

DOCUMENT RESUME

07426 - [C2727824] (Restricted)

The Health Service Plan of Pennsylvania, Inc.: A Federally Qualified Health Maintenance Organization. HRD-78-86; B-164031(5). September 26, 1978. 20 pp. + 3 appendices (6 pp.).

Report to Sen. Edward M. Kennedy, Chairman, Senate Committee on Human Resources: Health and Scientific Research Subcommittee; Sen. Richard S. Schweiker, Ranking Minority Member, Senate Committee on Human Resources: Health and Scientific Research Subcommittee; Rep. Paul G. Rogers, Chairman, House Committee on Interstate and Foreign Commerce: Health and the Environment Subcommittee; Rep. Tim Lee Carter, Ranking Minority Member, House Committee on Interstate and Foreign Commerce: Health and the Environment Subcommittee; by Robert F. Keller, Acting Comptroller General.

Issue Area: Health Programs: Health Maint. Organization's Compliance with Law: their Viability as Alternative to fee-for-service mode of Producing Care (1214).

Contact: Human Resources Div.

Budget Function: Health: Health Care Services (551).

Organization Concerned: Department of Health, Education, and Welfare; Health Service Plan of Pennsylvania, Inc.

Congressional Relevance: House Committee on Interstate and Foreign Commerce: Health and the Environment Subcommittee; Senate Committee on Human Resources: Health and Scientific Research Subcommittee. Rep. Paul G. Rogers; Rep. Tim Lee Carter; Sen. Edward M. Kennedy; Sen. Richard S. Schweiker.

Authority: Public Health Service Act (P.L. 94-63); 42 C.F.R. 110. Health Maintenance Organization Act of 1973, as amended; Health Maintenance Organization Amendments of 1976.

The Health Service Plan of Pennsylvania, Inc. (HSP) is authorized under the laws of the Commonwealth of Pennsylvania to provide prepaid health services. In March 1976, HSP applied for certification as a qualified health maintenance organization (HMO), and in April 1976, the Department of Health, Education, and Welfare (HEW) transitionally qualified HSP. As a transitionally qualified HMO, HSP must implement a plan which provides for bringing subscriber contracts into compliance with the Health Maintenance Organization Act of 1973 within 3 years. Findings/Conclusions: HSP generally has met the organizational and operational requirements of the HMO Act. Its membership was not broadly representative of its area, however, and compliance with the community rating requirement was unclear because HEW has not yet published program guidelines. Because it is unlikely that HSP will hold open enrollment in the near future, HSP's membership will become more broadly representative only if it obtains contracts to service medicaid and medicare recipients. HSP has made considerable effort to identify and cultivate its market; its projections and revenues and expenses were soundly based, and actual operating experience as of June 30, 1977, was

better than originally projected. Employers who offer a dual choice generally reported no significant effect on their costs as a result of including HSP in their benefit programs. HSP fully implemented, and in some instances expanded, the quality assurance program described in its qualification application.

(RRS)

REPORT BY THE

7824

# Comptroller General

OF THE UNITED STATES

## The Health Service Plan Of Pennsylvania, Inc.—A Federally Qualified Health Maintenance Organization

The Health Service Plan of Pennsylvania, Philadelphia, Pennsylvania, provides health care to members through a contract with a corporation of physicians. As of March 31, 1978, the Plan had 11,956 members.

The Plan offers the specified health benefits and generally meets the organizational and operational requirements of the Health Maintenance Organization Act of 1973, except that its membership is not broadly representative of the population residing in its service area.

The Plan has a fair chance of operating independently—without Federal financial assistance—after its first 5 years of operation as a qualified health maintenance organization.





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

B-164031(5)

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

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

This report discusses our findings and conclusions on the Health Service Plan of Pennsylvania, Inc., Philadelphia, Pennsylvania, a federally qualified health maintenance organization. A draft report was sent to the organization for review and comment. We have included its comments in the report.

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

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

You later agreed that since the summary report had drawn together the major issues developed during our evaluation of the 14 health maintenance organizations, only limited benefits would be gained from our issuing separate reports on the remaining 10 health maintenance organizations. Rather, we will furnish you with information for the 10 health maintenance organizations in summary form and continue our monitoring of the Department of Health, Education, and Welfare's management of the health maintenance organization program.

B-164031(5)

We believe that the public disclosure of our discussion of several of the issues in this and the earlier reports may inadvertently and inappropriately have an adverse effect upon the health maintenance organizations' marketing capabilities and financial viability. Therefore, we have limited the distribution of this report, and unless released by the subcommittees, we will restrict public release of this and the three earlier reports.

  
ACTING Comptroller General  
of the United States

REPORT BY THE  
COMPTROLLER GENERAL  
OF THE UNITED STATES

THE HEALTH SERVICE PLAN  
OF PENNSYLVANIA, INC.--A  
FEDERALLY QUALIFIED HEALTH  
MAINTENANCE ORGANIZATION

D I G E S T

The Health Service Plan of Pennsylvania Philadelphia, Pennsylvania, has generally met the organizational and operational requirements of the Health Maintenance Organization Act of 1973, except that its membership has not been broadly representative of the various age, social, and income groups in its service area. The Plan has served either none or very few medically indigent persons--Medicaid recipients--or elderly/high-risk individuals--Medicare beneficiaries. (See pp. 6 and 7.)

A health maintenance organization provides health care services to its members based on prepaid rates. This, in turn, provides incentives for an organization to emphasize preventive medicine to reduce overall health care costs.

The Plan's operating experience has been better than originally projected. On this basis and in view of the large potential market, GAO believes the Plan has a fair chance of operating independently--without Federal financial assistance--after its first 5 years of operation as a qualified health maintenance organization.

Employers in the Plan's service area must include a health maintenance organization in their employees' health benefit plans. Most employers that GAO contacted said that differences in administrative costs were negligible--they paid no more for their employees to participate in the Plan than in other health plans. (See p. 15.)

The Plan has started the planned quality assurance program that was approved by the Department of Health, Education, and Welfare. (See p. 18.)

The Plan concurs with GAO's overall conclusions concerning quality assurance, benefits, and financial performance. However, it believes that it is premature to conclude that it does not meet the requirement for enrolling a broadly representative population. (See app. II.)

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

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ABBREVIATIONS

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

## CHAPTER 1

### INTRODUCTION

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

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

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

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

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

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

This evaluation concerns the Health Service Plan of Pennsylvania, Inc. (HSP), Philadelphia, Pennsylvania, and is one in a series of evaluations of HMOs to be made in compliance with the act. At the request of the Chairman

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

#### HEALTH SERVICE PLAN OF PENNSYLVANIA

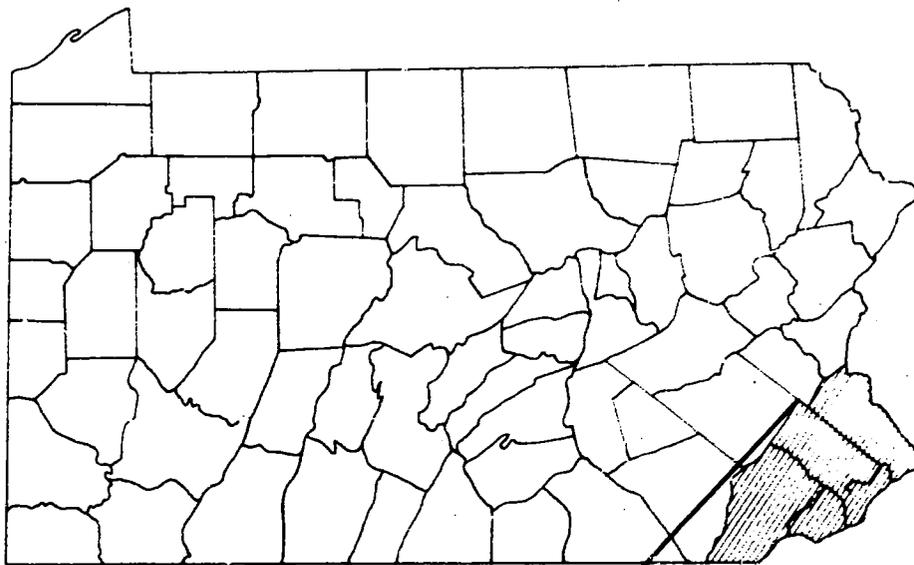
HSP was chartered as a nonprofit corporation in April 1970 and, under the laws of the Commonwealth, is authorized to provide prepaid health services. On April 1, 1974, HSP began providing prepaid services for about 180 subscribers who were employees of Hahnemann Medical College and Hospital.

In March 1975, HSP applied for certification as a qualified HMO, and in April 1976 HEW "transitionally qualified" HSP. As a transitionally qualified HMO, HSP is required to implement a time-phased plan which, within 3 years after qualification, provides for bringing subscriber contracts in effect on the date of qualification into compliance with organizational and operational requirements of the HMO Act.

Pennsylvania statutes permit HSP to provide health services anywhere in the Commonwealth, but HSP serves the residents of only a five-county area in southeastern Pennsylvania. The five counties are Philadelphia, Bucks, Chester, Delaware, and Montgomery. (See p. 3.) The estimated total population of these counties as of July 1, 1974, was about 3.8 million.

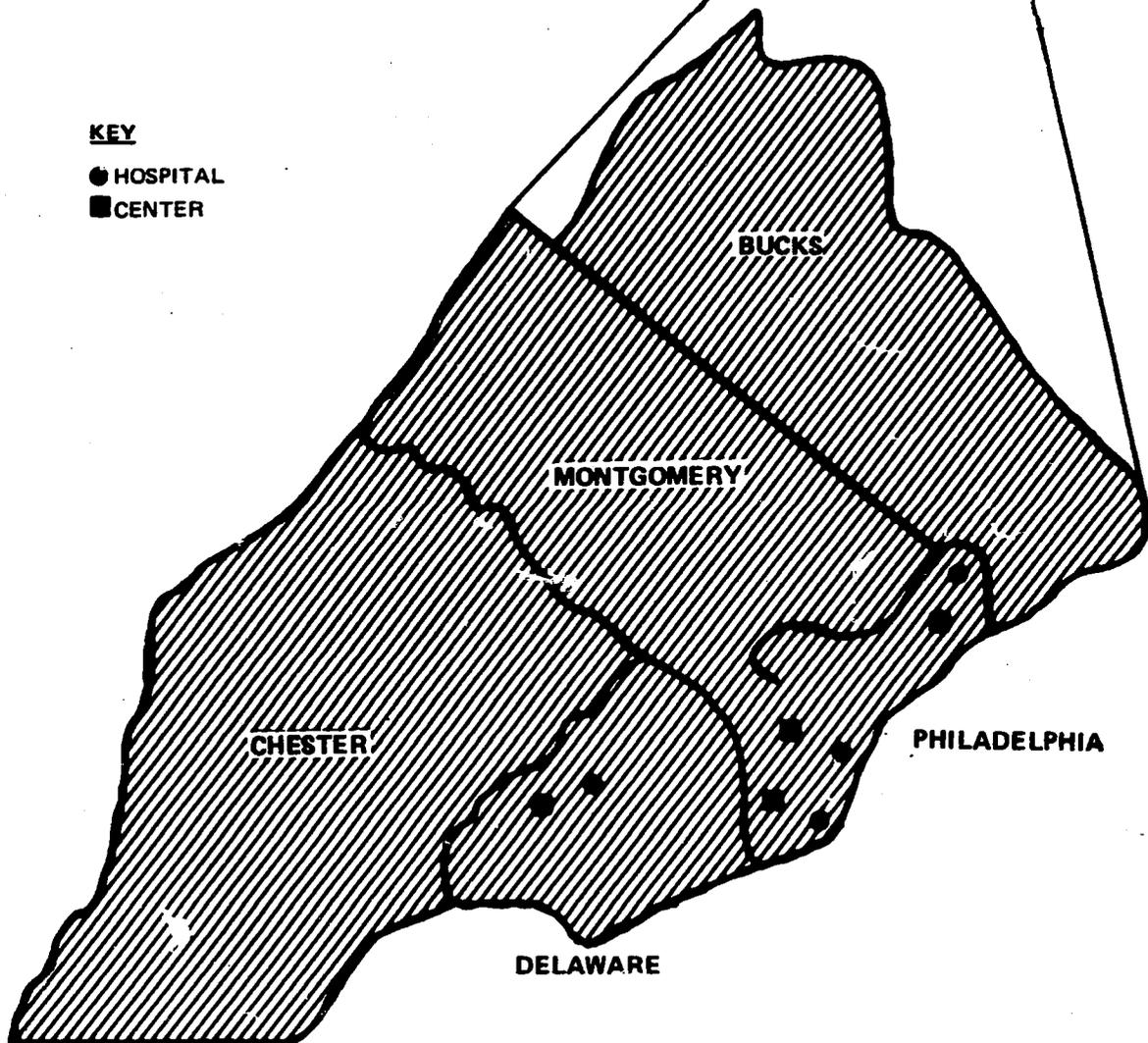
HSP is an administrative and marketing organization which contracts with five hospitals for the delivery of inpatient care and with a corporation of physicians for the delivery of outpatient care. The corporation provides outpatient care at four health centers which in total have the capacity of serving about 25,500 members. No services are provided on a fee-for-service basis. As of March 1978 HSP was serving 11,956 members (subscribers and their families) on a prepaid basis.

# HEALTH SERVICE PLAN OF PENNSYLVANIA SERVICE AREA



## KEY

- HOSPITAL
- CENTER



## FEDERAL FINANCIAL ASSISTANCE

Before the HMO Act, financial assistance was available to prepaid health plans under section 314(e) of the Public Health Service Act (repealed by Public Law 94-63). From January 1972 through June 1974, HSP received three initial development grants totaling \$508,507 under section 314(e).

The HMO Act authorized loans to help qualified public and nonprofit private HMOs meet their operating expenses during their first 36 months of operation. On May 10, 1976, HEW made a loan in the amount of \$2,213,000, effective April 1, 1976, to HSP.

## SCOPE OF EVALUATION

We made our review at the Health Services Administration Headquarters, Rockville, Maryland; HEW region III office, Philadelphia, Pennsylvania; and HSP.

To evaluate HSP's ability to meet the requirements and purposes of the act, we

- compared its organizational structure and provision of health services to related requirements set forth in the act and HEW regulations;
- determined what programs it had established to provide health services to medically underserved areas, high-risk individuals, and the medically indigent;
- compared its limited financial history to the financial projection it submitted in applying for a Federal loan;
- reviewed its financial projections and related assumptions to assess their reasonableness;
- interviewed selected employers which it had contacted regarding the offering of this plan as an alternative health benefit plan; and
- determined what program it had developed to assure and evaluate the quality of care provided to its members.

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

## CHAPTER 2

### HAS HSP BEEN ABLE TO MEET THE ORGANIZATIONAL AND OPERATIONAL REQUIREMENTS OF THE HEALTH MAINTENANCE ORGANIZATION ACT?

The HMO Act directs qualified HMOs to be fiscally sound, offer specified health benefits, and meet certain other organizational and operational requirements, including the use of a community rating system to develop subscriber rates. (See app. III.) HSP's financial viability is discussed in chapter 3. HSP offers the specified health benefits and generally meets the organizational and operational requirements of the act, except that its membership is not broadly representative of the population residing in its service area.

HEW has not published program guidelines for interpreting some operational requirements. For example, although HMOs must establish a community rating system for fixing periodic payments, HEW has not published guidelines to be used in developing such a system. (See p. 7.)

The HMO Act encourages--but does not require--HMOs to serve medically underserved areas. HSP has not directed its services to underserved populations within its service area. (See p. 9.)

### ENROLLMENT OF MEMBERS BROADLY REPRESENTATIVE OF ITS SERVICE AREA

Section 1301(c)(3) of the act requires an HMO to enroll persons broadly representative of the various age, social, and income groups within its service area. However, Federal implementing regulations do not define a "broadly representative" membership.

HSP had enrolled very few Medicare (high-risk) recipients and did not serve any Medicaid (medically indigent) recipients. These facts suggest that HSP does not have a membership broadly representative of the above mentioned groups in its service area.

One mechanism which can give all age, social, and income groups access to HSP membership is open enrollment. But, as a result of the 1976 HMO amendments, HSP is not required to offer open enrollment. (See p. 7.)

### Medicare recipients

As of January 1, 1977, HSP had only seven members eligible for Medicare. These members either enrolled in HSP during a limited open enrollment period held in 1970 or were converted from "under 65" plans when they became eligible for Medicare.

HSP's marketing efforts have been directed toward employer groups, and, in the absence of any open-enrollment periods or until the Pennsylvania Insurance Department approves the rate structure for its Medicare benefit package, additional "over 65" memberships will result only when individuals enrolled in existing group and nongroup plans become eligible for Medicare.

On January 5, 1977, HSP filed a proposed rate structure for a Medicare benefit package with the Pennsylvania Insurance Department. The program is a conversion plan for members who become eligible for Medicare benefits and who enroll in both hospital and medical services insurance of Medicare. In commenting on our draft report, HSP said that as of April 7, 1978, the rate structure had not been approved.

An HSP official said that HSP did not plan to enter into a contract with HEW to serve Medicare beneficiaries on a pre-paid basis.

### Medicaid recipients

In 1972 HSP anticipated receiving a contract from Pennsylvania's Department of Public Welfare to undertake a project in west Philadelphia to provide prepaid services to about 10,000 Medicaid recipients. However, the Department awarded contracts to two other prepaid health plans in the area.

HSP's executive vice president said that in November 1976 he requested that Commonwealth officials include HSP as a health service provider for Medicaid recipients. However, the officials said that, because of a shortage of funds, the Commonwealth was not expanding its involvement in pre-paid health plans in the Philadelphia area.

In April 1977, the Commonwealth invited HSP to submit a proposal to provide health services to Medicaid beneficiaries in south Philadelphia. HSP declined the request because of unsatisfactory contract stipulations, such as the Commonwealth's designating a specific catchment area from which

the HMO could enroll Medicaid beneficiaries. HSP's president expects the terms of the proposed contract to be changed, and HSP will respond if the changes are satisfactory.

#### No open-enrollment period

Prior to being amended, section 1301(c)(4) of the act required HMOs to have a 30-day period of open enrollment annually, unless an HMO obtained a waiver from HEW. To obtain a waiver, an HMO had to show that, among other considerations, open enrollment would jeopardize its financial viability.

In October 1976, about 6 months after HSP became qualified, the President signed the 1976 HMO Amendments which relaxed open-enrollment requirements. The act, as amended, now requires open enrollment for only those HMOs that

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

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

Without these changes, HSP would have been required to hold a 30-day open enrollment by the end of March 1977 or obtain a waiver from HEW. But, as a result of the amendments, HSP will not be required to hold open enrollment in the near future. As of March 1978 HSP had 11,956 members, had been providing comprehensive health services on a prepaid basis for less than 3 years, and was incurring an operating deficit.

#### THE COMMUNITY RATING SYSTEM

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

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

Nominal differentials in rates are permitted for certain categories of members to reflect differences in administrative costs for collecting payments. Differentials in rates may also be established for members enrolled under contracts with employees of States, political subdivisions of States, and other public entities. The fixed, community-rated payment may be supplemented by additional nominal copayments which may be required for the provision of specific basic health services.

HSP considers its five-county service area as a single region and applies its rates equally. In developing a rate structure, HSP projected the cost per member per month for inpatient hospital services, professional services, out-patient ancillary health services, health facilities operations, social work services, emergency services, data processing, adverse utilization reserves, reinsurance, administration, marketing, and debt service. In converting the cost per member per month to a rate structure, HSP allocated expected costs among the various rate categories, as shown below, in such a fashion that its rates would be competitive with other health care plans.

HSP's rate structure for its qualified group plan for 1976, 1977, and 1978 was approved by the Pennsylvania Insurance Department in July 1976. It provided for both two-step and three-step rates. HSP quotes either the two-step or three-step rate structures to employers depending on the rate structures of other available employee health benefit plans.

For contracts  
beginning or  
renewing in

	<u>Three-step rate</u>			<u>Two-step rate</u>	
	<u>Single</u>	<u>Double</u>	<u>Family</u>	<u>Single</u>	<u>Family</u>
2d quarter 1976	\$28.30	\$56.60	\$71.50	\$28.30	\$67.55
3d quarter 1976	28.90	57.80	73.00	28.90	69.00
4th quarter 1976	29.50	59.00	74.55	29.50	70.40
1st quarter 1977	30.10	60.20	76.00	30.10	71.80
2d quarter 1977	30.65	61.30	77.40	30.65	73.10

The above rates are based on the assumption that a member will make copayments for only mental health and home health services. The rates could be less if a member elects to make copayments for other services, such as for each visit to a health service center or for the first 10 days of hospital inpatient care. In essence, the more services for which members make copayments, the lower the monthly rate will be.

Nongroup members are provided the same basic benefit package as group members. However, only the three-step rate plan is available to these members, and their rates are 15-percent higher than the rates charged to group members to cover the additional cost of individual billing and collection.

HEW had not published guidelines to interpret how the act's requirement for community rating should translate into a rate structure. As a result, we could not determine whether HSP's rate structure complies with the requirement for a community rating system.

#### SERVICE TO MEDICALLY UNDERSERVED AREAS

HEW designates areas with a shortage of personal health services as medically underserved areas. The HMO Act encourages HMOs to serve medically underserved areas by providing for grants to fund up to 100 percent of feasibility survey, planning, and initial development costs for HMOs which will draw not less than 30 percent of their membership from medically underserved populations. Grants to HMOs drawing less than 30 percent of their members from underserved areas may not exceed 90 percent of cost. HSP, however, did not obtain any grants under the HMO Act.

Within HSP's five-county service area, only Philadelphia County contains any medically underserved areas. HEW has designated 85 of the 365 census tracts in Philadelphia County as medically underserved. HSP's executive vice president stated that HSP had not emphasized or concentrated on enrolling people from these tracts. Instead, HSP had directed its marketing efforts to employer groups located in the service area without considering where prospective enrollees live.

#### CONCLUSIONS

HSP generally met the organizational and operational requirements of the HMO Act. However, its membership was not broadly representative of its area, and compliance with the community rating requirement was not clear because HEW had not published program guidelines to interpret how the act's requirement for community rating should translate into a rate structure.

HSP's membership was not broadly representative of its service area, as evidenced by the lack of enrollment of Medicaid recipients and limited enrollment of Medicare recipients. Because it is unlikely that HSP will hold open

enrollment in the near future, we believe HSP's membership will become more broadly representative only if it obtains Commonwealth and Federal contracts to serve Medicaid and Medicare recipients.

HSP acknowledged in its comments that it lacked active Medicare enrollees and a Medicaid contract. However, HSP believes that to conclude that it does not meet the requirement for enrolling a broadly representative population is premature at this time because both situations are beyond its control at present and are typical of most HMOs. (See app. II.)

In the absence of HEW program guidelines on how community rating should translate into a rate structure, we could not determine whether HSP had complied with the community rating requirement.

Certain areas within HSP's service area have been designated as medically underserved, and the HMO Act encourages HMOs to serve these areas. HSP had not directed its marketing efforts toward these areas but had aimed its primary marketing effort at employer groups in its service area without regard to where employees live.

### CHAPTER 3

#### WILL HSP BE ABLE TO OPERATE WITHOUT CONTINUED FEDERAL FINANCIAL ASSISTANCE?

Section 1301(c)(1) of the HMO Act requires each qualified HMO to be fiscally sound. However, because a developing HMO may have difficulty in meeting its operating expenses, section 1305 of the act provided for Federal loans of up to \$2.5 million to assist it during its first 36 months of operation. In May 1976, HEW made a \$2,213,000 loan to HSP to cover its operating losses through March 1979. We believe HSP should be able to operate without additional Federal financial assistance, but sufficient data was not available for us to make a firm conclusion.

In our reviews of other HMOs, our actuarial staff projected the HMOs' financial future based on their operating experiences. However, our actuarial staff did not project HSP's financial future because HSP had not been operating long enough as a qualified HMO to provide sufficient experience data. HSP was not qualified until April 1976, and HSP's enrollment of employer groups was delayed 3 months thereafter while waiting for the Commonwealth to approve the rates for HSP's federally qualified plan. As of December 31, 1976, HSP had enrolled 1,312 members; only 779 were enrolled in a qualified benefit plan. The remaining 533 members were enrolled in less comprehensive nonqualified plans. According to HEW officials, all group members were enrolled in the qualified plan as of January 1978.

To assess HSP's viability, we (1) compared its enrollment and financial projections to its limited actual experience data and (2) evaluated the reasonableness of assumptions underlying its projections as submitted to HEW in its qualification application.

#### COMPARISON OF ACTUAL AND PROJECTED DATA

##### Enrollment status

In April 1976, the month of Federal qualification, HSP had a total enrollment of 465 members. One employee group accounted for 424 of the 465 members, and the remainder was nongroup members. From July 1976, when the Pennsylvania Insurance Department approved the rates for HSP's qualified health benefits plan, through January 1977, HSP enrolled 27

additional employee groups with 1,264 members. As of March 1978, HSP had enrolled 11,956 members or 17 percent more than originally projected. A comparison of HSP's projected and actual enrollment at various times is presented below.

<u>Year</u>	<u>Month</u>	<u>Total members</u>		
		<u>Projected</u>	<u>Actual</u>	<u>Difference</u>
1976	April	450	465	15
	June	490	484	(6)
	September	730	542	(188)
	December	1,550	1,312	(238)
1977	January	1,850	1,903	53
	June	4,000	4,780	780
	September	5,800	8,091	2,291
1978	March	10,200	11,956	1,756

As the above chart shows, HSP's enrollment has greatly improved since December 1976. In January 1977 HSP's executive vice president stated that he believed HSP's enrollment status was better than expected because:

- Several major employee groups included in earlier projections had delayed enrolling and were scheduled to enroll during 1977. They included, for example, employees of the Commonwealth of Pennsylvania and the city of Philadelphia.
- The total backlog of groups planning to enroll was approximately 130.
- Initial marketing contacts had been made with about 1,000 potential groups.
- Initial enrollment penetration had varied from 2 to 25 percent, but as the marketing staff becomes more skilled and as awareness and acceptance of HSP and the HMO concept grows among consumers, the overall penetration percentage is expected to increase.

In June 1977 HSP's president stated that if the present enrollment trend continues (as indicated in the above chart, this trend in growth has continued), it will achieve its break-even point of 22,000 members in September 1978, 6 months earlier than projected. HSP has a large potential market. More than 9,000 firms in its service area may be subject to the HMO Act.

## Financial status

In its loan application, HSP submitted a 5-year financial projection which showed it would incur operating losses of about \$2.2 million from April 1, 1976, to March 31, 1979. HSP estimated it would break even during the fourth year, with a net operating profit of about \$197,000 and an average annual membership of 27,500 enrollees.

As of June 30, 1977, there have not been any factors which have adversely affected HSP's financial performance. Through June 30, 1977, HSP's financial performance has closely paralleled the projections in its Federal loan application. Our comparison of HSP's projected and actual income and expenses for the 15-month period ended June 30, 1977, showed the actual deficit was 4.4 percent or \$41,584 less than the projected deficit of \$943,026. Revenues were greater than projected and expenses were less than projected as shown below.

	<u>Projection</u>	<u>Actual</u>	<u>Difference</u> <u>(projection</u> <u>less actual)</u>	
			<u>Amount</u>	<u>Percent</u>
Income	\$ 565,992	\$ 572,285	(\$ 6,293)	1.1
Expenses	<u>1,509,018</u>	<u>1,473,767</u>	<u>35,251</u>	2.3
Net income (loss)	<u>(\$943,026)</u>	<u>(\$901,482)</u>	<u>(\$41,544)</u>	4.4

The HSP president said if HSP believes that enrollment will reach the break-even point in September 1978, it may waive the third installment of its loan authorization--\$213,000 in April 1978--and limit its loan obligation to \$2 million, rather than the \$2,213,000 approved by HEW.

## ASSUMPTIONS UNDERLYING FINANCIAL PROJECTIONS

As previously mentioned, HSP's actual operating data was too limited for our actuarial staff to project its viability. However, we evaluated the reasonableness of the assumptions which HSP used to prepare the projections submitted to HEW in its qualification application.

HSP's projection of revenues and costs was well conceived. Proposed staffing levels seemed adequate, and projected cost inflation factors were reasonable based on recent historical rates. Projected increases in subscriber

rates were not high enough to threaten HSP's competitiveness with other health benefit plans, and hospital utilization rates appeared very conservative; that is, they were projected to be higher than rates experienced by other HMOs.

### CONCLUSION

HSP had made considerable effort to identify and cultivate its market--about 130 firms had agreed to offer HSP to their employees in the near future. HSP's potential market contains more than 9,000 firms which may be subject to the HMO Act, and this market appears to be adequate as long as HSP's rates are competitive and high quality medical service is delivered to the members. The March 1978 enrollment of 11,956 members exceeded the projected enrollment of 10,200 by 17 percent.

HSP's projections of revenue and expenses were soundly based and its actual operating experience as of June 30, 1977, was better than originally projected. In April 1978, HSP pointed out that its operating experience continued to be better than projected. Based upon this statement and in view of the large potential market made possible by dual choice, we believe HSP has a fair chance of operating independently--without Federal financial assistance--after its first 5 years of operation as a qualified HMO.

## CHAPTER 4

### WHAT IS THE EFFECT OF DUAL CHOICE

#### ON EMPLOYERS AND HSP?

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

We contacted 18 employers in the HSP service area to determine

- the effect on employers' costs of offering HSP to employees as an optional health plan in compliance with the HMO Act,
- employer reactions to the act,
- how HSP has used dual choice and its effect upon HSP, and
- union response to HSP and the HMO Act.

Of the 18 employers contacted, 13 had offered the HSP plan to employees, 4 had agreed to offer the plan in the future, and 1 had refused to offer the plan. Four of the employers who had offered dual choice were insurance companies; two of whom had self-insured health benefit plans.

Employers offering dual choice generally reported no significant effect on their costs as a result of including HSP in their health benefit programs. Of the 18 employers we interviewed, about half expressed a favorable attitude toward the act and the other half were indifferent. Only one employer resented the act.

#### ECONOMIC IMPACT ON EMPLOYERS

Employers who offered dual choice to their employees indicated generally that differences in administrative costs were negligible. Some employers, however, anticipated a reduction in their administrative workload because they no longer will have to process claims for employees who join HSP.

Of the 17 employers who had offered or agreed to offer HSP as a dual-choice option, 12 stated that their premium contributions had remained or generally will remain the same because they make a predetermined contribution no matter what health plan an employee chooses. Three employers said the HSP plan would cost them less, and two said it would cost them more or less depending on the type of coverage--individual or family--selected by the employee. For example, one employer's contributions for individual coverage are higher under the HSP plan because the employer pays the total premium. At the same time, the employer's contributions for family coverage does not differ because the employee is required to pay the difference in premium costs between the HSP plan and the competing plan(s).

The employers we interviewed stated generally that alternate health plan representatives did not express any opinions regarding HSP. Four employers indicated they had encountered difficulties with their alternate health plans regarding assurances of continuity of coverage, particularly for pre-existing conditions such as pregnancy, for those employees who may wish to transfer from HSP to the alternate plan. To obtain such assurances, a higher employee contribution to the alternate plan may be required.

#### EMPLOYER ATTITUDE

Of the 18 employers, 8 expressed a favorable attitude toward the HMO concept and the dual-choice requirement, 9 had adopted a neutral attitude toward the dual-choice requirement, and 1 resented the requirement, citing it as government interference in its internal affairs.

The employer who had refused to offer HSP said although the health planning group was in favor of the HSP plan, management believed that offering enrollment in any HMO was not in the employees' or the firm's best interests at that time. The employer did not give any specific reasons as to why it determined that offering the HSP plan was not in the best interest of the employees.

Another firm stated that, before it signed a contract with HSP, the union representing some of its employees had decided to reject the HSP plan. The firm, however, agreed to offer the HSP plan to its nonunion employees.

According to the HSP executive vice president other employers had refused to offer the HSP plan, but HSP had no summary information on the number of refusals. He said some

refusals resulted from ignorance of the dual-choice requirement and others were merely delaying tactics. When HSP feels a refusal is based on ignorance, it initiates a follow up contact to explain the requirement to the firm. However, when a refusal is thought to be a delaying tactic, HSP generally does not follow up because HSP believes it makes more effective use of its marketing resources by contacting new employers in its large potential market.

HSP's executive vice president said generally HSP has not emphasized the employers' legal obligation. The marketing approach has been to explain the plan benefits and request employer support. He said that, overall, employers contacted by HSP had responded favorably.

#### CONCLUSION

Employers offering dual choice generally reported no significant effect on their costs as a result of including HSP in their health benefit programs. Most employers made predetermined health benefit contributions regardless of which health benefit plan an employee chose, and their administrative costs had not increased.

HSP still has a large number of employers available to be contacted. Therefore, HSP has not felt a need to impose the dual-choice requirement upon employers that refuse to offer the HSP plan.

## CHAPTER 5

### DESCRIPTION OF HSP'S

#### QUALITY ASSURANCE PROGRAM

Section 1301(c)(8) of the HMO Act requires a qualified HMO to have organizational arrangements for an ongoing quality assurance program which (1) emphasizes the need to monitor and evaluate the results of health services provided and (2) includes a review of health services provided by physicians and other health professionals. HEW's implementing regulations require further that the program provide for systematic collection of data on performance and patient results, interpretation of this data, and the institution of needed changes. The regulations, however, do not provide criteria for assessing the adequacy of a quality assurance program.

In its application for certification, HSP stated that it had adopted a quality assurance program which addressed quality of health care from two aspects--quality of health services and quality of medical care. By October 1977 HSP had fully implemented, and in some instances expanded, its planned quality assurance program.

#### QUALITY OF HEALTH SERVICES

This aspect of HSP's quality assurance program is concerned primarily with the efficiency of the general operation of the health facilities and the manner in which health care is delivered.

According to HSP's qualification application, the Subscriber Services Committee of HSP's board of directors is responsible for the quality of health services. A majority of this committee must be comprised of board members who represent unions, employers, government, and HSP members. The committee has access to comprehensive data concerning health service utilization, compliance with professional standards, outcome assessments, patient satisfaction, and community acceptance. This information gives the committee the ability to make recommendations to the board of directors to resolve grievances and improve the quality of health services.

#### QUALITY OF MEDICAL CARE

This aspect of HSP's quality assurance program is directly concerned with the nature, value, and effectiveness

of procedures provided by physicians, allied health professionals, and paraprofessionals. Primary responsibility for assuring quality of medical care is assigned to HSP's medical director, each health care center's medical director (who is a member of the corporation of physicians which provides professional services on a contract basis), a professional affairs committee of HSP's board of directors, and an audit committee of the physician corporation.

The monitoring function of the medical director has been expanded. Weekly primary care staff conferences provide feedback of observations to the staff of all centers. The medical director and his deputy review daily information from Subscriber Relations, emergency encounters, and bills from out-of-group services, including laboratory studies and records of services and treatments for patient visits. The medical director and his deputy also direct the audit activities described below and perform corrective action and feedback.

HSP has a five-part program to provide assurance of quality medical care.

- Professional standards: This element defines the qualifications, means of selection, and principles of practice for physicians who provide professional services.
- Utilization control: This element provides for achieving the most effective use of health care personnel, facilities, and other resources. The medical director at each delivery site must (a) review and approve all hospital admissions and external referrals daily and (b) review encounter data weekly to insure that necessary corrective action is taken. Utilization data from each delivery site must be submitted weekly for review by the HSP medical director and the professional affairs committee. In addition, a hospital services coordinator (public health nurse) has been hired to ascertain the daily status of each hospitalized patient in participating and nonparticipating hospitals and to report to the medical director and the primary physician, simultaneously facilitating discharge planning. Ambulatory utilization data is still obtained from encounter forms. Utilization statistics are reported monthly for each physician. A new management information system has been developed, but its use depends only on the final corrections and the printing of the encounter forms.
- Peer review: The primary care team (physicians, nurses, and physician assistants) perform audits on randomly selected records every 2 weeks at each center.

Two team members must agree that a health care, documentation, or recordkeeping deficiency exists before reporting it. The medical director prepares these deficiency reports and submits them to the medical group's quality assurance committee which meets on the second Wednesday of each month. Six of these audits were made between August and October 1977. A copy of each audit report is sent to the responsible primary physician. The medical director and the committee identify areas of deficiencies for further targeted auditing and for corrective administrative and educational intervention. The minutes of the quality assurance committee are submitted to the HSP professional affairs committee.

--Professional standards review: This element includes applying procedures to assure that the services for which health care professionals and institutions receive payment conform to appropriate professional standards for the provision of health care. The audit committee of the corporation of physicians is responsible for this review.

--Medical director monitoring and corrective function: Using information obtained from encounter forms, HSP's medical director is responsible for the audit of services made by health care providers and basic compliance with standards for continuing care. Together with the medical directors of the health care centers, HSP's medical director is to identify serious or repetitive deviations from adopted standards of care, attempt to find the reasons for such deviations, and suggest ways to correct such problems.

#### HEW EVALUATION

HEW reviewed HSP's quality assurance program during a site visit in October 1975 and found that controls over specialty referrals and emergency medical care were weak and that no apparent provision for hospitalization review activity had been made. In a subsequent site visit in March 1976, an HEW official stated that HSP had developed tighter utilization controls and that the proposed control mechanisms were satisfactory.

#### CONCLUSION

HSP had fully implemented, and in some instances expanded, the quality assurance program described in its qualification application.

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## United States Senate

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

May 24, 1976

B-164031(5)

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

Dear Mr. Staats:

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

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

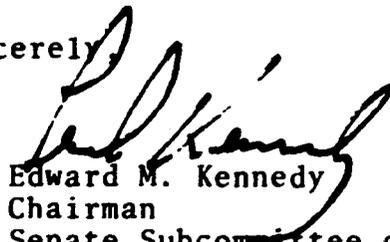
As your staff complete the reviews of each HMO, we would like reports on each review forwarded to us (and as previously discussed with our staff, copies to the Chairman and Ranking Minority Member of the House Subcommittee on Health and Public Environment, Interstate and Foreign Commerce Committee).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

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



Richard S. Schweiker  
Ranking Minority Member  
Senate Subcommittee on  
Health

Sincerely,



Edward M. Kennedy  
Chairman  
Senate Subcommittee on  
Health

Health Service Plan  
of Pennsylvania



A Federally-Qualified  
Health Maintenance  
Organization

R. Robert Herrick  
President

April 7, 1978

Gregory J. Ahart, Director  
United States General  
Accounting Office  
Washington, DC 20548

SUBJECT: GAO Report on Health Service  
Plan of Pennsylvania

Dear Mr. Ahart:

Thank you for the opportunity to comment on the subject report and to provide more current information.

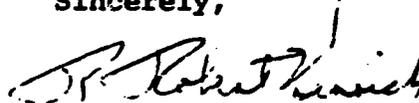
As of March 31, 1978, HSP has increased its membership to 11,956. Operating experience continues to be better than projected. Thus, HSP revenue and expense projections continue to be verified by operating results, which strongly indicate that HSP will be able to operate without continued Federal financial assistance.

HSP concurs with the overall conclusions of the GAO report with respect to quality assurance, benefits and financial performance. However, we believe that it is premature to conclude that HSP does not meet the requirements for enrolling a broadly representative population. This conclusion is solely based on the lack of a Medicaid contract and an active enrollment of Medicare beneficiaries. Both situations are beyond HSP control at present and are typical of most HMOs. HSP has actively sought to serve both groups as documented in the report and intends to achieve this goal. However, State Medicaid contracts are not available to HSP at present. HSP has evaluated a proposed contract with the Social Security Administration for Medicare eligible. We have chosen an alternative, however, and a Medicare program which does not require contracting with Social Security Administration has been filed, but not yet approved by appropriate State authorities. This program will provide HSP

Medicare Coordinated Benefits through the Group plan with agreement of the employer, or, in the absence of such agreement, through Non-Group conversion. In both cases, a more equitable posture by the contracting state and Federal agencies would be helpful to all HMOs. Therefore, based on our actions, we believe we are in the process of meeting the requirements of the Act and these conclusions are premature.

May I express my appreciation to you for the cooperation of your audit team. If I can provide further information please contact me.

Sincerely,



R. Robert Herrick  
PRESIDENT

RRH:rlh

HSP's COMPLIANCE WITH ORGANIZATIONAL AND OPERATIONAL  
REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS (note a)

	<u>Compliance</u>	<u>Non-compliance</u>
The HMO shall be a legal entity which provides:	X	
1. Basic health services for a basic health service premium which is	X	
--paid on a periodic basis without regard to the dates health services are provided;	X	
--fixed without regard to the frequency, extent, or kind of health service actually furnished;	X	
--fixed under a community rating system; and	b/Not determined	
--may be supplemented by additional nominal payments, except that such payments may not serve as a barrier to delivery of health services.	X	
2. Supplemental health services which are paid for on a fee-for-service basis or a prepayment basis under a community rating system.	b/Not determined	
Basic health services shall be provided through health professionals who are members of the staff of the HMO, through a medical group, or through an individual practice association unless the health professional's services are unusual or infrequently used or the basic health service was provided because it was medically necessary and could not be provided by such a health professional.	X	
Basic and supplemental health services shall be available, accessible, and be provided in a manner that assures continuity and when medically necessary, be available and accessible 24 hours a day and 7 days a week.	X	
A member of an HMO shall be reimbursed by the organization for his expenses in securing basic or supplemental health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization.	X	
An HMO should have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary.	c/Not determined	
An HMO should assume full financial risk on a prospective basis for the provision of health services, except that the HMO may obtain insurance or make other arrangements for certain cases.	X	
An HMO shall enroll persons who are broadly representative of the various age, social, and income groups within the area it serves.		X
An HMO shall have an open enrollment period of not less than 30 days at least once during each consecutive 12-month period during which it accepts, up to its capacity, individuals in the order in which they apply, unless the HMO demonstrates to the Secretary the need for a waiver.	(d)	

APPENDIX III

APPENDIX III

	<u>Compliance</u>	<u>Non-compliance</u>
An HMO shall not expel or refuse to reenroll any member because of his health status or his requirements for health service.	X	
An HMO shall be organized in such a manner that assures that at least one-third of the membership of the policymaking body of the HMO be members of the organization, except in the case of an HMO that has a medically underserved population in its service area.	X	
An HMO shall be organized in such a manner that provides a meaningful procedure for hearing and resolving grievances between the HMO and the members of the organization.	X	
An HMO shall have an organizational arrangement for an ongoing quality assurance program which stresses health outcomes and provides review by physicians and other health professionals of the process followed in the provision of health services.	X	
An HMO shall provide for its members		
--medical social services and	X	
--health education services.	X	
An HMO shall provide or make arrangements for continuing education for its health professional staff.	X	
An HMO shall provide for an effective procedure for developing, compiling, evaluating, and reporting to the Secretary statistics and other information on the following areas		
--cost of operations;	X	
--patterns of utilization of services;	X	
--availability, accessibility, and acceptability of its services;	e/Not determined	
--to the extent practical, developments in the health status of its members; and	e/Not determined	
--such other matters as the Secretary may require.	e/Not determined	
a/We assessed HSP's compliance with Federal regulations (42 CFR 110, dated October 18, 1974) which implemented the original HMO Act of 1973, because as of January 31, 1977, HEW had not issued new regulations implementing the HMO Amendments of 1976.		
b/HEW has not issued guidelines interpreting how community rating requirements should translate into a premium structure; therefore, we could not assess HSP's compliance.		
c/Discussed in chapter 3.		
d/The HMO Amendments of 1976 relaxed this requirement before HSP's scheduled period of open enrollment occurred. (See p. 7.)		
e/HEW has not established reporting requirements for this item.		

(102012)