

HRD-76-128

9-3-76

# REPORT TO THE CONGRESS

093672



BY THE COMPTROLLER GENERAL  
OF THE UNITED STATES

---

## Factors That Impede Progress In Implementing The Health Maintenance Organization Act Of 1973

Department of Health, Education, and Welfare

This report discusses factors which have impeded, and continue to impede, the carrying out of the Federal Health Maintenance Organization program. Information is provided on the need for more effective and efficient management by the Department of Health, Education, and Welfare and for legislative changes to better meet the objectives of the Health Maintenance Organization Act of 1973.

HRD-76-128

~~707507~~

SEPT. 3, 1976

093672



COMPTROLLER GENERAL OF THE UNITED STATES

WASHINGTON, D.C. 20548

B-164031(5)

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

This report describes the progress and problems encountered by the Department of Health, Education, and Welfare in implementing the Health Maintenance Organization Act of 1973. A significant problem has been the ambiguities in the law. The report also discusses ways to improve the Federal Health Maintenance Organization program, including the proposed amendments being considered by the Congress.

Because we are required under section 1314 of the act to make several evaluations of Health Maintenance Organizations, we initiated this review to give the Congress an interim informational report on the Department's efforts in implementing the act. This review, however, was initiated pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

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

A handwritten signature in black ink, appearing to read "A. J. Kellum".

Acting Comptroller General  
of the United States

C o n t e n t s

		<u>Page</u>
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	The Health Maintenance Organization	
	Act of 1973	1
	Pre-HMO Act activities	3
	Current legislation	4
	Scope of review	4
2	SLOW PROGRESS IN IMPLEMENTING THE ACT	6
3	FACTORS WHICH HAVE IMPEDED OR COULD IMPEDE PROGRAM IMPLEMENTATION	8
	Responsibility for administration has been fragmented and efforts to put the program into operation have not been coordinated	8
	Impact of inadequate staff resources	12
	Untimely issuance of final regulations and guidelines to implement HMO Act	18
	Status of Federal override of certain restrictive State laws	24
	Difficulties perceived with the act's organizational and operating re- quirements	29
	Negative impact of less than antici- pated funding on HMO program devel- opment	33
	Conclusions	36
	Recommendations	36
	Agency comments and our evaluation	37
	Matters for consideration by the Con- gress	40
4	STATUS OF HMO EVALUATIONS	42
	Progress of GAO evaluation	42
	Progress of HEW evaluation	43
	Conclusions	44
	Agency comments and our evaluation	44
	Matters for consideration by the Con- gress	45

APPENDIX

Page

I	Questionnaire	46
II	Letter dated July 28, 1976, from the Assistant Secretary, Comptroller, HEW	53
III	Principal HEW officials responsible for activities discussed in this report	60

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
HSA	Health Services Administration

COMPTROLLER GENERAL'S  
REPORT TO THE CONGRESS

FACTORS THAT IMPEDE  
PROGRESS IN IMPLEMENTING  
THE HEALTH MAINTENANCE  
ORGANIZATION ACT OF 1973  
Department of Health, Education,  
and Welfare

D I G E S T

This act authorized \$325 million for fiscal years 1974-77 to help finance a 5-year Health Maintenance Organization demonstration program.

By June 30, 1976--2-1/2 years after passage of the act--only 17 Health Maintenance Organizations were certified as complying with the act's requirements. During this period, 168 projects received grants for feasibility studies, planning, and early development activities, and it is anticipated that additional projects will receive grants during the remaining 2-1/2 years of the demonstration program.

On several occasions the Department of Health, Education, and Welfare (HEW) revised its estimates of the number of Health Maintenance Organizations that will be operational by 1978; it now anticipates that only 80 might be certified under the act by the end of the demonstration program.

Several complex and interrelated factors have impeded and will continue to impede the program.

--Responsibility for administration has been fragmented and efforts to put the program into operation have not been coordinated. (See p. 8.)

--The staff to administer financial assistance and regulations has been limited in numbers and in expertise. (See p. 12.)

--Issuance of final regulations and guidelines to implement and enforce the act

has not been timely; in fact, some regulations still have not been issued. (See p. 18.)

--State laws have been restrictive. (See p. 24.)

--Difficulties have been perceived with the Health Maintenance Organization administrative and operating requirements included in the act. (See p. 29.)

--Financing has been lower than expected. (See p. 33.)

Furthermore, of the \$250 million authorized for grants and contracts under the act, HEW has requested only \$70 million through fiscal year 1977. Many grant applicants have not been able to comply with the requirements of the act and, thus, moneys appropriated for grants and contracts were not obligated.

Sections 1314 and 1315 of the act require extensive program evaluations of Health Maintenance Organizations by GAO and HEW. Several GAO evaluations are to be reported to the Congress by December 1976. During the first 2-1/2 years, HEW has not devoted enough resources to fulfilling section 1315. This low priority appears to be continuing into fiscal year 1977.

However, in view of the slow progress in establishing Health Maintenance Organizations under requirements of the law and the lack of a means to determine reliably the impact of health delivery systems on the public health, GAO's reporting on the required evaluations by December 1976 is not feasible.

#### RECOMMENDATIONS

The Secretary of HEW should

--obtain additional staff, especially in the regions, with expertise in marketing,

actuarial analysis, and financial management;

--issue all final regulations and guidelines required to administer the nationwide Health Maintenance Organization program more effectively and uniformly; and

--identify how much State laws restrict the development of Health Maintenance Organizations and seek whatever legislative amendments are appropriate to correct the situation.

#### AGENCY COMMENTS

HEW maintained that the report is negative in tone and cited four areas in which HEW believes unsubstantiated inferences are drawn. GAO agreed that HEW's failure to utilize all appropriated grant funds should not be implied as a fault of the Department. However, the facts developed by GAO more than adequately support the findings and conclusions concerning fragmented program administration, inadequate program resources, and delayed publication of regulations. (See pp. 37 to 40.)

HEW agreed with the first two recommendations but suggested that the third be deleted. (See p. 57.) GAO believes, however, that if the recommendation is not implemented considerable Federal grant funds could be awarded in States with restrictive laws before the laws are tested. (See p. 40.)

#### MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO testified on specific aspects of the House (H.R. 9019) and Senate (S. 1926) bills to amend the Health Maintenance Organization Act and concurred in the need to revise the legislation. These bills recognized that the slow program progress was partly due to complexities in the act.

Because of the problems HEW experienced in attempting to carry out the act, the Congress, in developing legislation to achieve a program goal by a specific time, should

--provide time needed to develop and issue regulations and guidelines and

--synchronize funding with the status of program implementation.

The Congress should consider an amendment to section 1311 exempting Health Maintenance Organizations from additional State laws that might restrict a Health Maintenance Organization's development. This should not be done until HEW has implemented section 1311.

Amendments to the Health Maintenance Organization Act were passed by the House on November 7, 1975, and by the Senate on June 14, 1976. These proposed amendments, ordered to be reported by the House-Senate Conference Committee in September 1976, will alter the Federal Health Maintenance Organization program significantly. GAO's views on some of these amendments are discussed on the following pages.

--Restrictive State laws (p. 29).

--Principal activity of a medical group (pp. 29 and 30).

--Basic and supplemental health services (pp. 30 and 31).

--Open enrollment (pp. 31 and 32).

--Community rating (pp. 32 and 33).

--Evaluations (p. 45).

## CHAPTER 1

### INTRODUCTION

The Health Maintenance Organization (HMO) concept calls for establishing an entity to (1) provide specific health services to its members--either directly or through arrangements with others--and (2) be compensated by predetermined, prepaid rates. Prepayment distinguishes HMOs from most other health care providers, which charge patients or their insurers for each service rendered.

### THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973

The Health Maintenance Organization Act of 1973 (42 U.S.C. 300e)(Supp. IV, 1974), approved December 29, 1973, amended the Public Health Service Act to provide 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 HMOs.

The act spells out in considerable detail the definition of and the operating requirements for an HMO. Among other things, the act (1) specifies the basic and supplemental health services to be provided the HMO member, (2) the basis for fixing the rate of prepayment, (3) the requirement that HMOs have open enrollment periods for individual members without restrictions (such as preexisting medical conditions), and (4) the organizational structure of an HMO.

The act authorizes a program designed to help develop new, and expand existing, HMOs by

- providing financial assistance through grants, contracts, and loans;
- providing a market for HMOs by requiring certain employers to include in any employees' health benefits plan the option of membership in an HMO that the Secretary of Health, Education, and Welfare has "qualified" as complying with the requirements of the HMO Act; and
- preempting restrictive State laws and practices which could hinder the development and operation of a qualified HMO.

The act authorized Federal financial assistance for the 5-year HMO demonstration program as follows:

- Grants and contracts to public or private nonprofit organizations for HMO feasibility studies, planning, and initial development.
- Loans to public or private nonprofit organizations for initial operating assistance.
- Loan guarantees to non-Federal lenders on loans made to private profitmaking organizations for planning for, initial development of, and initial operating assistance to HMOs serving the medically underserved.

When the House Committee on Interstate and Foreign Commerce reported the proposed HMO legislation to the full House in August 1973, its report stated that continuing Federal financial assistance to the program should not be necessary after a 5-year demonstration period, during which it was hoped that about 100 new HMOs would become operational.

Amounts authorized and appropriated follow.

Funding Levels for HMOs

	Fiscal year					Total
	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	
(millions)						
<b>Authorization:</b>						
Grants and contracts	\$ 25.0	\$55.0	\$85.0	\$85.0	\$-	\$250.0
Capitalization of loan fund	<u>a/75.0</u>	-	-	-	-	<u>75.0</u>
Total	<u>\$100.0</u>	<u>\$55.0</u>	<u>\$85.0</u>	<u>\$85.0</u>	<u>\$-</u>	<u>\$325.0</u>
<b>Appropriation:</b>						
Grants and contracts	<u>b/\$25.0</u>	\$15.0	\$15.0	\$15.0	\$-	\$ 70.0
Capitalization of loan fund	35.0	-	-	-	-	35.0
Program support (note d)	<u>.7</u>	<u>3.5</u>	<u>3.6</u>	<u>3.6</u>	-	<u>11.4</u>
Total	<u>\$60.7</u>	<u>\$18.5</u>	<u>\$18.6</u>	<u>c/\$18.6</u>	<u>\$-</u>	<u>\$116.4</u>
Obligations (grants only, through June 30, 1976)	\$ 5.5	\$17.0	\$ 8.6			

a/Authorized in the aggregate for fiscal years 1974 and 1975. Loans and loan guarantees from this authorization may be made through fiscal year 1978.

b/Remained available until June 30, 1975, because of late appropriation in fiscal year 1974.

c/Budget request contained in fiscal year 1977 President's budget.

d/Authorized under section 301 of the Public Health Service Act.

Through fiscal year 1977 the Department of Health, Education, and Welfare (HEW) has requested \$70 million of the \$250 million authorized for grants and contracts. The act also authorized \$50 million for certain research or studies into quality of care. HEW did not request any of these authorized funds.

#### PRE-HMO ACT ACTIVITIES

Starting in 1971 HEW allocated approximately \$31 million in Federal funds for research, development, evaluation, and technical assistance to aid prototype HMOs. HEW awarded grants and contracts under several sections of the Public Health Service Act.

- Section 304: for research, experiments, or demonstration projects to develop new or improved methods of organizing, delivering, or financing health services.
- Section 314(e): to any public or nonprofit private agency, institution, or organization to cover part of the cost of (1) providing services to meet health needs of limited geographic scope or of specialized regional or national significance or (2) initially developing and supporting new health services' programs.
- Section 910(c): for support of research, studies, investigation, training, and demonstrations designed to maximize the use of manpower in delivering health services.

Approximately \$17 million in direct grant assistance was provided to about 84 different organizations. In November 1975 we issued a report 1/ to the Congress on how grantees had used their grants and ways to improve such activities.

HMO legislation was introduced in the Congress in early 1971, passed by the Senate in September 1972, but not considered by the House before the end of the 92d Congress. Another year was spent debating the different House and Senate versions of the HMO legislation in the 93d Congress. A compromise bill (the HMO Act of 1973) was passed in December 1973.

---

1/"Effectiveness of Grant Programs Aimed at Developing Health Maintenance Organizations and Community Health Networks." (MWD-75-98, Nov. 21, 1975.)

## CURRENT LEGISLATION

Amendments to the HMO Act were passed by the House on November 7, 1975, and by the Senate on June 14, 1976. These proposed amendments, ordered to be reported by the House-Senate Conference Committee in September 1976, will significantly alter the Federal HMO program. Our views on these amendments are presented in the following chapters.

## SCOPE OF REVIEW

Our review was conducted at HEW headquarters in Washington, D.C., Health Services Administration (HSA) headquarters in Rockville, Maryland, and at all 10 HEW regional offices (I--Boston; II--New York City; III--Philadelphia; IV--Atlanta; V--Chicago; VI--Dallas; VII--Kansas City (Missouri); VIII--Denver; IX--San Francisco; and X--Seattle). We reviewed applicable legislation; HEW regulations and draft guidelines; formal public comments on draft HEW regulations; HEW grant, loan, and HMO qualification files; HEW audit reports; HEW-sponsored research studies; and professional publications on health care delivery and evaluation.

As part of our review, we sent a questionnaire to 809 entities which, according to HEW regional officials, had been sent grant application packages between January and May 1974 because (1) they had requested a package or (2) the HEW regional offices felt they would be interested in financial assistance and thus likely to seek assistance under the act.

The purpose of our questionnaire was to determine

- why potential HMOs had not requested financial assistance and
- what problems were encountered by successful HMO applicants in complying with the act's requirements.

The questionnaires (see app. I) were mailed in April 1975. By the end of June 1975, 562 recipients had responded. Sixty-five of them had not received an application package and were thus eliminated from our analysis. Forty-one questionnaires were returned unanswered because the individual or organization could not be readily located or had gone out of business. These were also eliminated from our universe, resulting in a 73-percent response rate. The respondents were categorized by grant status and type of health care provided.

We also discussed our review with HEW officials, the Civil Service Commission, HMOs and HMO prototypes, schools of public health, medical schools, medical professional organizations, health insurance companies, labor organizations, and health care research organizations.

## CHAPTER 2

### SLOW PROGRESS IN IMPLEMENTING THE ACT

As of June 30, 1976, about 2-1/2 years after the Health Maintenance Organization Act was passed, only 17 HMOs were qualified as complying with the act's requirements. Although the program had funded 168 projects during this period with grants for feasibility studies, planning and initial development activities, and loans for operational assistance, this fell short of expectations. For example, the Department of Health, Education, and Welfare budget projections in November 1974 anticipated that between 180 and 200 HMO projects would be supported by July 1, 1975.

Also, as of January 1976, HEW's estimate of the minimum number of new operational HMOs to be developed with Federal assistance by the end of the 5-year demonstration program had been reduced from 141 to less than 80. HEW cited less than anticipated program funding as the reason for the reduced estimate.

Further evidence of slow progress in implementing the HMO program was the fact that

- final regulations had not, as of June 30, 1976, been issued to implement a critical section of the act dealing with the form of HEW's continued regulation of HMOs assisted by or qualified under the act;
- final regulations implementing the funding criteria for the HMO grant and loan programs were published in October 1974--about 10 months after the act's passage;
- final regulations outlining the HMO qualification process were not published until August 1975--19 months after the act's passage; and
- final regulations implementing the offering of HMOs by employers in health benefits plans were published in November 1975--about 22 months after the act's passage.

HEW implementation of the grant funding authorities, however, has not been slow. Most grant applicants could not comply with the act's requirements, resulting in over \$17.5 million of the \$40 million in grant funds available for fiscal years 1974 and 1975 remaining unobligated.

As of June 30, 1976, HEW had completed five overlapping, 13-week grant-funding cycles for fiscal year 1975 and the first of two grant-funding cycles for fiscal year 1976. From July 1, 1974, through June 30, 1976, HEW made 186 grant awards to 168 organizations totaling \$31.2 million. For the second cycle of fiscal year 1976, HEW received 33 grant applications requesting about \$1.7 million and approved funding of 18 projects for about \$900,000. As of June 30, 1976, grant awards to these projects were not made. HEW officials stated that these awards would not be made until the overall availability of grant funds through the transition quarter is determined.

By June 30, 1976, HEW also "qualified" 17 HMOs. Twelve of the 17 had received HMO loans or loan commitments which totaled about \$18.3 million.

Dissatisfaction with the act and its slow implementation have prompted the Congress to consider amending it. Oversight hearings by the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, in July 1975 and by the Subcommittee on Health, Senate Committee on Labor and Public Welfare, in November 1975 highlighted (1) HEW's slow progress in implementing the program and (2) some deficiencies in the act. Although the proposed amendments will eliminate some problems, additional ones that have prevented effective HEW administration of the act are not being addressed by HEW or by the legislation. These problems have led the respondents to our questionnaire and other recent studies 1/ to depict the HMO Act of 1973 as more of a detriment than an incentive to the development of the HMO concept.

---

1/Fortune 500 Survey, May 15, 1975, Twin City Health Care Development Project.

May 1974 Survey of HMO Reactions to the HMO Act, June 20, 1974, Interstudy.

Analysis of Barriers to Successful HMO Development, Mar. 28, 1975, General Research Corporation.

### CHAPTER 3

#### FACTORS WHICH HAVE IMPEDED OR

#### COULD IMPEDE PROGRAM IMPLEMENTATION

The problems encountered by the Federal Health Maintenance Organization program have been caused by a myriad of complex and interrelated factors. The following six factors have particularly hampered and could continue to hamper the development if the HMO concept.

1. Responsibility for administration has been fragmented and efforts to put the program into operation have not been coordinated.
2. Limited HMO staff, both in numbers and in types of expertise, to efficiently administer the financial assistance and regulatory aspects of the act.
3. Lack of timely issuance of final regulations and guidelines to implement and enforce the act.
4. Restrictive State laws.
5. Difficulties perceived with the HMO organizational and operating requirements included in the act.
6. Less than anticipated program funding.

#### RESPONSIBILITY FOR ADMINISTRATION HAS BEEN FRAGMENTED AND EFFORTS TO PUT THE PROGRAM INTO OPERATION HAVE NOT BEEN COORDINATED

While reviewing the act's implementation, we observed that no single organizational unit within the Department of Health, Education, and Welfare is responsible for implementing the entire HMO program. For the first 2 years of its existence, the program had been functionally organized within various HEW headquarters offices. Further, we found no formal system to account for the use of staff resources authorized for the program. During congressional hearings in July 1975 questions were raised regarding this organizational structure, and in November 1975 HEW began to develop a system to coordinate program activities and to account for staff resources used.

The primary responsibility for administering the grant, loan, and technical assistance programs for HMOs originally rested with the Office of HMOs. Until November 7, 1975, the Office was part of the Bureau of Community Health Services of the Health Services Administration. The Office of HMOs was one of six program offices within the Bureau of Community Health Services, which also has five functional divisions and two administrative support offices for such activities as policy development, monitoring and analysis, and health services financing. These divisions and offices are staffed from the resources appropriated for the legislatively authorized programs assigned to the Bureau.

Bureau of Community Health Services officials maintained that the HMO program was obtaining staff-years of effort equivalent to the number of staff positions authorized for the program. However, we found that the Bureau had no formal system to account for the use of its authorized staff resources. It just assumed that, if a task was accomplished on time, all staff resources were used. Thus, the Bureau could not determine the total amount of staff resources or the amount of staff resources each office or division devoted to a particular task--especially if the task was not completed as originally targeted.

During the July 1975 hearings before the House Subcommittee on the HMO amendments, concern was expressed that some of the HMO program's difficulties were due partly to the way HEW was administering the program. Both the House and Senate versions of the proposed HMO amendments would require HEW to administer the program through a single identifiable unit of the Department.

Responding to the House Subcommittee's concerns, HEW's Acting Assistant Secretary for Administration and Management on November 7, 1975, approved a proposal to consolidate the HMO program staff positions (approximately 58), then functionally distributed in the Bureau of Community Health Services, as one office within another HSA bureau--the Bureau of Medical Services.

Under this new organization, the Division of HMOs was established as one of five divisions within the Bureau of Medical Services. The Division's responsibilities include providing program leadership, developing program policies and guidelines, maintaining liaison with other Federal agencies and national organizations, providing technical assistance to the regional offices, approving grants and loans, and reporting data for the grant and loan program.

The qualification and continued regulation of HMOs is the responsibility of an HSA office separate from the bureaus and the regional offices--the Office of HMO Qualification and Compliance. This Office was established in June 1975, about 18 months after enactment of the law. As of June 30, 1976, the Office had an authorized fiscal year 1976 staffing level of 15 positions. Both the original act and the proposed amendments require that the continued regulation activities be administered in the Office of the Assistant Secretary for Health. During June 1976 the HMO loan activities were detailed but not officially transferred from the Division of HMOs to the Office of HMO Qualification and Compliance. (See p. 18.)

The regional operations for the HMO program have been conducted through HEW's 10 regional offices. The regional offices' responsibilities include monitoring and providing technical assistance to the HMO grant and loan projects. The regional health administrators who are responsible for this, as well as other health-related activities, report directly to the Office of the Assistant Secretary for Health and are not accountable to the Administrator of HSA or other agency heads.

#### HEW efforts to decentralize and functionalize the HMO program

The Public Health Service had decentralized and functionalized many of its health programs over the last few years. Operational authority was transferred from headquarters to the regional offices to insure that decisionmaking was closer to where the services were provided. The regional offices, in organizing and staffing the programs, had some flexibility under the direction and guidance of the Office of the Assistant Secretary for Health. Consequently, most regions have been structured along functional lines, where staff with needed specialized skills and expertise from various organizational units within the regional office complete a single program activity. This functional structure has minimized the visibility of categorical programs and resulted in staffing across programmatic lines.

Over the last few years, HEW's philosophy has been to decentralize its health programs. However, regional office officials disagree about whether the HMO program should be decentralized. Some regional health administrators and regional HMO staff opposed decentralization because they would need additional resources and specific regulations and guidelines on HMOs to uniformly implement the program. For example,

one HEW regional official said that, in light of specific HMO legislation, HEW needs a uniform grant process, which cannot be accomplished if each region is responsible for grants. Staff in another region pointed out that detailed headquarters involvement in funding decisions has delayed issuance of program regulations, policies, and guidelines. Still another region favored decentralizing the grant approval and award process but not the qualification or loan program.

At the time of our regional fieldwork in spring 1975, we found that the Bureau of Community Health Services had no management information system to trace or account for regional staff resources. Some regions did fill out monthly reports in which they estimated how many days were spent on such activities as monitoring, technical assistance, and grant application review to see if they were meeting work plan objectives. HEW stated in its July 28, 1976, comments to our draft report that such an information system was the responsibility of the Office of the Assistant Secretary for Health. However, HEW maintained that the Assistant Secretary's office had established such a system for regional accountability and that its information is available to the Bureau of Community Health Services. In a meeting in March 1976 with an HEW headquarters official responsible for coordinating regional staff resource reports, we were told that all regional offices were required to implement a manpower management system in fiscal year 1976. This system identifies estimates of the time needed to complete various work plan activities, such as HMO project monitoring, technical assistance, and grant application review. He stated, however, that this system was introduced to the regional offices during the spring of 1975 and that it requires a phased implementation over a 2-year period.

On July 14, 1975, we testified before the House Subcommittee that the lack of uniformity among the regional offices in implementing the HMO program was, in our opinion, partly due to HEW's failure to expeditiously issue final implementing regulations and guidelines to serve as a common base for the regional officials to make interpretations to program applicants. In HEW's testimony on the same day, the Assistant Secretary for Health acknowledged that the regional offices were interpreting guidelines differently, but added that regional office performance was steadily improving and that action was being taken to make uniformity possible. The November 7, 1975, reorganization of the HMO program did not change the regional operations.

However, the House Report (94-518) on H.R. 9019 noted the Subcommittee's concern that HMO staff be assigned to a single identifiable administrative unit in both the central and regional offices, stating that the program would function more effectively and that its administration would be easier for applicants and others to understand.

As part of our review, we sent a February 1976 memorandum to the Assistant Secretary for Health requesting additional information on why the regional offices were not included in the HMO reorganization. The Assistant Secretary, responding in a February 24, 1976, memorandum, said that the regional offices were excluded because their restructuring was still under review.

However, a June 17, 1976, draft report concerning HMOs prepared for the Assistant Secretary for Health by his office stated that:

"There have been several attempts to open the question of regional organization but it is fair to say that it has received little real consideration. \* \* \* At the present time, the Regional Office role is primarily providing technical assistance to grant and loan applicants, employers and other organizations interested in HMOs and making recommendations to the central office with respect to decision to be made. In short, all formal authority remains in headquarters. From time to time, questions have been raised about this mode of operation."

#### IMPACT OF INADEQUATE STAFF RESOURCES

##### Grant activities

HEW did not have the number and type of personnel needed to implement the HMO grant program. This staffing deficiency contributed to the lack of uniformity among the HEW regional offices in reviewing grant awards, monitoring grants, and providing technical assistance to grantees. Thus, the access to a national program of HMO development varied from region to region.

In early 1975 several regional officials told us that they did not have time to monitor their projects or provide technical assistance to them. We asked HEW regional office staff to prepare complete staffing charts providing data on staff availability and time spent on various direct and indirect program activities. Although the data was based on

estimates, it confirmed the statements made concerning a lack of adequate staff to monitor and provide technical assistance to HMO grantees.

Also, we were told of instances in which (1) a regional office discouraged the submission of grantee applications because of a lack of staff to process the applications and (2) regional offices could not make staff resources available to assist potential grant applicants.

In February 1974 the Administrator of HSA allocated 50 positions for the HMO program to the regional offices. In September 1975, 46 (33 professional and 13 clerical) positions were filled. This did not mean, however, that 46 people were working full time on the HMO program. While the Office of Regional Operations committed a total of 50 staff-year equivalents to the HMO program, the regional health administrators did not have to identify for HSA the specific individuals working on HMOs. Our fieldwork in the spring of 1975 showed, however, that individuals filling regional HMO professional positions were spending most, if not all, of their time working on HMOs. The individuals in the HMO clerical positions were not necessarily working on HMOs, even part time, since there was a shortage of clerical-secretarial help in some of the regions and such employees were used where needed. Followup discussions with HMO regional officials in January 1976 disclosed that several regions had still not been staffed to their authorized level.

Although some regional offices' failure to provide technical assistance to grantees was partly because of a staff shortage, lack of staff expertise was also a problem. When the Administrator of HSA allocated 50 positions to the regional offices, he emphasized the need for specialists in marketing, actuarial analysis, and financial management who also have knowledge of prepaid health plans. Few regions had filled their positions with persons having such expertise. Most of the regional staff were "generalists" with expertise in health care delivery systems, hospital administration, disease control, or Federal grants management and usually a general knowledge of prepaid health care. Several regional officials said that individuals with the desired expertise will not work for the Federal Government at the salaries offered.

After our fieldwork in the spring of 1975, we found that a number of regional positions, including some for the HMO program, had been downgraded by HEW personnel officials. A regional health administrator noted to headquarters that

this action will hamper, if not bar, attempts to recruit competent professionals, especially in large urban communities, where higher salaries must be offered to attract qualified people.

On November 21, 1975, the Assistant Secretary for Health, testifying before the Senate Subcommittee, stated that additional positions were to be allocated to the regional offices. HSA officials informed us in May 1976 that the program was staffed with 50 central office positions and 60 regional office positions. Ten vacancies were transferred to the regional offices in March 1976, and action was being taken to fill the remaining vacancies. However, in July 1976, an HEW regional office official said that a vacant position transferred to his office was not assigned to the HMO program. HEW formal comments on July 28, 1976, noted that training of staff had been intensive at both regional and central levels. More than 15 sessions conducted by senior staff had oriented newly assigned personnel into the HMO concept and the Division's operating procedures. Detailed training in financial analysis was provided by staff experts at 5 sessions. A similar sequence in the field of marketing was to be initiated. The staff had developed and were implementing an ongoing, intensive training program in grant evaluation and monitoring for the new personnel.

#### Loan activities

HEW also does not have the number and type of personnel, especially in the regions, with the expertise needed to effectively monitor the loan and the loan guarantee program.

The HEW official responsible for overall Public Health Service loan activities agreed that there are not enough people or staff expertise in headquarters to monitor HMO loan and loan guarantees and there is no such expertise in the regional offices. For example, in September 1975 HEW contracted a marketing consultant to help review loan applications, acknowledging that not enough headquarters staff had the marketing expertise to effectively review an HMO's marketing capabilities.

In March 1976 the headquarters official responsible for the HMO loan program reaffirmed the lack of expertise in the regional offices to monitor loans and loan guarantees. In a memorandum to the Acting Director of the Division of HMOs, he stated that the loan and loan guarantee programs are centralized because a special knowledge, not generally available

in the regional offices, is required to administer such programs. Consequently, staff for the HMO loan program was to be filled using authorized headquarters positions. However, he stated that there has been a staff reduction of nearly one-half in his office, while the volume of loan activity has more than tripled since the Division of HMOs was formed on November 7, 1975. Although he only requested that one position that he was losing to the regions be retained in his office, he indicated that for the next fiscal year additional staff would be needed.

HSA officials commented in May 1976 that personnel were available in the regional offices who had the necessary background in accounting and in the HMO program to help handle the loan activity as volume increases. Brief but intensive training by headquarters loan staff, followed by an "apprenticeship" period, would provide the personnel needed to meet the anticipated workload. HEW affirmed its intent that the loan closing and financial management of the revolving loan fund would remain central office functions. As discussed on page 18, the central office staff level for loans had been decreased by the June 1976 assignment of loan officers to the Office of HMO Qualification and Compliance.

In testimony on the pending HMO amendments, we noted that if additional loan activity results from enactment of these amendments, which would remove some of the technical barriers to the full implementation of the loan program, HEW will need additional personnel, as well as uniform operating policies and procedures.

#### Promulgating regulations

The lack of enough staff with expertise in promulgating regulations is also a problem. For example, one factor delaying the issuance of final regulations to implement the HMO program is the lack of legal staff. Since January 1974 only one staff attorney has been assigned, part time (70 to 80 percent), to the program. The Assistant General Counsel for Public Health considers this staffing level too low, considering the number of regulations and related legal opinions required by the HMO program. (See p. 18.) The Assistant Secretary for Health, testifying on the proposed HMO amendments, noted that the staffing of the Office of General Counsel is supported by the allocation for the Office of the Secretary and not by the HMO appropriation.

## Qualification activities

As of June 30, 1976, the Office of HMO Qualification and Compliance had filled 9 professional and 4 clerical-secretarial staff positions of the 15 authorized. The Office, at that time, had 21 HMO qualification applications in process and 137 entities indicating intent to apply. An application reportedly takes an average of 84 staff-days to process, and additional applications would have about a 6-month waiting period to begin processing. The Director of the Office of HMO Qualification and Compliance indicated in January 1976 that his Office, which had been receiving about six qualification applications per month, had the staffing capacity to process only about two. Consequently, for each month of progress, his Office was falling behind an additional 2 months. Furthermore, he was concerned that the amount of time (about 50 percent) his staff must spend on compliance activities for qualified HMOs leaves even less time to reduce the application backlog.

The Assistant Secretary for Health acknowledged in both his July and November 1975 testimony that additional specialized-skill personnel for the HMO program were needed and stated that as many as possible would be assigned.

In February 1976 additional staff in HEW headquarters and several regional offices were assigned to assist in the processing and compliance activities of the Office of HMO Qualification and Compliance. Also, according to HMO qualification officials, additional staff from the Social Security Administration and the Division of HMOs were assisting them part time. However, the Office Director, commenting on the June 17, 1976, draft report to the Assistant Secretary for Health, indicated that using regional office and Social Security Administration personnel to review qualification applications was "a disaster and the office and agency will be suffering from its consequences for some time to come."

Further, in a published interview on April 13, 1976, the Director of the Office of HMO Qualification and Compliance stated in response to a question about the severity of his staffing problem:

"Very serious. The whole qualification process got started late compared to the grant program. There were fifty people working on grants before the first qualification person was hired. Thirteen are now working on qualification compared to 110 working on grants in Washington and the regional offices. We

need 17 more people right now. A staff of 30 is really necessary to handle our present and projected workload through fiscal year 1977. Our staff shortages have resulted in a current backlog in excess of five man-years in terms of the effort required to review applications. By June 30, the backlog will likely exceed ten man-years for only our qualification responsibilities. Compliance, dual choice, and writing regulations are also time-consuming responsibilities of our office. Without relief of some sort, that level of backlog will continue through fiscal year 1977. The qualification process now generally takes about four to six months for an individual applicant. I would like to get to the point where the process takes three to four months and our backlog is eliminated. Cutting two months off the long end is about the best we can do. By comparison, it takes three months alone just to process grant applications." 1/

The Administrator of HSA, in a June 3, 1976, memorandum to the Assistant Secretary for Health, acknowledged a need for additional staff in the Office of HMO Qualification and Compliance to handle the qualification backlog. He stated that the qualification office is experiencing unacceptable delays in processing applications for HMO qualification, noting that:

"\* \* \* the most complex and time-consuming aspect of qualification review is the determination of financial viability. In this regard, we currently rely heavily on contractor personnel and consultants to supplement our in-house OHMOQ&C [Office of HMO Qualification and Compliance] staff. This method of financial review is expensive and does not permit the same level of quality and control as would exist if the review were strictly an in-house operation. Moreover, the use of outside contractors and consultants presents potential conflict of interest situations, since nearly all of the consultant firms having expertise to perform HMO financial review are also active in providing technical assistance to such organizations. Finally, Congress had been critical of our reliance on contractors throughout the HMO program. \* \* \* Since the HMO Act requires the organizational separation of program developmental and qualification functions, it is not legally possible for the

---

1/The Group Health and Welfare News, May 1976.

OHMOQ&C to accept the financial analysis performed by the HMO Loan Program in the Division of Health Maintenance Organizations."

To meet the growing need for additional staff with the skills to perform the financial review of qualification applications, the Administrator of HSA proposed that four of the six persons staffing the HMO loan program in the Division of HMOs be transferred to the Office of HMO Qualification and Compliance. The other two persons would remain with the loan program to maintain its technical assistance, developmental, and monitoring functions. Furthermore, three additional employees would be transferred from the Division of HMOs for on-the-job training as qualification case officers.

On June 21, 1976, the six persons (five professional and one secretarial-clerical) staffing the loan program were detailed for 120 days to the Office of HMO Qualification and Compliance. An agency official in the loan office said that all but one of the five professional staff were assigned to review qualification applications, while the loan official responsible for HMO loan activities will continue to perform the financial review and monitoring functions, with the assistance of an outside consultant under contract with HEW. He viewed the situation as one of helping to reduce the qualification backlog while creating a staffing problem in the financial review of qualification applications, since the contract with the outside consultant to assist in the financial reviews will expire in October 1976 and no funds are available to renew it.

#### UNTIMELY ISSUANCE OF FINAL REGULATIONS AND GUIDELINES TO IMPLEMENT HMO ACT

The HMO Act of 1973 cannot be fully implemented or enforced until HEW publishes regulations in the Federal Register and issues administrative guidelines to program participants. The act makes 27 separate references to the need for the Secretary of HEW to develop implementing regulations. Also, by calling for secretarial "determination," "designation," "satisfaction," and "permission," the act refers at least 47 times to matters that could be covered by guidelines as well as regulations.

The regulations implementing the HMO Act of 1973 are contained in the Code of Federal Regulations; Title 42-- Public Health; Chapter 1; Subchapter J--Health Care Delivery Systems; Part 110--Health Maintenance Organizations. HEW has established nine subparts labeled A to I and an additional

section dealing with reimbursement of HMOs serving American Indians. The status and subject of the HMO regulations as of June 30, 1976, are summarized in the following table.

Status of HMO Regulations

<u>Title of subpart</u>	<u>Date of issuance</u>	
	<u>Notice</u> (note a)	<u>Final</u>
A. Requirements for an HMO	b/5-8-74	10-18-74
B. Federal financial assistance-- general: Designation of medically underserved areas (notice)	5-8-74	10-18-74  9- 2-75
C. Grants for feasibility surveys	5-8-74	10-18-74
D. Grants and loan guarantees for planning and for initial de- velopment costs	5-8-74	10-18-74
E. Loans and loan guarantees for initial operating costs	5-8-74	10-18-74
F. Qualification of HMOs	c/12-9-74	8- 8-75
G. Restrictive State laws and practices	5-8-74	10-18-74
H. Employee's health benefits plans	2-12-75	10-28-75
I. Continued regulation of HMOs	Being formulated as of 6-30-76	

Additional regulations  
for the HMO program

Indian health prepayment  
authority

a/Notice of Proposed Rulemaking.

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

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

The delay in issuing regulations was reported in a March 1975 HEW contract study to be a major barrier to successful HMO development. The study stated that:

"Delays in publication of the regulations as well as remaining uncertainties in those regulations have raised questions for some respondents about Federal commitment to HMO development and, in turn, reduced program support by key groups of providers, buyers, and potential financial backers.

"In addition \* \* \* the threat of being boxed in to a noncompetitive corner by the enforcement of the continuing regulation provision of the Act has deterred some HMO developers. This has, of course, been compounded by the absence of regulation on this point."

Our questionnaire asked if, in the respondents' view, the lack of final HEW regulations and guidelines to implement specific provisions of the act hindered an organization or group in becoming a federally qualified HMO. Over 70 percent of the respondents agreed that the absence of final guidelines and regulations for dual choice and continued Federal regulation of HMOs was such a hindrance.

The June 17, 1976, draft report to the Assistant Secretary for Health noted:

"Guidelines have not been issued for Part A and their absence has been quite harmful. Since the rules of the game are not clear an HMO does not at this point have a good understanding of what it must do to qualify. Each HMO is subjected to a "try us" obstacle course. Recognizing the complexity of the subject it should have been possible to produce a set of guidelines. \* \* \*"

#### Dual choice regulations--source of controversy and concern

Section 1310 of the HMO Act provides that every employer with at least 25 employees, who is required to pay the minimum wage and who provides health benefits to his employees, must offer the option of joining a qualified HMO. This is the dual choice provision.

We asked if the lack of final HEW regulations and guidelines implementing the provisions of section 1310 hindered

the organization or group in becoming a federally qualified HMO. Of the 297 respondents to this question, 215 (72 percent) agreed, 35 (about 12 percent) disagreed, and 47 (about 16 percent) agreed as much as disagreed.

Of the 297 respondents, 291 were identified by whether or not they had successfully applied for an HMO grant. Also, of the 297, 191 indicated that they were providing health services either through fee-for-service only, prepaid only, or a combination of fee-for-service and prepaid. As shown in the following table, the respondents with grants and those providing all or some of their health services on a prepaid basis were more concerned about the negative impact of being without final regulations than the other respondents in the subgroups.

Lack of Final Regulations for Dual Choice  
Hinders Becoming a Qualified HMO

	Respond- ents	Agree	Disagree	Agree as much as disagree
	—————(percent)—————			
<b>Grant status:</b>				
Successful appli- cants	68	83	77	10
Unsuccessful ap- plicants	63	71	16	13
Nonapplicants	<u>160</u>	72	7	21
Total	<u>291</u>			
<b>Health service pro- viders:</b>				
Prepaid	30	87	3	10
Fee-for-service	111	68	9	23
Combination	<u>50</u>	76	14	10
Total	<u>191</u>			

As noted on page 19, final regulations for dual choice were published on October 28, 1975. A major reason for the 22-month lag between the law's enactment and the issuance of these regulations was a lengthy dispute between the Department of Labor and HEW in interpreting congressional intent regarding the role of a collective bargaining agent when an employer meets the requirement of offering the dual choice of a qualified HMO in his employees' health benefits plan. The

dispute centered on whether the option for HMO membership must be offered directly to individual employees or whether it could be offered to appropriate bargaining representatives on behalf of such employees. HEW believed that the option of membership must be offered to individual employees, while the Department of Labor felt that the HMO should only be offered to the bargaining representatives on behalf of the employees. The final regulations reflect the Department of Labor's position. The proposed amendments also would assign a specific role to the collective bargaining agent.

Lack of final guidelines and  
a uniform policy for the  
loan and loan guarantee programs

The act provides for loans and loan guarantees to HMOs requiring financing for planning, initial development, and initial operating deficits (the amount by which operating costs exceed revenues in the first 36 months <sup>1/</sup> of operation). This support differs considerably from the HMO grant support in that it primarily deals with HMOs actually providing services to patients and requires that the recipient be fiscally sound in order to repay the loan. It is not intended that grant funds be recovered by the Government.

HEW has not developed uniform policies for administering and monitoring its loan and loan guarantee programs, including HMO activities. Loan applications were handled case by case, with guidance or policy decisions being sought as issues arose. HEW has not yet used its loan guarantee authority. The only two applications for loan guarantees were initially denied in April 1976. HEW is reconsidering those two applications.

HEW has recognized that the lack of a uniform loan and loan guarantee policy for departmental programs could theoretically lead to commitments to potential loan recipients which contradict the enabling legislation or are otherwise contrary to the financial interest of the United States. A program staff official responsible for HMO loan review (first a functional support group in the Bureau of Community Health Services, then a part of the Division of HMOs, and later detailed to the Office of HMO Qualification and Compliance) noted in January 1976 that the only Department loan policies are based on a series of memorandums and his personal knowledge. No formal HEW policy manual for loan programs comparable to the one for grant activity exists. The closest

---

<sup>1/</sup>Among other changes, the proposed amendments would extend this period of support to 60 months.

thing to such a document is the HMO loan application kit instructions, which the official considered to be a draft document needing revision. HEW commented in May 1976 that policy is contained in the series of memorandums prepared to address issues that arise during program administration.

Lack of a firm, uniform loan policy for HMOs is serious because the relationship between the HMO loan-guarantee program and the HMO qualification process is symbiotic. That is, for an HMO to receive a loan, it must operate as a qualified HMO; but to become qualified, it must be fiscally sound. For 12 of the 17 qualified HMOs, the Federal loan was necessary for fiscal soundness.

In describing the processes of loan application review and HMO qualification, the Director of the Office of HMO Qualification and Compliance noted in November 1975 that the effort is carried out:

"\* \* \* through a cumbersome arrangement involving two independent financial reviews, two independent site visits, and then a slowly integrated interweaving of the paperwork to have qualification and loan commitments appear to happen simultaneously."

In a previous report <sup>1/</sup> we pointed out that this arrangement has led to a situation in which the HEW qualification officials seriously questioned the fiscal soundness of an applicant but felt forced to qualify it since a loan had been approved.

HSA commented in May 1976 that this situation had changed in that the HMO loan activity and the HMO qualification activity were closely coordinated through frequent contact between operating personnel and regular weekly meetings between the directors of the Division of HMOs and the Office of HMO Qualification and Compliance. Problems encountered in the initial interactions between the groups had been resolved by working together.

However, the June 17, 1976, draft report prepared for the Assistant Secretary for Health noted that the relationship between the Division of HMOs and the Office of HMO Qualification and Compliance had been tense in the past

---

<sup>1/</sup>"Grants for Development of Health Maintenance Organizations in Region IV" (MWD-76-41, Oct. 4, 1975).

and indicated that it could deteriorate should the HMO amendments be enacted requiring all qualification and review functions to be administered in the Office of the Assistant Secretary.

Lack of effective coordination appears to be a primary reason that the loan officers were detailed in June 1976 to the Office of HMO Qualification and Compliance. While this action might reduce duplication, it removes the clear organizational separation between those who develop HMOs (via loan support) and those who qualify and regulate HMOs.

#### STATUS OF FEDERAL OVERRIDE OF CERTAIN RESTRICTIVE STATE LAWS

The preemption of certain restrictive State laws and practices by section 1311 of the act is considered essential to HMO development. This section provides for preempting State laws and practices which could hinder the development and operation of a qualified HMO or of an entity receiving Federal funds to become an HMO.

We found in all 10 regional offices that the HMO program officials were aware of restrictive State laws in their regions but generally had no plans for alleviating potential legal problems. Of the nine regional attorneys we contacted, only five indicated awareness of or involvement with restrictive State laws. The regional attorneys maintained that they needed final HEW guidelines to establish a definite policy to implement section 1311. All regions had a digest of State laws affecting HMOs that was prepared by an HEW contractor, but technical assistance to State officials and potential HMO programs came not from the limited regional resources, but primarily from one consultant.

In response to our statement on this matter before the House Subcommittee on Health and the Environment on July 14, 1975, HEW acknowledged that there are no formal guidelines for section 1311 (the final regulations for this section are basically a word-for-word restatement of the act). HEW policy was stated, however, as follows:

"If, during the feasibility study, legal barriers are identified by a grantee, an analysis of the situation would be performed by HMO program staff and by OGC [Office of General Counsel.] If it can be determined that the grantee has exhausted all reasonable organizational options; has acceptable

plans which would lead to a qualifiable HMO; and would be prevented from doing business because of one of the elements of State law specified in Section 1311; then that grantee would be provided with adequate grant funds to sustain a legal action, should the State elect to restrain the HMO from operating."

Final guidelines for section 1311 released in February 1976 were less specific than this statement in that HEW maintained section 1311 did not require or provide for any HEW administrative action or any specific remedy. Whether Federal financial assistance may be expended to pay for litigation or whether the Department of Justice would become involved were to be considered by HEW as possibilities. HEW's position is that it is impossible to determine what will happen with such laws until a federally qualified HMO attempts to provide services in a State with restrictive legislation; thus, section 1311 would be implemented case by case.

HEW's Assistant General Counsel for Public Health felt that section 1311 has not been and cannot be implemented by regulations, and that only a court adjudication could properly test the constitutionality of section 1311, authoritatively delineate the intent of the law, establish how Federal override provisions would be enforced, and determine when the section applies. Such an adjudication could, in his view, result from a suit brought by the State to enjoin the operation of an HMO, from a suit by an HMO or the United States to enjoin State enforcement of such provisions, or from an action for declaratory judgment.

However, he maintained that avoiding any unnecessary confrontation with the States is preferable. He also believes that an HMO would rarely be prevented from operating by a restrictive State law.

Although we do not disagree with this approach, we are concerned that considerable amounts of Federal grant funds can be awarded to projects in States with restrictive laws before the laws are tested in court.

HSA's comments in May 1976 stated that:

"\* \* \* not one of the 108 feasibility grants funded during fiscal year 1975 has determined that an HMO is not feasible because of a restrictive State law. To date, 20 of the feasibility grants have expired

resulting in a no-go determination. However, State law problems were not the major reasons for not going forward in any of these cases. Practically speaking, a qualified HMO is possible to operate in any State, after certain modifications are made where problems exist."

Our review of HEW's study of the 108 HMO feasibility grants did not alleviate our concern, however, since many of the grantees were determined by HEW not to have adequately studied the potential impact of State laws and regulations.

We asked recipients of our questionnaire if the lack of HEW regulations and guidelines on how certain State laws and regulations could be overridden by the HMO Act was a hindrance to becoming a qualified HMO. Of the 296 respondents, 182 (62 percent) agreed. Of the 296, we identified 289 by grant status and 189 who were health care providers. As noted in the following table, the majority of subgroup respondents agreed that the lack of regulations was a hindrance.

	<u>Respond-</u> <u>ents</u>	<u>Agree</u>	<u>Disagree</u>	<u>Agree as much</u> <u>as disagree</u>
	----- (percent) -----			
Grant status:				
Successful appli-				
cants	68	54	28	18
Unsuccessful ap-				
plicants	61	64	25	11
Nonapplicants	<u>160</u>	63	18	19
Total	<u>289</u>			
Health service pro-				
viders:				
Prepaid	29	72	14	14
Fee-for-service	111	68	17	15
Combination	<u>49</u>	51	27	22
Total	<u>189</u>			

We also noted that the response to this question varied considerably by HEW regional locations, as shown in the following table.

<u>Region</u>	<u>Respond-</u> <u>ents</u>	<u>Agree</u>	<u>Disagree</u>	<u>Agree as much</u> <u>as disagree</u>
I (Boston)	22	46	18	36
II (New York)	59	64	22	14
III (Philadelphia)	16	69	25	6
IV (Atlanta)	26	42	50	8
V (Chicago)	48	52	29	19
VI (Dallas)	48	77	15	8
VII (Kansas City)	11	91	9	-
VIII (Denver)	15	53	-	47
IX (San Francisco)	43	65	16	19
X (Seattle)	8	50	25	25
Total	<u>296</u>			

We asked a followup series of questions about which of the four types of State laws covered by section 1311 were particular hindrances to becoming a federally qualified HMO.

State Law Provisions Constituting  
Particular Hindrances to Becoming  
a Federally Qualified HMO

	<u>Total</u> <u>respondents</u>	<u>Agree</u>	<u>Disagree</u>	<u>Agree as much</u> <u>as disagree</u>
Medical society approval for HMO to do business in State	265	46	38	16
Physicians to constitute at least part of the HMO governing body	268	24	54	22
Local physicians to participate in providing services	265	24	57	19
HMOs to meet insurers' requirements for initial capitalization and financial reserves	274	60	26	14

Of the 274 respondents to the question concerning State laws governing insurers' capitalization and financial reserves, 268 respondents were identified by grant status and 173 had indicated that they were providing health services. The majority of all subgroups in these two specific analyses considered State capitalization and financial reserve laws as the greatest hindrance to becoming a federally qualified HMO.

The following table shows varied levels of concern in the 274 respondents listed by HEW region.

A Particular Hindrance to  
Becoming a Federal Qualified HMO  
Are State Laws Requiring HMOs  
to Meet Insurers' Requirements for  
Initial Capitalization and Financial Reserves

<u>Region</u>	<u>Respond- ents</u>	<u>Agree</u>	<u>Disagree</u>	<u>Agree as much as disagree</u>
	—————(percent)—————			
I (Boston)	20	50	30	20
II (New York)	54	72	19	9
III (Philadelphia)	15	80	7	13
IV (Atlanta)	26	50	35	15
V (Chicago)	43	49	32	19
VI (Dallas)	44	66	20	14
VII (Kansas City)	9	67	22	11
VIII (Denver)	14	64	36	-
IX (San Francisco)	42	50	29	21
X (Seattle)	7	57	43	-
 Total	 <u>274</u>			

Our May 1975 review of the HEW-sponsored digest of State laws affecting HMOs showed that most States had some laws and rules that could hamper HMO growth. For example:

- Sixteen States require the medical society to approve the furnishing of services by an HMO.
- Nineteen States require that physicians constitute all or part of an HMO's governing body.
- Thirty-nine States have requirements for insurers of health care services respecting initial capitalization and financial reserves against insolvency.

Although section 1311 overrode State laws prohibiting federally assisted or qualified HMOs from soliciting members through advertising, some State laws can circumvent the section by putting a limitation--to be set by the insurance commissioner--on marketing expenditures or requiring insurance commissioner approval for marketing procedures.

Also, section 1311 does not override all the restrictive State laws. Some problems have been identified by HEW which go beyond the section's scope. Some examples are: (1) 13 States require supervision of the HMO by the insurance commissioner, (2) 1 State requires that an HMO contract only with hospitals, (3) 1 State prohibits physicians from practicing with unlicensed persons, and (4) 15 States require that the insurance commissioner approve the HMO rate structure.

The proposed amendments would require the Secretary to develop a digest of State laws and regulations pertaining to the development, establishment, and operation of HMOs and, within 6 months of enactment (of the amendments), notify the Governor of each State of each State law and practice which appears to be inconsistent with the preemption of State laws and practices contained in section 1311. HEW has already developed such a digest, and we believe that the amendment will help clarify the position of newly developing HMOs prior to substantial Federal financial assistance.

#### DIFFICULTIES PERCEIVED WITH THE ACT'S ORGANIZATIONAL AND OPERATING REQUIREMENTS

Responses to our questionnaire indicated that organizational and operating requirements of the act could be slowing the development of qualified HMOs.

#### Principal activity of a medical group

The HMO Act, when defining and describing the organizational structures of HMOs, specifically requires that health professionals who are members of a medical group engage in HMO practice as their principal professional activity. Principal professional activity has been interpreted by regulations as 51 percent.

Of the 302 respondents to our question regarding the noncompetitiveness impact on HMOs of this requirement, 133 (about 44 percent) agreed that the principal professional activity requirement would make HMOs noncompetitive with other health benefits plans; 103 (about 34 percent) disagreed; and 66 (about 22 percent) had no opinion or basis to respond.

The proposed amendments address our respondents' concern by redefining medical groups so as to require that their members individually engage in coordinated group practice as their principal professional activity and collectively take substantial responsibility for the delivery of services to the members of the HMO. This would mean that each member of the group would have to give over half his time to the group practice but that no such requirement would apply to the amount of time each group member served HMO members. However, a substantial portion (over 35 percent) of the whole group's services would have to go to HMO members. HMOs would not have to meet this requirement for the first 3 years after qualification. The Secretary, in certain instances, would be authorized to waive the requirement beyond 3 years.

Basic health services

Our questionnaire asked if the basic health service requirements in the act would make HMOs noncompetitive with other types of health benefit plans. Of the 306 who responded to this question, 170 (about 56 percent) agreed that the comprehensive package of basic and supplementary health services required by the act would make HMOs noncompetitive. Of the 306, we identified 299 by grant status and 194 who were health service providers. As noted in the following table, in almost all subgroups a majority of respondents were concerned with the noncompetitiveness of the basic and supplementary benefit packages.

Comprehensive Basic and Supplementary Health Services Required by the HMO Act of 1973  
Would Make HMOs Noncompetitive with Other Types of Health Benefit Plans

	<u>Respond-</u> <u>ents</u>	<u>Agree</u>	<u>Dis-</u> <u>agree</u>	<u>Agree as much</u> <u>as disagree</u>	<u>No basis</u> <u>to respond</u>
	(percent)				
Grant status:					
Successful ap- plicants	68	57	30	12	1
Unsuccessful applicants	63	62	17	13	8
Nonapplicants	<u>168</u>	54	23	13	10
Total	<u>299</u>				
Health service providers:					
Prepaid	30	47	43	10	-
Fee-for-service	114	50	27	13	10
Combination	<u>50</u>	68	16	12	4
Total	<u>194</u>				

Respondents were particularly concerned with two of the basic services required by the act--treatment and services for alcohol or drug abuse and preventive dental care for children. Of 301 respondents to this question, 48 percent agreed that alcohol and drug abuse services made HMOs non-competitive and 40 percent expressed similar concerns about preventive dental care for children.

The proposed amendments would retain the treatment and services for alcohol and drug abuse in the basic benefits package and omit preventive dental care for children. However, the amendments would make some changes to make HMOs more competitive, including limiting the requirement for supplemental health services to only those for which enrollees have actually contracted.

### Open enrollment

The HMO Act requires that HMOs have an open enrollment period of not less than 30 days at least once a year. This requirement can be waived by the Secretary of HEW if the HMO can demonstrate that, among other things, such open enrollment will jeopardize its economic viability.

Of the 308 respondents to our question on this matter, 142 (46 percent) agreed that requiring open enrollment periods would make HMOs noncompetitive; 71 (23 percent) disagreed; and 95 (31 percent) had no opinion or no basis to respond. Most of those in the subgroups who expressed an opinion were concerned about open enrollment.

The greatest percentage of agreement with the statement that open enrollment would make HMOs noncompetitive came from those respondents who had HMO grants and from those who were providing health services on a prepaid basis.

The HMO Act allows the Secretary of HEW to waive the open enrollment requirement, and regulations issued October 18, 1974, outline the waiver process. An HEW official said that as of August 9, 1976, 18 requests for a waiver had been submitted but final action had not been taken because HEW criteria for justifying a waiver had not been finalized. Thus, the HMOs qualified as of June 30, 1976, have not been formally required to, nor formally waived of the requirement to, offer open enrollment.

The proposed amendments would defer the open enrollment requirement until the HMO (1) has been in existence for 5 years or has reached an enrollment of 50,000 members and (2) did

not incur a deficit in its most recent fiscal year. Moreover, HMOs would not be required to comply with the open enrollment requirement if they had enrolled a number of individuals during each year in excess of 3 percent of their total net increase in enrollment during the preceding calendar year. These amendments thus, for all practical purposes, would remove the open enrollment requirement since (1) none of the current 17 qualified HMOs have enrollments of 50,000 or more and (2) HEW's lack of administration of the less complicated waiver provision in the current law would probably continue to be lacking with the 3 percent formulation in the amendments.

### Community rating

The HMO Act requires HMOs to establish premiums based on a community rate rather than on an experience rate. This means that HMOs cannot establish prepayment rates based on health utilization experience, age, or sex differences among groups to whom they market. HMOs must establish one community rate for all members. One purpose of this is to spread equally among all HMO members the financial costs for comparable coverage.

Of the 307 respondents to the community rating question, 135 (44 percent) agreed that community rating requirements make HMOs noncompetitive; 79 (26 percent) disagreed; and 93 (30 percent) had no opinion or no basis to respond. Of the 307 respondents, we identified 300 by grant status, and 194 who were health care providers. Although most of the various subgroup respondents that expressed an opinion stated that community rating makes HMOs noncompetitive, the table below shows significant variations in the subgroup responses.

The Requirement That HMOs Fix Rates  
of Payments by a Community Rating  
System Rather Than by an Experience Rating  
System Would Make HMOs Noncompetitive  
with Other Types of Health Benefit Plans

	<u>Respond- ents</u>	<u>Agree</u>	<u>Disagree</u>	<u>Agree as much as disagree</u>	<u>No basis to respond</u>
	(percent)				
Grant status:					
Successful applicants	68	52	31	10	7
Unsuccessful applicants	63	36	33	19	13
Nonapplicants	<u>169</u>	45	21	11	23
Total	<u>300</u>				
Health service providers:					
Prepaid	29	59	28	10	3
Fee-for-service	114	40	26	10	24
Combination	<u>51</u>	47	31	14	8
Total	<u>194</u>				

The proposed amendments would delay imposing the community rating requirement for 4 years after an HMO becomes qualified. We have no information which indicates that such a delay will solve the problem affecting the market competitiveness of an HMO. Also, the full impact of community rating under the act is unclear because program guidelines containing the HEW interpretation of how community rating should translate into a premium rate structure, as acknowledged in the HEW comments on our draft report on July 28, 1976, have not been published.

NEGATIVE IMPACT OF LESS THAN  
ANTICIPATED FUNDING ON  
HMO PROGRAM DEVELOPMENT

As noted in chapter 2, HEW's inability to fully use the appropriated grant funds during fiscal years 1974 and 1975 was partly due to the grant applicants' failure to comply with the act. Although HEW had some valid reasons for not allocating all those funds, such underspending placed it in an untenable position for justifying increased appropriations for later fiscal years.

The fiscal year 1975 grant awards were made by HEW assuming grant budget levels of \$45 and \$65 million in fiscal years 1976 and 1977, respectively. HEW estimated (1) that continuation of fiscal year 1975 grantees to the next stage of development, recognizing an attrition rate, would require about \$30 million in fiscal year 1976 and (2) that initial funding of new project applicants would require an additional \$15 million.

In its budget justification for fiscal year 1976, HEW estimated that 165 grants would be made to projects in fiscal year 1975 for developing HMOs. Although 172 awards were made to 157 projects in fiscal year 1975, the available funds obligated were less than anticipated. HEW officials in their July 1975 testimony before the House Subcommittee attributed the reduction of funds obligated to several factors:

- Many applications were submitted by organizations that showed little understanding of the act and its purposes.
- The stringency of the act and regulations required equally stringent selection criteria and many organizations failed to meet these criteria for the funding level for which they applied.

--Some of the better qualified organizations (e.g., well-established medical groups, medical care foundations, and hospitals) elected to wait until all regulations were published before deciding whether to participate.

In October 1974 HEW submitted the fiscal year 1976 budget justification, which included a request for about \$50 million, to the Office of Management and Budget. According to agency officials, this amount would provide continued support to projects initially funded in fiscal year 1975 and initial support for new projects requesting assistance in fiscal year 1976. However, the Office of Management and Budget reduced the budget to \$18.6 million (\$15 million for grants and \$3.6 million for program support). Also, the Office's recommendations for fiscal year 1977 call for an \$18 million budget with an \$18 million extension of the grant authority through fiscal year 1978.

HEW appeals to the Office of Management and Budget to raise the budget allowances for fiscal years 1976 and 1977 were rejected and HMO program officials devised a funding plan in August 1975, based on the anticipated lower funding levels, for the duration of the authorized program. This plan, which was implemented in October 1975 by establishing a priority listing nationally and by region, would result in the early termination of some fiscal year 1975 grantees that would be funded if additional funds were available for fiscal year 1976.

In our November 21, 1975, testimony before the Senate Subcommittee, we said that HEW was considering a plan to allow some HMO grant projects funded in fiscal year 1975 to expire because of uncertain Federal funds to continue support. Responding to our testimony, the Assistant Secretary for Health testified on the same day that HEW has no intention of terminating support of meritorious projects of any kind if they are in the national interest and are serving the people. He informed the Subcommittee of his intention to seek the necessary funds to continue support for all viable projects and to fund additional new projects by either reprogramming within the present budget authority or by transferring within other authorities still in the limits of the President's budget request.

However, the Acting Administrator of HSA reported on January 9, 1976, that HSA was not able to propose reprogramming of about \$10 million needed for the HMO grant activity, which would result in not funding 35 feasibility projects and 5 planning projects for their next stage of

development. In a March 22, 1976, response to a February 9, 1976, request for information on this matter by the Chairman of the Senate Subcommittee on Health, the Secretary of HEW stated:

"The Health Services Administration has adjusted commitments to other ongoing programs in order to accommodate HMO priorities, to the extent that those priorities have been identified. The August 1975 projection by the HMO Program Director of a \$10 million shortfall has not been substantiated. That estimate was predicated on the assumptions that HMO amendments would be cleared by Congress and effected, and on a more rapid development of progress in currently funded HMO projects than has been experienced. You may be certain that we will continue to monitor the progress of program development through bimonthly project-by-project monitoring, and we have every intention of meeting our financial commitments to viable projects."

Consistent with his commitment to fund all viable projects, the Assistant Secretary for Health, in a June 11, 1976, memorandum to the Assistant Secretary, Comptroller, requested that additional funds be made available to the HMO program. He noted that the program will require the reprogramming of \$3,100,000 in grant funds in the transition quarter and an additional \$11,725,000 to the President's request (\$11,300,000 in grant funds and \$425,000 for 15 additional positions in the Office of HMO Qualification and Compliance) in fiscal year 1977 to fund all approved projects. He stated that the additional funds would permit the development of 111 qualified HMOs through September 30, 1979, for a total grant investment of \$95.4 million and would serve approximately 3,300,000 enrollees at maturity. He indicated that the present fiscal year 1977 funding level would produce only 89 HMOs through the same period at a total grant investment of \$75.3 million.

The Assistant Secretary, Comptroller, denied the request for additional funds and on July 8, 1976, the Assistant Secretary for Health appealed that decision through the Under Secretary to the Secretary of HEW. When we completed our review in August 1976, no decision had been made concerning the appeal.

## CONCLUSIONS

HEW has not organized, administered, or staffed the HMO program to effectively implement the HMO Act of 1973.

The headquarters' functionalized organization needed considerable coordination and cooperation among the functional components to do a concerted job of program implementation and monitoring. Without an adequate system to account for resources and without adequate numbers of and types of specialized staff, such a functionalized structure could not work efficiently or effectively.

We did not assess the impact of the November 1975 establishment of the Division of HMOs upon the staffing of and the accountability for the HMO program. However, the reorganization did not specifically address the needs for regional office accountability and the need for efficient coordination with the Office of HMO Qualification and Compliance.

The detail of loan staff from the Division of HMOs to the Office of HMO Qualification and Compliance may help reduce the qualification backlog, but it conflicts with congressional intent that the developmental and qualification functions remain organizationally separate within HEW.

Lack of staff, coupled with a lack of final regulations and guidelines, makes effective and uniform administration of a nationwide program of HMO grants, loans, qualifications, and regulations extremely difficult. Again, a final evaluation of program administration is premature until (1) all pending legislation is resolved, (2) HMOs operate under published regulations and guidelines, and (3) the amount of funds appropriated for the remainder of the program is established.

HEW has not taken any affirmative action to implement section 1311 except to provide limited technical assistance upon request. The Department has a "wait and see" policy, believing that each situation will be unique, especially regarding the need to actually support an HMO in a confrontation with a State. HEW does have data available, however, to identify which States could restrict developing HMOs.

## RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Assistant Secretary for Health to (1) obtain additional staff, especially in the regions, with sufficient expertise

in marketing, actuarial analysis, and financial management and (2) issue all final regulations and guidelines required by the act to more effectively and uniformly administer the nationwide HMO program.

Furthermore, we recommend that the Secretary identify the extent to which State laws may restrict the development of HMOs and seek legislative amendments consistent with the objectives of the restrictive State law provision contained in the act.

#### AGENCY COMMENTS AND OUR EVALUATION

##### Program administration

HEW, in commenting on our draft report on July 28, 1976 (see app. II), disagreed that the responsibility for the Federal HMO program administration has been fragmented. HEW maintained that the delegation of responsibility for HMO activities was clear and followed normal departmental procedures which have been demonstrably effective for implementing other legislation. Acknowledging that there were delays in implementing some aspects of the act, HEW maintained that the delays were due in part to the extraordinary need for communicating with many affected individuals and organizations both within and outside the Department, including the Congress.

The responsibilities for the HMO program, according to HEW, were decisively assigned.

"The initial delegation of responsibility to the Bureau of Community Health Services (BCHS) was expedited as a result of substantial pre-Act activity undertaken in anticipation of the eventual legislation.\* \* \* The Assistant Secretary for Health made parallel delegations: (1) to the Administrator, HSA, and subsequently to the Director, BCHS, for program and policy development, and (2) to the Regional Health Administrators for program implementation. A later reorganization moved the HMO program to another bureau of HSA. From the beginning, consistent with the act, qualification and compliance functions were established in a separate office within HSA to provide a measure of internal control. The Department has made an earnest effort to comply with rather specific intentions of the Congress, to communicate with Federal agencies and the public, and, at the same time, proceed with the implementation of the program."

We are not in a position to comment on how "demonstrably effective" HEW organization and delegation of responsibility has been for other legislation. We believe, however, that when many individuals and organizations are involved in implementing a program, considerable coordination and cooperation, as well as clear delegation of responsibility, are needed. The statements of the HEW headquarters and regional officials on pages 10 to 12 amply support our finding that such coordination and cooperation did not fully exist with the HMO program.

#### Resources allocated to program

HEW disagreed that inadequate resources were allocated to the HMO program, noting that the Department allocated resources to the program, both at the central office and in the regions, in excess of the staff-years authorized under the congressional appropriation. The Department, however, did agree with our recommendation that additional staff, with sufficient expertise, be obtained.

HEW maintained that the key point is not whether it monitored the actual number of days allocated in the work plans to determine if they were actually applied to HMO activities, but whether the tasks were accomplished on time. It further maintained that the Bureau of Community Health Services, HSA, and the immediate office of the Secretary all monitored the progress of those tasks identified in the work plan.

We believe the report sufficiently addresses several instances in which tasks identified in the work plans were not accomplished on time, such as the (1) inability of HEW regional office staff to adequately monitor and assist HMO projects, (2) lack of staff to process grant applications, (3) delays in publishing regulations and guidelines, and (4) backlog of applications for qualification. Although valid reasons may exist for delays in accomplishing some of these tasks, we believe that sound management practice requires a knowledge of the amount of time actually spent in completing tasks identified in the work plan.

#### Delays in issuance of regulations

HEW agreed that there were delays in the issuance of regulations and that all final regulations and guidelines should be issued, but added that:

"\* \* \* the Department made a very concerted effort to assure an opportunity for participation

in development of the regulations by the existing health care providers and institutions as well as the health insurance industry. Further, the evidence does not support the inference that slow development of the regulations had an adverse impact on the ability of potential grantees to apply. The Act itself set high standards for an HMO to achieve. \* \* \* The GAO report has not identified qualified applicants for developmental assistance which did not apply for a grant because of the time required to publish regulations. It is true that some operational HMOs which might have applied for qualification did not do so, pending publication of the regulations under Section 1310 of the Act. Delays in that process were largely attributable to complex, apparently contradictory requirements of the Act which required resolution of sensitive legal issues."

We believe that the data on pages 20 and 21, primarily from our questionnaire study, more than adequately supports the negative impact of the late issuance or nonissuance of regulations and guidelines. In our questionnaire survey, based on a universe supplied by HEW officials, the majority of respondents who had successfully applied for a grant indicated that the lack of final regulations and guidelines for continued regulation, "dual choice," and State law override were hindrances to becoming qualified. The inference of the negative impact of the delay in regulations is clearly noted in the quotations from an HEW contract study and the June 17, 1976, draft report to the Assistant Secretary for Health.

We agree with the Department that the HMO Act has been difficult to implement because of the legal complexities, and we have testified in support of the need to amend the law.

#### Utilization of appropriated funds

Our draft report implied that HEW was negligent for not spending all its appropriated funds. We agree with HEW's contention that its failure to utilize all the appropriated grant funds resulted not from a lack of applicants but from an inadequate number of proposals submitted which met the requirements of the act. Accordingly, the report has been revised to remove any direct implication that the Department is at fault for failing to utilize all the appropriated grant funds.

## Restrictive State laws

HEW does not concur in our recommendation that the Secretary take affirmative action identifying restrictive State laws and seek the necessary legislative amendments to section 1311 of the act. HEW noted that (1) in no case has the existence of certain restrictive State laws prevented the funding of grant applications which otherwise met the review criteria and (2) no State has taken action to restrict any of these projects because of conflicts with State laws. As we noted on pages 25 and 26, the data on which the Department bases its claim of no conflict with restrictive State laws was not sufficient to alter our concern that considerable Federal funds would be disbursed before such State laws were tested. The proposed amendments are in accord with our recommendation.

## MATTERS FOR CONSIDERATION BY THE CONGRESS

H.R. 9019, passed by the House on November 7, 1975, recognized that the slow program progress was partly due to certain complexities in the HMO Act. We testified on aspects of the House and Senate bills on July 14 and November 21, 1975, respectively, and concurred in the need to revise the legislation.

Because of the problems HEW experienced in implementing the HMO Act, we believe that the Congress, in developing legislation to achieve a program goal by a specific time, should (1) specifically provide the time needed to develop and issue implementing regulations and guidelines and (2) synchronize funding with the status of program implementation.

We believe that the wait and see position of HEW concerning implementation of section 1311 is justifiable in the absence of a more concise delineation of congressional intent on how to supersede State law. We believe that the proposed amendments requiring the Secretary of HEW to develop a digest of State laws and notify State Governors of State laws that would be affected by section 1311 of the act would allow HEW to take affirmative action consistent with a policy of nonconfrontation with the States. Furthermore, the Congress may wish to consider an amendment to section 1311 exempting HMOs from additional State laws considered to restrict an HMO's development. We believe, however, that this should not be done until HEW has demonstrated affirmative action in implementing section 1311.

We believe that the proposed amendments recognize many of the problems faced by HMOs under the current law; however, we note that the amendments concerning community rating and open enrollment postpone rather than directly address solutions in those areas.

## CHAPTER 4

### STATUS OF HMO EVALUATIONS

Sections 1314 and 1315 of the Health Maintenance Organization Act require extensive program evaluations of HMOs by both us and the Department of Health, Education, and Welfare.

Section 1315 requires the Secretary of HEW to report annually to the Congress on HMO program activities, including:

- A summary of grant and loan awards.
- Findings with respect to the ability of HMOs assisted under the act (1) to operate on a fiscally sound basis without continued Federal financial assistance, (2) to meet the organization and operation requirements of section 1301, (3) to include indigent and high-risk individuals in their membership, and (4) to provide services to medically underserved populations.

Also, HEW is to report on findings with respect to

- the operation of distinct categories of HMOs in comparison with each other,
- HMOs as a group in comparison with alternative forms of health care delivery, and
- the impact of HMOs on the public health.

Section 1314 of the act places similar evaluation requirements on us, with three exceptions: (1) we do not have to report annually to the Congress, (2) we must evaluate 50 HMOs financially assisted under the act after they have been delivering services for at least 36 months, and (3) we must study the economic effects on employers resulting from their compliance with the requirements of section 1310, the dual choice provisions of the act. This latter study and our evaluation of the operations of distinct categories of HMOs, of the operations of HMOs in comparison with alternative forms of health care delivery, and the effect of HMOs on the health care of the public are due in December 1976.

### PROGRESS OF GAO EVALUATION

Based on the slow progress in (1) the HMO grant, loan, and qualification programs and (2) the issuance of final

regulations concerning dual choice and "continuing regulation," there are not enough HMOs developed under the act for meaningful evaluation and reporting by December 1976. Further, we believe that a report by us on the 50 HMOs, possibly a decade after the act's passage, would be worth little to the Congress.

Also, there is no state-of-the-art agreement on what satisfactory methodologies have been developed to provide the comparative information for the impact on health determinations called for by section 1314(c).

The Congress acknowledged that our evaluation requirements under section 1314 appear to be unrealistic in view of the unanticipated delays in implementing the HMO Act of 1973. Accordingly, the proposed amendments to the act require us to (1) evaluate the operation of at least 10 or one-half, whichever is greater, of the HMOs that have received financial assistance under the act and that have qualified under section 1310 by December 31, 1976, and (2) report the results of such evaluation by June 30, 1978. In April 1975, we initiated an evaluation of two qualified HMOs to begin to meet our evaluations requirements under the proposed section 1314 of the act. Separate reports on the results of these two and later evaluations will be issued to the House and Senate health legislative subcommittees upon completion of each review. A consolidated report will be issued to the whole Congress before June 1978.

#### PROGRESS OF HEW EVALUATION

HEW has developed data-reporting requirements which, alone, will not provide sufficient information for the evaluations required by section 1315. HEW will rely on special studies to fully meet its evaluation requirements.

In fiscal year 1975 three studies concerning section 1315, prepared at a cost of about \$93,000, analyzed potential and existing operational prepaid plans regarding the (1) barriers to participation in the Federal programs authorized by the HMO Act, (2) economic viability of an HMO serving a rural population, and (3) cost competitiveness of HMOs compared to other prepaid plans and group health insurers in selected metropolitan areas.

The responsibility for HEW's section 1315 evaluations has been assigned to two separate operating groups within the Health Services Administration. Since the passage of the act, one group has had a considerable turnover in staff,

while the other has made several reassignments of the evaluation responsibility within the group. In September 1975 the two HSA groups started working agreements on establishing priorities for the evaluations. However, funding for the proposed fiscal year 1976 HMO special studies was reduced as part of a Public Health Service-wide reprogramming of evaluation funds for higher priority activities. Thus, the HSA fiscal year 1976 HMO evaluation effort is one preliminary study with a total budget of about \$37,500. This study proposes to establish the methodology of comparing qualified HMOs to alternative forms of health care. Additional studies have been proposed for fiscal year 1976 by the Office of the Assistant Secretary of Planning and Evaluation, but they are concerned with aspects of nonqualified prepaid health plans.

In July 1976 a meeting was held among HEW officials and experts in the prepaid health care field to discuss and develop a protocol for the evaluation requirements called for by section 1315. The meeting centered on a discussion of what new studies should be conducted and on the availability and comparability of data to evaluate HMOs. Contrary to HMO officials' concern about the need for a definitive protocol for a broad-based study of HMO evaluation, the final consensus was to continue HEW's present evaluation efforts.

#### CONCLUSIONS

During the first 2-1/2 years of the HMO program, HEW has not devoted significant resources to evaluate HMOs, as required by section 1315. This low-priority role for such evaluations appears to be continuing into fiscal year 1977.

Because of (1) the slow progress in implementing the law and establishing HMOs that comply with the law and (2) the lack of satisfactory methodologies to reliably determine the impact of any health delivery system on the health of the public, our reporting on the required evaluations by December 1976 is not feasible.

#### AGENCY COMMENTS AND OUR EVALUATION

HEW agreed that there have been only limited HMO evaluation activities and noted that several factors accounted for this: "One is by agreement with GAO because their own evaluation efforts have been so significant. A second is that in a program this new there is little to evaluate." HEW said, however, that a well-developed evaluation plan exists which will be implemented in a timely fashion.

We are not in a position to dispute that there is little to evaluate, but our findings contradict HEW's contention that a well-developed evaluation plan currently exists. As noted on page 44, HEW plans to continue present evaluation efforts. Although we sought to coordinate data collection from HMOs, no agreement was reached because we concluded that HEW's evaluation activities were and still are insufficient.

MATTERS FOR CONSIDERATION BY THE CONGRESS

We recommend favorable consideration of the proposed HMO Act amendment that revises the GAO evaluation requirements. We believe we can better meet the information needs of the Congress by substituting for the required 50 evaluations a review of selected HMOs certified by HEW as qualified operational entities. Such a review would provide more relevant and current information on the viability of the HMO concept.

**UNITED STATES GENERAL ACCOUNTING OFFICE****REGIONAL OFFICE****ROOM 1903 JOHN F. KENNEDY FEDERAL BUILDING  
GOVERNMENT CENTER****BOSTON, MASSACHUSETTS 02203**

April 4, 1975

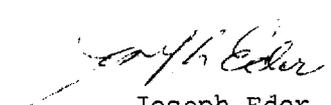
The United States General Accounting Office, an agency responsible for reporting to Congress on programs administered by the Executive Branch, is evaluating the Department of Health, Education, and Welfare's (HEW) implementation of grant and loan programs authorized by the Health Maintenance Organization (HMO) Act of 1973.

As part of our review, we want to identify the problems organizations are experiencing or expect to experience in attempting to comply with the Act. We also want to find out why some potential HMO's have not requested assistance under the Act.

Please assist us by giving your candid responses to the attached questionnaire. We plan to report the composite results of the questionnaire responses to the Congress for their use in considering possible further HMO legislation. Your experiences and opinions will help us make meaningful conclusions. Your answers will be kept confidential, and neither your name nor the name of your organization will be disclosed in our report. Readers will not be able to tell how you answered any questions because all answers to each question will be combined. The questionnaire is coded solely for our internal control and for follow-up. The questionnaire will not take long to complete and your timely response will reduce our need for follow-up.

Please complete and return the questionnaire in the enclosed postage paid envelope within five days. If you have any questions, please contact Mr. Anders T. Anderson at (617) 223-6536.

Sincerely,

  
Joseph Eder

Regional Manager

Enclosures

U.S. GENERAL ACCOUNTING OFFICE  
 SURVEY OF INDIVIDUALS AND GROUPS  
 EXPRESSING INTEREST IN FEDERAL FINANCIAL  
 ASSISTANCE FOR HEALTH MAINTENANCE ORGANIZATIONS

1. You have been identified as being interested in Federal financial assistance for health maintenance organizations because you were listed as a recipient of an application kit from the Department of Health, Education and Welfare (HEW). This kit consisted of background information, a copy of the Health Maintenance Organization (HMO) Act of 1973 (P.L. 93-222), an application blank, instructions, etc.

Did you receive such a kit?

- Yes (Go to Question 2)
- No (Go to Question 27)

BACKGROUND INFORMATION

2. What was your primary interest in obtaining the materials in the HMO application kit? (Check only one.)

- To consider applying for Federal financial assistance for my organization or group
- To study the legal impact of the HMO Act
- To evaluate the possible impact on the medical profession
- To study the impact of the HMO Act on society
- Other (Please specify) \_\_\_\_\_

3. Was the information in this application kit primarily for your own use or for the use of an organization or group? (Check one)

- Own use (Go to Question 4)
- Use of an organization or group (Go to Question 5)

4. Which best describes your profession? (Check one)

- Medicine or dentistry
- Social work
- Government
- Law
- Education
- Other (Please specify) \_\_\_\_\_

5. Which of the following best describes the type of organization or group with which you are affiliated? (Check one)

- An informal group of health service practitioners interested in affiliating for the purpose of providing health services.
- A group of health service practitioners already providing health services as a group on a fee-for-service basis.
- A pre-paid group practice
- A neighborhood health center
- Blue Cross and/or Blue Shield
- A foundation for medical care
- A medical society
- A hospital
- A medical school
- An insurance company
- A local or State government
- A union or trust fund
- A consumer/public group
- Other (Please specify) \_\_\_\_\_

6. Does your organization or group currently provide or arrange for the provision of health services?

- Yes, on a prepaid basis only (Go to Question 7)
- Yes, on a fee-for-service basis only (Go to Question 9)
- Yes, a combination of prepaid and fee-for-service basis (Go to Question 7)
- No (Go to Question 9)

AFTER COMPLETING QUESTION 4, GO TO QUESTION 27.

APPENDIX I

APPENDIX I

7. For how many years has your organization or group been providing services on a prepaid basis?  
 Number of years \_\_\_\_\_
8. Using your latest available data, indicate the number of prepaid enrollees that you have.  
 Number of prepaid enrollees \_\_\_\_\_
9. Has your organization or group filed a formal application for Federal financial assistance under the HMO Act (P.L. 93-222)? (NOT JUST A LETTER OF INTENT).  
 Yes (Go to Question 10)  
 No (Go to Question 18)

APPLICANTS

10. At the time of your application what was the intended profit status of the proposed HMO?  
 For profit  
 Non-profit  
 Uncertain
11. At the time of your application, for what type of an HMO were funds being sought?  
 An independent practice association HMO  
 A group practice HMO where physicians work as a medical group through a contract with the HMO  
 An employee HMO where physicians are salaried  
 Uncertain

12. For each type of Federal financial assistance that you requested under the HMO Act, indicate the date of the application in column (a) and place a mark (x) in one of the boxes under (b) to indicate the current status of the application. If you have submitted more than one application, either of the same or of different types, please give information on all such applications.

	(a) Date of Application (M/Y)	(b) CURRENT STATUS				
		Approved	Pending	Deferred	Rejected	Withdrawn
Feasibility Grant (1)						
(2)						
Planning Grant (1)						
(2)						
Initial Development Grant (1)						
(2)						
Initial Development Loan Guarantee						
Operational Loan						
Operational Loan Guarantee						

13. As part of your most recent application process, how much support or opposition did your organization or group receive from each of the following officials, societies, and agencies? (Check one box per row)

	No contact was made	A great deal of support	Some support	Neither support nor opposition	Some opposition	A great deal of opposition
HEW headquarters officials						
HEW regional officials						
State medical society						
Local medical society						
State comprehensive health planning agency (CHP)						
Local comprehensive health planning agency (CHP)						

APPENDIX I

APPENDIX I

IF THE CURRENT STATUS OF ANY OF YOUR APPLICATIONS IS EITHER "PENDING," "DEFERRED," "REJECTED," OR "WITHDRAWN," GO TO QUESTION 14. OTHERWISE, GO TO QUESTION 21.

14. What kind of feedback did you receive from HEW concerning your most recent application?

- Good, constructive criticism
- General, but thorough comments
- Some useful comments
- Only superficial comments
- No feedback

15. Has your most recent application either been rejected or withdrawn?

- Yes (Go to Question 16)
- No (Go to Question 22)

16. What is the likelihood that you will resubmit your application? (Check one)

- Very likely (Go to Question 22)
- Somewhat likely (Go to Question 22)
- As likely as not (Go to Question 17)
- Somewhat unlikely (Go to Question 17)
- Very unlikely (Go to Question 17)

17. What is tending to discourage you from resubmitting your application? (Check those which apply)

- Federal funds are no longer needed
- Lack of relevant feedback on my previous application
- The application process itself
- HEW regional officials
- HEW headquarters officials
- Other (Please specify) \_\_\_\_\_

AFTER COMPLETING QUESTION 17, GO TO QUESTION 22.

NON-APPLICANTS

18. Did your organization or group ever intend to apply for Federal financial assistance under the HMO Act?

- Yes (Go to Question 19)
- No (Go to Question 27)

19. Did your organization or group initiate some action in the application process, but not submit the application?

- Yes (Go to Question 20)
- No (Go to Question 21)

20. If you had initiated action in order to apply, how much support or opposition did your organization or group receive from each of the following officials, societies, and agencies? (Check one box per row)

	No contact was made	A great deal of support	Some support	Neither support nor opposition	Some opposition	A great deal of opposition
HEW headquarters officials						
HEW regional officials						
State medical society						
Local medical society						
State comprehensive health planning agency (CHP)						
Local comprehensive health planning agency (CHP)						

APPENDIX I

APPENDIX I

21. THE QUESTIONS BELOW LIST A NUMBER OF POSSIBLE REASONS WHY YOUR ORGANIZATION OR GROUP MAY NOT HAVE APPLIED FOR FEDERAL FINANCIAL ASSISTANCE UNDER THE HMO ACT OF 1973.

A. Please indicate the extent to which your organization or group agrees with each of the following statements concerning the application for Federal financial assistance under the HMO Act of 1973. (Check one box per item)

	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
The time necessary to complete the application was a deterrent					
The detailed information needed to complete the application was a deterrent					
Having to meet the requirements of the HMO Feasibility Study Guide was a deterrent					
Other application concerns (Please specify)					

B. Funds  
Please indicate the extent to which your organization or group agrees with each of the following statements concerned with HMO's which can comply with the requirements of the HMO Act of 1973. (Check one box per item)

	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
You do not require Federal funds.					
You feel Federal funds would take too long to obtain.					
You need more funds than the Federal Government can grant or loan to you.					
Other funding concerns (Please specify)					

C. Organization  
Please indicate the extent to which your organization or group agrees with each of the following statements concerned with HMO's which can comply with the requirements of the HMO Act of 1973. (Check one box per item)

	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
Your organization or group is not interested in setting up or running an HMO					
Your organization or group is not ready to look further into an HMO project at this time, but may be in the future.					
Your organization or group does not want Federal involvement in its HMO project					
Your organization or group feels it does not have the appropriate background to sponsor an HMO					
Other organizational concerns (Please specify)					

D. Community and Marketing  
Please indicate the extent to which your organization or group agrees with each of the following statements concerned with HMO's which can comply with the requirements of the HMO Act of 1973. (Check one box per item)

	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
Your organization or group has determined that there is little interest in the community for an HMO					
There are already enough prepaid medical plans in your area					
There are already enough potential HMO plans in your area					
Current economic conditions are inappropriate for considering an HMO					
Other community and marketing concerns (Please specify)					

PROVISIONS OF THE HMO ACT OF 1973

22. Based on your current and anticipated experiences with the provisions of the HMO Act and the regulations related to it, indicate the extent to which your organization or group agrees that each of the following requirements would make HMO's non-competitive with other types of health benefit plans. (Check one box per item)

	Have no basis to respond	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
The requirement that HMO's fix rates of payments by a 'community rating' system rather than by an 'experience rating' system (Sections 1301-(b)(1)(C), 1302(8))						
The requirement that HMO's have 'open enrollment' periods without knowledge of how the Secretary of HEW would grant waivers (Section 1301-(c)(4))						
The requirement that HMO's provide a comprehensive package of basic and supplementary health services (Section 1302(1) and (2))						
The requirement that the medical group engage in HMO practice as their principal (at least 51%) professional activity. (Section 1302(4)(C))						

23. Indicate the extent to which your organization or group agrees that each of the following services would tend to be an important factor in making the comprehensive package of health services expensive and, thus, non-competitive. (Check one box per item)

	Depends on the HEW guidelines	Strongly disagree	Generally disagree	Agree as much as disagree	Generally agree	Strongly agree
Physician services						
Inpatient and outpatient hospital services						
Emergency health services						
Short term, outpatient evaluative and crises intervention mental health services						
Medical treatment and referral services for alcohol and drug abuse or addiction						
Diagnostic laboratory and diagnostic and therapeutic radiologic services						
Home health services						
Voluntary family planning services						
Infertility services						
Preventive dental care for children						
Children's eye examinations to determine need for vision correction						

APPENDIX I

APPENDIX I

24. To what extent do you agree that the lack of final regulations and guidelines implementing the following provisions of the HMO Act are hindrances to your organization or group becoming a Federally qualified HMO?

Strongly disagree  
Generally disagree  
Agree as much  
Generally agree  
Strongly agree

	Strongly disagree	Generally disagree	Agree as much	Generally agree	Strongly agree
The lack of final regulations for employers to offer 'qualified' HMO's as a health benefit plan option is a hindrance (Section 1310)					
The lack of regulations on how HEW is going to establish continued regulation of HMO's is a hindrance (Section 1312)					
The lack of regulations on how certain state laws and regulations could be 'overridden' by the HMO Act is a hindrance (Section 1311)					
Medical society approval for HMO to do business in a state					
Physicians to constitute at least part of governing body					
Local physicians to participate in providing services					
HMO's to meet insurers requirements for initial capitalization and financial reserves					

25. What is the likelihood that you will submit an application for Federal financial assistance under the HMO Act of 1973 within the next year?

- Very likely
- Somewhat likely
- As likely as not
- Somewhat unlikely
- Very unlikely

26. How likely is it that your organization or group will become a Federally qualified HMO?

- Very likely
- Somewhat likely
- As likely as not
- Somewhat unlikely
- Very unlikely

27. If you do not mind, we would like to have your name, title, address and telephone number recorded here. This will enable us to:

- (1) identify you as a respondent so that we do not have to contact you further with regard to returning the questionnaire, and
- (2) contact you if there is a response on your questionnaire which we would like to have amplified.

\_\_\_\_\_  
(NAME)

\_\_\_\_\_  
(TITLE)

\_\_\_\_\_  
(BUSINESS ADDRESS)

\_\_\_\_\_  
(CITY, STATE AND ZIP CODE)

\_\_\_\_\_  
(BUSINESS TELEPHONE NUMBER)

28. Please use any remaining space or an additional sheet of paper to expand your answer to any of the questions or to record any comments you have about the implementation of the HMO Act of 1973 - how it has affected or could affect you and/or your organization.



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

Jul. 28 1976

Mr. Gregory J. Ahart  
Director, Manpower and  
Welfare Division  
United States General  
Accounting Office  
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Slow Progress in Implementing the Health Maintenance Organization Act of 1973." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

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

Sincerely yours,

A handwritten signature in cursive script that reads "John D. Young".

John D. Young  
Assistant Secretary, Comptroller

Enclosure

**NEW COMMENTS ON DRAFT REPORT TO THE CONGRESS OF THE UNITED STATES BY THE COMPTROLLER GENERAL OF THE UNITED STATES ON THE TOPIC "SLOW PROGRESS IN IMPLEMENTING THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973"**

**BACKGROUND**

Since the signing of the HMO Act in December 1973, the progress of the HMO program has been increasing at a steady pace, securing support from many groups across the country. Contrary to the negative tone of the report, the increasing, steady support from all portions of the private and public sectors has resulted in the following developments:

- . Significant accomplishments for internal program management have been: (1) completing all regulations essential to initiating the major aspects of the Act, extensive grant review criteria, and monitoring and reporting forms for program control, and (2) developing policies to insure uniform national guidance to all the Department's HMO efforts.
- . We received 375 applications for funds requesting \$59 million during the five review cycles in fiscal year 1975. From these, 172 grant awards were made to 157 organizations totalling \$22.5 million after careful review and evaluation to protect the Federal Government's investment in the private sector. An additional \$8.7 million in awards was made in the first cycle of fiscal year 1976, bringing to 186 the number of feasibility, planning, and initial development grants awarded to date to 168 organizations.
- . A qualified technical assistance activity, comprised of individuals who are expert in scarce skills, has been undertaken to aid organizations to meet the rigid criteria of the Act.
- . Awards for the development of HMOs were made to organizations in 42 States, the District of Columbia, and territories in fiscal year 1975.
- . Twenty-six States have enacted HMO enabling legislation, compared to 5 in 1972, 12 in 1973, and 19 in 1974.
- . The HMO program has provided 15 States with technical assistance in the development of prepaid Medicare-Medicaid contracts. Three States had contracts in 1971.
- . Evaluation studies have been completed on important aspects of the legislation; studies have also been made to document the barriers to the implementation of the HMO Act, to review certain aspects of the activity, and to make cost comparisons between the HMO and fee-for-service systems.

- . At their request, more than 75 presentations were made to professional, consumer, industrial, and labor groups, with audiences ranging up to 1,500 people.
- . Thirteen HMOs serving more than 90,000 enrollees are now qualified under the HMO Act.

#### GENERAL COMMENTS

While some of the statements in the report are accurate and objectively interpreted, there are at least four areas where the report draws inferences which are not substantiated by the facts. It is on these areas that the Department's response will focus. In addition, we are suggesting significant factual and technical changes to the report.

First, we object to the criticism that administration of the program has been fragmented. While there were delays in implementing some aspects of the Act, due in part to extraordinary need for communicating with many affected individuals and organizations both within and outside the Department, including the Congress, the responsibilities were decisively assigned. The initial delegation of responsibility to the Bureau of Community Health Services (BCHS) was expedited as a result of substantial pre-Act activity undertaken in anticipation of the eventual legislation. The delegation was clear and followed normal departmental procedures which have been demonstrably effective in implementing other legislation. The Assistant Secretary for Health made parallel delegations: (1) to the Administrator, HSA, and subsequently to the Director, BCHS, for program and policy development, and (2) to the Regional Health Administrators for program implementation. A later reorganization moved the HMO program to another bureau of HSA. From the beginning, consistent with the Act, qualification and compliance functions were established in a separate office within HSA to provide a measure of internal control. The Department has made an earnest effort to comply with rather specific intentions of the Congress, to communicate with Federal agencies and the public, and, at the same time, proceed with the implementation of the program.

A second allegation contained in the report is that inadequate resources were allocated to the program. The Department allocated resources to this program, both at the central office and in the regions, in excess of the man-years authorized under the congressional appropriation. The report concedes this but then criticizes the Department for not having monitored whether the actual number of days allocated in work plans were actually applied to HMO activities. That misses the point. The key question is whether the tasks were accomplished on time. BCHS, HSA, and the immediate Office of the Secretary all monitored progress in the accomplishment of those tasks identified in the work plan.

The report depicts the issuance of regulations as a process which was time-consuming. Those facts are not in dispute. The Department made

a very concerted effort to assure an opportunity for participation in development of the regulations by the existing health care providers and institutions as well as the health insurance industry. We believe that the process followed was appropriate for dealing with special interest groups. Further, the evidence does not support the inference that slow development of the regulations had an adverse impact on the ability of potential grantees to apply. The Act itself set high standards for an HMO to achieve. These were buttressed by explicit operational guidelines used by the Department in the review of applications. The approval rate was less than 50 percent. The GAO report has not identified qualified applicants for developmental assistance which did not apply for a grant because of the time required to publish regulations. It is true that some operational HMOs which might have applied for qualification did not do so, pending publication of the regulations under Section 1310 of the Act. Delays in that process were largely attributable to complex, apparently contradictory requirements of the Act which required resolution of sensitive legal issues.

Finally, the report faults the Department for failure to utilize all of the appropriated grant funds. That failure was not the result of a lack of applicants but resulted from the fact that there was not an adequate number of proposals submitted which met standards implied by the Act and articulated in our review guidelines. It would have been irresponsible for the Department to fund projects which did not pass the objective review process. It would have been easy to overfund those which did meet the standards so that they might not have required future year funding. To do so, however, would have not been responsible and would have been questionable from a legal perspective. Further, spending of all appropriated funds is not an adequate or accurate measure of program progress.

Our comments on the specific recommendations made in the report are as follow:

#### GAO RECOMMENDATION

The Secretary should direct the Administrator of HSA to obtain additional staff with sufficient expertise, especially in the regions, in the areas of marketing, actuarial analysis, and financial management.

#### DEPARTMENT COMMENT

We concur. There has been an effort to obtain staff with sufficient expertise both in the regions and in the central office since the start of the implementation of the Department's HMO program. The Administrator of HSA specifically addressed the issue of regional office expertise in a February 1974 memorandum to the Regional Health Administrators which contained sample qualifications in the three technical areas referred to in the recommendation.

GAO RECOMMENDATION

The Secretary should direct the Administrator of HSA to issue all final regulations and guidelines required by the Act to more effectively and uniformly administer the nationwide HMO program.

DEPARTMENT COMMENT

We agree that all final regulations and guidelines should be issued. However, final guidelines in certain areas, such as community rating and other provisions of Subpart A, have not been completed. It must be recognized that the complexity of the issues posed by the statute and the restrictive nature of certain requirements have made finalization of regulations and guidelines extremely difficult.

GAO RECOMMENDATION

The Secretary should take affirmative action to identify the extent to which State laws may restrict the development of HMOs and to seek legislative amendments consistent with the objectives of the restrictive State law provision contained in the Act.

DEPARTMENT COMMENT

We do not agree. In no case has the existence of certain restrictive State laws prevented the funding of grant applications which otherwise met the review criteria. Further, no State has taken action to restrict any of these projects because of conflicts with State laws. Based on our experience, it is possible for a qualified HMO to operate in any State, after certain modifications are made where problems exist. The Department provides assistance, at the request of the States, in the development of HMO enabling acts. As of April 15, 1976, 26 States have enacted such legislation. The Department, therefore, believes that State laws do not restrict the development of HMOs and that no legislative amendments are necessary. We suggest that this recommendation be deleted.

TECHNICAL COMMENTS

Page 13 - "The Regional Health Administrators (RHAs) who are responsible for this, as well as other health related activities, report directly to the Office of the Assistant Secretary for Health (OASH) and are not accountable to the Administrator of HSA or other agency heads."

This statement is not in error, but carries unnecessarily negative implications. We suggest, "The RHAs who are responsible for this, as well as other health activities

in the regional offices, report directly to the Assistant Secretary for Health."

Page 14 - ". . . BCHS had no management information system to trace or account for regional staff resources."

Without providing further information, this statement carries erroneous implications. Accountability for regional resources is a responsibility of OASH, not the individual program within PHS. The OASH has systems for regional accountability, and information is available to BCHS and all other PHS programs. These systems include:

1. Terminal Data Collection System - monthly reports reflecting full staffing information on all regional employees funded by the HMO and other program accounts.
2. Regional Accounting System - monthly accounting reports reflecting obligations and expenditures made against the HMO and other program accounts.
3. RHA Work Program - regional operational plans, in response to agency program guidance, identifying regional man-years committed to meeting specific HMO and other program objectives. This system includes holding regular management conferences between RHAs and agency heads to address operational issues in implementing program objectives and provides for agency requests of special reports on program status from the regions. Under this process, the RHAs have their own internal procedures for monitoring work program objectives and staff utilization.

Page 16 - "HEW does not have the number and type of personnel needed to implement the HMO grant program."

Training of staff has been intensive at both regional and central levels. Over 15 sessions conducted by senior staff have served to orient newly assigned personnel into the HMO concept and the operating procedures of the division. Detailed training in financial analysis has been provided by staff experts at five sessions. A similar sequence in the field of marketing is about to be initiated. Staff of the Technical Assistance Branch have developed and are implementing an ongoing, intensive training program in grant evaluation and monitoring for the new personnel.

Page 18 - "HEW also does not have the number and type of personnel with expertise, especially in the regions, needed to effectively monitor the loan and loan guarantee program."

Substantial training in the past 12 months has produced a core unit of four loan specialists, headed by a highly experienced chief. With assistance from a qualified contractor, which furnishes analyses of marketing strategies and implementation plans, this group has been able to respond to the present workload. Personnel who have the necessary background in accounting are now available in the regional offices and in the HMO program to assist in the loan activity as volume increases. Brief but intensive training by the Loan Branch staff, followed by an "apprenticeship" period, will provide the manpower needed to meet the anticipated workload. It is intended that the loan closing and financial management of the revolving loan fund will remain central office functions.

Page 42 - ". . . one indication of the slow progress of the HMO program was HEW's inability to fully utilize the appropriated grant funds during fiscal year 1975."

On the basis of reasons stated in the last paragraph of the general comments to this response, we believe the quotation should be rephrased to read, ". . . one indication of the problems caused by the restrictive nature of the Act was that only \$22.5 million was obligated of the \$40 million appropriated because most applicants were unable to comply with the Act."

Page 51 - ". . . HEW has not devoted a significant amount of resources to the evaluation of HMOs. . . ."

It is true that there has not been a high level of effort in the evaluation activities. That is due to several factors. One is by agreement with GAO because their own evaluation efforts have been so significant. A second is that in a program this new there is little to evaluate. There is, however, a well-developed evaluation plan which will be implemented in a timely fashion.

GAO note: Page references in this appendix may not correspond to page numbers in the final report.

PRINCIPAL HEW OFFICIALS  
RESPONSIBLE FOR ACTIVITIES  
DISCUSSED IN THIS REPORT

	<u>Tenure of office</u>	
	<u>From</u>	<u>To</u>
<b>SECRETARY OF HEW:</b>		
David Mathews	Aug. 1975	Present
Caspar W. Weinberger	Feb. 1973	Aug. 1975
<b>ASSISTANT SECRETARY FOR HEALTH:</b>		
Theodore Cooper	May 1975	Present
Theodore Cooper (acting)	Feb. 1975	Apr. 1975
Charles C. Edwards	Mar. 1973	Jan. 1975
<b>ADMINISTRATOR, HEALTH SERVICES</b>		
<b>ADMINISTRATION:</b>		
Louis M. Hellman	May 1976	Present
Robert Van Hoek (acting)	Feb. 1975	May 1976
Harold O. Buzzell	July 1973	Jan. 1975

Copies of GAO reports are available to the general public at a cost of \$1.00 a copy. There is no charge for reports furnished to Members of Congress and congressional committee staff members. Officials of Federal, State, and local governments may receive up to 10 copies free of charge. Members of the press; college libraries, faculty members, and students; and non-profit organizations may receive up to 2 copies free of charge. Requests for larger quantities should be accompanied by payment.

Requesters entitled to reports without charge should address their requests to:

U.S. General Accounting Office  
Distribution Section, Room 4522  
441 G Street, NW.  
Washington, D.C. 20548

Requesters who are required to pay for reports should send their requests with checks or money orders to:

U.S. General Accounting Office  
Distribution Section  
P.O. Box 1020  
Washington, D.C. 20013

Checks or money orders should be made payable to the U.S. General Accounting Office. Stamps or Superintendent of Documents coupons will not be accepted. Please do not send cash.

To expedite filling your order, use the report number in the lower left corner and the date in the lower right corner of the front cover.

GAO reports are now available on microfiche. If such copies will meet your needs, be sure to specify that you want microfiche copies.

**AN EQUAL OPPORTUNITY EMPLOYER**

**UNITED STATES  
GENERAL ACCOUNTING OFFICE  
WASHINGTON, D.C. 20548**

**OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE, \$300**

**POSTAGE AND FEES PAID  
U. S. GENERAL ACCOUNTING OFFICE**



**THIRD CLASS**