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The Health Maintenance Organization (HMO) Act of 1973 provided for a trial Federal program to develop alternatives to traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMO's. Through May 31, 1978, the Department of Health, Education, and Welfare (HEW) had awarded \$151.5 million in grant and loan assistance under the act to 215 organizations--\$71.3 million in grants and \$80.2 million in loans. Two additional organizations received loan guarantees for \$2.2 million. HEW considers 131 of the 215 organizations to be active grantees or active loan recipients. As of June 20, 1978, there were 63 federally qualified HMO's. A review of 14 HMO's indicated that each was generally providing health services in the manner required by the act and that each was generally organized and operated in the manner prescribed. The 14 HMO's, however, had not expended extensive effort to enroll elderly, indigent, or medically high-risk people. Three of the 14 HMO's reviewed have a good chance of being able to operate without Federal financial assistance within 5 years after qualification; 5 HMO's have a fair chance; and 6 have a poor chance. Of the six HMO's with a poor chance of operating without Federal assistance, three have received notices of noncompliance from HEW. Concern remains regarding HEW's ability to issue regulations and guidelines needed to implement the act effectively and uniformly and to organize the HMO program and obtain the numbers and types of personnel needed. Although the financial assistance proposed by H.R. 13266 could benefit HMO's, there are reservations about expanding the loan assistance because HEW has not demonstrated the ability to effectively monitor and administer the loan program already in effect. (RRS)

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Statement of
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Subcommittee on Health and the Environment
Committee on Interstate and Foreign Commerce
House of Representatives
on the
Implementation of the
Health Maintenance Organization
Act of 1973, as Amended

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss our current review of the implementation of the Health Maintenance Organization (HMO) Act of 1973, as amended. This review was initiated to satisfy the requirements placed on GAO by section 1314 of the HMO Act and to respond to the specific directives contained in the Senate report on the Health Maintenance Organization Amendments of 1976. In addition, I have a few comments on the HMO Act amendments proposed by H.R. 13266.

THE HEALTH MAINTENANCE ORGANIZATION
ACT OF 1973, AS AMENDED

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

Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMOs.

The original act spells out in considerable detail, the definition of and requirements for an HMO. Among other things, the act specified basic and supplemental health services to be provided to the HMO members, the basis for fixing the rate of prepayment, the requirement th HMOs have open enrollment periods for individual members without restrictions (such as on pre-existing medical conditions), and the organizational structure of an HMO. The original act authorized a 5-year demonstration program designed to promote the development of new HMOs and the expansion of existing HMOs by

- providing financial assistance through grants, contracts, and loans;
- providing a market for HMOs by requiring certain employers to offer employees the option of joining a qualified HMO (dual choice); and
- removing restrictive State laws and practices which could serve to hinder the development and operation of a qualified HMO.

The Health Maintenance Organization Amendments of 1976, (90 Stat, 1945) increased the flexibility of HMOs qualified

under the act with regard to basic and supplemental health services, options for staffing and organization, and waivers and delays of imposing open enrollment and community rating requirements. These amendments also increased the funding limits for the grant program and extended the period for use of loan funds to cover operating cost deficits from 36 months to 60 months.

BASIS FOR AND
SCOPE OF GAO REVIEW

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

- evaluate HMOs in regard to their ability to provide prescribed health services; meet organizational and operational requirements; enroll as members the indigent, the high-risk, and the medically underserved; and operate without continued Federal assistance;
- report on the effects of requiring certain employers to offer their employees the option of enrolling in a qualified HMO; and
- evaluate and compare HMOs with other forms of health care delivery.

The act, as amended in 1976, stipulated that we evaluate at least 10 or one-half (whichever is greater) of the HMOs federally qualified by December 31, 1976. At that time

27 HMOs were qualified by HEW and we have reviewed the activities of 14 of these HMOs. The act, as amended, required that we report on our review to the Congress by June 30, 1978. Our report has been issued and copies have been provided to you and the members of the Subcommittee.

PROGRESS IN
IMPLEMENTING THE ACT

Through May 31, 1978, HEW had awarded \$151.5 million in grant and loan assistance under the act to 215 organizations--\$71.3 million in grants and \$80.2 million in loans. Two additional organizations have received loan guarantees for \$2.2 million. Twenty-four of these organizations also received a total of \$8.6 million to develop HMOs under other sections of the Public Health Service Act prior to the passage of the HMO Act. HEW considers 131 of the 215 organizations to be active grantees or active loan recipients. None of the HMOs has defaulted on Federal loans or loan guarantees. There were 80 inactive grantee organizations, which had obtained grants totaling \$9.3 million. These latter organizations were either defunct or had obtained non-Federal financial support.

As of June 20, 1978, there were 63 federally qualified HMOs. Forty-five received more than \$117.7 million under this act, and two received loan guarantees. We can submit for the record a listing of the allocation of the

grant funds for feasibility studies and planning and initial development activities, and loans for operational assistance.

FINDINGS BASED
ON OUR REVIEW

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

In our evaluation of the HMOs' financial soundness, we focused mainly on the adequacy of management and on their ability to generate enough revenues to cover operating costs--or break even--within their first 5 years of operation.

as a qualified HMO. Although an HMO may break even, it must be recognized that breaking even does not automatically mean that an HMO can generate enough surplus revenue to repay its Federal loan, replace facilities, and finance future growth. If an HMO cannot repay its Federal loan on schedule and the Government delays repayment or forgives the loan, the Government in effect is continuing to assist the HMO financially.

We concluded that 3 of the 14 HMOs have a good chance of being able to operate without continued Federal financial assistance within 5 years after qualification; 5 HMOs have a fair chance; and 6 have a poor chance. Of the six with a poor chance, HEW has issued notices of noncompliance to three of them, based on their failure to maintain a fiscally sound operation. For one of the three, HEW has deferred \$216,000 of interest payments for calendar year 1978.

To determine the effect of the dual choice requirement on employers' costs, we interviewed 247 employers whose business establishments were within the targeted membership area of the 14 HMOs. Most were offering the HMO as a dual choice. The employers contacted reported no significant effect on their costs from offering the HMO as a health plan option. The employers informed us that the HMOs have not

used the dual choice requirement to force them to offer their plans but instead relied on marketing the merits of their plans. We also contacted officials of local labor unions to determine their views toward the HMO Act. The labor union reaction toward HMOs was mixed but mainly favorable.

No commonly accepted standards or techniques exist to evaluate quality of care provided by HMOs. Although HEW has been given the role of assuring the public that a qualified HMO delivers quality health care, HEW has not clearly stated its policy for determining the adequacy of an HMO's quality assurance program. However, HEW has told us that it has developed guidelines for quality assurance and that these guidelines, along with appropriate forms, systems, and procedures, will be in place by September 1978.

During our study we obtained descriptions of the quality assurance programs of each of the 14 HMOs and noted that the types of quality assurance programs varied. Further, we found that seven had not fully implemented their quality assurance programs.

IMPLEMENTING THE HMO ACT--
MORE NEEDS TO BE DONE

In our latest report to the Congress, we also commented on HEW's management of the program, and I will make a few statements regarding these matters.

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

Status of regulations
and program guidelines

Since our prior testimony and our September 1976 report, HEW has made a concerted effort to issue regulations in a timely manner. On June 8, 1977, HEW modified its regulation process by issuing interim regulations on requirements for and qualification of HMOs and financial assistance to HMOs. The issuance of interim regulations allowed HEW to implement the HMO Act, as amended, prior to resolving all the issues that would have to be covered in final regulations. As of June 22, 1978, final regulations had not been issued.

HEW's policies and guidance concerning the issues that arise when implementing the act and regulations are to be contained in program guidelines, but final guidelines concerning the organization and operation of an HMO have not been issued since the passage of the original act. As we reported in September 1976, HEW internally noted the harm to developing HMOs that was caused by the absence of these "rules of the game." HEW has told us that it plans to issue all final regulations and guidelines by about October 31, 1978.

Two examples of issues that need to be addressed in guidelines are open enrollment and community rating. The open enrollment requirement was greatly modified by the 1976 amendments by changing the time period during which the enrollment should occur and when the requirement was applicable. Secretarial waiver is still permitted. Although HEW has informed us that at least 11 HMOs would be required to have open enrollment this year, the Department has not prepared criteria for determining whether to grant an HMO a waiver from this requirement. However, HEW has told us that it is formulating waiver criteria which are to take effect on July 1, 1978.

The HMO Act also required HMOs to establish premiums based on a community rate rather than on an experience rate. HMOs must establish one community rate to spread

equally among all HMO members the costs for comparable coverage. As part of our review of the 14 selected HMOs we obtained descriptions of the different means by which each HMO translates community rating into a rate structure.

Confusion of what exactly constitutes community rating not only applies to those HMOs qualified by HEW but it also has posed problems for the Civil Service Commission in auditing the rates under the Federal Employees Health Benefits Program. As we noted in a report to the Civil Service Commission on January 23, 1978, we had concerns that the Civil Service Commission had not been able to determine the reasonableness and equity of the premium rates of the community-rated, comprehensive plans which provide services to Federal employees, like the Kaiser Plans in California. HEW told us on June 22, 1978, that it had consistently applied a proper interpretation of community rating during the past 18 months, although written guidelines had not been available, and that written guidelines on community rating would be issued in about 2 months.

Organization and Staffing

The 1976 HMO amendments required HEW to centralize all HMO program responsibilities, except for qualification and compliance, under one organizational unit. As stated

in the House report on the 1976 amendments, the central unit's responsibilities should include directing the activities of regional office HMO personnel. In December 1977, HEW centralized the headquarters program within the Office of the Assistant Secretary for Health, and on March 1, 1978, HEW appointed a Director-Designate of this centralized program. The December 1977 reorganization did not include the regional offices.

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

HEW has placed a high priority on addressing the issue of regional staff use.

Lack of staff with needed expertise also has been a continuing problem in the headquarters operation. To deal with this problem, the Administration requested 37 new

HMO program positions for fiscal years 1978-79 to increase total authorized personnel from 138 to 175. In February 1978, both the House and Senate Appropriations Committees approved the request.

One publicized aspect of the program resulting from the lack of staff 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 pending applications. In mid-1977, HEW had a backlog of 51 pending applications, but, by June 27, 1978, HEW had reduced the backlog to 31 by bringing in personnel from the regions and temporarily assigning grant and loan personnel to reviewing qualification applications. HEW plans to reduce the average waiting period for a decision on an application from 180 to 120 days.

Qualification delays have not only adversely affected HMO development, 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.

In a letter to the Chairman of the Senate Appropriations Committee in February 1978, HEW said that 13 of

the 37 newly authorized HMO program positions were allocated to the qualification function. As of June 27, 1978, HEW had filled none of the 13 positions.

Compliance officials who are responsible for monitoring HMO's compliance with the act and for monitoring the financial performance of HMOs with Federal loans have said that there are not enough staff to systematically monitor qualified HMOs. They characterized the compliance function as one of "putting out fires," allowing little time for advance planning and preparation. Moreover, as of June 22, 1978, HEW had not issued 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.

On June 22, HEW told us it was publishing in the Federal Register a draft compliance plan and notice of a public hearing to be held on July 5 and 6 to take comments on the plan. HEW plans to finalize the compliance plan by August 1, and its target for fully implementing the plan is January 1, 1979.

As of June 27, 1978, HEW had not yet hired a director for the compliance program and had not filled any of 24 planned positions for case officers and technical specialists. HEW's estimated completion date for recruiting the remainder of the compliance staff is November 1.

COMMENTS ON H.R. 13266

Increased financial assistance

I will now address H.R. 13266. Sections 2,5,6, and 9 provide for increased fund authorizations for existing sections of the HMO Act and call for new authority for new types of financial assistance. Under existing law, an HMO can obtain Federal financial assistance totalling \$4.65 million, of which \$2.5 million is available in the form of loans or loan guarantees to cover operating deficits. Under H.R. 13266, the maximum amount of Federal financial assistance would be \$9.65 million of which \$4 million would be available in the form of loans or loan guarantees to cover operating costs and \$2.5 million would be available in the form of loans or loan guarantees to acquire ambulatory care facilities.

We do not dispute the possibility that the additional financial assistance proposed by H.R. 13266 could benefit HMOs. However, we have reservations about expanding the loan assistance available to HMOs because HEW has not demonstrated the ability to effectively administer and monitor the loan program already in effect. As previously mentioned, we believe that some HMOs which have obtained Federal loans under existing authority are not financially sound.

During our review we found problems in loan program administration. We testified before this subcommittee on July 14, 1975, that HEW would "definitely need additional personnel as well as uniform policies and procedures" for the HMO loan program. However, as of June 22, 1978, the HMO loan branch remained understaffed and without a formal uniform loan policy. The loan branch's current staffing consists of a branch chief, one program analyst, and two support personnel. The branch chief told us that, under the existing loan program, he needs at least four program analysts and four support personnel to run the program effectively. He further stated that, if the proposed construction loan program for HMO ambulatory care facilities were enacted, he would need, at the minimum, seven program analysts and eight support personnel to handle the combined loan program effectively.

None of the 37 new positions approved by the House and Senate Appropriations Committees were allocated to the loan branch but HEW has told us that it plans to add an unspecified number of staff members to the loan branch. HEW also said that a proposed HMO program loan policy was being reviewed by HEW's Public Health Service loan policy officer and that the loan policy would be issued as soon as possible.

Financial disclosure

We support section 12 of H.R. 13266 which deals with financial disclosure because as a result of several reviews of Federal grant programs and the California prepaid health plans we believe there is a need for a clearer picture of the true costs and results of operation--including overall administrative costs and contractual inter-relationships--for entities that contract with or receive grants from Federal or Federal/State programs. Further, because of HEW's qualification and continuing regulation responsibilities, such disclosure would also be needed for entities that receive loan and marketing assistance (dual choice) under the act.

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

sanctions, such as dequalification, when it finds that third-party or self-dealing relationships have adversely affected an HMO.

Managerial training

Portions of section 10 of H.R. 13266 provide for an HMO management training program. We believe that there is substantial evidence of the need for managerial training for health maintenance organizations--including training to develop knowledgeable managers in the Federal program.

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