costs continue to rise about 10 percent annually due to inflation.

AVERAGE COSTS AND REVENUES PER MEMBER PER MONTH FOR HMOs WITH LESS THAN 2,200 MEMBERS AT QUALIFICATION, BY YEAR AND QUARTER (NOTE A)



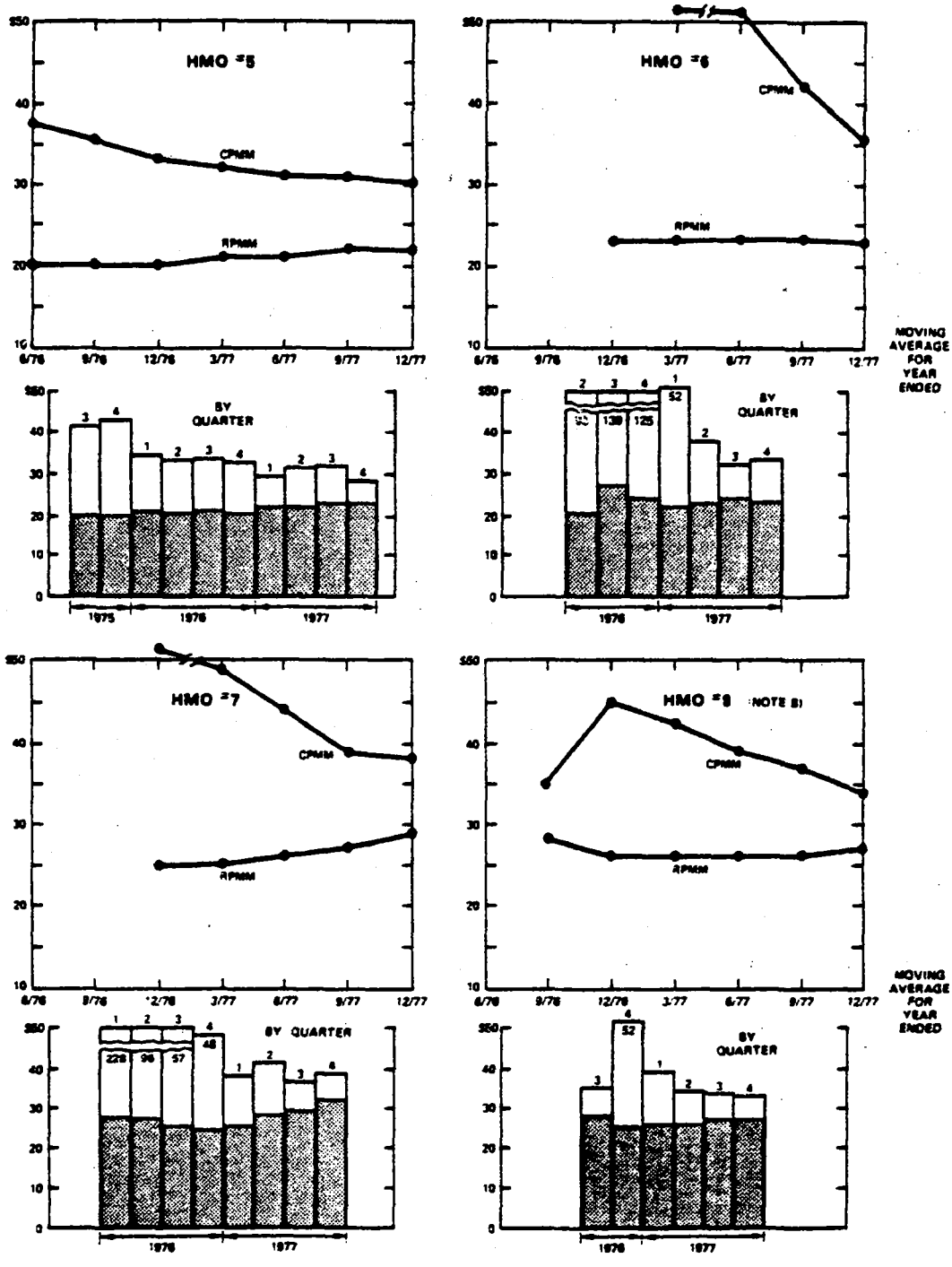
CPMM - COST PER MEMBER MONTH
RPMM - REVENUE PER MEMBER MONTH

RPMM — CPMM

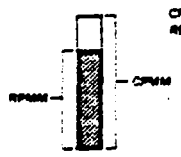
[a] COST AND REVENUE DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R 1498). THE HMOs IN THIS GROUP HAD BEEN OPERATING FROM 0 TO 2 YEARS AT QUALIFICATION.

[b] BECAUSE ONLY 4 QUARTERS OF FINANCIAL DATA WERE AVAILABLE FOR HMO 4, THE AVERAGE COSTS AND REVENUES FOR THE PERIODS ENDED MARCH 1977, JUNE 1977, AND SEPTEMBER 1977 INCLUDE DATA FOR ONLY 1, 2, AND 3 QUARTERS, RESPECTIVELY.

AVERAGE COSTS AND REVENUES PER MEMBER PER MONTH FOR HMOs WITH LESS THAN 2,200 MEMBERS AT QUALIFICATION, BY YEAR AND QUARTER (NOTE A)



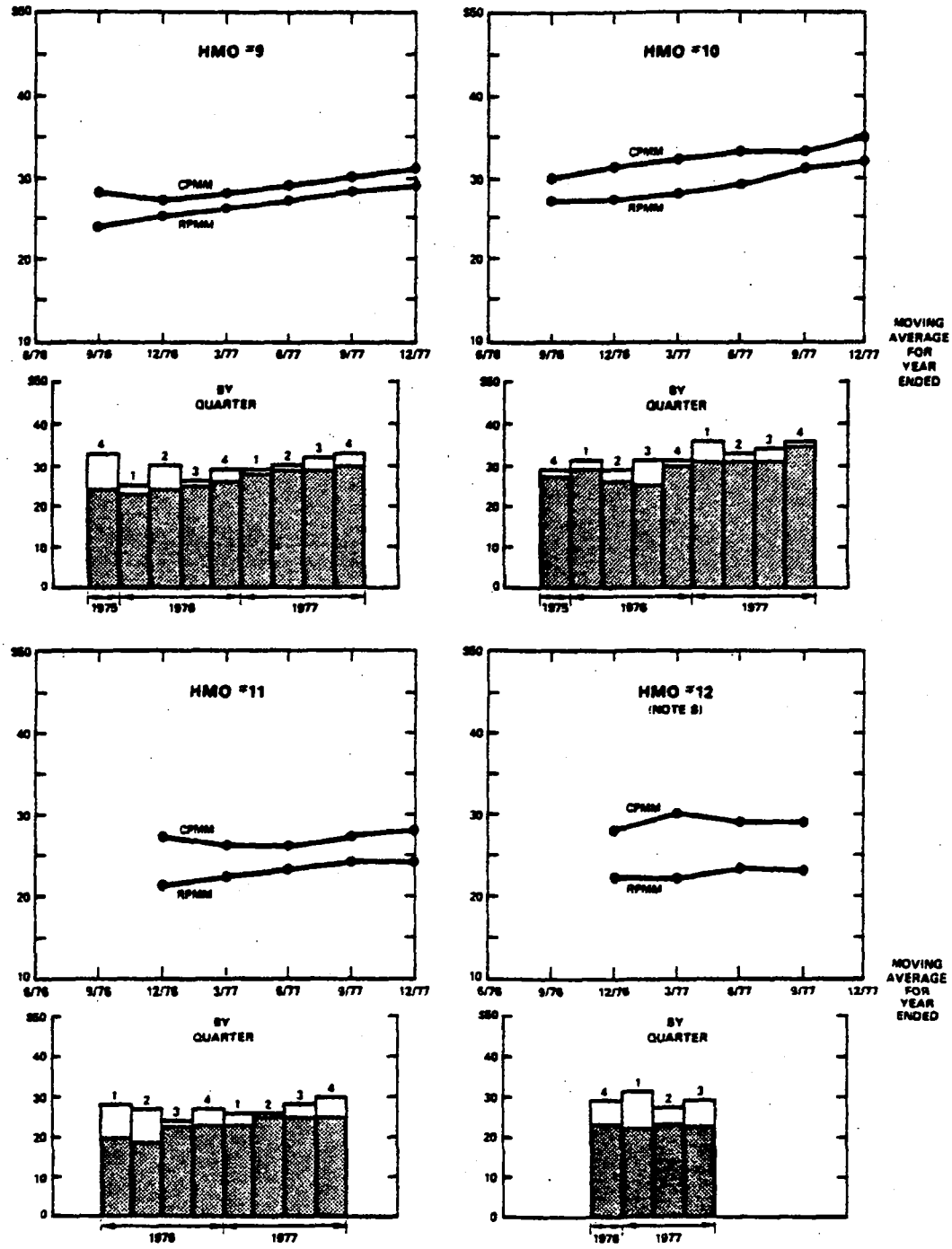
CPMM = COST PER MEMBER MONTH
RPMM = REVENUE PER MEMBER MONTH



A/ COST AND REVENUE DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1498). THE HMOs IN THIS GROUP HAD BEEN OPERATING FROM 0 TO 2 YEARS AT QUALIFICATION.

B/ BECAUSE ONLY 6 QUARTERS OF FINANCIAL DATA WERE AVAILABLE FOR HMO 8, THE AVERAGE COSTS AND REVENUES FOR THE PERIODS ENDED SEPTEMBER 1976, DECEMBER 1976, AND MARCH 1977 INCLUDE DATA FOR ONLY 1, 2, AND 3 QUARTERS, RESPECTIVELY.

AVERAGE COSTS AND REVENUES PER MEMBER PER MONTH FOR HMOs WITH MORE THAN 5,000 MEMBERS AT QUALIFICATION, BY YEAR AND QUARTER (NOTE A)

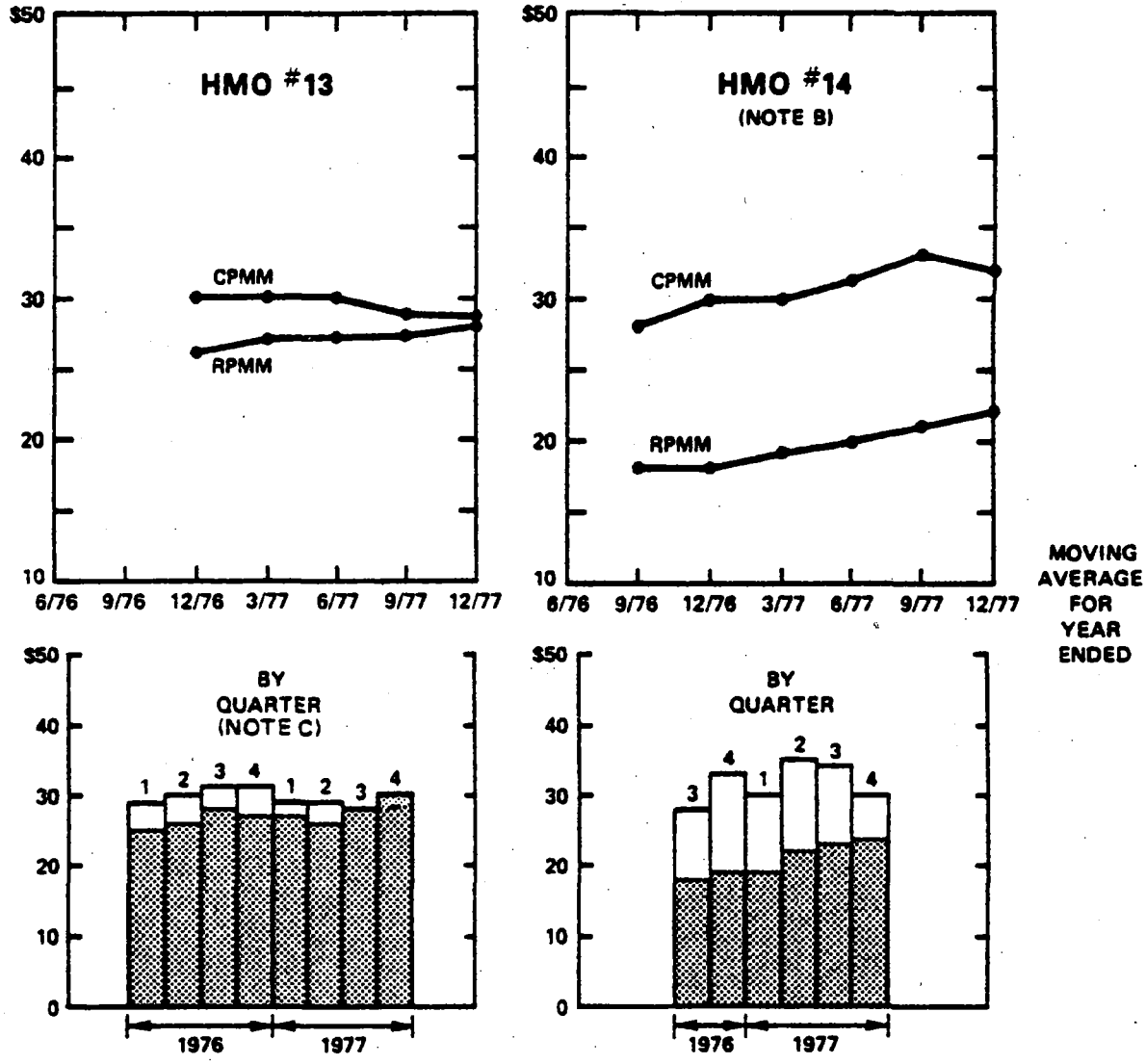


CPMM = COST PER MEMBER PER MONTH
RPMM = REVENUE PER MEMBER PER MONTH

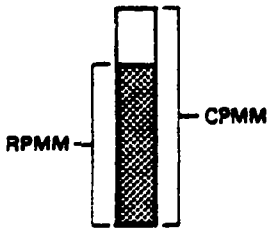
A/ COST AND REVENUE DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68A-1496). THE HMOs IN THIS GROUP HAD BEEN OPERATING FROM 1.75 TO 4.3 YEARS AT QUALIFICATION.

B/ BECAUSE ONLY 4 QUARTERS OF FINANCIAL DATA WERE AVAILABLE FOR HMO 12, THE AVERAGE COSTS AND REVENUES FOR THE PERIODS ENDED DECEMBER 1976, MARCH 1977, AND JUNE 1977 INCLUDE DATA FOR ONLY 1, 2, AND 3 QUARTERS, RESPECTIVELY.

AVERAGE COSTS AND REVENUES PER MEMBER PER MONTH FOR HMOs WITH MORE THAN 5,000 MEMBERS AT QUALIFICATION, BY YEAR AND QUARTER (NOTE A)



CPMM = COST PER MEMBER MONTH
RPMM = REVENUE PER MEMBER MONTH



A/ COST AND REVENUE DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1496). THE HMOs IN THIS GROUP HAD BEEN OPERATING FROM 1.75 TO 4.3 YEARS AT QUALIFICATION.

B/ BECAUSE ONLY 6 QUARTERS OF FINANCIAL DATA WERE AVAILABLE FOR HMO 14, THE AVERAGE COSTS AND REVENUES FOR THE PERIODS ENDED SEPTEMBER 1976, DECEMBER 1976, AND MARCH 1977 INCLUDE DATA FOR ONLY 1, 2, AND 3 QUARTERS, RESPECTIVELY.

C/ FOR THE FOURTH QUARTER OF 1977, HMO 13'S RPMM WAS $0.83 MORE THAN CPMM.

Average Monthly Cost Per Member,
Size and Length of Operating Experience
for 12 of 14 HMOs - Year Ended December 1977

Membership	HMO (note a)	Years in operation 2.0-3.9	Years in operation 4.0-6.5	Average costs per member per month	Costs per member per month quarter ended December 1977
7,500-12,499	1	X		$36.02	$36.28
	2	X		35.68	38.49
	5	X		30.09	28.49
	7	X		38.64	33.04
	13		X	29.29	29.45
	14	X		32.54	30.64
12,500-17,499	3	X		25.86	27.53
	8	X		34.36	33.04
	12		X	29.12	29.32
22,500-33,500	9		X	31.44	33.17
	10		X	35.01	36.29
	11		X	28.04	30.33

a/The HMO numbers in this column correspond to tne HMO numbers in tne charts on pages 29 - 32.

However, 7 of the 14 HMOs have projected that by the end of 1980 their average monthly costs per member will be about $30 to $33 or less. We believe the HMOs are too optimistic about their ability to hold down costs per member.

We also question the reasonableness of three other HMOs' cost projections. One HMO, which has a rising cost curve, predicts its monthly cost per member in 1980 will be about $39, which is only 9 percent more than its average 1977 cost of about $36. However, during the last 6 months of 1977 alone, the HMO's costs per member increased 7 percent. Another HMO has a level cost curve and predicts its monthly cost per member in 1980 will be $36 (about the same as its average 1977 cost). The third HMO's cost curve is leveling off and the HMO predicts that its monthly cost per member in 1979 will be $35.43, which is 8.3 percent lower than its average 1977 cost of $38.64.

Where we question the reasonableness of an HMO's cost projections, we must also question the reasonableness of its revenue projections because an HMO which has costs higher than projected costs will need to generate revenues which are higher than its projection to become financially independent.

PRICING STRATEGY: NO LESS IMPORTANT THAN COST CONTROL

As discussed, a major emphasis of the HMO concept is cost minimization and control. However, an HMO's pricing strategy is as important as cost control in its becoming financially independent.

In general, HMOs' primary competitors are insurance companies which offer health benefit plans. Under their plans, the insurer pays for the cost of covered health care services after a fee-for-service practitioner provides the services. Qualified HMOs generally offer more comprehensive coverage than insurance companies' plans, but broader coverage alone does not mean consumers will readily switch to HMO coverage. An HEW financial planning manual states:

> "In the final analysis, the [HMO] plan's premium must be competitive with the rates and premiums being offered by other health plans. * * * it should be assumed that the general public will not pay much over the current price of health care plans even if substantially better benefits are offered."

Consequently, a qualified HMO automatically faces a serious threat for its survival. By law, it generally must provide more comprehensive benefits than competitors, but, must charge about the same prices as competitors. For example, in January 1977, one HMO raised its subscriber rates 20 percent, which made it less competitive with Blue Cross. Its enrollment growth slowed and the HMO did not achieve its 1977 enrollment projections. The HMO's planned 1978 rate increase was 18 percent, but because of competition, the HMO limited its 1978 increase to 10.75 percent.

One obvious solution to the pricing dilemma is for an HMO to operate in a fashion which allows it to provide health care services at a lower cost than the fee-for-service system, which provides health care to individuals under insurance companies' plans. However, as discussed earlier, the 14 HMOs depend greatly on the fee-for-service system to serve their members, and cannot, therefore, take full advantage of the HMO concept's of efficiencies and economies of scale. Consequently, to be competitive, an HMO may be forced to sell its services for less than cost.

In the early stages of operation, it is not financially dangerous to sell services for less than cost. In fact, it may be necessary. A new HMO would be noncompetitive if its initial subscriber rates were set high enough so that total costs would be recovered from the outset of operations. The HMO Act recognizes this necessity and provides for Federal loans to finance deficits incurred during an HMO's first 5 years of operation. However, availability of funds makes it possible for an HMO to pursue an ultimately disastrous pricing strategy--that is, to underprice services over a relatively long period to be competitive in the market place.

Evidence of underpricing

To break even, an HMO must recover its fixed costs and the additional (variable) costs incurred to serve each new member. Therefore, an HMO's subscriber rates should provide enough revenue per member to cover variable costs added by each new member, plus some amount to contribute toward fixed costs. Eventually, as new members are added, the HMO should have enough revenue to cover variable and fixed costs (break even). As the HMO moves toward the break-even point, its quarterly deficits will become smaller. However, if the HMO's rates are too low to pay the variable costs and to contribute toward covering the fixed cost, the HMO will incur greater and greater losses as it adds new members.

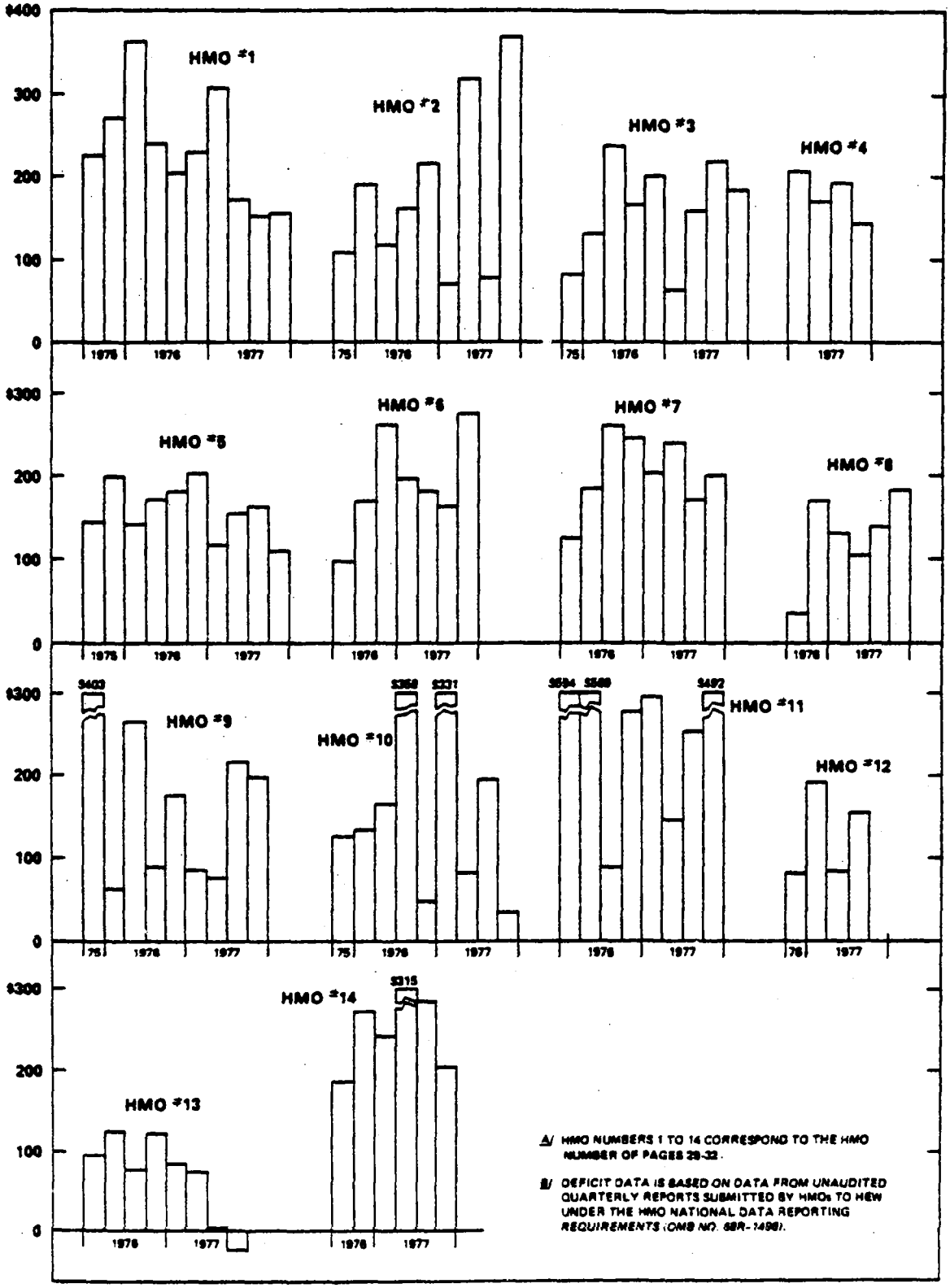
As shown in the chart on page 36, most HMOs had an erratic pattern of quarterly deficits. We believe that the erratic pattern is indicative of the HMOs' difficulties in both controlling costs and generating sufficient revenues to cover variable costs.

Example of an HMO hurt by underpricing

The chart for HMO 5 on page 36 shows the HMO's quarterly deficits over a 2-1/2 year period. The HMO has not established a consistent pattern of decreasing deficits largely because of underpricing.

The HMO's original subscriber rate structure was in line with the structure recommended by an actuarial consultant, but the HMO did not increase its rates during its first 2 years of operation. In its qualification application, the HMO used the actuarial consultant's study to support financial projections which showed that it could break even within 3 years. The consultant's report projected a third-year family

QUARTERLY DEFICITS OF 14 HMOs
(IN THOUSANDS OF DOLLARS) (NOTES A AND B)



A/ HMO NUMBERS 1 TO 14 CORRESPOND TO THE HMO NUMBER OF PAGES 29-32.

B/ DEFICIT DATA IS BASED ON DATA FROM UNAUDITED QUARTERLY REPORTS SUBMITTED BY HMOs TO HEW UNDER THE HMO NATIONAL DATA REPORTING REQUIREMENTS (OMB NO. 68R-1498).

rate of about $110 a month. However, as shown below, the HMO's third-year family rate was about $42 less than the consultant's rate, and the HMO's fourth-year rate for families was about $29 less than the consultant's projected third-year rate. Family contracts comprised about 36 percent of the HMO's subscriber contracts.

Rate category	Actuary's recommended 3d year rates	HMO's 1st and 2d year rates	HMO's 3d year rates	HMO's 4th year rates
Single	$ 28.34	$27.50	$29.95	$35.95
Couple	52.69	49.00	54.95	65.95
Family	110.07	59.95	67.50	81.00
Family (7 or more)	(a)	(a)	75.00	90.00

a/The HMO did not establish this rate category until its third year of operation.

The HMO established this rate structure to be competitively priced. The following table compares the HMO's third-year family rate to rates of competing health benefit plans. The comparison shows that the HMO's family rate would not have been competitive if the HMO had charged the actuarial consultant's recommended rate of about $110 a month.

Rate category	HMO monthly rate	Major private insurer monthly rate (note a)	Other private insurer monthly rate (note b)
Family	$67.50	$65.00	$73.34
Family (7 or more)	75.00	(c)	(c)

a/Typical high benefit package.

b/Average rates for six private employer groups.

c/Rates are same as for "family".

The HMO has not demonstrated its ability to increase rates enough to achieve financial independence. In July 1977 the HMO revised its financial plan and projected that it could break even within 5 years after qualification, rather

than 3 years as originally estimated. Its projected revenues were based on the assumption that, starting in September 1977, it would increase its subscriber rates annually by 25, 15, 7, 7, and 6 percent, successively.

In August 1977, an actuarial consultant analyzed the HMO's planned rate increases. The consultant stated in his report that a desirable rate schedule should (1) produce positive net income at the end of the projection period, (2) allow an HMO to repay borrowed capital, (3) enable an HMO to maintain a vigorous economic position, and (4) create reserves for replacement of facilities and for future growth. He concluded that the HMO's planned rate increases did not meet all these objectives and the planned 25-percent increase in September 1977 could be considered "required" for the HMO. However, the rate increase approved by the State was only 20 percent.

In our opinion, the HMO has knowingly underpriced its family subscriber rate to remain competitive, and this has contributed to its inability to break even within 3 years as originally projected. After projecting that it could break even within 5 years, the HMO has not been able to increase subscriber rates in accordance with the substantial rate increases on which the revised projection was based. Although the underlying cause of the HMO's financial problem is its inability to reduce costs to a level that would permit charging competitive rates for its services, the fact remains that continuing to charge rates which will not cover costs merely shifts the burden of rate increases to later years and enlarges the potential size of needed increases, perhaps beyond acceptable limits.

GOOD MANAGEMENT IS CRITICAL TO HMO SOUNDNESS

An article 1/ written by two HEW employees associated with the HMO program indicated that inadequate management was a major reason for many developing (not qualified) HMOs' failure. Lack of expertise was cited as evident in management planning, marketing management, and financial planning. It concluded that a shortage of persons trained to plan, develop, operate, and manage HMOs may limit HMO expansion more than availability of capital.

1/George B. Strumpf and Marie A. Garramone, "Why Some HMOs Develop Slowly," Public Health Report, Nov.-Dec. 1976, Vol. 91, No. 6, pp. 496-503.

Section 9 of S. 2534 proposes a federally financed training program to develop HMO managers. Based on our HMO evaluations, we believe this program is needed because we found inadequacies in planning, marketing management, financial management, and utilization control. Case studies of several HMOs follow.

Case #1

Inadequate planning

One HMO's planning of its outpatient facility location may have hampered marketing efforts. The HMO originally was established in 1972 as a family health center with the help of a grant awarded under section 314(e) of the Public Health Service Act. The family health center's mission was to provide medical services to a relatively small, poverty-stricken, inner-city area (18 square miles) where coordinated health care was virtually absent. In 1976 the family health center became a qualified HMO with a 25-mile radius service area (almost 2,000 square miles), which was far beyond the inner-city area.

In discussions with 20 employers who offered or planned to offer the HMO, 8 criticized the location of the HMO's medical facility. They commented either that the facility was in a "bad" neighborhood or that the distance from the suburban areas made it inconvenient. Some employers suggested that satellite facilities would generate more employee interest in the HMO.

Inadequate utilization controls

In December 1977, an HEW management analyst reported that a major reason for the HMO's financial problems was a lack of control over referrals and hospitalization. The analyst said the HMO had been allowing almost unlimited referrals. He also said the HMO had no preadmission program to determine a person's need for hospitalization and had only recently begun to track each patient's length of stay to determine whether it was within acceptable parameters.

Case #2

Inadequate marketing management

In March 1977, an HEW marketing consultant reviewed the HMO's marketing program and found several problem areas which had contributed to poor marketing performance.

--The marketing department was understaffed and did not have a separate departmental budget, and the marketing staff had not been properly trained.

--Management lacked an understanding of the relationship of marketing to sound HMO management, consumer service, and membership disenrollment.

He concluded that the HMO's marketing problems could have been minimized if the HMO had been managed by an experienced HMO administrator.

Financial management weaknesses

The HMO has had a history of financial management weaknesses. In December 1975, an HEW consultant stated that the HMO should have a cost accounting system that would, at a minimum, separate costs by medical specialty. The consultant said the system should distribute costs such as administration, marketing, hospitalization, referrals, supplies, and salaries. He felt that a lack of a cost accounting system raised the following issues.

--Inability to demonstrate reasonableness of pricing policy.

--Difficulty in determining reimbursement for services provided under future Medicare contracts.

--Eventual inability to control budgeted funds and an overall lack of financial management.

As of June 1977, the HMO did not have a cost accounting system such as the one recommended by the consultant. The HMO's system consisted of isolating variable costs in categories such as hospitalization and referrals and computing the cost per member per month for each category. The costs were not distributed by medical specialties, and the costs for various services were not determined.

An HEW financial analyst reported in April 1975 that the HMO had been planning its cash needs only on a day-to-day basis. He recommended that the HMO develop a formal cash needs forecasting system. As of February 1977 the HMO had not established a formal system. The HMO's comptroller said he had not prepared cash budgets regularly because he could not predict hospital and referral costs.

Case #3

Ineffective marketing

In January 1977, an HEW marketing consultant reviewed the HMO's marketing and concluded that its marketing was ineffective. The consultant noted that:

--Although the HMO at one time had accumulated employer data to define the market, the marketing staff had not kept the information up to date and did not have a working knowledge of target groups.

--The marketing staff had limited background in health insurance sales and benefits, and the staff had not developed effective techniques to counter competitors' tactics.

--The marketing staff had no financial incentives beyond basic salary, and the staff did not appear to be sales oriented.

Inadequate financial management

Failure to control administrative costs contributed greatly to the HMO's financial problems. During the first 12 months of operation, the HMO's actual enrollment was about 45 percent less than originally projected. However, actual administrative costs exceeded projected administrative costs for the period by $273,000--an overrun of about 58 percent.

In January 1977, an HEW official reviewed the HMO's operations and concluded that the HMO had inadequately managed its administrative costs. He pointed out the following.

--The HMO's personnel structure resembled that of an HMO with 25,000 to 40,000 members. 1/

--Although membership had lagged far behind original projections, the HMO's executive director had increased the administrative staff without regard to slow membership growth, as long as Federal loans were available.

1/Actual membership at that time was less than 6,000.

--The HMO's board of directors had not taken an active overseer role and seemed either to have been isolated from the HMO's actual status or to have abdicated its role as board of directors to the executive director.

Case #4

Lack of planning in marketing

The HMO lacked strategic long-range planning in marketing. The HMO had not developed a (1) formal list of employers in its service area, including data on firm size, location, industry, present health plan carrier, and contract renewal date and (2) a system to monitor progress with contacted employers. The HMO's marketing director said he spent about 90 percent of his time selling and did not have enough time to plan and monitor the system.

Inadequate financial management

In December 1977, a State regulatory agency found numerous internal control weaknesses which, according to the agency, jeopardized the reliability of the HMO's financial reporting system and inadequately protected assets against waste and theft. The agency said the HMO's general ledger had not been posted since June 1977, and the HMO had not prepared reliable financial statements since May. Other hindrances to reliable financial reporting cited by the agency were (1) absence of an accounting manual with adequate written instructions on policies and procedures and (2) chronic understaffing of the accounting department. The agency also noted that the HMO did not prepare cash budgets, despite evidence of serious cash flow problems, and that cash disbursements were handled in a manner which exposed the plan's cash assets to improper use.

THIRD-PARTY RELATIONSHIPS PRESENT POTENTIAL FOR ABUSE

Amendments proposed in S. 2534, S. 2676, and H. R. 11461 would require HMOs to publicly disclose third-party relationships which could adversely affect HMOs' financial soundness or reasonableness of payments to related organizations. We support this proposed requirement.

Six of the HMOs we evaluated have third-party relationships. Five were tied to insurance companies and one to a partnership composed of HMO officers. The relationships involved interlocking boards of directors, financial assistance,

management and marketing services, and facilities and equipment leases. We found no evidence of fraud; however, some relationships present the possibility of adverse effects. On the other hand, we also recognize that these relationships may have benefited the HMOs by providing

--management with expertise in the health insurance industry,

--financial assistance which otherwise might not have been available, and

--entrepreneurial initiative without which certain HMOs might not have been established.

Several examples of the relationships follow.

Example 1

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

In 1976, 5 of the HMO's 25-member board of directors were on the BC or BS boards of directors. BC's president served as the HMO's executive director for about 3 weeks in 1977. He said that the HMO's board of directors felt that a full-time executive director was not needed. Therefore, the board's executive committee recommended that he be appointed executive director, contingent on a legal determination that there would be no conflict of interest. The executive committee apparently recognized a possible conflict of interest and decided to promote the HMO's associate director to executive director. Before coming to the HMO in 1972, he had about 17 years experience with another BC organization.

The HMO has contracted with BC-BS to provide most administrative services including personnel, purchasing, accounts payable, general accounting, data processing, and subscriber contract administration. The HMO pays for the services based on an allocation of BC-BS's administrative expenses. The HMO has the right, but has not done so, to audit BC-BS's records.

BC-BS performs marketing services for the HMO. The HMO's marketing manager coordinates the HMO's sales effort with BC-BS and reports to the HMO's executive director. However, the HMO's two full-time marketing representatives report to the BC-BS vice president for marketing. According to the executive director, the HMO's representatives market to only new employee groups, while the BC-BS staff markets to employee groups that already offer the HMO as a health benefit option. The HMO's former executive director advocated an independent HMO marketing staff because he felt that the HMO lacked advocacy and that competition was limited.

Example 2

In 1973 the HMO signed a 5-year management services agreement with Prudential Insurance Company of America, and in 1977 the agreement was extended through mid-1979. Prudential manages the HMO on a day-to-day basis and provides consultant assistance. The HMO's executive director and controller are Prudential employees. For these management services, the HMO pays Prudential 150 percent of the salaries of the Prudential employees and a monthly fee of $1,000. In mid-1978 the monthly fee will be increased to $3,000. Prudential has made various consultant services available to the HMO including actuarial, accounting, legal, marketing, and loan services. Prudential has loaned the HMO a total of $1.5 million.

Example 3

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

In 1973 the partnership leased a tract of land from the partner who is the HMO's president and borrowed about $1.1 million to build a health center large enough to serve about 40,000 members. In mid-1974, the HMO leased the building and agreed to pay all costs associated with the building, including principal and interest on the building mortgage, taxes, insurance, and maintenance.

The HMO applied for Federal qualification 6 months after leasing the health center. In the application, the HMO estimated that it could break even by mid-1978 with

10,000 members--about 30,000 less than the center's capacity. The HMO now estimates that by December 1981 it will have about 20,400 members, or about 20,000 members less than capacity. This means the HMO has been paying for unused space since it opened and will continue to pay for excess capacity for at least several years.

As of June 1976, the HMO's balance sheet showed that it had purchased furniture and office equipment with Federal grant funds at a cost of about $12,600. All medical equipment and some office equipment used by the HMO had been leased from the partnership; however, neither the HMO nor the partnership could provide an equipment inventory listing which segregated grant-purchasing equipment from partnership equipment. As a result of poor control over equipment, about $2,300 of grant-purchased equipment had been mistakenly included in the equipment lease agreement between the HMO and the partnership. The HMO, therefore, had been paying rent on its grant-purchased equipment. To correct the error, the partnership agreed to lease an additional $20,000 of equipment to the HMO at no charge for about 1 year.

CONCLUSIONS

Eight of the HMOs we evaluated have a fair to good chance of achieving financial independence within 5 years after qualification, and 6 have a poor chance. Our evaluations focused primarily on their managerial adequacy and ability to break even within 5 years. However, it should be remembered that an HMO may not generate enough surplus after breaking even to repay its Federal loan, replace facilities, or finance future growth. HMOs which cannot achieve financial independence within 5 years after qualification will probably need continued Federal financial assistance.

The 14 HMOs generally encountered a cost floor of about $30 to $35 per member per month, and we believe some HMOs are too optimistic about their ability to maintain monthly costs near the $30 level through 1980. Unless the HMOs can achieve efficiencies and economies of scale which may be available by reducing their dependence on the fee-for-service system, their costs per member generally will rise during 1978-80. In addition, some HMOs may have endangered their financial soundness by underpricing their services over a relatively long period in order to be competitive. As a result, some HMOs which have been qualified for as long as 3 years face the prospect of having to raise subscriber rates substantially to overcome not only inflation, but a wide gap between costs and revenues per member.

Based on our evaluations, we have reached several general conclusions about factors which affect the ability of HMOs to become financially independent.

--HMOs which depend heavily on health care resources in the fee-for-service sector lack control over a significant portion of their costs. HMOs may control their utilization of these resources, but do not control managers in the fee-for-service sector who make decisions affecting cost, efficiency, and effectiveness.

--An HMO's pricing strategy is as important as cost control. Consistently underpricing services to be competitive may be expedient in the short term but can lead to difficulties in the long term. In our opinion, in the short term, an HMO generally should be able to establish subscriber rates which will generate at least enough revenue per member to cover variable costs. If because of competitive pressures an HMO cannot establish rates which will cover variable costs, the HMO may eventually face a gap between revenues and costs so large that it cannot increase its rates enough to close the gap and break even.

--Effective management is critical for an HMO's success. As an independent enterprise, an HMO must be able to adequately control costs and utilization, budget and plan for the future, and market its services. Federal loans should not be used to subsidize poor management but to establish well-planned, well-managed business entities. Properly trained managers are needed.

--Although third-party relationships may aid HMOs, the relationships may present possibilities for abuse which could harm an HMO's financial soundness. The potential for minimizing adverse effects of third-party relationships on an HMO's operations exists through public disclosure.

RECOMMENDATION TO THE SECRETARY OF HEW

The Secretary of HEW should develop guidelines governing third-party relationships in HMOs.

RECOMMENDATION TO THE CONGRESS

S. 2534 proposes a training program to develop HMO managers. We recommend enactment of this program. S. 2534, and S. 2676, and H. R. 11461 propose requirements for public disclosure of third-party relationships or transactions which could adversely affect an HMO's financial soundness. We recommend enactment of such requirements. (See p. 62 for comments on provisions which would expand the HMO loan program.)

AGENCY COMMENTS AND OUR EVALUATION

In its general comments, HEW stated that it believed that our projections regarding the HMOs' likelihood of success was made at too early a stage of their progress to firmly determine their ultimate success. We recognize the uncertainties inherent in attempting to predict whether developing organizations can achieve financial success. However, we believe that the financial and managerial issues which we identified in reviewing the 14 individual HMOs provide a basis for reaching conclusions as to whether an HMO has a reasonable chance of achieving financial viability.

Moreover, with regard to the six HMOs about which we expressed doubts as to their ability to achieve financial independence, HEW stated that it had issued notices of noncompliance to three of the six HMOs based on their failure to maintain fiscally sound operations and that it was reevaluating the other three HMOs and had asked them for updated financial reports.

HEW concurred with our recommendation that guidelines should be established for third-party relationships. HEW stated that written rules are now being developed and will be published in the Federal Register as they are approved.

HEW also concurred with our conclusion that there is a need for a training program to develop HMO managers, but it did not concur with our recommendation that the Congress enact the training program proposed by S. 2534. HEW believes the training can be accomplished under existing authorities.

We continue to believe that good management is such an important part of the continued development of the HMO concept that it warrants the enactment of a special program to develop highly-skilled HMO managers.

CHAPTER 5

WHAT IS THE EFFECT OF DUAL CHOICE ON EMPLOYERS?

Section 1310 (the dual choice provision) of the HMO Act, as amended, requires certain employers to offer their employees the option of enrolling in a qualified HMO. The provision applies to employers who (1) employ at least 25 persons in the service area of a qualified HMO, (2) are required to pay the minimum wage, and (3) offer a health benefit program to their employees. An employer does not have to contribute more to the cost of an HMO plan than it contributes to other health benefit plans.

To determine the effect of the dual choice requirement on employers' costs, we interviewed 247 employers, 187 of whom were offering dual choice. We also contacted officials of 20 local unions to determine their views toward the HMO concept or the act.

The employers we contacted reported no significant effect on their costs from offering dual choice, and HMOs have not relied heavily on the dual choice requirement to market their plans. Unions' reactions toward HMOs were mixed but mostly favorable.

ECONOMIC EFFECT ON EMPLOYERS HAS BEEN NEGLIGIBLE

As of June 1977, 13 of the HMOs we reviewed had signed a total of 1,458 group contracts with employers who had 25 or more employees. 1/ The employers had a total of about 706,000 employees; about 49,000 were enrolled in the HMOs. The HMOs' success in enrolling individuals who work for employers with 25 or more employees is summarized on the following page.

1/We included no data for one HMO because information on numbers of employees was extremely limited. For another HMO, data is for June 1976, because June 1977 data was not readily available.

Size of firm (by number of employees)	Number of firms offering dual choice	Total number of employees	Number of employees enrolled in the HMOs	Percentage of employees enrolled in the HMOs
25-49	325	11,473	2,402	20.9
50-99	319	21,943	3,221	14.7
100-249	346	53,191	6,036	11.3
250-499	197	67,881	5,906	8.7
500-999	130	87,939	6,258	7.1
1,000 or more	141	463,947	25,107	5.4
Total	1,458	706,374	48,930	6.9

Offering dual choice has not significantly affected employers' costs for employee health benefit programs. Of the 187 employers who offered dual choice, 159 said their contributions for employees' participation in health benefit plans had remained the same or decreased. One hundred thirty-three employers indicated that they made fixed contributions regardless of which plan employees chose.

Only 22 employers claimed that dual choice had increased administrative costs of their health benefit programs. However, most employers had noticed no change in administrative costs. Some employers stated that administrative costs had decreased because they no longer had to process insurance claims for employees enrolled in HMOs.

Because the HMO concept embraces preventive medicine, employers with employees who join HMOs theoretically could benefit indirectly through decreased illness-related, employee absences. However, none of the employers we interviewed provided any evidence that HMO members were absent less because of illness. It should be recognized, though, that about 70 percent of these employers had offered dual choice for less than 2 years and over 50 percent for less than 1 year. In our opinion, several years' experience is necessary before a meaningful absence trend could be developed.

Dual choice has not significantly affected employers' relationships with alternative health benefit plans. Only 3 of 187 employers said that relationships with alternative plans had been affected adversely.

HMOs HAVE NOT EMPHASIZED THE DUAL CHOICE REQUIREMENT

HMOs generally have not emphasized employers' legal obligation to offer dual choice. Only 2 of the 187 employers said that an HMO had used the dual choice requirement to pressure them into offering the HMO. Under HEW regulations, an employer is not required to offer dual choice unless an HMO has requested in writing that the employer offer the HMO as a health benefit option.

All of the HMOs had sent some written requests to employers. The number of requests ranged from 3 to 3,000. Some HMOs had written all employers subject to the act, while others had written only reluctant employers who required "encouragement." After gaining access, the HMOs generally had stressed their plans' benefits and requested employer support, probably because an HMO will enroll few employees without it. None of the HMOs had taken formal legal action to force employers to offer dual choice.

We believe the dual choice requirement has helped HMOs' marketing efforts. Forty-three employers said they had offered dual choice primarily or solely because of the requirement. Of 60 employers who were not offering dual choice, 20 said they would offer dual choice only because of the law.

Thirty-eight employers resented the dual choice requirement. Some characterized the requirement as additional Federal "interference" in their businesses.

UNIONS' ATTITUDES TOWARD HMOs ARE GENERALLY FAVORABLE

Section 1310 of the act, as amended, does not compel unions to offer dual choice to union members. It directs employers to offer dual choice to employees' collective bargaining representatives; however, the representatives are not required to accept the offer.

Of the twenty unions contacted, seven did not express either favorable or unfavorable opinions. Thirteen favored the HMO concept or the act because it:

--Stresses preventive medicine and potentially can reduce medical care costs.

--Gives employees the ability to choose the health plan best suited to their health needs.

Five unions had been instrumental in the initial development and/or funding of three HMOs we evaluated. Another union planned to sponsor a federally qualified HMO by mid-1978.

One HMO we evaluated had experienced significant problems with unions. Local unions' officials said unions in the HMO's service area had expressed strong resistance to the HMO because of conflicts between the HMO and the unions' officials, not weaknesses in the HMO plan or the HMO Act. Only two unions had group contracts with the HMO, and only about 600 members were eligible under these contracts. The unions' officials said they knew of no restrictions that would prevent them from offering dual choice. They mentioned that one union had presented the HMO plan at a membership meeting, but that after a local union leader said local policy permitted selection of only one health plan, union members chose their present carrier.

CONCLUSION

From statements given by employers contacted during our review, we conclude that the dual choice requirement has not had a significant effect on employers' costs. HMOs have not emphasized the dual choice requirement in marketing their plans, and unions generally have reacted favorably toward HMOs.

CHAPTER 6

QUALITY ASSURANCE PROGRAMS

Section 1301(c)(8) of the act requires HMOs to have organizational arrangements for an ongoing program to assure the quality of health services. HEW regulations state that quality assurance programs must

--stress health outcomes to the extent consistent with the state-of-the-art;

--provide a method for physicians and other health professionals to review health care delivery processes;

--systematically collect data on services provided and patient results, provide interpretation of such data to practitioners, and institute needed change; and

--meet standards of a Professional Standards Review Organization (PSRO) established under the Social Security Act for services provided by hospitals and other operating health care facilities or organizations.

The HMOs we evaluated had been certified by HEW as meeting the requirements of the act and regulations; however, during our evaluations, we noted that:

--Quality assurance programs varied among HMOs.

--HMOs' quality assurance programs were not necessarily in place when they began operating as qualified HMOs.

--Standards for quality assurance programs were still in the development stage.

QUALITY ASSURANCE PROGRAMS VARY

The HMO Act and HEW regulations provide a broad framework for designing a quality assurance program. The framework emphasizes health outcomes, health care delivery processes, collection and interpretation of health care data, and PSRO standards. However, as discussed later, there is no body of knowledge from which HMOs can identify commonly accepted, specific ways for dealing with the first three areas.

In the fourth area, PSROs have not developed standards on the total care provided by HMOs. PSRO activities have focused mainly on short-term hospital care; however, the HMOs we evaluated do not control the hospitals which provide inpatient care to their members. They rely on local hospitals to furnish inpatient care. Additionally, PSRO review of outpatient care is not required by law. HEW has funded several demonstration projects to develop guidelines for reviewing outpatient care, but, as of January 1978, guidelines had not been completed.

Lacking a common base of knowledge from which to work, HMOs have incorporated a variety of features in their quality assurance programs, including peer review committees, outcome review systems, pharmacy committees, automated data management systems, professional standards committees, clinical data systems, drug profile systems, and membership surveys.

QUALITY ASSURANCE PROGRAMS NOT IN PLACE FROM BEGINNING

At the time of qualification, each HMO had made plans for an ongoing quality assurance program, but this does not mean that each had fully implemented its plans at the time it started operating as a qualified HMO. As of June 1977, only 7 of the 14 HMOs had fully implemented their programs. We recognize that it may be unrealistic to expect all HMOs--regardless of size or age--to have a fully functioning program immediately after qualification. However, we believe that HEW should closely monitor each HMO's progress toward full implementation and should establish a target date for each HMO to have its program fully implemented.

STANDARDS FOR QUALITY ASSURANCE PROGRAMS ARE STILL IN THE DEVELOPMENT STAGE

Although HEW is responsible for certifying that HMOs meet the requirements of the act, HEW has not finalized formal procedures for determining whether an HMO's system for assuring the quality of inpatient and outpatient services complies with the act. In early 1978, the Office of HMO Qualification and Compliance prepared a draft version of standards dealing primarily with outpatient care and methods for assessing compliance, but, as of March 1978, the final version had not

been issued. 1/ As of mid-February 1978, HEW had not made site visits to any qualified HMOs to assess their compliance with the quality assurance provisions of the act.

Section 4 of the HMO Act authorized $10 million for HEW to contract for a comprehensive study of quality assurance programs with the following objectives.

--Analyze past and present mechanisms for assuring quality health care, identify strengths and weaknesses of major prototypes of quality assurance systems, and compare the costs of such prototypes.

--Establish basic principles (the scope of systems, methods for assessing care, data requirements, specifications for developing criteria relating to desired outcomes of care, and ways to assess responsiveness of care to consumer needs) to be followed in effective quality assurance systems.

--Assess programs designed to improve performance of health care providers and institutions.

--Define the specific needs for a program of research and evaluation of quality assurance methods.

--Provide methods for assessing quality of care from the consumers point of view.

HEW has awarded one contract under section 4. In June 1975, HEW contracted with the Institute of Medicine of the National Academy of Sciences for a limited version of the study described in section 4. HEW awarded a 12-month, $300,000 contract to the Institute to accomplish the following objectives.

--Describe and assess the effect of operational quality review programs, based on existing written information and supplemented by information obtained in selected site visits.

--Review in detail literature on several topics designated as "priority areas" because of their importance in

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1/The draft version is based on an accreditation survey for outpatient care developed by the Accreditation Council for Ambulatory Health Care, a national organization representing health care provider associations.

determining (1) effectiveness of quality assurance programs and (2) the absence of reviews that integrate and analyze relevant information. 1/

--Assess the reliability of certain hospital utilization data to determine its usefulness for evaluating the impact of PSROs.

The Institute's final report, issued in November 1976, described existing quality assurance programs and recommended areas for further study. The report did not provide specific criteria for assessing the adequacy of quality assurance programs, but it set forth the following general characteristics of an ideal quality assurance system:

--The existence of an organizational entity for assessing quality of care.

--The establishment of standards or criteria against which quality is assessed.

--A routine system for gathering information on a representative sample of the total population of patients or potential patients.

--A process for providing the results of review to patients, the public, providers, and sponsoring organizations.

--Methods for instituting corrective action.

CONCLUSIONS

While the HMO Act and Federal regulations provide a broad framework for HMO quality assurance programs, HEW and, therefore, HMOs still lack specific, definitive standards for these programs. As a result, HMOs have designed programs which include a variety of features. To become qualified, an HMO must have a planned quality assurance program; however, many of the HMOs we evaluated had not fully implemented their programs at the outset of operations. As of early 1978, HEW had not made site visits to assess HMOs' compliance with

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1/The "priority areas" included outcome-oriented approaches to quality assurance for outpatient care and long-term care, methods for changing behavior patterns of health care providers, and patient and consumer involvement in quality assurance programs.

quality assurance requirements and had not finalized procedures for assessing compliance.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to develop and disseminate guidelines for designing HMO quality assurance programs and to implement a procedure for reviewing HMOs' compliance with the requirements.

AGENCY COMMENTS

HEW concurred with our recommendation and stated that a comprehensive compliance plan, including guidelines for quality assurance, has been developed. HEW expects the guidelines--with appropriate forms, systems, and procedures--to be in place within 3 months.

CHAPTER 7

MORE NEEDS TO BE DONE TO IMPLEMENT THE HMO ACT

In September 1976, we reported that several aspects of HEW's implementation of the HMO Act had hampered program development. The problems included (1) fragmented responsibility and uncoordinated efforts in implementing the program, (2) not enough staff with needed expertise to administer the program effectively, and (3) slow issuance of final regulations and guidelines for implementing and enforcing the act.

In March 1978, in testimony before the Subcommittee on Health and Scientific Research, Senate Committee on Human Resources, HEW acknowledged these problems and said that it had taken, or planned to take, steps to correct these problems and revitalize the HMO program. However, because many of the corrective actions were too recent for positive results to have developed, we still have some of the same concerns we reported in 1976.

ORGANIZATION AND STAFFING

The 1976 HMO amendments required HEW to centralize all program responsibilities, except qualification and compliance functions, under one organizational unit. As stated in the House report on the 1976 amendments, 1/ the central unit's responsibilities should include directing activities of regional personnel. In December 1977, HEW centralized the HMO headquarters program, including qualification and compliance functions, within the Office of the Assistant Secretary for Health, but the reorganization did not address regional office responsibilities. Effective March 1, 1978, HEW appointed a director for the centralized headquarters program and one of his responsibilities will be to deal with the use of regional staff.

HEW still does not have the numbers and types of personnel needed to implement the HMO program effectively. As we reported in 1976, few regional offices employ personnel with needed expertise because few people with this knowledge in marketing, actuarial analysis, and financial management, and

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1/House of Representatives Report No. 94-518, dated Sept. 26, 1975, p. 11.

with broad HMO knowledge are willing to work at the grade levels and salaries offered. This raises questions about the ability of regions--which are the initial contact points for potential HMOs--to monitor HMOs effectively and provide technical assistance.

Lack of staff with needed expertise also has been a continuing problem in the headquarters operation. One publicized problem has been delays in the HMO qualification review process. Several HMOs have had to wait for more than a year for a decision on their qualification applications. In mid-1977, HEW had a backlog of 51 pending applications, but by March 1978, HEW had reduced the backlog to 29 by bringing in personnel from the regions and temporarily assigning grant and loan program personnel to this process. HEW plans to reduce the average waiting period for a decision on an application from 180 to 120 days.

Qualification delays have not only affected HMO development adversely, but have also increased program costs. Investigative staff of the House Appropriations Committee noted recently that almost $4 million in additional grant funds had been spent to sustain HMO grant projects until their qualification applications could be processed.

We also found problems in loan program administration. As of mid-February 1978, the HMO loan branch had no formal, uniform loan policy and had only two staff members--a loan officer and a program analyst--to review loan applications and prepare loan award documents. In addition, the chief of the compliance branch of the Division of HMO Qualification and Compliance which is responsible for monitoring the financial performance of HMOs with Federal loans said he does not have enough staff to systematically monitor qualified HMOs. He characterized the compliance function as one of "putting out fires," allowing little time for advance planning and preparation. Moreover, as of mid-March 1978, HEW had not drafted regulations to implement the compliance program required under the HMO Act. As a result, HEW's compliance policy has evolved on an ad hoc basis, rather than in a systematic fashion.

An important objective of the compliance program should be to minimize fraud and abuse in the HMO program. The importance of this objective was highlighted in October 1977 by the enactment of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) which apply to HMOs with Medicare or Medicaid contracts. HEW's compliance program

must assure that qualified HMOs serve Medicare and Medicaid recipients properly and effectively.

In February 1978, the Senate Appropriations Committee approved HEW's request for 37 new HMO program positions, increasing authorized positions from 138 to 175. Thirty-six of these positions are allocated to the qualification and compliance office and none to the loan branch.

STATUS OF REGULATIONS AND PROGRAM GUIDELINES

In 1976, we reported that delays in issuing final regulations and guidelines had hampered HMO program development. In June 1977, to issue regulations implementing the 1976 HMO amendments, HEW issued interim regulations dealing with HMO organizational and operational requirements, qualification, and financial assistance. Interim regulations have the force of law and enable the HMO program to work while final regulations are being prepared. As of June 8, 1978, final regulations had not been issued. (See p. 60.)

In 1976, we reported that HEW had not issued guidelines to clearly define requirements for HMOs. As stated in our report, an internal HEW study has noted that the absence of guidelines has hindered the program because "rules of the game" are not clear to HMOs. As of February 1978, HEW still had not issued the necessary guidelines. Examples of issues that HEW needs to address in guidelines are open enrollment and community rating. (See pp. 8 and 18.)

CONCLUSIONS

HEW has taken some steps to deal with HMO program management problems which we reported in 1976. However, most of the actions are either too recent to guage their effectiveness or not comprehensive enough to correct the problems. That is, HEW has (1) centralized the headquarters program under a newly appointed director but has not resolved the question of regional staff use, (2) allocated new positions to the qualification and compliance office which is understaffed but no new positions were allocated to the loan branch which, we believe also is understaffed, and (3) issued interim regulations to implement the 1976 amendments but has not issued final regulations and guidelines defining requirements for HMOs.

STATUS OF HEALTH MAINTENANCE ORGANIZATION REGULATIONS AS OF JUNE 8, 1978

TITLE OF SUBPART OF REGULATIONS	DATE OF ISSUANCE							
	HMO ACT OF 1973		HMO AMENDMENTS OF 1976					
			INITIAL REGULATIONS			REVISED REGULATIONS		
	NPRM (note a)	Final	NPRM (note a)	INTERIM	FINAL	NPRM (note a)	INTERIM	FINAL
A. Requirements for an HMO	b/5/ 8/74	10/18/74	-	6/ 8/77	-	(c)		
B. Federal Financial Assistance: General	5/ 8/74	10/18/74	-	6/ 8/77	-	3/17/78		
C. Grants for Feasibility Surveys	5/ 8/74	10/18/74	-	6/ 8/77	-		2/10/78	(d)
D. Grants and Loan Guarantees for Planning and Initial Development Costs	5/ 8/74	10/18/74	-	6/ 8/77	-		2/10/78	(d)
E. Loans and Loan Guarantees for Initial Operating Costs	5/ 8/74	10/18/74	-	6/ 8/77	-		2/10/78	(d)
F. Qualification of HMOs	e/12/ 9/74	8/ 8/75	-	6/ 8/77	-		-	(f)
G. Restrictive State Laws and Practices	5/ 8/74	10/18/74	-	-	-		-	(g)
H. Employee's Health Benefit Plans	2/12/75	10/28/75	-	4/25/78	-	(d)	-	
I. Continued Regulation of HMOs and Other Entities	9/17/76	-	-	-	(c)		-	
J. Reconsiderations and Hearings	9/17/76	-	-	-	(h)		-	

Additional Regulations for the HMO Program	Original	Revised	
Designation of Medically Underserved Areas and Population Groups (note i)	9/ 2/75	10/15/76	
Indian Health Prepayment Authority	-	-	
Definition of Services and Payments for Medicare/Medicaid Programs			2/10/78

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a/Notice of Proposed Rulemaking.

b/HEW began its grant award program after the publication of this notice, advising applicants that they would be bound by the final regulations.

c/Publication expected soon.

d/Draft with Office of General Counsel.

e/HEW began its qualification program after publication of this notice, but only for HMOs qualifying for initial development grant and loan guarantees to expand and for loan support of initial operating costs. Applicants were also advised of their commitment to conform with the final regulations.

f/Revision of Part 110.605 is being considered with respect to evaluation and determination of qualification. Changes will depend on Subpart J.

g/No changes under consideration.

h/Need for regulations being considered in light of HMO amendments.

i/A list of medically underserved areas and the methodology for their identification and a summary of the comments of comprehensive health planning agencies on the applications of the methodology.

NOTE: Interim and final regulations both have the force of law. Interim regulations unlike final regulations, however, are issued in order to have some formal rules until final regulations are formulated.

RECOMMENDATIONS TO THE SECRETARY OF HEW

HEW has committed itself to restructuring and revitalizing the HMO program, and, as part of this effort, we recommend that the Secretary of HEW

--obtain additional staff with needed expertise for regional offices and the loan branch, as well as the qualification and compliance office;

--issue all final regulations and guidelines needed to administer the nationwide HMO program more effectively and uniformly, with special emphasis on guidelines and regulations about compliance, open enrollment, community rating, and fraud and abuse; and

--issue a formal, uniform loan policy for administering the loan program.

RECOMMENDATIONS TO THE CONGRESS

Amendments to the HMO Act proposed in S. 2534 and S. 2676 would increase the ceiling on operating loans from $2.5 to $5.0 million. Additionally, S. 2534, S. 2676, H. R. 11461, H. R. 9788, and H.R. 11388 propose a loan program for HMO outpatient care facilities. An expanded loan program undoubtedly would help some HMOs, however, HEW has not developed a formal, uniform loan policy, nor has it effectively monitored HMOs' financial performance. As discussed in chapter 4, we have substantial doubts about the financial soundness of six of the HMOs we evaluated. We believe the Government should not be exposed to greater financial risk until HEW demonstrates the ability to adequately manage the existing loan program. Accordingly, we recommend that the Congress defer action on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program.

AGENCY COMMENTS AND OUR EVALUATION

HEW concurred with our recommendations to the Secretary and made the following comments:

--Recruitment of staff to fill the 37 new positions is underway, primarily to meet the needs of the qualification and compliance functions, but additional positions (number unspecified) will be added to the loan

branch. Also, a high priority has been given to improving the definition of the appropriate regional staff role.

--HEW has implemented a plan to issue all final regulations and guidelines by about October 31, 1978.

--Draft loan policies have been developed which are being reviewed by the Public Health Service loan policy officer.

HEW disagreed with our recommendation that the Congress defer action on proposals to increase total loans available to HMOs until HEW demonstrates it can effectively administer the existing loan program. HEW pointed out that, although it has not developed a formal uniform loan policy and has not effectively monitored some HMOs' financial performance, improvements and changes are already in process. HEW also stated that:

--The present maximum loan amount may be reasonable under present circumstances for operating losses. Additional loan funds should be available for construction or equipment purchases, particularly in light of comments in the report pointing out that staff and group model HMOs are generally more effective in operation. These types of HMOs are the ones most in need of construction funds.

--Its experience has shown that staff and group model HMOs are experiencing extreme difficulty in financing the construction and equipping of ambulatory care facilities. Construction authority and increasing the maximum loan amount would significantly benefit these new HMOs.

--It is also important to note that the available loan amount of $2.5 million was set in 1973 and has not been modified in spite of the fact that national health care expenditures have escalated from $77 billion in that year to about $140 billion last year.

Although we concur with HEW that increased loan availability for HMOs would be beneficial, we continue to believe that the Government should not be exposed to additional financial risk until HEW

--issues a formal, uniform HMO loan policy;

--demonstrates that it can effectively monitor HMOs' financial performance; and

--obtains needed additional staff for the HMO loan branch.

APPENDIX I

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

JUN 22 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Can Health Maintenance Organizations be Successful?--An Analysis of 14 Federally Qualified Health Maintenance Organizations." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX I

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ON THE COMPTROLLER GENERAL'S DRAFT REPORT ENTITLED, "CAN HEALTH MAINTENANCE ORGANIZATIONS BE SUCCESSFUL? -- AN ANALYSIS OF 14 FEDERALLY QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS"

GENERAL COMMENTS

We agree with many of the findings in the report and think that it is generally accurate in its evaluation of the 14 qualified health maintenance organizations (HMOs) at the time they were examined. However, we think some of the projections regarding the likelihood of HMO success have been made at too early a stage in the HMOs' progress to firmly determine their ultimate success. While the report is valuable for highlighting some issues, we believe that the General Accounting Office (GAO) was required to evaluate particular areas of operation before the HMOs had sufficient operating experience upon which to base valid generalized observations. The report recognizes that an HMO is a private business with an independent board of directors and, as such, is subject to problems typical of new enterprises. After three years of assessing organizations for qualification, we are now in a position to comprehensively evaluate applicants using our past experience. A new organizational structure for the entire program, combined with recently approved additional positions for qualification, is expected to result in a high HMO success rate. In addition, $1.8 million of existing funds has been reprogrammed for technical assistance and other support activities.

GAO RECOMMENDATION

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to develop and disseminate guidelines for use by HMOs in implementing the community rating requirement of the HMO Act.

DEPARTMENT COMMENT

We concur. Although we have during the past 18 months consistently applied a proper interpretation of community rating, this interpretation has not been available in written guidelines. Such guidelines are now being written and will be formally distributed in approximately 2 months.

GAO RECOMMENDATION

The Secretary of HEW should direct the Assistant Secretary for Health to develop criteria for approving and disapproving requests for waiver of the open enrollment requirement.

DEPARTMENT COMMENT

We concur. Such criteria are being established in the form of guidelines to take effect July 1, 1978.

APPENDIX I

GAO RECOMMENDATION TO THE CONGRESS

We recommend that the Congress defer action on proposals intended to stimulate Medicaid and Medicare enrollments until HEW demonstrates that it could effectively administer proposed changes in the reimbursement methods and implement an effective compliance program.

DEPARTMENT COMMENT

We do not believe that the Congress needs to defer action on the proposed HMO reimbursement reform.

The Department is publishing in the Federal Register a draft compliance plan and notice of a public hearing to take comments on the plan on July 5 and 6. By August 1, a compliance plan will be finalized which will more than meet the statutory requirement. In addition, the Department has expressed support in its response to the Senate Permanent Subcommittee on Investigations of several new legislative authorities and plans to undertake administrative actions to strengthen our compliance program.

Based on our past experience with cost reimbursement under Medicare, we are committed to developing methods which would result in prospective setting of reimbursement rates which are reasonable. HMO rate setting methodology under Medicare and Medicaid should be based upon the following principles:

1. Prospective rate setting Medicare and Medicaid HMO rates should be prospective. The HMO should be fully at risk and there should be no retroactive adjustments to the rate once it has been established.

2. Adjusted community rate setting - Medicare and Medicaid HMO rates should be based upon the community rate established for the HMO's general population. The community rate should be adjusted to reflect the special benefits and demographic characteristics of the Medicare and Medicaid population.

3. Rates established lower than corresponding fee-for-service costs - Federal and State governments should pay HMOs, on the average, no more than they pay to the fee-for-service sector.

4. HMO savings should accrue to public beneficiaries - Some of the cost savings that will result from Medicare and Medicaid beneficiaries choosing an HMO should be translated into increased benefits and/or lower costs to enrollees. This should provide a strong incentive to join HMOs and would reward beneficiaries for their choice of efficient delivery mechanisms.

To this end, we proposed legislation which would mandate a standard method for determining rates of reimbursement to HMOs under Medicare and Medicaid which embody these principles. We have discussed our proposed reimbursement method with several legislative staff members and Members of Congress and are considering revisions to meet their concerns.

In addition, the Department has offered assistance to States in the determination of a proper rate of reimbursement to HMOs under Medicaid. This assistance is being provided by a contractor. Further, a demonstration grant to the State of California has resulted in manuals which will assist States in more accurately determining the fee-for-service costs for Medicaid enrollees.

As stated elsewhere in the Department's comments, guidelines for establishing community rates are now being written and will be formally distributed in about two months.

GAO RECOMMENDATION

The Secretary of HEW should develop guidelines governing third-party relationships in HMOs.

DEPARTMENT COMMENT

We agree that written rules should be established for allowable third-party relationships. Such rules are now in process of development and will be published in the Federal Register as they are approved.

GAO RECOMMENDATION TO THE CONGRESS

S. 2534 proposes a training program to develop HMO managers. We recommend enactment of this program.

DEPARTMENT COMMENT

We concur in the need, but believe that the training can be accomplished under existing authorities.

GAO RECOMMENDATION

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to develop and disseminate guidelines for designing HMO quality assurance programs and to implement a procedure for reviewing HMOs' compliance with the requirements.

DEPARTMENT COMMENT

We concur. A comprehensive compliance plan, including guidelines for quality assurance, has been developed. We expect these guidelines, with appropriate forms, systems and procedures, to be in place within 3 months.

GAO RECOMMENDATION

We recommend the Secretary of HEW obtain additional staff with needed expertise for regional offices and the loan branch, as well as for the qualification and compliance office.

DEPARTMENT COMMENT

We concur. Recruitment of the staff to fill the 37 new positions is in progress, primarily to meet the needs of the qualification and compliance functions. Additional positions will be added to the loan branch also. A high priority has been given to the improved definition of the appropriate regional staff role as a basis for this analysis.

GAO RECOMMENDATION

We recommend the Secretary of HEW issue all final regulations and guidelines needed to administer the nationwide HMO program more effectively and uniformly, with special emphasis on guidelines and regulations regarding the subjects of compliance, open enrollment, community rating, and fraud and abuse.

DEPARTMENT COMMENT

A plan has been implemented to complete issuance of all final regulations and guidelines by approximately October 31.

GAO RECOMMENDATION

We recommend the Secretary of HEW issue a formal, uniform policy for administering the loan program.

DEPARTMENT COMMENT

We concur. Draft Public Health Service (PHS) loan policies and specific HMO program loan policies have been developed and are currently being reviewed by the PHS loan policy officer. This review will be expedited as consistent with thoroughness and accuracy to permit early implementation of these policies.

In addition, the Department has made other legislative recommendations with respect to monitoring the loan fund designed to require loan recipients to maintain funds in separate accounts and to report on expenditures of such funds to the Department.

GAO RECOMMENDATION TO THE CONGRESS

Amendments to the HMO Act proposed in S. 2534 and S. 2676 would increase the ceiling on operating loans from $2.5 to $5 million. Additionally, S. 2534, S. 2676, H.R. 11461, H.R. 9788, and H.R. 11388 propose a loan program for HMO outpatient care facilities. An expanded loan program undoubtedly would help some HMOs; however, HEW has not developed a formal, uniform loan policy; HEW has not effectively monitored HMOs' financial performance; and, as discussed in chapter 4, we have substantial doubts about the financial soundness of 6 of the HMOs we evaluated. We believe the Government should not be exposed to greater financial risk until HEW demonstrates the ability to adequately manage the existing loan program. Accordingly, we recommend that the Congress defer action on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program.

APPENDIX I

DEPARTMENT COMMENT

GAO is correct that a formal, uniform loan policy has not been developed, and that some HMOs' financial performance has not been effectively monitored. However, we do not agree that the amendments should be deferred. Improvements and changes are already in process.

The amendments are needed because publication of PHS and HMO program loan policies is imminent. Active recruitment and training of additional compliance officers is in progress. All regulations for the program will be issued and arrangements have been made within the Office of HMOs to expedite the issuance of new regulations and guidelines as these are necessitated by new statutory authorities. These needed amendments should not be delayed.

While the present maximum loan amount may be reasonable under present circumstances for "operating losses," additional loan funds should be available for necessary construction, equipment, et cetera. This is particularly true in the light of the comments in the report pointing out that staff and group model HMOs are generally more effective in operation, and they are the ones most in need of construction funds.

Our experience has shown that staff and group model HMO's are experiencing extreme difficulty in financing the construction and equipping of ambulatory care facilities. Construction authority and increasing the maximum loan amount would significantly benefit these new HMO's.

It is also important to note that the available loan amount of $2.5 million was set in 1973 and has not been modified in spite of the fact that national health care expenditures have escalated from $77 billion in that year to about $140 billion last year.

Taken together, these factors argue stongly for an increased level of operating deficit support which must be coupled with a higher level of compliance surveillance than has existed in the past. The compliance capacity is now being built. With the increased ceiling requested for operating deficit loans, it will be possible to attain the twin goals of substantially increased HMO service availability and protection of the financial interests of the Federal Government.

With respect to the fiscal soundness of the 6 HMOs about which GAO has doubt, the Department has issued a notice of non-compliance under the provisions of Section 1312 to 3 of them, based on their failure to maintain a fiscally sound operation. These 3 are HMOs cited by GAO as having a poor chance of achieving breakeven. The 3 remaining HMOs are being reevaluated and have been requested to furnish updated financial reports.

APPENDIX II

QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS
RECEIVING FEDERAL FINANCIAL ASSISTANCE UNDER
THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973, AS AMENDED
THROUGH DECEMBER 31, 1977

Region	Organization	Grants				Direct Loans	Total Assistance
		Feasibility	Planning	Initial Development	Total		
I	Connecticut Family Health Care Bridgeport, Conn.	$ -	$ 103,492	$ 967,550	$ 1,071,042	$ 2,500,000	$ 3,571,042
I	Community Health Care Center Plan New Haven, Conn.	-	-	362,461	362,461	2,090,000	2,452,461
I	Rhode Island Group Health Association, Providence, R.I.	50,000	-	a/1,492,255	1,542,255	2,500,000	4,042,255
II	Central Essex Health Plan East Orange, N.J.	-	93,145	951,462	1,044,607	2,178,000	3,222,607
II	Group Health Plan of New Jersey Guttenberg, N.J.	45,000	125,000	a/1,063,145	1,233,145	2,478,000	3,711,145
II	Health Care Plan of New Jersey Moorestown, N.J.	-	124,995	a/787,784	912,779	1,771,000	2,683,779
II	Rutgers Community Health Plan New Brunswick, N.J.	-	125,000	1,000,000	1,125,000	2,000,000	3,125,000
II	Capital Area Community Health Plan Albany, N.Y.	-	a/315,464	970,409	1,285,873	1,832,000	3,117,873
II	Genesee Valley Group Health Association, Rochester, N.Y.	-	-	298,500	298,500	2,500,000	2,798,500
II	Manhattan Health Plan, Inc. New York, N.Y.	49,876	125,000	999,611	1,174,487	2,500,000	3,674,487
II	Westchester Community Health Plan White Plains, N.Y.	-	114,902	1,000,000	1,114,902	2,500,000	3,614,902
III	Georgetown University Community Health Plan, Washington, D.C.	-	-	884,251	884,251	1,982,000	2,866,251
III	Group Health Association Washington, D.C.	50,000	-	-	50,000	-	50,000
III	Penn Group Health Plan, Inc. Pittsburgh, Pa.	-	-	602,439	602,439	1,000,000	1,602,439
III	Health Maintenance Organization of Pennsylvania, Elkins Park, Pa.	42,906	108,235	663,965	815,106	2,500,000	3,315,106
III	Health Service Plan of Pennsylvania Philadelphia, Pa.	-	-	-	---	2,213,000	2,213,000
IV	Florida Health Care Plan Daytona Beach, Fla.	-	-	124,456	124,456	2,058,000	2,182,456
IV	Health Care of Louisville Louisville, Ky.	-	120,566	a/ 894,715	1,015,281	2,500,000	3,515,281
V	North Communities Health Plan Evanston, Ill.	-	-	a/ 478,618	478,618	1,250,000	1,728,618
V	Anchor Organization for Health Maintenance Chicago, Ill.	34,005	-	704,723	738,728	-	738,728
V	Metro Health Plan of Indianapolis Indianapolis, Ind.	-	-	-	---	1,264,000	1,264,000
V	Health Central, Inc. Lansing, Mi.	50,000	121,084	1,000,000	1,171,084	2,500,000	3,671,084
V	Group Health Plan of S.E. Michigan Detroit, Mi.	-	227,129	996,371	1,223,500	2,500,000	3,723,500
V	SHARE Health Plan St. Paul, Minn.	50,000	-	a/ 525,000	575,000	850,000	1,425,000
V	Marion Health Foundation Marion, Ohio	-	-	a/ 419,115	419,115	681,000	1,100,115
V	Group Health Cooperative of South Central Wisconsin Madison, Wis.	-	250,000	1,000,000	1,250,000	2,500,000	3,750,000
VII	Community Group Health Plan (Prime Health) Kansas City, Mo.	-	112,381	1,000,000	1,112,381	2,273,000	3,385,381
VIII	Choice Care Health Services Fort Collins, Colo.	-	-	a/ 280,837	280,837	728,000	1,008,837
VIII	Colorado Health Care Services, Inc. Denver, Colo.	-	-	a/ 548,617	548,617	1,413,000	1,961,617
VIII	Rocky Mountain Health Maintenance Organization, Grand Junction, Colo.	-	-	192,937	192,937	332,000	524,937
VIII	Family Health Program Salt Lake City, Utah	-	-	211,716	211,716	-	211,716
IX	MaxiCare Hawthorne, Calif.	-	a/ 169,592	-	169,592	-	169,592
IX	Family Health Services Pomona, California	-	-	-	---	2,500,000	2,500,000
IX	Foundation Health Plan Sacramento, Calif.	-	-	710,215	710,215	2,292,000	3,002,215
IX	Health Alliance of Northern California, San Jose, Calif.	-	120,488	601,736	722,224	2,342,000	3,064,224
X	IEN Health Association Boise, Idaho	-	124,934	1,000,000	1,124,934	1,747,000	2,871,934
X	Portland Metro Health Plan Portland, Oregon	-	-	455,188	455,188	2,500,000	2,955,188
X	Cooperative Health Plan of Greater Spokane Spokane, Wash.	50,000	122,500	494,940	1,172,480	2,500,000	3,672,480
X	Sound Health Association Tacoma, Wash.	-	-	304,738	304,738	[illegible]	1,304,738
	Total	$ [illegible]	$2,903,905	$ [illegible]	$27,517,868	$ [illegible]	$ [illegible]

a/Includes expansion grants as follows: 3 projects received feasibility expansion grants totaling $396,533; 2 projects received planning expansion grants totaling $1,244,979; and 3 projects received initial development expansion grants totaling $360,261.

APPENDIX II

EXAMPLES OF FACTORS AFFECTING GAO CONCLUSIONS ABOUT HMOs' ABILITY TO BECOME FINANCIALLY INDEPENDENT WITHIN 5 YEARS AFTER QUALIFICATION

HMO	Management problems	Monthly cost per member in 1977 (note a)	Monthly revenue per member in 1977 (note a)	1977 Cost-revenue difference per member: Monthly	1977 Cost-revenue difference per member: Percent of excess cost over revenue	Cost curve characteristics: Recent trend: Direction	Recent trend: Number of months observed	Recent trend: Change (in percent)	Overall trend: Direction	Overall trend: Number of months observed
1	Yes	$36.02	$28.64	$ 7.38	25.8	Up	6	+ 7.0	Leveling	30
2	Yes	35.68	27.99	7.69	27.5	Up	3	+15.9	Leveling	27
3	No	25.86	22.09	3.77	17.1	Up	3	+16.0	Leveling	27
4 (note d)	No	36.46	26.30	10.16	38.6	Down	6	-11.5	Down	12
5 (note e)	Yes	30.09	22.90	7.19	31.4	Down	3	- 9.4	Leveling	30
6 (note f)	No	35.68	23.82	11.86	49.8	Up	3	+ 2.3	Down	21
7 (note g)	Yes	38.64	29.50	9.14	31.0	Up	3	+ 6.4	Leveling	24
8 (note h)	No	34.36	27.32	7.04	25.8	Down	6	- 4.2	Down	16
9	No	31.44	29.27	2.17	7.4	Up	12	+13.0	Up	27
10	No	35.01	32.58	2.43	7.5	Up	12	+15.9	Up	27
11	No	28.04	24.89	3.15	12.7	Up	12	+11.5	Up	24
12 (note i)	Yes	29.12	23.38	5.74	24.6	Up	3	+ 7.2	Leveling	12
13 (note j)	No	29.29	28.19	1.10	3.9	Up	3	+ 2.5	Leveling	24
14 (note k)	Yes	32.54	22.82	9.72	42.6	Down	6	-12.6	Up	18

a/ Cost and revenue data is based on data from 1977 unaudited quarterly reports submitted by HMOs to HEW under the HMO National Data Reporting Requirements (OMB No. 68R-1496).

b/ The 5, 10, and 15% columns show what the HMO's year-5 costs per member per month will be if its 1977 costs per member per month increase at these rates through year 5.

c/ These are the annual percentage increases in revenue per member per month needed to meet the projected year-5 costs per member per month shown in the adjacent columns to the left.

d/ Because of HMO 4's downward cost trend, we assumed cost per member per month would decrease to $31.00 for 1978 and then begin to increase during 1979-1981.

e/ Because of HMO 5's overall and recent cost trend experience, we assumed cost per member per month would remain at $30.09 during 1978 and then begin to increase during 1979 and 1980.

f/ Because of HMO 6's down overall cost trend, we assumed cost per member per month would decrease to $32 for 1978 and then begin to increase during 1979 and 1980.

g/ Because of HMO 7's overall cost trend, we assumed cost per member per month would remain at $38.64 during 1978 and then begin to increase during 1979 and 1980.

h/ Because of HMO 8's downward cost trend, we assumed cost per member per month would decrease to $33 for 1978 and then begin to increase during 1979-1981.

i/ Data for 1977 is for the 12-month period ended 9/77. Data for quarter ended 12/77 was not available.

j/ For the quarter ended December 1977, HMO 13 did break even.

k/ Because of HMO 14's recent cost trend experience, we assumed cost per member per month would be about $31 during 1978 and would begin to increase during 1979 and 1980.

APPENDIX II

Projected costs per member per month during fifth year after qualification at different rates of increase (note b)			Annual percentage increase in revenue needed to break even in fifth year at different rates of increase (note c)			National average annual percentage increase in medical care consumer price index 1973 - 1977	HMO expects additional fixed cost	Percent of costs paid to fee-for-service providers (note a)	Year 5-year period ends
5 percent	10 percent	15 percent	5 percent	10 percent	15 percent				
$41.70	$47.94	$54.78	13.3	18.7	24.1	10.5	Yes	48	1980
39.34	43.17	47.19	18.6	24.2	29.9	10.5	Yes	31	1979
29.94	34.42	39.33	10.7	15.9	21.2	10.5	Yes	46	1980
35.99	41.26	47.15	8.1	11.9	15.7	10.5	No	31	1981
33.17	36.41	39.79	13.2	16.8	20.2	10.5	Yes	24	1980
35.28	38.72	42.32	14.0	17.6	21.1	10.5	No	31	1981
42.60	46.75	51.10	13.0	16.6	20.1	10.5	No	69	1980
38.20	43.92	50.19	8.7	12.6	16.4	10.5	No	73	1981
36.40	41.85	47.82	7.5	12.7	17.8	10.5	Yes	42	1980
40.53	46.60	53.25	7.5	12.7	17.8	10.5	Yes	34	1980
32.46	37.32	42.65	9.2	14.5	19.7	10.5	Yes	36	1981
35.40	42.63	50.93	10.9	16.2	21.5	10.5	Yes	37	1981
33.91	38.98	44.55	6.4	11.4	16.5	10.5	No	79	1980
34.18	37.51	41.00	14.4	18.0	21.6	10.5	Yes	47	1981

PRINCIPAL OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office			
	From		To	
SECRETARY OF HEW:				
Joseph A. Califano, Jr.	Jan.	1977	Present	
David Mathews	Aug.	1975	Jan.	1977
Caspar W. Weinberger	Feb.	1973	Aug.	1975
ASSISTANT SECRETARY FOR HEALTH:				
Julius Richmond	June	1977	Present	
James F. Dickson (acting)	Jan.	1977	June	1977
Theodore Cooper	May	1975	Jan.	1977
Theodore Cooper (acting)	Feb.	1975	Apr.	1975
Charles C. Edwards	Mar.	1973	Jan.	1975
ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION:				
George I. Lythcott	Sept.	1977	Present	
John H. Kelso (acting)	Jan.	1977	Sept.	1977
Louis M. Hellman	Apr.	1976	Jan.	1977
Robert Van Hoek (acting)	Feb.	1975	Apr.	1976
Harold O. Buzzell	July	1973	Jan.	1975

(102028)