HEALTH MAINTENANCE ORGANIZATIONS

(ARCHIVED--01/18/82)

ISSUE BRIEF NUMBER IB81077

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MAJOR ISSUES SYSTEM

DATE ORIGINATED 05/05/81
DATE UPDATED 01/22/82

FOR ADDITIONAL INFORMATION CALL 287-5700

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ISSUE DEFINITION

In FY81, the authorities contained in Title XIII of the Public Health Service (PHS) Act expired. Among other things, Title XIII has provided Federal support for the development and operation of health maintenance organizations (HMOs). The Reagan Administration proposed to phase out assistance for the development and operation of HMOs. According to the Administration, future development of HMOs can be funded through the private sector.

BACKGROUND AND POLICY ANALYSIS

The term "health maintenance organization" generally describes an entity which provides specific health services to its members for a prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly payment insures some portion of the costs of health services that a subscriber may incur during a period of time.

However, an HMO is different from the fee-for-service system and traditional health insurance programs in at least three respects. First, it is different in its approach to payment to providers of health care services. In an HMO, providers are at risk and are not reimbursed for each of the services they provide, as physicians in the fee-for-service system generally are.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system by either providing directly or arranging to have provided those services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own provider or providers whom the plan might then pay.

Finally, a member of an HMO most often is allowed to choose his own physician within the plan. However, the member is not allowed, except under extraordinary circumstances of medical emergency, to seek care from physicians or other providers outside the plan.

These aspects of the HMO concept are alleged to give the HMO a capacity and a financial incentive to control the utilization of health services so as to reduce overall health care costs.

The term, health maintenance organization, was first advanced by Dr. Paul Ellwood in 1970, and was intended to include two basic HMO models: (1) the prepaid group practice model, and (2) the individual practice association or medical care foundation model. In both models, the HMO receives periodic payments of fixed amounts in return for the services it provides to HMO members.

Under the group practice model, however, most medical services are provided by physicians who are members of a group practice. Some physicians may be either employees of the HMO or members of a separate entity which contracts with the HMO to provide medical services to HMO members.

Physicians in these arrangements are paid in a variety of ways -- the two most common being either by salary, or as a group where the HMO pays the group fixed payments per member each month.

Under the individual practice association or IPA model, physicians in a community, generally a county, or group of counties, contract with the HMO to provide medical services out of their private offices, which can be either solo or group practices. Physicians in IPAs are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physician. In other words, the fewer expenses incurred by the HMO by the end of the year, the higher the income is likely to be for physicians at that time.

Group practice HMOs either own their own hospitals, as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is the most common among group practice HMOs, and is the prevailing practice with individual practice association HMOs.

Because providers are at risk and are not reimbursed for each of the services they provide, HMOs are intuitively attractive as a means for cost control because they alter the usual economic incentives in medical care and give providers a stake in holding down costs. Evidence tends to support this theory, particularly when the response to HMO incentives is compared to the prevailing system of third-party reimbursement for providers. Studies have found that the total cost of medical care (i.e., premium plus out-of-pocket costs) for HMO enrollees is lower than it is for comparable people with conventional insurance coverages. The lower costs are clearest for enrollees in HMO group practices, where total costs are from 10% to 40% below the costs of conventional insurance enrollees. Although the evidence is relatively meager, by comparison, costs for enrollees in individual practice associations appear no lower than for enrollees in conventional insurance arrangements.

Most of these cost differences have been found to be the result of hospitalization rates lower than those of conventionally insured populations. And these lower hospitalization rates are due almost entirely to lower admission rates; the average length of stay of a person in a hospital shows little difference in the HMO as opposed to the conventional arrangement. For example, the last National HMO Census of Prepaid Health Plans noted, for 1979, the inpatient hospital utilization rate for all HMO plans was 412 days per 1,000 members per year. This compares to an average of about 730 days per 1,000 Blue Cross enrollees nationally in 1978.

In addition, physician visits per member per year for all HMO plans averaged 3.4, and total health plan encounters, including those with the HMOs' nurse practitioners or physicians assistants, per member per year for all plans averaged 4.5 in 1979. The national average was about 5 physician visits per person per year.

It should be noted that although there is substantial evidence of lower total costs for HMO enrollees, a recent study by Harold Luft, "Trends in Medical Care Costs: Do HMOs Lower the Rate for Growth?," indicates that there is little evidence that costs in HMOs are growing less rapidly than in the overall health care sector. This study and its findings suggest that HMOs may not have the solution to the problem of escalating medical costs within the prevailing third-party reimbursement system.

It should also be noted that it is not precisely clear why HMOs produce the cost savings they do for their enrollees. Some persons have suggested that HMOs serve a younger, healthier, and wealthier population. But studies are not all that conclusive about this subject. In fact, some studies have found no statistically significant differences between HMO members and people with conventional third-party coverage.

This is characteristic of the HMO literature in general. It is seldom conclusive. This can in part be explained by the nature of the subject under investigation; there is no one single model for the HMO or prepaid group practice. That is, there are group practice HMOs and IPA HMOs. In addition, HMOs vary in size from a few thousand enrollees to more than 1 million. In some cases, enrollees are a homogeneous population, such as a university faculty. In other cases, the population is heterogeneous. The geographic base of enrollment may be concentrated in a single town such as Columbia, Maryland, or dispersed through several metropolitan areas, such as in the Kaiser plans in California.

In addition, the literature on HMOs is incomplete. Available data vary in depth and quality, and by far the majority of studies on HMOs relate to a few large, well-established plans.

Finally, there exist no randomized, controlled experiments that involve the assignment of a representative group of persons to a range of health insurance plans and HMOs. Therefore, while it is possible to say that costs are lower in one situation than in another, because of lower hospital admission rates, it is not possible to determine whether the differences are the result of the general characteristics of plans, of the unique features of the providers, or the differences among the people selecting each plan.

TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

Title XIII of the Public Health Service Act was established when Congress enacted the Health Maintenance Organization Act of 1973, P.L. 93-222. The authority was extended and revised twice -- once in 1976 (P.L. 94-460) and again in 1978 (P.L. 95-559) -- before its third revision in 1981.

Among other things, Title XIII has provided Federal support for the development and operation of HMOs. Grants and contracts have been awarded for feasibility surveys and for the planning and initial development of HMOs or for the expansion of existing HMOs. Loan guarantees have also been available for planning and initial development. In addition, loans and loan guarantees are available to HMOs for the first 5 years of their operation. Finally, another section in Title XIII provides loans and loan guarantees for the acquisition and construction of ambulatory health care facilities.

Title XIII also establishes standards for Federal qualification of HMOs. To qualify under Title XIII, an HMO must provide certain specified basic health services. It must be organized in a certain fashion and the HMO must be fiscally sound. In addition, prior to revisions made in 1981, the payment for enrollment in an HMO could be fixed only under a community rating system.

Generally, under a community-rating system, the same premium is charged for the same benefits to all individuals or groups regardless of age, sex composition, and cost experience of the insured. Under experience rating, on the other hand, premiums vary according to the cost experience of each group served. Members of some groups pay higher average premiums than members of

other groups under this method. The use of experience rating has in practice tended to make health services most expensive for groups at highest risk and/or the highest utilizers of services, such as the aged or chronically ill. Under the community rating system of Title XIII, on the other hand, the HMO must price its services according to the experience in utilization that it has had with its entire enrolled membership.

In addition, prior to revisions made in 1981, Title XIII required a qualified HMO that had provided comprehensive health services on a prepaid basis for at least 5 years or had an enrollment of at least 50,000 members to have an open enrollment period. During open enrollment, the HMO was required to accept individuals for membership without regard to preexisting illnesses, medical condition, or degree of disability.

There is for HMOs an incentive to seek qualified status under Title XIII and to meet these and other requirements. Once an HMO is qualified, it is able to take advantage of what is known as the dual choice requirement. Under this provision of Title XIII, an employer which is subject to the minimum wage provisions of the Fair Labor Standards Act and which employs at least 25 persons is required to include in its health benefits plan (if it has one, that is) the option of joining a federally qualified HMO serving the area.

As of January 1981, there were 242 HMOs in the country serving over 9 million people. In 1971, there had been only 39 HMOs serving 3.9 million people.

A survey conducted by InterStudy, a research organization in Minnesota, found operating HMOs to be distributed among the States, as follows, for July 1980:

TABLE 1. Operating HMOs by State, July 1980

State	Number of plans	Membership July 1980
Alabama	1	2,696
Arizona	4	161,859
California	32	3,992,388
Colorado	6	198,478
Connecticut	7	74,011
District of Columbia	3	185,849
Florida	8	147,125
Georgia	2	8,912
Hawaii	2	147,218
Idaho	1	11,381
Illinois	12	238,048
Indiana	2	27,769
Iowa	1	6,200
Kentucky	4	33,620
Louisiana	3	23,682
Maine	2	4,527
Maryland	11	96,517
Massachusetts	10	173,731
Michigan	10	224,529
Minnesota	10	409,632
Missouri	5	111,283
Nebraska	2	16,885
New Hampshire	1	11,185
New Jersey	9	148,401
New Mexico	2	20,001
New York	12	971,402
North Carolina	1	33,914
North Dakota	1	2,803
Ohio	12	247,033
Oregon	8	334,216
Pennsylvania	10	137,317
Rhode Island	4	34,918
South Carolina	1	5,654
Texas	8	93,536
Utah	2	27,901
Washington	7	390,403
West Virginia	3	14,431
Wisconsin	16	392,047
Guam	1	21,925
Total	236	9,183,397

Of the 242 operational HMOs, 120 are federally qualified. These 120 HMOs have a membership of over 6 million persons.

As of the end of FY80, 617 grants had been awarded under the HMO Act. These grants totaled $127.5 million.

By the end of FY80, 81 HMOs had received direct loans, totaling $168.6 million and 4 HMOs had received loan guarantees totaling $7.8 million.

Of the 120 currently qualified HMOs, 63 have received grants and loans, 19 have received grants only, 7 have received loans only, 3 have received loan guarantees, and 28 have received no assistance.

Authorization and appropriations for Title XIII are indicated in table 2.

TABLE 2. Budget history for Title XIII

	Authorizations*	Appropriations
FY79	$31 million	$ 3.0 million (grants)
		$1.5 million (technical assistance)
		$8.5 million (program support)
FY80	$65 million	$ 3.8 million (grants)
		$1.5 million (technical assistance)
		$9.2 million (program support)
FY81	$68 million	Appropriations bill not yet enacted

* for grants and contracts only

CURRENT ISSUES

On Mar. 10, 1981, the Reagan Administration proposed the following levels of funding for the Title XIII HMO program.

Proposed Budget Authority

(in millions of dollars)

1980	1981	1982
$54.5	$27.6	$8.2

The proposal for $27.6 million in 1981 and $8.2 million in 1982 required a rescission of $28 million for 1981 and a further reduction of $20 million in 1982 for the Title XIII authority.

According to the Reagan Administration, grant funds and loans would be provided in 1981 to complete the last stage of development of new HMOs or the expansion of a limited number of existing HMOs. The Reagan proposal would have terminated all grants to HMOs by 1982. According to the Administration, further development of HMOs can be funded through the private sector.

At a time of increasing concern about the need to limit Federal expenditures to balance the Federal budget, questions have been raised about the extent of private sector involvement in HMO development. An examination of available data on developing HMOs reveals that there were 226 preoperational HMOs in the country as of February 1981. According to a survey conducted by InterStudy, 82 of these are federally funded HMOs and 144 are privately funded. Table 3 indicates the distribution of these preoperational plans by State.

InterStudy also attempted to determine the source of support for privately funded preoperational HMOs. A very rough and preliminary survey of these plans indicates three major sources of funding. These are indicated in Table 4.

TABLE 3. Known preoperational plans by State as of February 1981

State	Total	Federally funded	Privately funded*
Alabama	4	2 GP	2 GP
Alaska	2	1 IPA	1 unknown
Arizona	8	0	6 IPA; 1 GP; 1 network
Arkansas	1	1 GP	0
California	23	5 IPA; 1 network	9 IPA; 6 GP; 2 unknown
Colorado	0	0	0
Connecticut	6	3 IPA; 1 staff	1 IPA; 1 unknown
Delaware	2	0	2 unknown
Florida	9	3 staff; 3 unknown	1 IPA; 1 GP; 1 unknown
Georgia	5	2 IPA	1 IPA; 1 GP; 1 unknown
Hawaii	2	0	1 GP; 1 unknown
Idaho	1	0	1 IPA
Illinois	8	1 IPA; 1 GP; 1 staff	5 IPA
Indiana	6	1 staff	1 IPA; 1 GP; 3 unknown
Iowa	1	0	1 unknown
Kansas	4	1 IPA; 3 GP	0
Kentucky	0	0	0
Louisiana	4	0	2 IPA; 1 GP; 1 unknown
Maine	2	1 IPA	1 network
Maryland	5	2 IPA	2 IPA; 1 GP
Massachusetts	15	5 IPA; 2 GP	5 IPA; 1 GP; 2 unknown
Michigan	10	1 IPA; 1 GP	6 IPA; 1 GP; 1 unknown
Minnesota	5	1 staff	1 IPA; 3 unknown
Mississippi	2	1 IPA; 1 GP	0
Missouri	7	2 IPA; 1 GP; 1 staff	2 IPA; 1 unknown
Montana	0	0	0
Nebraska	2	0	1 GP; 1 unknown
Nevada	1	1 GP	0
New Hampshire	0	0	0
New Jersey	9	1 IPA; 1 staff	5 IPA; 2 GP
New Mexico	0	0	0
New York	15	3 IPA; 3 staff	7 IPA; 1 GP; 1 unknown
North Carolina	6	1 staff	1 IPA; 2 GP; 2 unknown
North Dakota	4	2 GP	1 IPA; 1 GP
Ohio	5	1 GP	1 IPA; 2 GP; 1 unknown
Oklahoma	2	0	2 GP
Oregon	2	0	1 GP; 1 unknown
Pennsylvania	8	1 IPA; 2 GP; 1 unknown.	2 IPA; 2 unknown
Rhode Island	1	0	1 IPA
South Carolina	1	1 IPA	0
South Dakota	1	1 unknown	0
Tennessee	3	2 GP; 1 staf	0
Texas	14	2 IPA; 3 GP	2 IPA; 3 GP; 4 unknown
Utah	7	0	2 IPA; 2 GP; 3 unknown
Vermont	2	1 IPA	1 unknown
Virginia	3	1 IPA; 1 unknown	1 GP
Washington	4	1 IPA	2 IPA; 1 GP
West Virginia	2	1 GP; 1 unknown	0
Wisconsin	2	0	1 IPA; 1 unknown
Wyoming	0	0	0
Totals	226 plans	82 plans (24 GP; 36 IPA; 1 network; 14	144 plans (68 IPA; 36 GP; 2 network; 38 unknown)

staff; 7 unknown)

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*Includes prefeasibility stage

Group Practice Model (GP) refers to an HMO that contracts with a group of health professionals for the provision of health services to HMO members. The health professionals work out of a common facility, pool their income from practice as members of the group, distributing it among themselves according to a pre-arranged plan. If the HMO employs its physicians on a salaried basis, it is also referred to as a staff model.

Staff Model HMO is similar to the prepaid group practice HMO model except that the physicians are employees of the HMO, rather than independent contractors.

Individual Practice Association Model (IPA) -- An IPA is an organized group of independent practitioners and/or small groups of physicians gathered together for the purpose of deciding on what basis they shall contract for their services. In an IPA-type HMO, the HMO entity contracts with the IPA organization or directly with individual health professionals who agree to provide health services to HMO members in accordance with a compensation agreement. The health professionals work out of their individual offices and are usually reimbursed by the IPA on a fee-for-service basis.

Network Model -- The network HMO contracts with more than one medical group and/or IPA organization to deliver care to HMO members in different geographic locations. Each medical group or IPA provides a full range of comprehensive benefits and is contractually linked to a central point of accountability. The benefit package and premiums for each of the medical groups and IPAs in a network are often identical. The prepaid group practice network is characterized by separate and independent delivery points, of which the HMO member selects one to receive all health services. Most of the network programs in existence were developed by Blue Cross and Blue Shield Plans. The HMO Act does not specifically recognize this model and classifies such programs as IPAs.

TABLE 4. Estimates of funding sources for privately developing HMOs, February 1981*

Sources of funding/sponsor	Number of developing plans
Insurers (5)	11
Insurer & medical society	1
Other national firm (Medserco)	3
Subtotal	15
Blue Cross plans	4
Blue Shield plans	3
Blue Cross & Blue Shield	5
Blue Cross & medical society	2
Blue Cross & hospital	1
Blue Shield & hospital	1
Blue Shield & group practice & hospital	1
Blue Cross & Blue Shield & group practice	1
Subtotal	18
Medical societies	13
Multi-specialty group practice	8
Hospitals (1 or more)	7
Corporations	3
Foundations	1
Academic medical centers	1
University	1
County medical center	1
Partnership of physicians	2
Subtotal	37**
Total	70

* This list does not include approximately 50 plans which are in the "prefeasibility stage" of development and about 20 plans for whom the funding source is unknown.

** Of these plans it may be expected that the bulk of the development capital is coming from the sponsoring agency itself. Most of these 37 firms are health providers who plan to use existing health facilities, staff, and administrators to serve the HMO and who thus require less seed money. It is not uncommon,

however, for medical societies, hospitals, and group practices to solicit local employers and unions for relatively small amounts of additional funding.

Beyond assumptions about private sector investment in HMOs, other issues arise with regard to the locus of this investment. InterStudy's preliminary survey does not provide detailed information about the location of the service areas for these projected HMOs, but it is likely they will be developed in metropolitan areas. Questions arise about whether this leaves for the Federal Government a role to provide assistance for the establishment or expansion of HMOs in areas where the private sector has been reluctant to invest resources, namely rural areas and low-income communities. Some would argue that money can not be productively invested in such areas because of the difficulty in securing enrollments sufficient for the HMO to become financially viable. Others, however, suggest that with careful planning and selection HMOs can be successful in such areas and, in the process, serve as important providers of health care services in these communities.

The Administration also indicated its intention to introduce legislation that would amend requirements for the Federal qualification of HMOs. It would do so to increase incentives for private sector investment in the development in HMOs. Since the establishment of the title XIII authority in 1973, existing HMOs and potential developers of HMOs have argued that the various requirements specified in title XIII for Federal qualification have produced barriers to development and have prevented HMOs from competing effectively with the traditional fee-for-service system. There have been, for instance, proposals to amend title XIII's specifications for community rating, open enrollment, and basic benefits, and the 1976 and 1978 revisions of the title XIII authority modified these requirements. Most recently, there have again been proposals to modify these and other requirements for Federal qualification. At hearings before the House Energy and Commerce Committee on Mar. 19, 1981, the Health Insurance Association of America testified that both the comprehensive benefit package and the community rating requirements of title XIII do not allow the HMO to compete equitably with traditional health insurance plans that do not face such requirements or regulations. As a result, "the goal of injecting competition into the system may be thwarted if HMOs are effectively prohibited from competing." Others, such as Group Health Association of America, an organization representing HMOs across the country, suggest that requirements such as these provide distinguishing characteristics to HMOs and are a necessary part of the regulatory framework for providing Federal qualification to an organziation which can then request an employer to include it as an option in its health benefit plan under the dual choice provisions of title XIII.

Finally, as Congress considered legislation extending title XIII authority, other issues about the fiscal soundness of federally assisted HMOs arose. In 1978, the General Accounting Office (GAO) issued a report on 14 HMOs that it had examined. GAO found that only 3 of the 14 had a good chance of achieving financial independence within their first 5 years of operation after qualification and before the end of their eligibility for operating assistance. Five had only a fair chance of financial independence, and six had a poor chance.

More recently, the Office of Health Maintenance Organizations of the Department of Health and Human Services indicated that 28 qualified HMOs are experiencing financial problems serious enough to be considered in noncompliance with title XIII requirements for fiscal soundness. In addition, 10 qualified HMOs have gone out of business in the last 2 years.

Under such circumstances, questions were raised about the effectiveness of the screening process developed by the Office of HMOs for awarding Federal

assistance to applicants and for qualifying HMOs. Others suggested that such findings indicate that the Federal Government simply can not make decisions as effectively as the private sector about appropriate investments in financially viable HMOs.

Some people suggested that the financial difficulties of HMOs might be explained, in part at least, by the various requirements for Federal qualification. For example, does open enrollment and its implications for an HMO being required to accept a chronically ill person over age 65 create financial difficulties for the HMO? To what extent does the community rating requirement of title XIII result in higher premiums for HMOs and therefore fewer enrollees who decide to choose the less expensive experience-rated premium of the Blue Cross plan? What impact do these enrollees have on the revenues and expenses of HMOs?

The Congress considered legislation which proposed to phase out grant assistance to HMOs and to amend requirements for the Federal qualification of HMOs. On May 6, 1981, the Senate Committee on Labor and Human Resources marked up S. 1029 and ordered the bill favorably reported with amendments. On May 12, 1981, the House Committee on Energy and Commerce marked up a clean bill, H.R. 3398, and ordered it favorably reported with amendments. This bill was included in the House Reconciliation Act of 1981, H.R. 3982 passed June 26, 1981. S. 1029's authorizations were included in the Senate's Reconciliation Act passed June 25. Summaries of these bills follow under LEGISLATION. First, a description is provided of the various amendments of the Title XIII authority made by the Omnibus Budget Reconciliation Act of 1981.

LEGISLATION

The Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, included revisions and extensions of the Title XIII, HMO authority. Among other things, it authorizes for fiscal years 1982, 1983, and 1984 $20 million for grants and contracts for feasibility surveys and for the planning and initial development of HMOs which received such assistance during or before FY81. It authorizes $1 million for each of the fiscal years 1982 through 1984 for technical assistance and management training. The Reconciliation Act also authorizes such sums as necessary for fiscal years 1982 through 1984 in order to assure that the HMO loan fund has a balance of at least $5 million at the end of each fiscal year and to meet the obligations of this fund, including those resulting from defaults on loans. Finally, it extends the authority of loans and loan guarantees for initial costs of operation and extends eligibility for such assistance to private, for profit HMOs.

P.L. 97-35 also amends the various requirements for Federal qualification of HMOs. It deletes the list of supplemental health services which a qualified HMO can offer and specifies that these services mean any health service which is not included in the definition of basic health services. It revises the community rating requirements for qualified HMOs to allow HMOs to use a community rating system or a community rating by class system. The open enrollment requirement for qualification is repealed. Federally qualified HMOs would also be required to demonstrate every 2 years (or such longer period as regulations may prescribe) to the Secretary that they continue to meet the standards for qualification.

HMOs are also required to adopt an arrangement satisfactory to the Secretary to protect their members from incurring liability for any fees

which are the legal responsibility of the HMO. These arrangements may include hold harmless contracts with any hospital that is regularly used by the HMO member, insolvency insurance, adequate financial reserves, or other arrangements acceptable to the Secretary.

H.R. 3398 (Waxman et al.)

Included in the House Omnibus Reconciliation Act of 1981, H.R. 3982, as passed. Authorizes for each of the fiscal years 1982-84 such sums as may be necessary for grants and contracts for the planning and initial development of HMOs which received Title XIII assistance in FY81. To assure that the HMO loan fund has a balance of at least $5 million at the end of each fiscal year and to meet the obligations of this fund, including those resulting from defaults on loans, also authorizes for each of the fiscal years 1982 through 1984, $40 million, or such greater amount as may be necessary for these purposes.

Authorizes loan guarantees for planning and initial development to continue to be made between FY82 and FY84 for the purposes and under the circumstances currently specified in Title XIII and without regard to the entity having received assistance in FY81.

Extends eligibility for loans and loan guarantees for the initial costs of operation of HMOs to private, for-profit HMOs. Increases the aggregate amount of principal of loans made or guaranteed or both for initial costs of operation from $4.5 million to $7 million and increases the amount of such loans which may be disbursed in any 12-month period from $2 million to $3 million. Extends the authority for these loans through FY86. Repeals current restrictions on the amount of loan guarantees which can be made to for-profit HMOs in any fiscal year.

Extends eligibility for loans and loan guarantees for ambulatory health care facilities to private, for-profit HMOs. For loans and loan guarantees for ambulatory health care facilities, requires that the HMO provide certification that its revenues exceed its cost of operation. Also requires the HMO to provide assurances that during the period of the loan or loan guarantee its revenues will exceed its costs of operation (including the cost of repaying the loan). Also requires the HMO to provide assurances for loan assistance that it had been unable to secure a loan from the private market, and for a loan guarantee, that it would be unable to secure a loan without the Federal guarantee.

Amends provisions of Title XIII which specify the interest rate for loans awarded to HMOs to allow the Secretary to change the rate of interest on disbursements of loans, after an initial disbursement, to a rate prevailing for marketable obligations of the United States with comparable maturities.

Extends the authority for the National Health Maintenance Organization Intern Program and for the provision of technical assistance by the Secretary to HMOs. Authorizes for these purposes $1 million for each of the fiscal years 1982-84.

Clarifies Title XIII's requirement that an HMO be a legal entity which, as its primary purpose, provides health services in a specified manner.

Repeals the requirement that an HMO have an open enrollment period. Also repeals the requirement that one-third of the policy-making body of a private HMO be members of the HMO and that one-third of the advisory board of a

public HMO be members of the HMO. In addition, eliminates requirements that the HMO have a role for members in the planning and policy-making of the organization.

Deletes from the definition of the term basic health services which a qualified HMO must offer (1) short-term outpatient evaluative and crisis intervention mental health services and (2) medical treatment and referral services for the abuse of and addiction to alcohol and drugs. Adds the specification that an employer offering a federally qualified HMO may require the HMO to offer these services, for such payment as the HMO determines to be necessary to cover these services.

Deletes the list of supplemental health services which a qualified HMO can offer and specifies that the term "supplemental health services" means any health service which is not included in the definition of basic health services.

Revises Title XIII's requirements for community rating to allow a qualified HMO to determine its rates either under the community rating system of current law or on an actuarial per class basis.

Amends the dual choice provisions of Title XIII to require an employer which includes in a health benefits plan an HMO that is owned or controlled by a commercial insurance carrier or by a nonprofit carrier (such as Blue Cross/Blue Shield), either of which provides coverage to a substantial percentage of the residents of the service area of the HMO, to also include one other qualified HMO which provides services in an area where at least 25 employees reside and in the same manner (i.e., through a staff/group or IPA or individual physicians under contract) as the owned or controlled HMO (if such an HMO exists).

Amends those dual choice provisions of Title XIII which require an employer to include in its health benefits plan more than one federally qualified HMO. For purposes of an employer being required to offer a staff or group HMO in its health benefits plan, requires this HMO model to provide more than one-half of its basic health services through physicians or other health professionals who are members of the staff or group. For purposes of an employer being required to offer an IPA-HMO in its health benefits plan, amends Title XIII specifications to allow the employer to offer an IPA, or a plan providing basic health services through individual physicians and other health professionals under contract with an HMO, or a combination of IPA, staff, or physicians under contract.

Repeals the requirement that after the first four fiscal years after it becomes qualified, an HMO can not enter into contracts with physicians other than members of the staff, medical groups, or IPAs if the amounts paid under those contracts with other physicians for basic or supplemental health services provided by physicians exceed 15% (30% in rural areas) of the total estimated amount to be paid in that fiscal year to such physicians' services.

Repeals provisions which give priority for assistance to HMOs which serve medically underserved populations. The measure also repeals provisions which require a set-aside of appropriations for HMOs serving nonmetropolitan areas.

Amends the current law requirement that basic services be available and accessible to an HMO's members within the area served by the HMO promptly, in a manner which assures continuity, and when medically necessary, available 24 hours a day. Allows an HMO whose service area is located wholly in a

nonmetropolitan area to make a basic health service available outside its service area if the service is not a primary or emergency health service and if there is an insufficient number of providers of the service in the area served by the HMO.

Amends the requirements specifying that an HMO assume full financial risk on a prospective basis for the provision of basic health services to provide that an HMO may make arrangements with physicians or other health professionals, health care institutions, or any combination of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services.

Amends requirements for financial disclosure by qualified HMOs. Amends Title XV of the Public Health Service Act, Health Planning, sec. 1527, which prohibits a State from requiring a certificate-of-need for the institutional health services offered by an HMO, or combination of HMOs, which has more than 50,000 members. Amends this section to prohibit a State, effective July 1, 1982, from requiring a certificate-of-need for the institutional health services of an HMO, regardless of the number of members of the HMO.

H.R. 3398 introduced May 1, 1981; referred to Committee on Energy and Commerce. Ordered to be reported May 12, 1981. Included in the House Omnibus Reconciliation Act of 1981, H.R. 3982, passed by the House June 26, 1981.

S. 1029 (Hatch)

Continues Federal assistance only for those applicants which received funding under Title XIII prior to Oct. 1, 1981. Specifically extends the authorities for grants, contracts, and loan guarantees for the planning and initial development of HMOs which received assistance prior to Oct. 1, 1981. Continues for such applicants the authority for loans and loan guarantees for the initial costs of operation and allows the interest rates for such loans to vary from time to time so as to reflect changes in the rate of interest prevailing for marketable obligations of the United States with comparable maturities. Authorizes for such grants and contracts $15 million and for the HMO loan fund $35 million. Deletes provisions which give priority for assistance to HMOs which serve medically underserved populations. Also deletes provisions which require a set-aside of appropriations for HMOs serving nonmetropolitan areas.

Repeals the community rating and open enrollment requirements for Federal qualification.

Adds a "contractual model" to the staff, group practice, and independent practice association models already delineated in Title XIII to be eligible for Federal qualification. Specifies that under the contractual model, the HMO could contract with individual physicians to provide basic health services so long as these physicians agreed not to hold members of the HMO financially and personally liable for payment of services provided but not paid for by the HMO in the event of the HMO's default.

Amends the separate corporate entity requirement of Title XIII to allow an HMO to be part of another corporate entity if that entity provides assurances satisfactory to the Secretary that the HMO will remain financially viable for the duration of its certification for Federal qualification.

Requires HMOs to assure that members would not be held liable for the

costs of services provided by hospitals regularly used by the HMO. Provides that the HMO could either enter into "hold harmless" contracts with such hospitals, or secure default insurance for such protection, or maintain adequate financial reserves, or take other such measures as the Secretary considers appropriate for such purposes. Specifies that this requirement would not apply in States where law already requires an HMO to take "hold harmless" measures to protect its members.

Requires that HMOs periodically demonstrate to the Department of Health and Human Services, but no more frequently than every 2 years, that they are in compliance with requirements specified for qualification. Allows the Secretary to delegate to the States the responsibility for this accreditation but only to the extent he finds that a State is able and willing to do so.

Extends the authority for the National Health Maintenance Organization Intern program and for technical assistance to HMOs. Authorizes for these purposes $1 million for each of the fiscal years 1982 through 1984.

S. 1029 introduced Apr. 29, 1981; referred to Committee on Labor and Human Resources. Reported with amendments favorably May 15, 1981. Authorizations for S. 1029 were included in the committee's Reconciliation package for the Senate Budget Committee and in the Senate Omnibus Reconciliation Act of 1981, S. 1377, passed by the Senate June 25, 1981.

HEARINGS

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and Environment. Health maintenance organizations. Hearings, 97th Congress, 1st session. Mar. 18 and 19, 1981. Washington. Not yet printed.

U.S. Congress. Senate. Committee on Labor and Human Resources. Health maintenance organizations. Hearings, 97th Congress, 1st session. Apr. 22, 1981. Washington. Not yet printed.

CHRONOLOGY OF EVENTS

08/13/81 -- H.R. 3982 was signed into law as P.L. 97-35.

07/31/81 -- Senate passed conference report on H.R. 3982, the Omnibus Budget Reconciliation Act of 1981.

07/30/81 -- House passed conference report on H.R. 3982, the Omnibus Budget Reconciliation Act of 1981.

06/26/81 -- House passed Omnibus Reconciliation Act of 1981, H.R. 3982, as passed, containing provisions of H.R. 3398.

06/25/81 -- Senate passed Omnibus Reconciliation Act of 1981, S. 1377, containing authorizations for S. 1029.

06/10/81 -- Senate Labor and Human Resources Committee reported Reconciliation package containing authorizations for S. 1029.

05/12/81 -- House Committee on Energy and Commerce marked up H.R.

3398 and ordered the bill favorably reported with amendments (H.Rept. 97-88).

05/06/81 -- Senate Committee on Labor and Human Resources marked up S. 1029 and ordered the bill favorably reported with amendments (S.Rept. 97-127).

04/29/81 -- House Energy and Commerce Subcommittee on Health and Environment marked up H.R. 2480 and ordered a clean bill favorably reported with amendments.

04/27/81 -- S. 1029 introduced by Senator Hatch and referred to Committee on Labor and Human Resources.

03/17/81 -- H.R. 2550 introduced by Representatives Madigan and Broyhill and referred to the Committee on Energy and Commerce.

03/11/81 -- H.R. 2480 introduced by Representatives Waxman and Gramm and referred to the Committee on Energy and Commerce.

03/10/81 -- The Reagan Administration provided details about its FY81 and FY82 Budget Proposals for HMOs and indicated its intention to introduce legislation amending the title XIII authority.

ADDITIONAL REFERENCE SOURCES

Luft, Harold S. Assessing the evidence on HMO performance. Milbank Memorial Fund quarterly. Special issue: HMO promise and performance, v. 58, no. 4, Fall 1980: 501-536.

----- How do health maintenance organizations achieve their "savings"? Rhetoric and evidence. New England journal of medicine, v. 298, 1978: 1336-1343.

----- Trends in medical care costs: do HMOs lower the rate of growth? Medical care, v. 18, 1980: 1-16.

U.S. General Accounting Office. Can health maintenance organizations be successful? -- an analysis of 14 federally qualified "HMOs"; report to Congress by the Comptroller General of the United States. Washington, U.S. Govt. Print. Off., June 30, 1978. (Publication No. HRD-78-125)

U.S. Department of Health and Human Services. Justification of appropriation estimates for Committee on Appropriations, fiscal year 1982. v. 4, amended March 1981.

U.S. Department of Health and Human Services. Office of Health Maintenance Organizations. 5th annual report to the Congress, fiscal year 1979. Washington, U.S. Govt. Print. Off., 1981. Publication No. (PHS) 81-50138.