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Staff Questions With Responses of the Department of Health, Education, and Welfare

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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TOM VAIL, *Chief Counsel*

COMMITTEE ON FINANCE,
U.S. SENATE,
Washington, D.C.

Letter of Transmittal

DEAR MR. CHAIRMAN: On July 20, 1971, during the course of the Committee's Executive Session, the staff indicated the desirability of securing from the Department of Health, Education, and Welfare additional information with respect to the Health Maintenance Organization provisions in H.R. 1.

The HMO approach is a major and significant part of the Department of Health, Education, and Welfare's efforts to develop possible solutions to health care problems. In view of the broad implications and potential impact of the HMO alternative, it appeared valuable to develop as much substantive background information as possible for the Committee's use in evaluating the Department's views concerning specific aspects of HMO organization and operation, as well as their proposed policies with respect to quality of care and cost considerations.

The Department's responses to these staff questions, which appear on the following pages will, hopefully, assist the Committee in its evaluation of the HMO concept and its proposed implementation. As Under Secretary John G. Veneman notes in his covering letter, the preparation of answers to the staff questions also provided the Department with an opportunity to review their policies with respect to the HMO proposals.

Sincerely,

TOM VAIL,
Chief Counsel.

COMMITTEE ON FINANCE.
U.S. SENATE.
Washington, D.C., July 20, 1971.

Hon. JOHN G. VENEMAN,
Under Secretary, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. VENEMAN: The staff of the Finance Committee is developing information for the Committee's consideration of H.R. 1. In that regard, we certainly appreciate and acknowledge your assistance to date.

The Health Maintenance Organization provision in H.R. 1 is a key element in the bill and in your overall approach to health care and its financing.

In view of the importance and significance of the HMO provision, it would be appreciated if you could provide us, as soon as possible, with substantive responses to the enclosed series of questions relating to HMO's.

These questions should enable you to better prepare your presentation to the Committee. At the same time, your answers will undoubtedly provide valuable background for the Committee's consideration.

Thank you again for your cooperation.

Sincerely,

TOM VAIL,
Chief Counsel.

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., September 13, 1971.

Mr. TOM VAIL,
Chief Counsel, Senate Committee on Finance, U.S. Senate, Washington, D.C.

DEAR TOM: Enclosed are the responses to the questions on Health Maintenance Organizations requested in your letter to me dated July 20.

I regret the delay, but in view of the importance of the Health Maintenance Organizations to the Administration's health strategy we used the opportunity to review our policies in relation to H.R. 1 S. 1623, and S. 1182 with all the concerned agencies.

Sincerely,

JOHN G. VENEMAN,
Under Secretary.

Preface of Department of Health, Education, and Welfare to Submission of Finance Committee Questions-Answers

Since its initial legislative introduction as an option for Medicare beneficiaries, the health maintenance organization (HMO) approach has been further developed until it now represents a major element in this Administration's programs to improve the Nation's health care system. In this larger context, HMO is a generic term, encompassing a variety of organizational structures and approaches which have in common, the combination of financing and delivery mechanisms so that both consumers and providers have a stake in maintaining health and, when services are required, in assuring the most efficient and effective use of available facilities and services.

Legislation and administrative rules for each Federal program involving HMO's will of necessity include measures taking into account that particular program's beneficiaries, service benefit package, actuarial calculations, and other limitations. However, we intend that there be a consistent and compatible approach to HMO's from all the Federal programs, since regardless of the beneficiary population served—whether Medicare, Medicaid, Family Health Insurance, or the population covered by private health insurance—there must be safeguards or patient rights, assurance that services are in fact available, and that they meet appropriate quality standards. Thus, administrative rules under S. 1182 will be compatible with rules under H.R. 1 and S. 1623 to the end that HMO's given support through grants or loan guarantees will have the potential for qualifying as HMO's under Medicare, and the other program such as FHIP which may be adopted. It is desired that HMO's will serve a mix of the population, and thus be eligible under all the Federal as well as private programs. Hopefully, we can achieve a consistent means for evaluating the potential of HMO's to contract with the Federal Government for coverage of beneficiaries, so that an HMO would not have to meet unnecessarily different standards or contract requirements.

At the same time, it must be recognized that some organizations meeting the basic definitions of HMO may not wish to contract with any or all Federal programs through the capitation arrangement. Some HMO's may not be able to provide or arrange for all Medicare services, for example, it should be noted that the Medicare program currently provides an optional reimbursement approach for group practice prepayment plans and other entities whose patterns of operation and organization represent or approximate those we would expect of HMO's under Medicare. Although this reimbursement mechanism is related to specific services provided to beneficiaries, it does allow for determination and collection of deductibles and coinsurance on an actuarial equivalence basis. This optional payment approach would be retained and we expect that some HMO-type organizations, due to limitations on services or for other reasons, may wish to continue this

method of reimbursement under Medicare. At the same time, they may be able to contract as an HMO for Medicaid enrollees, or with the general population.

It should also be noted, that some organizations which may initially contract as HMO's for Federal beneficiaries, may subsequently be found deficient in performance under one or more programs—either through not providing the full range of covered services or for other reasons. Under these circumstances, the HMO contract might be terminated, but the providers associated with the organization could continue to be paid for providing services to beneficiaries under other fee for service or group practice prepayment methods.

As requested, the questions are answered here in terms of H.R. 1 and reflect HMO requirements and operation in general, as well as in specific application to Medicare and Medicaid.

Questions and Responses

1. In specific terms, for purposes of H.R. 1, how is a health maintenance organization defined? Does this definition differ from that in other HMO legislation? If so, how?

Response. The attached table (see Appendix) provides the H.R. 1 definition of an HMO, together with comparison of differences between H.R. 1, S. 1182 (The HMO Assistance Act), and S. 1623 (The National Health Insurance Partnership Act, Title I, National Health Insurance Standards, and Title II, Family Health Insurance Plan). The definitions are identical except for the following differences:

a. *Population coverage:* H.R. 1 speaks to Medicare beneficiaries and requires at least half of enrollees to be under age 65; S. 1623, FHIP, speaks to coverage of eligible families and requires that at least half of enrollees be neither FHIP nor Medicaid eligible; and S. 1182 and S. 1623, NHISA are generic definitions which do not have specific mention of population groups.

b. *Benefits and services covered:* H.R. 1 requires HMO's to provide or arrange for Parts A and B services of Medicare; S. 1623, FHIP, requires coverage of FHIP services and S. 1623, NHISA, requires coverage of at least NHISA services, S. 1182 has a broad generic definition of services to be covered, but mentions the minimum of physicians services, hospital care, emergency care, and preventive medical services.

c. *Minimum size:* The two titles of S. 1623 require a minimum of 10,000 enrollees, whereas H.R. 1 and S. 1182 do not speak to minimum size.

The differences in HMO definition in the various bills are not generally inconsistent or incompatible. They arise because of the nature of the HMO which combines capacity to deliver health services with the capacity to finance benefit packages. In general, an HMO is one which assumes responsibility for the maintenance of health of a defined population. This is not unlike the responsibility of a private physician to care for his patients. From the HMO standpoint, it should have the basic capacity to provide or arrange for any health services, which could include formal contractual arrangements with other providers. This is the kind of generic service package envisioned in the basic HMO Assistance Act (S. 1182), which would require a capacity to provide or arrange for any health services needed, but as a minimum would require the HMO to provide directly, or have formal arrangements for the provision and payment of, physicians care, hospital care, emergency care, and preventive services.

On the other hand, the H.R. 1 and S. 1623 legislation speak to the capacity of the HMO to provide directly or to arrange *and* pay for specific benefit packages for special population groups which enroll with them. An HMO may well have several different kinds of benefit packages for different population groups if it enrolls Medicare, Medic-

aid, FHIP, and private patients. Most HMO's now operating serve different groups with different packages, for example, the high and low option service packages available to the Federal employees.

2. What is the minimum size and financial resources required of an HMO in order to assure its economic, medical and insurance capacity to cope with the expense of enrollees who develop extremely high cost acute, chronic or unusual illnesses?

Response. We do not think it is desirable to set minimum requirements as to an HMO's size or financial resources. Different minimum size standards would be needed for different types of HMO organizations, and for HMO's in different types of localities, since we believe that such minimum standards will vary with the type of the organization. For example, we are exploring the possibility of requiring HMO's below a certain size to obtain performance bonds as a substitute for large reserves.

We recognize that the costs of catastrophic illnesses can present serious problems for some HMO's, and are therefore exploring additional means of safeguarding HMO's, and the Medicare program against the adverse impact of such costs. We are looking into the requirements of State law as to financial reserves for insurance companies, and are also exploring the possibility of permitting HMO's to reinsure against the cost of catastrophic illnesses. We recognize, too, that the small HMO, and the HMO in the rural or poverty area, is especially vulnerable to higher-than-anticipated costs that are the result not of unrealistic estimates or of inefficient management, but simply of random statistical variation. We are therefore considering permitting such HMO's to reinsure part of their total costs; it would of course be important, under such an approach, for the HMO to remain at risk for a substantial portion of its total costs to retain the desired financial incentives to keep costs down.

3. To what extent would an HMO be required to directly provide covered services through its own personnel and facilities? (For example, the Kaiser Health Foundation provides virtually the total range of health care services through its own operations.)

Response. H.R. 1 provides that a health maintenance organization must furnish health care services to its members "either directly or through arrangements with others * * * (through institutions, entities, and persons meeting the applicable requirements of section 1861)."

The emphasis in H.R. 1 is not on the HMO's direct ownership or employment of all the facilities and people it utilizes to provide health care services to its members. Rather, the important point is the control which the HMO is required to exercise over these facilities and personnel. For example, the bill would require an HMO to demonstrate to the Secretary's satisfaction proof of its financial capacity to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically; and to assure that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it established in accordance with regulations.

With respect to the Kaiser Foundation Health Plan, it should be pointed out that Kaiser provides health care services to its members in much the same way as an HMO would under the provisions of H.R. 1. The Kaiser health plan is not a single unit, but a large organization consisting of three major components. The overall Kaiser Foundation Plan, Inc. contracts with its members (groups and individuals) to arrange for medical and hospital services for them. It contracts also with about twelve separate Permanente medical groups (physicians' partnerships) for all physicians' and related paramedical services. It further contracts with the Kaiser Foundation Hospitals for hospital facilities and services, with the overall Kaiser Foundation Health Plan keeping responsibility only for out-of-area and certain special emergency benefits. Accordingly, it can be seen that the Kaiser Foundation Health Plan is neither a provider nor an insuring organization but subcontracts primary health care responsibilities to others qualified to perform them.

4. What proportion of HMO's are expected to be "full service" HMO's in the sense that they would directly provide—rather than arrange for—the major part of necessary health care services?

Response. Since every HMO would be expected to meet the requirements set forth in the law with regard to the services that must be provided, every HMO would therefore be considered to be "full service." As pointed out in the answer to question 3, the essential point is the responsibility which the HMO undertakes to provide these services, rather than whether the services are provided directly by the HMO's own employees or through arrangements with others.

We expect that effective management of total care needs can be accomplished under a variety of organizational structures, and we cannot predict the degree to which one organizational structure will predominate over another.

In general, these structures can be characterized in terms of two major dimensions: (1) the degree of centralization and control to the extent of owning and operating all or most facilities directly; and (2) the degree of commitment to prepayment, in terms of relative proportion of services devoted to the enrolled prepaying population versus also using resources for fee-for-service practice.

The Kaiser Foundation Health Plans and the Group Health Cooperative of Puget Sound represent HMO type arrangements which are highly centralized and highly committed. The HIP model and the Group Health Association in Washington, D.C., represent lesser degrees of centralization (i.e., use of community hospitals) and lesser degrees of commitment (i.e., some use of physician groups which have significant fee-for-service practice and/or relatively high use of part-time consulting specialists). Finally, the Medical Society Foundation model represents a high degree of decentralization among facilities and sources providing the services with prepayment commitments generally limited to specific beneficiary groups having specifically itemized benefit packages.

5. Would there be a minimum requirement of full-time medical staff in an HMO? If the answer is yes, what minimum ratios of full-time medical personnel to enrollees would you propose?

6. Would a minimum physician-enrollee ratio be required of a prospective HMO? If yes, what ratio?

7. Would a minimum admixture of basic medical specialties be required of physician-providers or organizers of an HMO or, for example, could they all be general practitioners?

If a range of specialties is required, what specialties must be adequately represented in an HMO medical group?

8. Are the medical specialists represented in an HMO or with whom it has arrangements required to have appropriate professional credentials for their specialties—such as board eligibility or certification for surgeons?

Response. While requirements will be established to assure adequate attention to and control over the quality of services provided by the HMO, we do not believe that ratios and numerical staffing requirements will necessarily achieve this goal. Since decisions regarding type, quantity and duration of services involve highly professional judgments, we intend to emphasize development of mechanisms and procedures to assure adequate professional review of the totality of services provided. Such review would encompass not only the care provided to individual patients but would also encompass general patterns of care in order to assure effective overall utilization of facilities and sources.

In the event we decide to set minimum requirements as to full-time medical staff and medical specialty representation or minimum physician-enrollee ratios, it would seem necessary that they vary with the population served by the HMO. In some areas, for example, virtually all surgery is performed by general practitioners and general surgeons; in other areas pediatricians and internists, rather than general practitioners, commonly provide the primary medical care services. Also, of course, some types of paramedical personnel might be available to HMO's in some localities, but not to others, and this factor would need to be taken into account in setting standards. HMO's can be expected to mirror these variations. An important consideration for us, in approaching issues relating to minimum requirements of various kinds, will be whether the HMO has the capability of providing Medicare beneficiaries with all needed Part A and Part B services that are reasonably necessary at an acceptable level of quality. One requirement we are giving serious consideration to is that each beneficiary be under the care of a primary physician who assumes responsibility for coordination of his services and for the continuity of his care.

9. Would an HMO be required to arrange for the full range of Medicare-covered services including optometry, podiatry, and possibly chiropractic care?

Response. For purposes of title XVIII, the definition of health maintenance organization would require the organization to provide all services covered under parts A and B of Medicare. The manner in which these services are furnished could differ among HMO's. For example, the optometry and podiatry services presently covered under

the law can be furnished by medical doctors or osteopaths specializing in the care of the eyes and feet or by optometrists or podiatrists. Therefore, an HMO would be free to provide these services in the manner best suited to its staff arrangements. There would be no requirement that each HMO employ an optometrist or podiatrist, but there would be nothing to preclude such an arrangement if the HMO so desired. Chiropractic care is not currently covered under Medicare.

Under Medicaid the range of services required to be provided would be tied to the individual State's coverage provisions. Although a comprehensive range of services is desirable, it is anticipated that in the course of the benefit package negotiations between the State agency and the HMO certain Medicaid services included in the State Plan may be excluded. Under existing legislation the responsibility for the range of services provided by the HMO resides in the State. The Medicaid eligible individual should continue to receive all services covered in the State Plan from sources outside the HMO where necessary.

10. Many months of work have been devoted to development of the HMO proposal. Presumably that effort has resulted in the development of a model HMO contract and the specific actuarial methodology which would be applied in developing a premium rate under an HMO contract. (For example, the actuarial methodology would obviously include factors adjusting for age cohorts, disabled persons, institutionalized persons, and characteristics such as income, race, sex, geographic location, etc. of those enrolled in relation to their proportions in the total eligible population in an area.) Would you please provide copies of (a) the model HMO contract and (b) the complete actuarial methodology which would be employed in calculating a premium rate? Additionally, for purposes of understanding precisely how the contract and actuarial calculations would be utilized, please provide (c) a sample completed contract and actuarial calculation applied to the conditions and situation of an HMO. (d) How would such calculations be made in the case of a new HMO as opposed to an existing HMO?

Response. (A) We are now working on a model contract under title XVIII and will forward it to you when it is completed. As you know, the Medicaid program has contracted HMO's to provide health services to the Medicaid eligibles. There is no standard contract per se under the Medicaid program. We are enclosing a contract which shows the usual characteristics of the ones which have been issued by the Department.*

(B) The basic methodology for calculating the actuarial equivalents under Medicare has been developed. The method will take into account the differences in utilization of services and the variation in cost due to age, sex, geographical location, and selection of risk. As the first step, the actuaries plan to calculate the standard rates based on the total population in the Nation. In other words, national rates will be calculated for each quinquennial age group and by male and female. Then these standard national rates will be applied to the age and sex distribution of the enrollees in an HMO.

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* The contract referred to was made a part of the official files of the Committee.

Geographical factors for each county of the United States will be derived based on the actual experience under the Medicare program. If a county has a reasonable cross section of different types of institutions and the practitioners and the HMO provides at least comparable quality care and comparable community service, then that county factor will be used to apply to an HMO located within that county. On the other hand, if the county does not have a reasonable cross section of institutions or practitioners, or a county covers too large or too small of an area relative to an HMO service area, then the actuaries plan to group more than one county together to derive the geographical factor or to identify a subsection of a county and derive a separate factor based on the data from the American Hospital Association and from the Bureau of Labor Statistics.

The standard national rates will be modified by the underwriting rules used by a particular HMO. Each HMO will be treated individually and this individual analysis will require the use of judgment and may need to be worked out in cooperation with the HMO. Complete and definite rules cannot be set down at least at this time. One factor which will be taken into account as a factor in determining the effect of selection of risks is the percentage of new enrollees who are institutionalized.

We are studying the necessity and technical feasibility of including additional variables in our basic methodology for calculating actuarial equivalents. It should be emphasized that determination of actuarial equivalence necessarily has to be based in part on individual consideration of a particular HMO and professional judgment in evaluating the organization. It is impossible to set down a mechanical procedure for calculating the geographical factor and the adjustments for selection of risks because there could be thousands of variations in these factors. Whenever an organization wants to become an HMO under the Medicare program, the Office of the Actuary will need to calculate the capitation rate. The potential HMO will decide whether or not it will wish to participate as an HMO after noting what its reimbursement rate will be.

In addition, we are considering the question of the extent to which retroactive adjustments to the prospective capitation payment may be necessary. It is anticipated, for example, that retroactive adjustments would be made for the difference in the projected population of an HMO and the actual enrollment; for any epidemics which might have occurred that affected costs; and for any *significant* deviation between the projected increase in health care costs and the utilization rate (on a nationwide basis) as compared to the actual experience.

We would expect that basically similar methodology would be used under Medicaid. However certain adjustments would be needed to take account of differences in the two programs, for example, to recognize that the HMO may not provide the full range of Medicaid-covered services in a particular State.

(C) As noted above, we are in the process of developing a sample contract.

(D) We are trying to develop reimbursement mechanisms that will permit new HMO's to participate in the program without being disadvantaged by the fact that accurate estimates of actual enrollment

(both in terms of numbers and in terms of demographic characteristics), and staffing may not be possible. Basically, we would propose that a prospective capitation be paid for those elements of HMO operation which can be reliably predicted in advance, and that interim rates be established, or other provision be made, for factors which cannot be reliably estimated.

11. If fee-for-service medicine has an inherent potential for overutilization to maximize profit, does the prepayment approach have an inherent potential for under-servicing to maximize return? What specific mechanisms, what specific procedures, and what specific criteria do you propose to employ to assure appropriate utilization and proper quality of care in HMO's? For example, how would you assure that necessary patient referrals to specialists outside of the HMO will be made when the referral costs the HMO money?

Response. We plan to assure appropriate utilization and quality through four specific means of control:

1. *Regulations.*—These will specify the minimum essential conditions of participation for all HMO's. The regulations will cover such areas as:

Legal structure;
Contract period and amendments to contracts;
Methods and amounts of capitation payments;
Responsibility for out-of-plan services;
Disclosure of information;
Specific mechanisms for internal quality control;
Staffing patterns, availability of services, location, qualifications of staff, assurance of prompt access;
Organizational elements and relationships;
Essentials of contractual arrangements where services are not provided directly;
Medical management, including choice of a managing physician for each beneficiary;
Unit record systems and ability to meet routine reporting requirements and sampling of encounter forms;
Enrollment procedures, information, and timing;
Fiscal resources and capacity; and
Procedure for consumer grievances and assessment of consumer satisfaction.

All providers used by the HMO will be required to meet all present Medicare quality standards.

2. *Contractual arrangements.*—Heavy reliance will also be placed on evaluating the extent and degree to which each HMO meets the basic standards. This will be done at the time of contract agreement and will necessarily rely on professional judgment to a great extent. The denial of an HMO contract would in no way interfere, however, with that organization's ability to receive Medicare payments through the usual fee-for-service or cost arrangements.

3. *Reporting and monitoring.*—Regular reporting of utilization data would be required of the HMO, including aggregate statistics as well as a sample of encounter forms. The Department is now in the

process of designing the reporting requirements for HMO's, and developing the kinds of criteria and indicators for poor utilization of low quality which would signal poor HMO performance. Such indicators can be developed and will signal the need for on-site medical and fiscal audits. Such audits, if confirming the poor performance, would result in termination of the contracts.

4. *Consumer information.*—There will be provision for enrollees to disenroll from HMO's with which they become dissatisfied. Disenrollment may take place during any open enrollment period or following adequate notice of intent to disenroll. Also, there will be requirements that the HMO regularly disclose to its enrollees and the public in its area of operation information about its services, utilization and quality indicators, such as proportion of certified specialists.

12. The largest portion of the health care dollar goes for institutional care. Where an HMO is established by a group of physicians who directly contribute their own services but who "arrange" for all other services (such as hospital care), is that HMO functioning as an insurance mechanism for the bulk of health care? And, in this example, is "comprehensiveness" descriptive of the "financing" being placed at one source as contrasted to the "care" itself? In this illustration the care is provided by and in a variety of settings under a variety of arrangements.

Response. If a group of physicians establishes an HMO and arranges for all nonphysician Medicare services to be furnished by outside providers (i.e., hospitals, extended care facilities, home health agencies, etc.) it would be carrying out in a sense an insurance function with respect to such care. However, since the physician makes the decision as to the type of care necessary for the patient, a physician group operating as an HMO has a direct and effective control over the utilization of services by the patient. This arrangement differs fundamentally from that of an insurance company which simply pays the bills and in practice has little control over the type of services or how much care is provided. Since the HMO physician group supervises the medical and related health care services wherever they are provided, it does have control over the quality of the care furnished and, through its financial arrangements with other providers, has leverage to see that the medically appropriate care is given.

13. If an insurance company—such as a Blue Cross or Blue Shield plan—establishes an HMO, exactly what medical care services would those plans provide directly? Or, would they, in effect, simply provide a legal structure and organizational "umbrella" covering a variety of arrangements with different types of health care providers? If the answer is yes, then isn't this basically an extension of the insurance function rather than the provision of care function?

Response. It is expected that there would be some variation in the organizational structure of HMO's, including HMO's that might be started by insurance mechanisms such as Blue Cross or Blue Shield. It is not intended, though, that the HMO merely provide a legal structure and organizational umbrella for various health care providers. It is expected that, in determining whether a given organization meets

the definition of HMO for purposes of participation in the Medicare program, an important criterion used will be whether the organization can organize and provide to its members care of acceptable quality, in a systematic and efficient manner. We would expect that the test of whether an organization met this criterion would differ for different types of organizations. For example, an HMO that does not provide services to its enrollees directly would have to demonstrate that it nevertheless was coordinating the health care services to its beneficiaries. Failure to provide care directly doesn't prevent it from providing care efficiently, and systematically, and from assuring the continuity and coordination of services to Medicare beneficiaries. Our intention would be to permit organizations to participate as HMO's—and thus qualify for reimbursement under the advantageous HMO formula—only if the over-all method of delivering services to beneficiaries represents an improvement over the method by which such services were made available to beneficiaries prior to implementation of the HMO provision.

14. Exactly what is the difference between a premium payment and a capitation payment for health care services?

Response. Premium payments and capitation payments are methods of paying in advance for the cost of health services. First, there are technical differences between what is intended to be understood by the two terms—e.g., different types of organizations are at risk with respect to the health care cost protection purchased, the rate-setting procedures differ and are subject to different State laws. Second, the term capitation is used when payment is made prospectively to the person or institution providing the care, so that he has an opportunity to tailor his expenditures to a specific amount of income. The successful cost and utilization controls achieved by group practice prepayment plans in the past has been attributed in part to the fact that such plans have been able to attract enrollees (or sponsoring organizations, such as unions), who have had a strong interest in using the capitation payment as a means of controlling costs and curbing unnecessary utilization of services, while maintaining quality of care. When these organizations have used capitation payment financing to obtain care, they have sought to pass on the effect of a prearranged payment to the reimbursement made to the physicians and institutions who provide the care.

15. Is there any maximum amount—in percentage or dollar terms—which an HMO could retain above the actual costs of providing care and overhead?

Response. H.R. 1 includes a specific provision designed to guard against retention of excessive profits or funds collected for services provided to Medicare beneficiaries. Under this provision the HMO's contract with the Secretary would require, following each accounting period, a certified public statement from the HMO of the amount and rate of retention for its Medicare enrollees and for all other enrollees. Generally, the HMO's permissible rate of retention with respect to its Medicare enrollees could not exceed the retention rate for its non-Medicare enrollees. This retention could be utilized by the HMO for any purpose it deems appropriate, such as increased incentive payments to physicians or general expansion of services.

If the rate of retention for Medicare HMO enrollees exceeds 90 percent of the rate for its other enrollees, a full audit would be required. Where, upon audit, the rate of retention for Medicare beneficiaries is determined to be excessive, the HMO would be required to repay the excessive amount to the trust funds unless the monies are used to provide additional benefits or reduce the premium rates of Medicare beneficiaries. An excessive rate of retention is (1) a rate of retention for Medicare enrollees which exceeds the rate for other enrollees or (2) if more than one-half of the HMO membership is over age 65, a rate which exceeds the rate of retention of comparable organizations for non-Medicare enrollees.

16. HMO's would seem to have the greatest potential for enrollment in heavily-populated areas. Would it be good public policy for an aged beneficiary enrolled in an HMO in California to receive, perhaps, twice as much in Medicare benefits as an older beneficiary in rural Iowa who was not enrolled in an HMO? For example, where an HMO's total costs and retention amounted to 50 percent of per capita costs the other 45 percent of premium would be passed on to the HMO-enrolled beneficiary in the form of reduced or eliminated deductibles, coinsurance, and co-payment requirements or perhaps increased benefits. Should some upper limit be established on the percentage of premium which might be utilized to increase benefits or decrease cost-sharing?

Response. It is highly improbable that under the reimbursement formula for HMO's in H.R. 1 a 45 percent share of the premium would be passed on to HMO beneficiaries. The current optimum estimate for an efficient HMO with a background of practical experience in the provision of health services would be no more than 10 percent and more likely in the 2 percent to 5 percent range. It would not be judicious to penalize an efficient HMO if it is providing comparable health services at a much lower cost.

Placing limitations on an effective health care system in an urban area simply because such a system is not yet available in a rural area would be contrary to the national goal of encouraging alternative systems for the delivery of quality health services. Regional variations exist now under the current health care delivery system. The Administration is hopeful that with the enactment of the proposed HMO Assistance Act of 1971, the National Health Insurance Partnership Act, and H.R. 1, the possibility of developing additional HMO's in medically deprived areas would be significantly enhanced.

17. The most recent HEW statistics reveal that 19 percent of Medicare beneficiaries account for some 68 percent of total program costs. Thus, the remaining 81 percent of the people enrolled in Medicare could be provided full benefits for 32 percent of total per capita costs. In view of these facts, what specific procedures have been developed to assure that an HMO seeks enrollment from among the total aged population and that the HMO does not in fact "screen out" high-cost elderly applicants while maintaining an appearance of "open" enrollment? How is it proposed to identify and prevent an HMO with restricted capacity and an overabundance of applicants from "selecting out" those persons who are high-risk?

18. If an HMO's enrollment comes from employed groups, with its Medicare eligibles derived from retirees or employees of those employed groups, to what extent would that HMO be required to accept aged beneficiaries outside of those employed groups?

Response. We would include in regulations requirements that the HMO make its coverage available to qualified applicants on a first come first served basis, and we would develop procedures for checking on an HMO's performance in this area. It should be noted, though, that the HMO's enrollment will not in most case be totally "open." Many Medicare enrollments, perhaps most, will come from enrolled members of employed groups reaching 65 or becoming disabled. Finally, we believe it would be infeasible to completely eliminate the possibility of skewed Medicare enrollment arising from selection—including self-selection—of risks, whether deliberate or inadvertent, as a result of factors related to income, geographic location, awareness of the advantages, access or membership based on employment-related enrollment. We intend, therefore, to adjust the capitation payment made to an HMO to reflect, to the extent possible, its actual enrollment and not to assume the enrollment consists of typical patients.

19. Beneficiaries presently covered under Medicare with high medical care costs, such as the institutionalized aged, are most likely, because of their extensive need for care, to have long-established relationships with certain providers and practitioners. Is it reasonable to assume that a substantial proportion of these high-cost beneficiaries would abandon their existing relationships to enroll in an HMO? Why? Assuming that those beneficiaries with high medical care needs and costs do not abandon their existing sources of care and service, would those initially enrolling in HMO's then constitute a nonrepresentative relatively low-cost segment of the aged population? And, for such skewed enrollment, would their per capita costs be significantly lower than 95 percent of overall per capita costs—at least during the first several years of HMO operation?

Response. We cannot assume that the Medicare beneficiaries enrolled in HMO's will be a representative cross-section of all Medicare beneficiaries. The actuarial adjustments will take into consideration skewed enrollment by providing adjustments in the capitation rate.

It is, of course, true that HMO's wanting to participate under Medicare will be faced with the problem of attracting Medicare beneficiaries. Some existing prepaid group practice plans will have been participating under Medicare and will have Medicare enrollees who may wish to continue their enrollment when the plan becomes HMO. Furthermore, we can anticipate some HMO's will be able to offer special advantages to Medicare beneficiaries to make participation more attractive, such as the availability of broader services than are covered by Medicare without charge other than the capitation or payment by the plan of Medicare deductible and/or coinsurance amounts. We would hope, too, that as the superior performance of HMO's become better known, they will attract more and more members. Furthermore, if the plan can operate as is anticipated, they will be able to offer added benefits financed in part from the profit from the capitation paid by Medicare. Finally, under H.R. 1, an HMO must use its retention rates be-

yond the normal retention rate of its enrollees under age 65 for additional services without charge to the Medicare enrollee or return the money to the Department of Health, Education, and Welfare. Consequently, there will be incentives for the HMO's to use funds in excess of normal retention to provide additional services to Medicare enrollees.

20. H.R. 1 mandates payment of "reasonable" premiums by the medically-indigent as well as authorizing States to apply various deductible and co-payment requirements with respect to services used by such persons. How would premium and any deductible and co-payment requirements be supplied with respect to medically-indigent persons enrolled in an HMO? How would the medically-indigent be identified in advance of their use of covered services so that appropriate premiums could be charged?

If not identified in advance, would premiums be charged only when services had been used and would that constitute "adverse selection?"

Response. Assuming that the State has a medically needy program and identifies such individuals in advance of a need for services, they would be offered the choice of enrolling in an HMO in the same way as the categorically needy. The collection of the premium required of the medically needy by H.R. 1 could be handled in one of two ways: (a) it could be collected by the HMO, with the difference between the premium amount and the full HMO capitation being paid for by the State: (b) it could be paid to the States, with the State then paying the full HMO capitation as it would for the caegorically needy.

If the HMO normally includes various forms of co-payments and deductibles, the medically needy enrollee would be required to comply. This could be combined actuarially with the premium in such a way that the HMO enrollee would not pay more in cost-sharing than the non-HMO person.

The medically needy would be identified in the same manner as the categorically needy, on the basis of income level. If not identified in advance and at a time coincident with an open enrollment period of the HMO, the medically indigent would not be covered by the HMO, except possibly on a one-time, fee-for-service basis.

21. Would the difficulties inherent in the collection of deductibles and co-payments from a low-income population deter an HMO from seeking enrollment from among the medically-indigent?

Response. Yes, this difficulty might very well deter HMO's from seeking enrollment among the medically needy. If an HMO does not charge co-payments and deductibles to its regular enrollees, the State should be given the option of excusing the medically needy who enroll in HMO's from paying deductibles and co-payments. This would encourage the medically needy to enroll in HMO's. The incentive matching for HMO's provided by Section 207 of H.R. 1 would make up to the States the potential loss incurred by this.

If the State chooses or is required to charge co-payments and deductibles to medically needy who enroll in HMO's which do not ordinarily

collect such payments from their regular enrollees, this could be done by calculating the actuarial value of the co-payments and deductibles, and adding this amount to the premium.

22. An HMO may own its own hospital, pharmacy, laboratory, radiological service and extended care facility. Can the HMO reimburse its related facilities and services on any basis—charges, costs, etc.—it desires?

23. If the HMO can pay charges could it increase charges levied by related organizations for covered services (such as laboratory and X-ray) so as to absorb any "excess" premium and evade retention limits which would otherwise have been available for coverage improvements and thus maximize its profits?

Response. We recognize that since HMO's will be permitted to obtain services from closely related organizations, it will be necessary to safeguard the Medicare program against evasion of the rule limiting HMO retention amounts through excessive payments to such related organizations. In determining retention amounts, we anticipate adopting policies concerning payments by HMO's to related organizations that are consistent with our policies with respect to related organizations under Medicare generally. Similarly, the present rules on compensation of owners would be applied to the retention calculation for HMO's.

Since, generally, payments—other than retention—are not proposed to be based on the costs of the HMO, excessive payments made by the HMO would not normally be of concern. In the event cost were made the basis for some payments, the Medicare rules on reasonableness of costs, related organizations, and compensation of owners would apply.

24. Certain State hospital associations have expressed interest in establishing HMO's. If such HMO's were established could the member hospitals throughout a State then pay themselves for hospital care on a charges basis as opposed to Medicare and Medicaid's present system of controlled cost reimbursement?

Response. One crucial question with respect to whether any organization, including a State hospital association, could participate under Medicare as an HMO would be whether it could demonstrate that it could provide, within the reimbursement limits established by H.R. 1, all reasonably necessary Part A and Part B services to Medicare beneficiaries in a manner that assures that the beneficiary receives services of an acceptable level of quality. The coordination of services and continuity of care intended to be achieved under the HMO's would have to be demonstrated.

Systems of reimbursement that would be acceptable would have to be such that they develop incentives for the efficient and effective provision of services. One problem that would have to be solved if the case cited developed might be that the base for costing services—the amount of cost in a non-HMO setting—might be hard to arrive at if there were only an HMO (and no non-HMO arrangements) in the area served. Other areas might serve as adequate standards but if other areas could not serve, the issue of whether excessive amounts were being reimbursed would have to be faced directly.

25. An HMO, under its arrangement with a hospital, may agree to pay that hospital's charges—in contrast to Medicare costs—for services to an HMO beneficiary. Assume two Medicare beneficiaries (one an HMO enrollee) each in equal need of hospital care, and only one bed available in the hospital. Could the regular Medicare beneficiary be disadvantaged in competing for the available bed because the HMO might pay the hospital $10 or $15 more a day than would be paid under the Medicare reimbursement formula?

Response. There is a possibility that in isolated cases a regular Medicare beneficiary might be disadvantaged in competing for an available hospital bed because the HMO might pay more than would be paid under the Medicare reimbursement formula. We do not believe this will be widespread. First, if HMO's give a larger profit to hospitals than do others, their competitive position will be weakened. This difference could be made up from reduced use and if hospitals cooperate in the reduction, a reward to them may be warranted. In many cases of hospitals with both HMO and non-HMO services (some HMO's will use their own hospitals and virtually no non-HMO patients will be admitted), the HMO physicians (and patients) will make up a minority. If the hospital makes a practice of giving undue preference (unreasonable in terms of patient condition) to HMO enrollees because of the improved profit potential, we are sure the balance of the physicians on the hospital staff will protect their rights, and those of their patients in regard to admitting procedures.

26. Could a teaching hospital organize an HMO and pay itself for "teaching" or "supervisory" physician services on a fee-for-service basis even though the conditions of Section 227 of H.R. 1 were not met? If so, would this serve to inflate benefit costs and leave less, if any, of the premium for coverage improvements or reduction in deductible and co-payment requirements?

Response. We would expect that any HMO that incurred teaching costs could include such costs, subject to criteria in regulations that would be consistent to the extent possible with the provisions of section 227 of H.R. 1. We would intend that the Medicare program would not pay twice for services rendered in a teaching setting. And, while supervisory physicians might be members of a medical group by which they were reimbursed on a fee-for-service basis, our intention would be to limit the HMO's capitation payment to such a group to an amount consistent with the Medicare program's more general policies concerning reimbursement of physicians in a teaching setting. One way of reflecting this policy would be to provide that if a resident provided a service in the HMO setting, the base for comparison in determining how much the service would have cost elsewhere would be the cost of a comparable service by a resident elsewhere.

27. In the actuarial calculation of per capita costs from one year to the next, will the calculation be based upon the cost of providing the statutory benefits only or would it also include the cost of such increased benefits or reduced deductibles and co-payments which the HMO's experience enables it to provide?

Response. Reimbursement under Medicare will be made only with respect to services covered under Medicare. H.R. 1 specifically states that the capitation rate should be equal to 95 percent of the amount that would be payable for services covered under Medicare if such services were to be furnished by other than HMO's. Thus, the actuarial calculation from one year to the next will be based on the cost of these services as covered under the Medicare program. If the HMO covers the SMI copayments, or provides other noncovered benefits, the medical payment would not be increased thereby. We would expect an essentially similar approach to be followed under Medicaid. However, specific negotiation of amounts will be the prerogative of the State agency.

28. Would the premium paid to an HMO be adjusted to reflect differences in the type of hospital or hospitals with which it has arrangements? For example, would any reduction be made where the HMO has arranged for care in a nonteaching hospital as opposed to a teaching hospital?

Response. It is anticipated that the use of geographical factors in our basic methodology for determining actuarial equivalence will offer some assurance that the hospital services received by HMO enrollees are reasonably comparable to the services provided by other institutions in the HMO's area. Our adjustments for such basic factors as utilization of services, age, and selection of risk will also, of course, provide some adjustment for variations in types of hospital services utilized. We are investigating the possibilities for developing more refined adjustments for differences in types of hospitals providing services, since we recognize that failure to take adequate account of this factor could result in severe hardship for certain HMO's having arrangements with major teaching hospitals and possible advantage to HMO's that contract with hospitals with less than average teaching costs.

29. Would unpaid deductible, copayment and coinsurance amounts be a risk assumed by the HMO or would such bad debts be separately reimbursable by the public programs?

Response. We believe that any unpaid deductible, copayment and coinsurance amounts should not be reimbursed separately by Medicare.

An HMO can charge its Medicare enrollees a premium to cover the value of deductibles and coinsurance. If the HMO provides such enrollees only those services covered under Parts A and B of Medicare, its premium rate cannot exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under Medicare if they were not enrolled in an HMO. This amount for the deductibles and coinsurance would be converted into a monthly premium amount which would be charged each beneficiary unless absorbed by the HMO under its capitation payment. The Secretary will be responsible for assuring that these premiums are not excessive. The premiums would be billed in advance on a periodic basis. The regulations will allow the HMO to terminate a beneficiary's plan membership if he fails to pay such premiums timely. Thus the amount of bad debts for failure to pay the deductible and coinsurance should be small.

In addition, allowance for bad debts should be made in the computation of the capitation payment. Where bad debts resulting from uncollectible deductibles and coinsurance amounts are of the kind included as a proper item of cost in determining reimbursement to hospitals, extended care facilities, and home health agencies, they would be automatically reflected in the base cost to the program on which the HMO reimbursement would be determined.

30. How do "health maintenance" services differ from what are ordinarily regarded as diagnostic and therapeutic services?

Response. Health maintenance services include the conventionally accepted diagnostic and therapeutic health benefits, but may also include broader services to the extent they can be provided and financed; e.g., periodic examinations; complete immunization programs; surveillance of dietary, personal, and social situations which can detract from health; tuberculosis and other special programs where indicated; etc. Even without such additional programs, however, a major function of the HMO would be the coordination of the individual's medical program to ensure that he has access in an orderly and supervised way to the full range of needed health care services.

31. Would an HMO be required to emphasize "health maintenance" services over ordinary diagnostic and therapeutic services? If so, how and in what proportions?

Response. As noted in the answer to question 30, "health maintenance services" is a generic term which includes the usual diagnostic and therapeutic services, although it may also include additional services. It is anticipated that the basic Medicare package of hospital and medical services would continue to receive major emphasis, with additional services being included to the extent that they are covered under the program.

32. In terms of the aged population which has high morbidity, exactly what would "health maintenance" consist of in an HMO?

Response. The basic concept of a health maintenance system is to provide the proper medical care in the appropriate setting. With the choice of levels of care available through an HMO, it is expected that elderly patients with chronic diseases, such as emphysema or heart disease, will receive more total supportive care outside the hospital setting than is available to non-HMO enrollees. It is also expected that the HMO setting will provide better overall medical supervision of potential problems, thus preventing, as much as is possible with an aged group, the need for high cost institutional care.

33. Is an HMO, as envisaged in H.R. 1, expected to provide an annual physical examination or other thorough medical screening procedure for each older beneficiary enrolled?

Response. It is expected that such a procedure will be offered as an inducement to the older beneficiary to enroll in an HMO. We cannot, of course, specifically require that an HMO offer such services, since the current Medicare program does not cover routine physical examinations. However, since HMO's emphasize preventive care, we believe that many will, as a matter of policy, offer such services without charge to Medicare beneficiaries.

34. Medicare's benefit structure does not include coverage of routine annual exams or immunizations, thus the annual per capita costs calculation would not include such costs. How would the costs of such services be paid for the Medicare beneficiary enrolled in an HMO?

Response. H.R. 1 would permit an HMO to provide to its enrollees services in addition to those basic Medicare benefits required to be provided to all Medicare beneficiaries, with the proviso that the HMO must furnish the enrollees with information on the portion of its premium rate applicable to such additional services. Accordingly, routine annual examinations, immunizations, and other additional health care services not covered in the basic Medicare package could be provided on a prepayment basis to Medicare beneficiaries if they elected to receive them.

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APPENDIX

Comparison of HMO Provisions in Various Bills

H.R. 1 Social Security Amendments of 1971	S. 1182 Health Maintenance Organization Assistance Act of 1971
§ 226(b) of H.R. 1—The term "health maintenance organization" means a public or private organization which—	§ 1102 (of new title XI of the Public Health Service Act) (1) (and for the purposes of title VII) the term "health maintenance organization" means a public or private organization which—
(1) provides, either directly or through arrangements with others, health services to individuals enrolled with such organization under subsection (e) of this section, on a per capita prepayment basis;	(1) Same, excluding reference to subsections of H.R. 1
(2) provides, either directly or through arrangements with others, to the extent applicable in subsection (c) (through institutions, entities, and persons meeting the applicable requirements of section 1861 of the Social Security Act) all of the services and benefits covered under parts A and B of this title. [title XVIII]	(2) provides, either directly, or through arrangements with others and through institutions, entities, and persons meeting the applicable requirements of sec. 1861 of the Social Security Act, all those health services which a defined population might reasonably require in order to be maintained in good health, including as a minimum: —emergency care, —inpatient hospital and physician care, and —outpatient preventive medical services —ambulatory physician care
(3) provides physicians' services (A) directly through physicians who are either employees or partners of such organization, or (B) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis;	(3) same
(4) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;	(4) same
(5) except as provided in subsection (h), has at least half of its enrolled members consisting of individuals under age 65;	(5) Not applicable

S. 1623 NATIONAL HEALTH INSURANCE PARTNERSHIP ACT TITLE I—NATIONAL HEALTH INSURANCE STANDARDS	S. 1623 NATIONAL HEALTH INSURANCE PARTNERSHIP ACT TITLE II—FAMILY HEALTH INSURANCE PLAN
604(a) [of new title VI of the Social Security Act] The term "health maintenance organization" means a public or private organization which—	§ 628(b) [of new title VI of the Social Security Act] The term "health maintenance organization" means a public or private organization which—
(1) Same, excluding reference to subsections of H.R. 1	(1) Same, except that it refers to individuals enrolled under subsection (e) of Sec. 628 of the new title VI of the Social Security Act
(2) provides (through institutions, entities, and persons meeting the applicable requirements of section 1861 of the Social Security Act), all of the services and benefits covered under section 603; [of the new title VI of that Act]	(2) provides, to the extent applicable in subsection (c) of this section (through institutions, entities; and persons meeting the applicable requirements of section 1861), all of the services covered under this part [Part B of new title VI of the Social Security Act]
(3) same	(3) same
(4) same	(4) same
(5) requires that the HMO have: not less than ten thousand enrolled members;	(5) except as provided in subsection (h) and (i) of this section, has not less than ten thousand enrolled members at least half of whom are not covered under the family health insurance plan and are not eligible for medical assistance under a State plan approved pursuant to title XIX;

H.R. 1 Social Security Amendments of 1971	S. 1182 Health Maintenance Organization Assistance Act of 1971
(6) assures that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and	(6) same, but requires authorization of regulations by Secretary
(7) has an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of paragraph (5))	(7) same, except for: 1. Exclusion of references to subsections of H.R. 1 2. Inclusion of waiver in the case of conflict with provider conditions under title XVIII or new title VI of Social Security Act

S. 1623 NATIONAL HEALTH INSURANCE PARTNERSHIP ACT TITLE I—NATIONAL HEALTH INSURANCE STANDARDS	S. 1623 NATIONAL HEALTH INSURANCE PARTNERSHIP ACT TITLE II—FAMILY HEALTH INSURANCE PLAN
(6) same, but requires authorization of regulations by the Secretary	(6) same,
(7) same, excluding references to subsections of H.R. 1	(7) same, but requires authorization of regulations by the Secretary