HMOs —The View from the Program

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THE HEALTH MAINTENANCE Organization Act of 1973 is almost uniquely complex. Many complicated issues existed which had to be resolved before the Health Maintenance Organization (HMO) Program could move forward. But now it is moving forward and, in my opinion, it is off to a good start. Funding regulations have been published, and the grant and loan programs are being initiated. The remaining regulations will be issued as notices of proposed rulemaking during calendar year 1975.

Although the authorizing legislation, Public Law 93–222, was not signed until December 1973, exactly 1 year ago from the date of this writing, implementation of the HMO Program within the Health Services Administration's Bureau of Community Health Services is moving right on target and on a logical schedule. Yet, because of the complexity of the HMO concept and its novel qualities, many misunderstandings have occurred pertaining to the implementation of the concept and some still occur. Perhaps it is now appropriate to step back and review from the perspective of our experience how we arrived where we are.

First of all, it behooves us to know exactly what an HMO is. An HMO is an organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

The concept is not new. The Ross-Loos Clinic in Los Angeles, Calif., began operating such a system of health care services in 1929. At about the same time a similar activity was initiated in Elk City, Okla. Growth of the movement was slow at first, but in the late thirties, the Group Health Association in Washington, D.C., began operation and was followed shortly by the Kaiser Health Plan in California and the Group Health Cooperative of Puget Sound in Seattle, Wash.

These organizations and others which subsequently joined the roster of prepaid group practice organizations have established excellent reputations as providers of high quality care within an organized system. Special care was taken to assure that the enrollees received the most appropriate services through the most appropriate providers. Emphasis was placed upon ambulatory care and preventive services in an effort to maintain the health of the enrollees and to minimize expensive inpatient acute care. As a result, because quality health care was available and readily accessible, the enrollees in these groups have been highly satisfied and health care costs have been contained with no sacrifice in the quality of the services provided.

Advantages

Substantial data have been accumulated in various studies to show that operation under a health maintenance organization format results in a reduction in days of inpatient care of approximately 50 percent, coupled with a substantial increase in the outpatient services and preventive services rendered to enrollees. Since hospital care is far more expensive than out-

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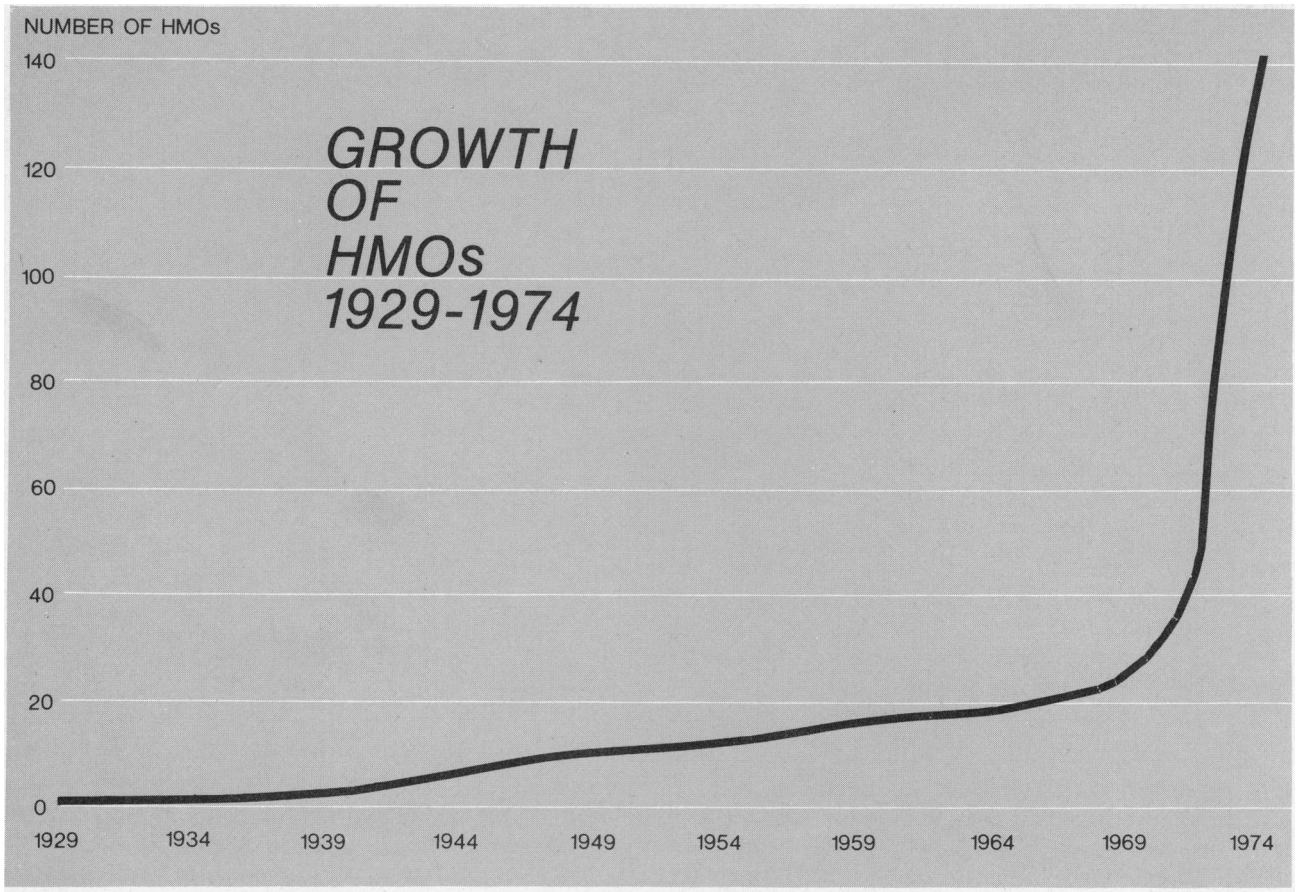

patient services and preventive services, all indications point to the fact than an HMO system significantly reduces the cost of health care without lowering the quality of care.

When health care costs accelerated rapidly in the period following implementation of the Medicare and Medicaid programs, a re-examination of the health care system appeared imperative. In the course of the analysis and during subsequent strategy sessions, the concept of HMOs was one of the principal suggestions that surfaced.

After thorough study, a decision was made to promote HMOs as a major Federal initiative. Former President Richard M. Nixon announced this initiative in his Health Message to Congress in February 1971. This is the key date in the growth of the HMO movement in terms of both the legislation and the health care industry.

Bills, Revisions, and Compromises

Legislatively, a series of bills was introduced in both Houses of Congress. One bill was introduced by the Administration, another by Edward Kennedy in the Senate, and still another by William Roy in the House of Representatives. These bills were examined thoroughly in the light of extensive public hearings and during discussions among persons from various elements of the health care industry. Legislative language was revised, compromises were achieved, and finally, in the late fall of 1973, the Health Maintenance Organization Act was passed by Congress, signed by the President, and enacted into law.

During that same period, from early 1971 to late 1973, an experimental program was undertaken in the Health Services and Mental Health Administration (HSMHA) Department of Health, Education, and Welfare, to determine how effectively HMOs could carry forward, in a variety of operational formats and environmental settings, the same quality of care and the same ability to contain costs that had been so amply demonstrated by the prototype organizations.

Of 79 organizations awarded grant funds for HMO development in this experimental program, 29 are now in operation and serving more than 150,000 people. In 35 instances the decision was reached—usually jointly by the sponsor and HSMHA—that an HMO activity would not be feasible in these particular settings. The remaining 15 organizations are completing the process of developing into operational HMOs.

Private Sector, State Activities

Announcement of the Federal initiative in the President's 1971 health message stimulated activity in the private sector. From 33 in February 1971, the number of operational HMOs has grown to 142. These organizations were created by physician groups, con-

sumer groups, hospitals, Blue Cross or Blue Shield organizations, or private carriers. More than 5 million people in the United States are served by these 142 HMOs. Figure 1 shows the sites of the HMO prototypes in existence before February 1971 and figure 2, the sites of all HMOs operating in October 1974.

The consideration and passage of HMO-enabling legislation also stimulated activity by individual States. As of December 1974, 19 States have passed HMO-enabling legislation, thus creating a climate—both nationally and locally—that is more supportive to HMO development and operation than it had been before. Fifteen States have also taken advantage of the benefits of HMO health care by contracting with HMOs to provide health care to Medicaid recipients. In this activity, California has taken the lead, and more than 250,000 Californians are now being served through this health care modality.

The States, the Federal establishment, and the operators of HMOs learned a great deal during the past 3 years that can be extremely beneficial as we move into the 5-year program authorized by Public Law 93-222. This act serves primarily to remove restrictive barriers that could have blocked the growth of the HMO movement. By removing these barriers, HMOs now have access to capital and markets and are freed from certain restrictive elements of State laws.

The Act

The HMO Act contains several main sections. Let us examine some of them, first briefly and then in a little more detail. In one section, a health maintenance organization is defined in terms of the services which it must render and the manner in which it must be organized and operated. Another spells out a series of authorities by which organizations can be supported in their development of HMOs through explicit phases of feasibility, planning, initial development, and initial operations. In addition, the act stipulates that every employer subject to section 6 of the Fair Labor Standards Act who employs 25 or more persons to whom a health benefits plan is offered, must, under certain specified circumstances, offer to those employees the option of membership in a qualified HMO. Another section of the act supersedes certain restrictive provisions of State laws which would have prevented the operation of otherwise qualified HMOs.

To be qualified under the act, an HMO must provide to its enrollees the following basic services without limits as to time or cost:

- Physician services, including consultation and referral
- Outpatient services
- Inpatient hospital services
- Medically necessary emergency health services
- Short-term outpatient evaluative and crisis intervention mental health services
- Diagnostic laboratory and diagnostic and therapeutic radiological services
- Home health services and preventive health services, including voluntary family planning services, infertility services, preventive dental care for children, and eye refractions for children

Payment for the services must be on a community-rated basis. Co-payments are permitted if they do not constitute a barrier to care. In addition, the act requires provision of certain supplemental services if manpower is available and members wish to contract for such services.

The supplementals include services of facilities for intermediate and long-term care; vision, dental, and mental health services; long-term rehabilitative services; and the provision of prescription drugs.

If these services are to be prepaid, then payment must also be on a community-rated basis. However, it is possible for the HMO to provide the supplemental services on a fee-for-service basis.

Organization and Operation of HMOs

With respect to organization and operation, the HMO must—

- Show fiscal soundness and provide provisions against insolvency
- Take full financial risk with only limited reinsurance
- Enroll persons broadly representative of the service area

Figure 1. Sites of prototypes of health maintenance organizations before February 1971

Figure 2. Sites of federally funded and other health maintenance organizations, October 1974

Figure 3. Sites of health maintenance organization projects under Public Law 93-222, by stage of development, October 1974

- Provide for open enrollment periods
- Not expel any member because of health status
- Have a policy-making body, of which at least one-third consists of members of the HMO
- Provide meaningful hearings and grievance procedures
- Show that is has satisfactory quality assurance arrangements
- Provide medical social services and health education for its members
- Provide continuing education for its health professionals

The HMO must also be able to report to the Secretary of Health, Education, and Welfare, to the public, and to its members data relative to the cost and utilization of the services which are provided.

The Building Mechanisms

In order to build an organization which will comply with the terms of this act, sponsors can receive several categories of support. The first of these is a feasibility grant. Feasibility grants are limited to $50,000; their purpose is to determine whether it is feasible to operate and market an HMO in the geographic area of concern. Once feasibility is demonstrated satisfactorily, the grantee is eligible for the next level of support—a planning grant. The maximum that a grantee can receive for planning is $125,000. During this phase the sponsor is required to perform the detailed planning of those tasks which will take him from feasibility to the point of implementation.

The next stage is that of initial development, which can be funded up to a limit of $1 million. During this phase, the features which were previously planned are put into effect. The health delivery system is assembled and the physicians and other professionals are brought on board, the organizational arrangements are completed, and the marketing strategy is implemented.

During the later phases of the development activity the nascent HMO can apply for qualification under the act. It must be able to demonstrate that it fully meets the requirements of the act in all aspects. Simultaneously, application can be made for support of initial operating deficits that the organization may encounter during the period of enrollment buildup. To be eligible for such a loan, which is set at a maximum of $2.5 million over a 3-year period, it is necessary that the organization be qualified. HMO sites by phase of development (feasibility, planning, initial development, and operating deficit) are shown in figure 3.

In the awarding of funds under the grant and loan authorities, several priorities must be observed. Two of these are legislated priorities: (*a*) that 20 percent of the funds expended shall be for projects in rural or non-metropolitan areas, provided a sufficient number of qualified applicants present themselves and, other things being equal, (*b*) that a project which will serve a medically underserved area will receive priority in the awarding of grants.

There are also administrative priorities to be observed. It is the intent of the program to spread HMO activity geographically and also to continue to support a pluralism among the various types of HMOs.

Congressional appropriations for fiscal years 1974 and 1975 made $37 million available to the program for grants and $35 million to capitalize the loan fund. The loan fund's capital is replenished by the sale of the HMO obligations to the Federal Financing Bank. Thus, a far greater scale of activity than the initial $35 million is possible.

Dual Option

The employees health benefits section of the act, sometimes known as the mandatory dual option section, does require that each employer operating under section 6 of the Fair Labor Standards Act, who employs 25 or more persons and provides them with a health benefits plan, must also offer these employees the option of membership in a qualified HMO which provides services in the area in which they reside. If there is more than one HMO in the area, then the option must include one of each type of HMO specified in the act, a group practice type and an individual practice type.

The employer is required to pay no more as the result of this section of the law, than he would otherwise be required to pay under his existing agreements. It is expected that implementation of this section of the act will go far toward improving the HMO's access to markets and will greatly assist in assuring the financial viability of these organizations.

An important provision of the legislation requires that, in order to gain the benefits of the mandatory dual option provision, any HMO which has been qualified under the act, or which has been funded under the terms of the act, will be subject to continuing regulation by the Federal Government to assure that it continues to live up to the standards which were established during its qualification.

State Laws

Because HMO development and operation has been inhibited in certain States in the past, the present bill contains a section concerning restrictive State laws and practices. Specifically, this section of the act supersedes any portion of a State law which would require:

- Medical society approval for the organization and operation of an HMO
- That a set number of physicians be members of the HMO governing body
- Participation in the delivery of services by all or a certain number of physicians in the area
- That the initial capitalization and financial reserves established by the organization to protect against its insolvency would be judged on the same basis as those of insurance companies

Furthermore, this section of the act stipulates that a State may not establish or enforce laws preventing an HMO from soliciting members through advertising or other nonprofessional aspects of its operation.

Program Structure and Accomplishments

The HMO program is being implemented by two units within the Health Services Administration. The developmental activities are centered within the Office for Health Maintenance Organizations of the Bureau of Community Health Services. Program activities are conducted through the operating divisions of the Bureau as well as through HMO staff in the regional offices of the Department of Health, Education, and Welfare. With respect to the qualification and continuing regulatory activities, it was deemed appropriate to set up a separate unit—a qualification/regulation unit—in the office of the administrator. In this way, the possibility of bias is removed from the area of qualification.

Accomplishments of the program to date include the development of the funding regulations which were published as a notice of proposed rulemaking May 8, 1974, and in final form October 18, 1974 (*1*). The notice of proposed rulemaking for qualification of HMOs was published December 9, 1974, (*2*) and the final regulations should be out early in 1975, possibly before publication of this article. The notices of proposed rulemaking for the mandatory dual option and for the continuing regulation may also be published early in 1975.

New and stringent criteria have been developed for evaluating funding applications under the terms of the act. These criteria are based on the act, the regulations, and also upon the experiences and observations in developing projects during the experimental phase which preceded the enactment of the legislation.

New reporting requirements appropriate to each phase of the activity have been formulated in order to track accurately the progress of projects and to determine which ones are eligible for advancement to the next phase of their development.

Several activities are in progress to coordinate HMO interests among the various elements of the Federal Government. The activities involve the Social Security Administration, with its provisions for HMO care for Medicare beneficiaries; the Social and Rehabilitation Service and State title XIX agencies concerned with HMO health care for Medicaid recipients; and the developing HMO programs of the Civil Service Commission and Civilian Health and Medical Program of the Uniformed Services. Uniform qualification and reporting requirements, regardless of the program involved, would be beneficial to the Federal Government as well as to the operating health maintenance organizations.

To date, two rounds of grant funding have been conducted and, as a result, 67 new organizations have begun the process of HMO development. Three more rounds are planned during the course of the 1975 fiscal year in an effort to open participation to greater numbers of people. As funded projects progress through the developmental stages, they will be accepted for advancement on an individual basis if they demonstrate conclusively they are indeed ready to embark upon the next phase of their operations.

It is the Program's intent during the next 4 years to establish at least 150 health maintenance organizations that will show the way for the private sector as it, too, takes part in the continued expansion of the availability of health care through HMOs.

National Health Insurance

Expansion of health care delivery capability through the advancement of HMO development will, I am certain, arrive in time to be of invaluable service to a national health insurance system when such legislation is enacted.

Each of the major national health insurance bills before the Congress includes a reference to the HMO as a legitimate entity for the delivery of health care services. When national health insurance does come into being, the expanded demands on the health services system will be better met because of the expanded capacity of HMOs.

With all the optimism concerning the contribution that successful HMOs can make to the health care industry—their ability to provide quality care with cost containment and efficiency and their ability to improve the accessibility and availability of health care—it must be remembered that the HMO is not a panacea for all health care problems. There may indeed be areas where the HMO may not be the most effective answer to some problems.

The HMO was advanced as an option, an option for those providers and those consumers who wish to take advantage of its benefits. It is intended to be one more valuable alternative among the choices that the citizens of this nation can make in determining how they wish to receive their health care. It is the objective of the Health Services Administration to make the alternative available to as many Americans as possible.

References

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